

By the Committee on Health, Aging, and Long-Term Care; and  
Senators Jones and Saunders

317-2695-03

1                                   A bill to be entitled  
2           An act relating to medical malpractice;  
3           providing legislative findings; amending s.  
4           46.015, F.S.; revising requirements for setoffs  
5           against damages in medical malpractice actions  
6           if there is a written release or covenant not  
7           to sue; creating s. 381.0409, F.S.; providing  
8           that creation of the Florida Center for  
9           Excellence in Health Care is contingent on the  
10          enactment of a public-records exemption;  
11          creating the Florida Center for Excellence in  
12          Health Care; providing goals and duties of the  
13          center; providing definitions; providing  
14          limitations on the center's liability for any  
15          lawful actions taken; requiring the center to  
16          issue patient safety recommendations; requiring  
17          the development of a statewide electronic  
18          infrastructure to improve patient care and the  
19          delivery and quality of health care services;  
20          providing requirements for development of a  
21          core electronic medical record; authorizing  
22          access to the electronic medical records and  
23          other data maintained by the center; providing  
24          for the use of computerized physician order  
25          entry systems; providing for the establishment  
26          of a simulation center for high technology  
27          intervention surgery and intensive care;  
28          providing for the immunity of specified  
29          information in adverse incident reports from  
30          discovery or admissibility in civil or  
31          administrative actions; providing limitations

1 on liability of specified health care  
2 practitioners and facilities under specified  
3 conditions; providing requirements for the  
4 appointment of a board of directors for the  
5 center; establishing a mechanism for financing  
6 the center through the assessment of specified  
7 fees; requiring the Florida Center for  
8 Excellence in Health Care to develop a business  
9 and financing plan; authorizing state agencies  
10 to contract with the center for specified  
11 projects; authorizing the use of center funds  
12 and the use of state purchasing and travel  
13 contracts for the center; requiring the center  
14 to submit an annual report and providing  
15 requirements for the annual report; providing  
16 for the center's books, records, and audits to  
17 be open to the public; requiring the center to  
18 annually furnish an audited report to the  
19 Governor and Legislature; amending s. 395.004,  
20 F.S., relating to licensure of certain health  
21 care facilities; providing for discounted  
22 medical liability insurance based on  
23 certification of programs that reduce adverse  
24 incidents; requiring the Office of Insurance  
25 Regulation to consider certain information in  
26 reviewing discounted rates; creating s.  
27 395.0056, F.S.; requiring the Agency for Health  
28 Care Administration to review complaints  
29 submitted if the defendant is a hospital;  
30 amending s. 395.0193, F.S., relating to peer  
31 review and disciplinary actions; providing for

1 | discipline of a physician for mental or  
2 | physical abuse of staff; limiting the liability  
3 | of certain participants in certain disciplinary  
4 | actions at a licensed facility; amending s.  
5 | 395.0197, F.S., relating to internal risk  
6 | management programs; requiring a system for  
7 | notifying patients that they are the subject of  
8 | an adverse incident; requiring risk managers or  
9 | their designees to give notice; requiring  
10 | licensed facilities to annually report certain  
11 | information about health care practitioners for  
12 | whom they assume liability; requiring the  
13 | Agency for Health Care Administration and the  
14 | Department of Health to annually publish  
15 | statistics about licensed facilities that  
16 | assume liability for health care practitioners;  
17 | requiring a licensed facility at which sexual  
18 | abuse occurs to offer testing for sexually  
19 | transmitted diseases at no cost to the victim;  
20 | creating s. 395.1012, F.S.; requiring  
21 | facilities to adopt a patient safety plan;  
22 | providing requirements for a patient safety  
23 | plan; requiring facilities to appoint a patient  
24 | safety officer and a patient safety committee  
25 | and providing duties for the patient safety  
26 | officer and committee; amending s. 456.025,  
27 | F.S.; eliminating certain restrictions on the  
28 | setting of licensure renewal fees for health  
29 | care practitioners; directing the Agency for  
30 | Health Care Administration to conduct or  
31 | contract for a study to determine what

1 information to provide to the public comparing  
2 hospitals, based on inpatient quality  
3 indicators developed by the federal Agency for  
4 Healthcare Research and Quality; creating s.  
5 395.1051, F.S.; requiring certain facilities to  
6 notify patients about adverse incidents under  
7 specified conditions; creating s. 456.0575,  
8 F.S.; requiring licensed health care  
9 practitioners to notify patients about adverse  
10 incidents under certain conditions; amending s.  
11 456.026, F.S., relating to an annual report  
12 published by the Department of Health;  
13 requiring that the department publish the  
14 report to its website; requiring the department  
15 to include certain detailed information;  
16 amending s. 456.039, F.S.; revising  
17 requirements for the information furnished to  
18 the Department of Health for licensure  
19 purposes; amending s. 456.041, F.S., relating  
20 to practitioner profiles; requiring the  
21 Department of Health to compile certain  
22 specified information in a practitioner  
23 profile; establishing a timeframe for certain  
24 health care practitioners to report specified  
25 information; providing for disciplinary action  
26 and a fine for untimely submissions; deleting  
27 provisions that provide that a profile need not  
28 indicate whether a criminal history check was  
29 performed to corroborate information in the  
30 profile; authorizing the department or  
31 regulatory board to investigate any information

1 received; requiring the department to provide  
2 an easy-to-read narrative explanation  
3 concerning final disciplinary action taken  
4 against a practitioner; requiring a hyperlink  
5 to each final order on the department's website  
6 which provides information about disciplinary  
7 actions; requiring the department to provide a  
8 hyperlink to certain comparison reports  
9 pertaining to claims experience; requiring the  
10 department to include the date that a reported  
11 disciplinary action was taken by a licensed  
12 facility and a characterization of the  
13 practitioner's conduct that resulted in the  
14 action; deleting provisions requiring the  
15 department to consult with a regulatory board  
16 before including certain information in a  
17 health care practitioner's profile; providing  
18 for a penalty for failure to comply with the  
19 timeframe for verifying and correcting a  
20 practitioner profile; requiring the department  
21 to add a statement to a practitioner profile  
22 when the profile information has not been  
23 verified by the practitioner; requiring the  
24 department to provide, in the practitioner  
25 profile, an explanation of disciplinary action  
26 taken and the reason for sanctions imposed;  
27 requiring the department to include a hyperlink  
28 to a practitioner's website when requested;  
29 providing that practitioners licensed under ch.  
30 458 or ch. 459, F.S., shall have claim  
31 information concerning an indemnity payment

1 greater than a specified amount posted in the  
2 practitioner profile; amending s. 456.042,  
3 F.S.; providing for the update of practitioner  
4 profiles; designating a timeframe within which  
5 a practitioner must submit new information to  
6 update his or her profile; amending s. 456.049,  
7 F.S., relating to practitioner reports on  
8 professional liability claims and actions;  
9 revising requirements for a practitioner to  
10 report claims or actions that were not covered  
11 by an insurer; requiring the department to  
12 forward information on liability claims and  
13 actions to the Office of Insurance Regulation;  
14 amending s. 456.051, F.S.; establishing the  
15 responsibility of the Department of Health to  
16 provide reports of professional liability  
17 actions and bankruptcies; requiring the  
18 department to include such reports in a  
19 practitioner's profile within a specified  
20 period; amending s. 456.057, F.S.; allowing the  
21 department to obtain patient records by  
22 subpoena without the patient's written  
23 authorization, in specified circumstances;  
24 amending s. 456.063, F.S.; authorizing  
25 regulatory boards or the department to adopt  
26 rules to implement requirements for reporting  
27 allegations of sexual misconduct; authorizing  
28 health care practitioner regulatory boards to  
29 adopt rules to establish standards of practice  
30 for prescribing drugs to patients via the  
31 Internet; amending s. 456.072, F.S.; providing

1 for determining the amount of any costs to be  
2 assessed in a disciplinary proceeding;  
3 prescribing the standard of proof in certain  
4 disciplinary proceedings; amending s. 456.073,  
5 F.S.; authorizing the Department of Health to  
6 investigate certain paid claims made on behalf  
7 of practitioners licensed under ch. 458 or ch.  
8 459, F.S.; amending procedures for certain  
9 disciplinary proceedings; providing a deadline  
10 for raising issues of material fact; providing  
11 a deadline relating to notice of receipt of a  
12 request for a formal hearing; amending s.  
13 456.077, F.S.; providing a presumption related  
14 to an undisputed citation; amending s. 456.078,  
15 F.S.; revising standards for determining which  
16 violations of the applicable professional  
17 practice act are appropriate for mediation;  
18 amending s. 458.320, F.S., relating to  
19 financial responsibility requirements for  
20 medical physicians; requiring maintenance of  
21 financial responsibility as a condition of  
22 licensure of physicians; providing for payment  
23 of any outstanding judgments or settlements  
24 pending at the time a physician is suspended by  
25 the Department of Business and Professional  
26 Regulation; providing for an alternative method  
27 of providing financial responsibility;  
28 requiring the department to suspend the license  
29 of a medical physician who has not paid, up to  
30 the amounts required by any applicable  
31 financial responsibility provision, any

1 outstanding judgment, arbitration award, other  
2 order, or settlement; amending s. 459.0085,  
3 F.S., relating to financial responsibility  
4 requirements for osteopathic physicians;  
5 requiring maintenance of financial  
6 responsibility as a condition of licensure of  
7 osteopathic physicians; providing for payment  
8 of any outstanding judgments or settlements  
9 pending at the time an osteopathic physician is  
10 suspended by the Department of Business and  
11 Professional Regulation; providing for an  
12 alternative method of providing financial  
13 responsibility; requiring that the department  
14 suspend the license of an osteopathic physician  
15 who has not paid, up to the amounts required by  
16 any applicable financial responsibility  
17 provision, any outstanding judgment,  
18 arbitration award, other order, or settlement;  
19 providing civil immunity for certain  
20 participants in quality improvement processes;  
21 defining the terms "patient safety data" and  
22 "patient safety organization"; providing for  
23 use of patient safety data by a patient safety  
24 organization; providing limitations on use of  
25 patient safety data; providing for protection  
26 of patient-identifying information; providing  
27 for determination of whether the privilege  
28 applies as asserted; providing that an employer  
29 may not take retaliatory action against an  
30 employee who makes a good-faith report  
31 concerning patient safety data; requiring that



1 a specific statement be included in each final  
2 settlement statement relating to medical  
3 malpractice actions; providing requirements for  
4 the closed claim form of the Office of  
5 Insurance Regulation; requiring the Office of  
6 Insurance Regulation to compile annual  
7 statistical reports pertaining to closed  
8 claims; requiring historical statistical  
9 summaries; specifying certain information to be  
10 included on the closed claim form; amending s.  
11 458.331, F.S., relating to grounds for  
12 disciplinary action against a physician;  
13 redefining the term "repeated malpractice";  
14 revising the standards for the burden of proof  
15 in an administrative action against a  
16 physician; revising the minimum amount of a  
17 claim against a licensee which will trigger a  
18 departmental investigation; amending s.  
19 459.015, F.S., relating to grounds for  
20 disciplinary action against an osteopathic  
21 physician; redefining the term "repeated  
22 malpractice"; revising the standards for the  
23 burden of proof in an administrative action  
24 against an osteopathic physician; amending  
25 conditions that necessitate a departmental  
26 investigation of an osteopathic physician;  
27 revising the minimum amount of a claim against  
28 a licensee which will trigger a departmental  
29 investigation; amending s. 460.413, F.S.,  
30 relating to grounds for disciplinary action  
31 against a chiropractic physician; revising the

1 standards for the burden of proof in an  
2 administrative action against a chiropractic  
3 physician; providing a statement of legislative  
4 intent regarding the change in the standard of  
5 proof in disciplinary cases involving the  
6 suspension or revocation of a license;  
7 providing that the practice of health care is a  
8 privilege, not a right; providing that  
9 protecting patients overrides purported  
10 property interest in the license of a health  
11 care practitioner; providing that certain  
12 disciplinary actions are remedial and  
13 protective, not penal; providing that the  
14 Legislature specifically reverses case law to  
15 the contrary; requiring the Division of  
16 Administrative Hearings to designate  
17 administrative law judges who have special  
18 qualifications for hearings involving certain  
19 health care practitioners; amending s. 461.013,  
20 F.S., relating to grounds for disciplinary  
21 action against a podiatric physician;  
22 redefining the term "repeated malpractice";  
23 amending the minimum amount of a claim against  
24 such a physician which will trigger a  
25 department investigation; amending s. 466.028,  
26 F.S., relating to grounds for disciplinary  
27 action against a dentist or a dental hygienist;  
28 redefining the term "dental malpractice";  
29 revising the minimum amount of a claim against  
30 a dentist which will trigger a departmental  
31 investigation; amending s. 624.462, F.S.;

1 authorizing health care providers to form a  
2 commercial self-insurance fund; amending s.  
3 627.062, F.S.; providing that an insurer may  
4 not require arbitration of a rate filing for  
5 medical malpractice; providing additional  
6 requirements for medical malpractice insurance  
7 rate filings; providing that portions of  
8 judgments and settlements entered against a  
9 medical malpractice insurer for bad-faith  
10 actions or for punitive damages against the  
11 insurer, as well as related taxable costs and  
12 attorney's fees, may not be included in an  
13 insurer's base rate; providing for review of  
14 rate filings by the Office of Insurance  
15 Regulation for excessive, inadequate, or  
16 unfairly discriminatory rates; requiring  
17 insurers to apply a discount based on the  
18 health care provider's loss experience;  
19 amending s. 627.0645, F.S.; excepting medical  
20 malpractice insurers from certain annual  
21 filings; requiring the Office of Program Policy  
22 Analysis and Government Accountability to study  
23 and report to the Legislature on requirements  
24 for coverage by the Florida Birth-Related  
25 Neurological Injury Compensation Association;  
26 creating s. 627.0662, F.S.; providing  
27 definitions; requiring each medical liability  
28 insurer to report certain information to the  
29 Office of Insurance Regulation; providing for  
30 determination of whether excessive profit has  
31 been realized; requiring return of excessive

1 amounts; amending s. 627.357, F.S.; providing  
2 guidelines for the formation and regulation of  
3 certain self-insurance funds; amending s.  
4 627.4147, F.S.; revising certain notification  
5 criteria for medical and osteopathic  
6 physicians; requiring prior notification of a  
7 rate increase; authorizing the purchase of  
8 insurance by certain health care providers;  
9 creating s. 627.41491, F.S.; requiring the  
10 Office of Insurance Regulation to require  
11 health care providers to annually publish  
12 certain rate comparison information; creating  
13 s. 627.41492, F.S.; requiring the Office of  
14 Insurance Regulation to publish an annual  
15 medical malpractice report; creating s.  
16 627.41493, F.S.; requiring a medical  
17 malpractice insurance rate rollback; providing  
18 for subsequent increases under certain  
19 circumstances; requiring approval for use of  
20 certain medical malpractice insurance rates;  
21 providing for a mechanism to make effective the  
22 Florida Medical Malpractice Insurance Fund in  
23 the event the rollback of medical malpractice  
24 insurance rates is not completed; creating the  
25 Florida Medical Malpractice Insurance Fund;  
26 providing purpose; providing governance by a  
27 board of governors; providing for the fund to  
28 issue medical malpractice policies to any  
29 physician regardless of specialty; providing  
30 for regulation by the Office of Insurance  
31 Regulation of the Financial Services

1 Commission; providing applicability; providing  
2 for initial funding; providing for tax-exempt  
3 status; providing for initial capitalization;  
4 providing for termination of the fund;  
5 providing that practitioners licensed under ch.  
6 458 or ch. 459, F.S., must, as a licensure  
7 requirement, obtain and maintain professional  
8 liability coverage; creating s. 627.41495,  
9 F.S.; providing for consumer participation in  
10 review of medical malpractice rate changes;  
11 providing for public inspection; providing for  
12 adoption of rules by the Financial Services  
13 Commission; requiring the Office of Insurance  
14 Regulation to order insurers to make rate  
15 filings effective January 1, 2004, which  
16 reflect the impact of the act; providing  
17 criteria for such rate filing; amending s.  
18 627.912, F.S.; amending provisions prescribing  
19 conditions under which insurers must file  
20 certain reports with the Department of Health;  
21 requiring the Financial Services Commission to  
22 adopt by rule requirements for reporting  
23 financial information; increasing the  
24 limitation on a fine imposed against insurers;  
25 creating s. 627.9121, F.S.; requiring certain  
26 claims, judgments, or settlements to be  
27 reported to the Office of Insurance Regulation;  
28 providing penalties; amending s. 766.102, F.S.;  
29 revising requirements for health care providers  
30 providing expert testimony in medical  
31 negligence actions; prohibiting contingency

1 fees for an expert witness; amending s.  
2 766.106, F.S.; providing for application of  
3 common law principles of good faith to an  
4 insurance company's bad-faith actions arising  
5 out of medical malpractice claims; providing  
6 that an insurer shall not be held to have acted  
7 in bad faith for certain activities during the  
8 presuit period and for a specified later  
9 period; providing legislative intent with  
10 respect to actions by insurers, insureds, and  
11 their assigns and representatives; revising  
12 requirements for presuit notice and for an  
13 insurer's or self-insurer's response to a  
14 claim; requiring that a claimant provide the  
15 Agency for Health Care Administration with a  
16 copy of the complaint alleging medical  
17 malpractice; requiring the agency to review  
18 such complaints for licensure noncompliance;  
19 permitting written questions during informal  
20 discovery; amending s. 766.108, F.S.; providing  
21 for mandatory mediation; creating s. 766.118,  
22 F.S.; providing a maximum amount to be awarded  
23 as noneconomic damages in medical negligence  
24 actions; providing exceptions; amending s.  
25 766.202, F.S.; redefining the terms "economic  
26 damages," "medical expert," "noneconomic  
27 damages," and "periodic payment"; amending s.  
28 766.206, F.S.; providing for dismissal of a  
29 claim under certain circumstances; requiring  
30 the court to make certain reports concerning a  
31 medical expert who fails to meet

1 qualifications; amending s. 766.207, F.S.;

2 providing for the applicability of the Wrongful

3 Death Act and general law to arbitration

4 awards; amending s. 768.041, F.S.; revising

5 requirements for setoffs against damages in

6 medical malpractice actions if there is a

7 written release or covenant not to sue;

8 amending s. 768.13, F.S.; revising guidelines

9 for immunity from liability under the "Good

10 Samaritan Act"; amending s. 768.77, F.S.;

11 prescribing a method for itemization of

12 specific categories of damages awarded in

13 medical malpractice actions; amending s.

14 768.81, F.S.; requiring the trier of fact to

15 apportion total fault solely among the claimant

16 and joint tortfeasors as parties to an action;

17 requiring the Office of Program Policy Analysis

18 and Government Accountability and the Office of

19 the Auditor General to conduct an audit of the

20 health care practitioner disciplinary process

21 and closed claims and report to the

22 Legislature; creating ss. 1004.08 and 1005.07,

23 F.S.; requiring schools, colleges, and

24 universities to include material on patient

25 safety in their curricula if the institution

26 awards specified degrees; creating a workgroup

27 to study the health care practitioner

28 disciplinary process; providing for workgroup

29 membership; providing that the workgroup

30 deliver its report by January 1, 2004; creating

31 s. 766.1065, F.S.; providing for mandatory

1           presuit investigations; providing that certain  
2           records be provided to opposing parties;  
3           providing subpoena power; providing for sworn  
4           depositions of parties and medical experts;  
5           providing for mandatory in-person mediation if  
6           binding arbitration has not been agreed to;  
7           providing for a mandatory presuit screening  
8           panel hearing in the event of mediation  
9           impasse; creating s. 766.1066, F.S.; creating  
10          the Office of Presuit Screening Administration;  
11          providing for a database of volunteer panel  
12          members; prescribing qualifications for panel  
13          membership; providing a funding mechanism;  
14          providing panel procedures; providing for  
15          determination and recordation of panel  
16          findings; providing for disposition of panel  
17          findings; providing immunity from liability for  
18          panel members; providing appropriations and  
19          authorizing positions; providing for  
20          construction of the act in pari materia with  
21          laws enacted during the 2003 Regular Session or  
22          2003 Special Session A of the Legislature;  
23          providing for severability; providing for  
24          retroactive application; providing effective  
25          dates.

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

Section 1. Findings.--



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

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

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

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

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

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

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

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

30           (9) The Legislature finds that the Governor's Select  
31 Task Force on Healthcare Professional Liability Insurance has

1 established that a medical malpractice insurance crisis exists  
2 in the State of Florida which can be alleviated by the  
3 adoption of comprehensive legislatively enacted reforms.

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

7 (11) The Legislature finds that ensuring that  
8 physicians continue to practice in Florida is an overwhelming  
9 public necessity.

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

13 (13) The Legislature finds, based upon the findings  
14 and recommendations of the Governor's Select Task Force on  
15 Healthcare Professional Liability Insurance, the findings and  
16 recommendations of various study groups throughout the nation,  
17 and the experience of other states, that the overwhelming  
18 public necessities of making quality health care available to  
19 the citizens of this state, of ensuring that physicians  
20 continue to practice in Florida, and of ensuring that those  
21 physicians have the opportunity to purchase affordable  
22 professional liability insurance cannot be met unless  
23 comprehensive legislation is adopted.

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

28 Section 2. Subsection (4) is added to section 46.015,  
29 Florida Statutes, to read:

30 46.015 Release of parties.--

31

1           (4)(a) At trial pursuant to a suit filed under chapter  
2 766 or pursuant to s. 766.209, if any defendant shows the  
3 court that the plaintiff, or his or her legal representative,  
4 has delivered a written release or covenant not to sue to any  
5 person in partial satisfaction of the damages sued for, the  
6 court shall set off this amount from the total amount of the  
7 damages set forth in the verdict and before entry of the final  
8 judgment.

9           (b) The amount of any setoff under this subsection  
10 shall include all sums received by the plaintiff, including  
11 economic and noneconomic damages, costs, and attorney's fees.

12           Section 3. Effective upon this act becoming a law if  
13 SB 4-B or similar legislation is adopted in the same  
14 legislative session or an extension thereof and becomes law,  
15 section 381.0409, Florida Statutes, is created to read:

16           381.0409 Florida Center for Excellence in Health  
17 Care.--There is created the Florida Center for Excellence in  
18 Health Care which shall be responsible for performing  
19 activities and functions that are designed to improve the  
20 quality of health care delivered by health care facilities and  
21 health care practitioners. The principal goals of the center  
22 are to improve health care quality and patient safety. The  
23 long-term goal is to improve diagnostic and treatment  
24 decisions, thus further improving quality.

25           (1) As used in this section, the term:

26           (a) "Center" means the Florida Center for Excellence  
27 in Health Care.

28           (b) "Health care practitioner" means any person as  
29 defined under s. 456.001(4).

30           (c) "Health care facility" means any facility licensed  
31 under chapter 395.

1           (d) "Health research entity" means any university or  
2 academic health center engaged in research designed to  
3 improve, prevent, diagnose, or treat diseases or medical  
4 conditions or an entity that receives state or federal funds  
5 for such research.

6           (e) "Patient safety data" means any data, reports,  
7 records, memoranda, or analyses of patient safety events and  
8 adverse incidents reported by a licensed facility pursuant to  
9 s. 395.0197 which are submitted to the Florida Center for  
10 Health Care Excellence or the corrective actions taken in  
11 response to such patient safety events or adverse incidents.

12           (f) "Patient safety event" means an event over which  
13 health care personnel could exercise control and which is  
14 associated in whole or in part with medical intervention,  
15 rather than the condition for which such intervention  
16 occurred, and which could have resulted in, but did not result  
17 in, serious patient injury or death.

18           (2) The center shall directly or by contract:

19           (a) Analyze patient safety data for the purpose of  
20 recommending changes in practices and procedures which may be  
21 implemented by health care practitioners and health care  
22 facilities to prevent future adverse incidents.

23           (b) Collect, analyze, and evaluate patient safety data  
24 submitted voluntarily by a health care practitioner or health  
25 care facility. The center shall recommend to health care  
26 practitioners and health care facilities changes in practices  
27 and procedures that may be implemented for the purpose of  
28 improving patient safety and preventing patient safety events.

29           (c) Foster the development of a statewide electronic  
30 infrastructure that may be implemented in phases over a  
31 multiyear period and that is designed to improve patient care

1 and the delivery and quality of health care services by health  
2 care facilities and practitioners. The electronic  
3 infrastructure shall be a secure platform for communication  
4 and the sharing of clinical and other data, such as business  
5 data, among providers and between patients and providers. The  
6 electronic infrastructure shall include a "core" electronic  
7 medical record. Health care practitioners and health care  
8 facilities shall have access to individual electronic medical  
9 records subject to the consent of the individual. Each health  
10 insurer licensed under chapter 627 or chapter 641 shall have  
11 access to the electronic medical records of its policyholders  
12 and, subject to s. 381.04091, to other data if such access is  
13 for the sole purpose of conducting research to identify  
14 diagnostic tests and treatments that are medically effective.  
15 Health research entities shall have access to the electronic  
16 medical records of individuals, subject to the consent of the  
17 individual and subject to s. 381.04091, and to other data if  
18 such access is for the sole purpose of conducting research to  
19 identify diagnostic tests and treatments that are medically  
20 effective.

21 (d) Inventory hospitals to determine the current  
22 status of implementation of computerized physician order entry  
23 systems and recommend a plan for expediting implementation  
24 statewide or, in hospitals where the center determines that  
25 implementation of such systems is not practicable, alternative  
26 methods to reduce medication errors. The center shall identify  
27 in its plan any barriers to statewide implementation and shall  
28 include recommendations to the Legislature of statutory  
29 changes that may be necessary to eliminate those barriers.

30  
31

1       (e) Establish a simulation center for high technology  
2 intervention surgery and intensive care for use by all  
3 hospitals.

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

6  
7 This section does not limit the scope of services provided by  
8 the center with regard to engaging in other activities that  
9 improve health care quality, improve the diagnosis and  
10 treatment of diseases and medical conditions, increase the  
11 efficiency of the delivery of health care services, increase  
12 administrative efficiency, and increase access to quality  
13 health care services.

14       (3) Notwithstanding s. 381.04091, the center may  
15 release information contained in patient safety data to any  
16 health care practitioner or health care facility when  
17 recommending changes in practices and procedures which may be  
18 implemented by such practitioner or facility to prevent  
19 patient safety events or adverse incidents if the identity of  
20 the source of the information and the names of persons have  
21 been removed from such information.

22       (4) All information related to adverse incident  
23 reports and all patient safety data submitted to or received  
24 by the center shall not be subject to discovery or  
25 introduction into evidence in any civil or administrative  
26 action. Individuals in attendance at meetings held for the  
27 purpose of discussing information related to adverse incidents  
28 and patient safety data and meetings held to formulate  
29 recommendations to prevent future adverse incidents or patient  
30 safety events may not be permitted or required to testify in  
31 any civil or administrative action related to such events.

1 There shall be no liability on the part of, and no cause of  
2 action of any nature shall arise against, any employee or  
3 agent of the center for any lawful action taken by such  
4 individual in advising health practitioners or health care  
5 facilities with regard to carrying out their duties under this  
6 section. There shall be no liability on the part of, and no  
7 cause of action of any nature shall arise against, a health  
8 care practitioner or health care facility, its agents, or  
9 employees, when it acts in reliance on any advice or  
10 information provided by the center.

11 (5) The center shall be a nonprofit corporation  
12 registered, incorporated, organized, and operated in  
13 compliance with chapter 617, and shall have all powers  
14 necessary to carry out the purposes of this section,  
15 including, but not limited to, the power to receive and accept  
16 from any source contributions of money, property, labor, or  
17 any other thing of value, to be held, used, and applied for  
18 the purpose of this section.

19 (6) The center shall:

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

25 2. Include procedures for ensuring the confidentiality  
26 of data which are consistent with state and federal law.

27 (7) The center shall be governed by a 10-member board  
28 of directors appointed by the Governor.

29 (a) The Governor shall appoint two members  
30 representing hospitals, one member representing physicians,  
31 one member representing nurses, one member representing health

1 insurance indemnity plans, one member representing health  
2 maintenance organizations, one member representing business,  
3 and one member representing consumers. The Governor shall  
4 appoint members for a 2-year term. Such members shall serve  
5 until their successors are appointed. Members are eligible to  
6 be reappointed for additional terms.

7 (b) The Secretary of Health or his or her designee  
8 shall be a member of the board.

9 (c) The Secretary of Health Care Administration or his  
10 or her designee shall be a member of the board.

11 (d) The members shall elect a chairperson.

12 (e) Board members shall serve without compensation but  
13 may be reimbursed for travel expenses pursuant to s. 112.061.

14 (8) The center shall be financed as follows:

15 (a) Notwithstanding any law to the contrary, each  
16 health insurer issued a certificate of authority under part  
17 VI, part VII, or part VIII of chapter 627 shall, as a  
18 condition of maintaining such certificate, make payment to the  
19 center on April 1 of each year, in the amount of \$1 for each  
20 individual included in every insurance policy issued during  
21 the previous calendar year. Accompanying any payment shall be  
22 a certification under oath by the chief executive officer  
23 which states the number of individuals upon which such payment  
24 was based. The health insurer may collect this \$1 from  
25 policyholders. The center may direct the insurer to provide an  
26 independent audit of the certification which shall be  
27 furnished within 90 days. If payment is not received by the  
28 center within 30 days after April 1, interest at the  
29 annualized rate of 18 percent shall begin to be charged on the  
30 amount due. If payment has not been received within 60 days  
31 after interest is charged, the center shall notify the Office



1 of Insurance Regulation that payment has not been received  
2 pursuant to the requirements of this paragraph. An insurer  
3 that refuses to comply with the requirements of this paragraph  
4 is subject to the forfeiture of its certificate of authority.

5 (b) Notwithstanding any law to the contrary, each  
6 health maintenance organization issued a certificate of  
7 authority under part I of chapter 641 and each prepaid health  
8 clinic issued a certificate of authority under part II of  
9 chapter 641 shall, as a condition of maintaining such  
10 certificate, make payment to the center on April 1 of each  
11 year, in the amount of \$1 for each individual who is eligible  
12 to receive services pursuant to a contract with the health  
13 maintenance organization or the prepaid health clinic during  
14 the previous calendar year. Accompanying any payment shall be  
15 a certification under oath by the chief executive officer  
16 which states the number of individuals upon which such payment  
17 was based. The health maintenance organization or prepaid  
18 health clinic may collect the \$1 from individuals eligible to  
19 receive services under contract. The center may direct the  
20 health maintenance organization or prepaid health clinic to  
21 provide an independent audit of the certification which shall  
22 be furnished within 90 days. If payment is not received by the  
23 center within 30 days after April 1, interest at the  
24 annualized rate of 18 percent shall begin to be charged on the  
25 amount due. If payment has not been received within 60 days  
26 after interest is charged, the center shall notify the Office  
27 of Insurance Regulation that payment has not been received  
28 pursuant to the requirements of this paragraph. A health  
29 maintenance organization or prepaid health clinic that refuses  
30 to comply with the requirements of this paragraph is subject  
31 to the forfeiture of its certificate of authority.

1           (c) Notwithstanding any law to the contrary, each  
2 hospital and ambulatory surgical center licensed under chapter  
3 395 shall, as a condition of licensure, make payment to the  
4 center on April 1 of each year, in the amount of \$1 for each  
5 individual who, during the previous 12 months, was an  
6 inpatient discharged by the hospital or who was a patient  
7 discharged by the ambulatory surgical center. Accompanying  
8 payment shall be a certification under oath by the chief  
9 executive officer which states the number of individuals upon  
10 which such payment was based. The facility may collect the \$1  
11 from patients discharged from the facility. The center may  
12 direct the facility to provide an independent audit of the  
13 certification which shall be furnished within 90 days. If  
14 payment is not received by the center within 30 days after  
15 April 1, interest at the annualized rate of 18 percent shall  
16 begin to be charged on the amount due. If payment has not been  
17 received within 60 days after interest is charged, the center  
18 shall notify the Agency for Health Care Administration that  
19 payment has not been received pursuant to the requirements of  
20 this paragraph. An entity that refuses to comply with the  
21 requirements of this paragraph is subject to the forfeiture of  
22 its license.

23           (d) Notwithstanding any law to the contrary, each  
24 nursing home licensed under part II of chapter 400, each  
25 assisted living facility licensed under part III of chapter  
26 400, each home health agency licensed under part IV of chapter  
27 400, each hospice licensed under part VI of chapter 400, each  
28 prescribed pediatric extended care center licensed under part  
29 IX of chapter 400, and each health care services pool licensed  
30 under part XII of chapter 400 shall, as a condition of  
31 licensure, make payment to the center on April 1 of each year,

1 in the amount of \$1 for each individual served by each  
2 mentioned entity during the previous 12 months.  
3 Accompanying payment shall be a certification under oath by  
4 the chief executive officer which states the number of  
5 individuals upon which such payment was based. The entity may  
6 collect the \$1 from individuals served by the entity. The  
7 center may direct the entity to provide an independent audit  
8 of the certification which shall be furnished within 90 days.  
9 If payment is not received by the center within 30 days after  
10 April 1, interest at the annualized rate of 18 percent shall  
11 begin to be charged on the amount due. If payment has not been  
12 received within 60 days after interest is charged, the center  
13 shall notify the Agency for Health Care Administration that  
14 payment has not been received pursuant to the requirements of  
15 this paragraph. An entity that refuses to comply with the  
16 requirements of this paragraph is subject to the forfeiture of  
17 its license.

18 (e) Notwithstanding any law to the contrary, each  
19 initial application and renewal fee for each license and each  
20 fee for certification or recertification for each person  
21 licensed or certified under chapter 401 or chapter 404, and  
22 for each person licensed as a health care practitioner, as  
23 defined in s. 456.001(4), shall be increased by the amount of  
24 \$1 for each year or part thereof for which the license or  
25 certification is issued. The Department of Health shall make  
26 payment to the center on April 1 of each year in the amount of  
27 the total received pursuant to this paragraph during the  
28 preceding 12 months.

29 (f) The center shall develop a business and financing  
30 plan to obtain funds through other means if funds beyond those  
31

1 that are provided for in this subsection are needed to  
2 accomplish the objectives of the center.

3 (9) The center may enter into affiliations with  
4 universities for any purpose.

5 (10) Pursuant to s. 287.057(5)(f)6., state agencies  
6 may contract with the center on a sole-source basis for  
7 projects to improve the quality of program administration,  
8 such as, but not limited to, the implementation of an  
9 electronic medical record for Medicaid program recipients.

10 (11) All travel and per diem paid with center funds  
11 shall be in accordance with s. 112.061.

12 (12) The center may use state purchasing and travel  
13 contracts and the state communications system in accordance  
14 with s. 282.105(3).

15 (13) The center may acquire, enjoy, use, and dispose  
16 of patents, copyrights, trademarks, and any licenses,  
17 royalties, and other rights or interests thereunder or  
18 therein.

19 (14) The center shall submit an annual report to the  
20 Governor, the President of the Senate, and the Speaker of the  
21 House of Representatives no later than October 1 of each year  
22 which includes:

23 (a) The status report on the implementation of a  
24 program to analyze data concerning adverse incidents and  
25 patient safety events.

26 (b) The status report on the implementation of a  
27 computerized physician order entry system.

28 (c) The status report on the implementation of an  
29 electronic medical record.

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1           (d) Other pertinent information relating to the  
2 efforts of the center to improve health care quality and  
3 efficiency.

4           (e) A financial statement and balance sheet.

5  
6 The initial report shall include any recommendations that the  
7 center deems appropriate regarding revisions in the definition  
8 of adverse incidents in s. 395.0197 and the reporting of such  
9 adverse incidents by licensed facilities.

10           (15) The center may establish and manage an operating  
11 fund for the purposes of addressing the center's cash-flow  
12 needs and facilitating the fiscal management of the  
13 corporation. Upon dissolution of the corporation, any  
14 remaining cash balances of any state funds shall revert to the  
15 General Revenue Fund, or such other state funds consistent  
16 with appropriated funding, as provided by law.

17           (16) The center may carry over funds from year to  
18 year.

19           (17) All books, records, and audits of the center  
20 shall be open to the public unless exempted by law.

21           (18) The center shall furnish an annual audited report  
22 to the Governor and Legislature by March 1 of each year.

23           (19) In carrying out this section, the center shall  
24 consult with and develop partnerships, as appropriate, with  
25 all segments of the health care industry, including, among  
26 others, health practitioners, health care facilities, health  
27 care consumers, professional organizations, agencies, health  
28 care practitioner licensing boards, and educational  
29 institutions.

30           Section 4. Subsection (3) is added to section 395.004,  
31 Florida Statutes, to read:

1           395.004 Application for license, fees; expenses.--  
2           (3) A licensed facility may apply to the agency for  
3 certification of a quality improvement program that results in  
4 the reduction of adverse incidents at that facility. The  
5 agency, in consultation with the Office of Insurance  
6 Regulation, shall develop criteria for such certification.  
7 Insurers shall file with the Office of Insurance Regulation a  
8 discount in the rate or rates applicable for medical liability  
9 insurance coverage to reflect the implementation of a  
10 certified program. In reviewing insurance company filings with  
11 respect to rate discounts authorized under this subsection,  
12 the Office of Insurance Regulation shall consider whether, and  
13 the extent to which, the program certified under this  
14 subsection is otherwise covered under a program of risk  
15 management offered by an insurance company or self-insurance  
16 plan providing medical liability coverage.

17           Section 5. Section 395.0056, Florida Statutes, is  
18 created to read:

19           395.0056 Litigation notice requirement.--Upon receipt  
20 of a copy of a complaint filed against a hospital as a  
21 defendant in a medical malpractice action as required by s.  
22 766.106(2), the agency shall:

23           (1) Review its adverse incident report files  
24 pertaining to the licensed facility that is the subject of the  
25 complaint to determine whether the facility timely complied  
26 with the requirements of s. 395.0197; and

27           (2) Review the incident that is the subject of the  
28 complaint and determine whether it involved conduct by a  
29 licensee which is potentially subject to disciplinary action.  
30  
31

1           Section 6. Subsection (3) and paragraph (a) of  
2 subsection (9) of section 395.0193, Florida Statutes, are  
3 amended to read:

4           395.0193 Licensed facilities; peer review;  
5 disciplinary powers; agency or partnership with physicians.--

6           (3) If reasonable belief exists that conduct by a  
7 staff member or physician who delivers health care services at  
8 the licensed facility may constitute one or more grounds for  
9 discipline as provided in this subsection, a peer review panel  
10 shall investigate and determine whether grounds for discipline  
11 exist with respect to such staff member or physician. The  
12 governing board of any licensed facility, after considering  
13 the recommendations of its peer review panel, shall suspend,  
14 deny, revoke, or curtail the privileges, or reprimand,  
15 counsel, or require education, of any such staff member or  
16 physician after a final determination has been made that one  
17 or more of the following grounds exist:

18           (a) Incompetence.

19           (b) Being found to be a habitual user of intoxicants  
20 or drugs to the extent that he or she is deemed dangerous to  
21 himself, herself, or others.

22           (c) Mental or physical impairment which may adversely  
23 affect patient care.

24           (d) Mental or physical abuse of a nurse or other staff  
25 member.

26           (e)~~(d)~~ Being found liable by a court of competent  
27 jurisdiction for medical negligence or malpractice involving  
28 negligent conduct.

29           (f)~~(e)~~ One or more settlements exceeding \$10,000 for  
30 medical negligence or malpractice involving negligent conduct  
31 by the staff member.

1           ~~(g)(f)~~ Medical negligence other than as specified in  
2 paragraph (d) or paragraph (e).

3           ~~(h)(g)~~ Failure to comply with the policies,  
4 procedures, or directives of the risk management program or  
5 any quality assurance committees of any licensed facility.

6           (9)(a) If the defendant prevails in an action brought  
7 by a staff member or physician who delivers health care  
8 services at the licensed facility against any person or entity  
9 that initiated, participated in, was a witness in, or  
10 conducted any review as authorized by this section, the court  
11 shall award reasonable attorney's fees and costs to the  
12 defendant. Monetary liability pursuant to this subsection  
13 shall not exceed \$250,000 except when intentional fraud is  
14 involved.

15           Section 7. Subsections (1), (3), and (8) of section  
16 395.0197, Florida Statutes, are amended, present subsections  
17 (12) through (20) of that section are redesignated as  
18 subsections (13) through (21), respectively, and a new  
19 subsection (12) is added to that section, to read:

20           395.0197 Internal risk management program.--

21           (1) Every licensed facility shall, as a part of its  
22 administrative functions, establish an internal risk  
23 management program that includes all of the following  
24 components:

25           (a) The investigation and analysis of the frequency  
26 and causes of general categories and specific types of adverse  
27 incidents to patients.

28           (b) The development of appropriate measures to  
29 minimize the risk of adverse incidents to patients, including,  
30 but not limited to:

31



- 1           1. Risk management and risk prevention education and  
2 training of all nonphysician personnel as follows:  
3           a. Such education and training of all nonphysician  
4 personnel as part of their initial orientation; and  
5           b. At least 1 hour of such education and training  
6 annually for all personnel of the licensed facility working in  
7 clinical areas and providing patient care, except those  
8 persons licensed as health care practitioners who are required  
9 to complete continuing education coursework pursuant to  
10 chapter 456 or the respective practice act.
- 11           2. A prohibition, except when emergency circumstances  
12 require otherwise, against a staff member of the licensed  
13 facility attending a patient in the recovery room, unless the  
14 staff member is authorized to attend the patient in the  
15 recovery room and is in the company of at least one other  
16 person. However, a licensed facility is exempt from the  
17 two-person requirement if it has:  
18           a. Live visual observation;  
19           b. Electronic observation; or  
20           c. Any other reasonable measure taken to ensure  
21 patient protection and privacy.
- 22           3. A prohibition against an unlicensed person from  
23 assisting or participating in any surgical procedure unless  
24 the facility has authorized the person to do so following a  
25 competency assessment, and such assistance or participation is  
26 done under the direct and immediate supervision of a licensed  
27 physician and is not otherwise an activity that may only be  
28 performed by a licensed health care practitioner.
- 29           4. Development, implementation, and ongoing evaluation  
30 of procedures, protocols, and systems to accurately identify  
31 patients, planned procedures, and the correct site of the

1 planned procedure so as to minimize the performance of a  
2 surgical procedure on the wrong patient, a wrong surgical  
3 procedure, a wrong-site surgical procedure, or a surgical  
4 procedure otherwise unrelated to the patient's diagnosis or  
5 medical condition.

6 (c) The analysis of patient grievances that relate to  
7 patient care and the quality of medical services.

8 (d) A system for informing a patient or an individual  
9 identified pursuant to s. 765.401(1) that the patient was the  
10 subject of an adverse incident, as defined in subsection (5).  
11 Such notice shall be given by the risk manager, or his or her  
12 designee, as soon as practicable to allow the patient an  
13 opportunity to minimize damage or injury.

14 (e)~~(d)~~ The development and implementation of an  
15 incident reporting system based upon the affirmative duty of  
16 all health care providers and all agents and employees of the  
17 licensed health care facility to report adverse incidents to  
18 the risk manager, or to his or her designee, within 3 business  
19 days after their occurrence.

20 (3) In addition to the programs mandated by this  
21 section, other innovative approaches intended to reduce the  
22 frequency and severity of medical malpractice and patient  
23 injury claims shall be encouraged and their implementation and  
24 operation facilitated. Such additional approaches may include  
25 extending internal risk management programs to health care  
26 providers' offices and the assuming of provider liability by a  
27 licensed health care facility for acts or omissions occurring  
28 within the licensed facility. Each licensed facility shall  
29 annually report to the agency and the Department of Health the  
30 name and judgments entered against each health care  
31 practitioner for which it assumes liability. The agency and

1 Department of Health, in their respective annual reports,  
2 shall include statistics that report the number of licensed  
3 facilities that assume such liability and the number of health  
4 care practitioners, by profession, for whom they assume  
5 liability.

6 (8) Any of the following adverse incidents, whether  
7 occurring in the licensed facility or arising from health care  
8 prior to admission in the licensed facility, shall be reported  
9 by the facility to the agency within 15 calendar days after  
10 its occurrence:

11 (a) The death of a patient;

12 (b) Brain or spinal damage to a patient;

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

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

17 (e) The performance of a wrong surgical procedure;

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

21 (g) The surgical repair of damage resulting to a  
22 patient from a planned surgical procedure, where the damage is  
23 not a recognized specific risk, as disclosed to the patient  
24 and documented through the informed-consent process; or

25 (h) The performance of procedures to remove unplanned  
26 foreign objects remaining from a surgical procedure.

27

28 The agency may grant extensions to this reporting requirement  
29 for more than 15 days upon justification submitted in writing  
30 by the facility administrator to the agency. The agency may  
31 require an additional, final report. These reports shall not

1 be available to the public pursuant to s. 119.07(1) or any  
2 other law providing access to public records, nor be  
3 discoverable or admissible in any civil or administrative  
4 action, except in disciplinary proceedings by the agency or  
5 the appropriate regulatory board, nor shall they be available  
6 to the public as part of the record of investigation for and  
7 prosecution in disciplinary proceedings made available to the  
8 public by the agency or the appropriate regulatory board.  
9 However, the agency or the appropriate regulatory board shall  
10 make available, upon written request by a health care  
11 professional against whom probable cause has been found, any  
12 such records which form the basis of the determination of  
13 probable cause. The agency may investigate, as it deems  
14 appropriate, any such incident and prescribe measures that  
15 must or may be taken in response to the incident. The agency  
16 shall review each incident and determine whether it  
17 potentially involved conduct by the health care professional  
18 who is subject to disciplinary action, in which case the  
19 provisions of s. 456.073 shall apply. The agency shall forward  
20 a copy of all reports of adverse incidents submitted to the  
21 agency by hospitals and ambulatory surgical centers to the  
22 Florida Center for Excellence in Health Care, as created in s.  
23 381.0409, for analysis by experts who may make recommendations  
24 regarding the prevention of such incidents. Such information  
25 shall remain confidential as otherwise provided by law.  
26 (12) If appropriate, a licensed facility in which  
27 sexual abuse occurs must offer the victim of sexual abuse  
28 testing for sexually transmissible diseases and shall provide  
29 all such testing at no cost to the victim.  
30 Section 8. Section 395.1012, Florida Statutes, is  
31 created to read:

1           395.1012 Patient safety.--

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

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

14           Section 9. Subsection (1) of section 456.025, Florida  
15 Statutes, is amended to read:

16           456.025 Fees; receipts; disposition.--

17           (1) It is the intent of the Legislature that all costs  
18 of regulating health care professions and practitioners shall  
19 be borne solely by licensees and licensure applicants. It is  
20 also the intent of the Legislature that fees should be  
21 reasonable and not serve as a barrier to licensure. Moreover,  
22 it is the intent of the Legislature that the department  
23 operate as efficiently as possible and regularly report to the  
24 Legislature additional methods to streamline operational  
25 costs. Therefore, the boards in consultation with the  
26 department, or the department if there is no board, shall, by  
27 rule, set renewal fees which:

28           (a) Shall be based on revenue projections prepared  
29 using generally accepted accounting procedures;

30  
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1 (b) Shall be adequate to cover all expenses relating  
2 to that board identified in the department's long-range policy  
3 plan, as required by s. 456.005;

4 (c) Shall be reasonable, fair, and not serve as a  
5 barrier to licensure;

6 (d) Shall be based on potential earnings from working  
7 under the scope of the license;

8 (e) Shall be similar to fees imposed on similar  
9 licensure types; and

10 ~~(f) Shall not be more than 10 percent greater than the~~  
11 ~~fee imposed for the previous biennium;~~

12 ~~(g) Shall not be more than 10 percent greater than the~~  
13 ~~actual cost to regulate that profession for the previous~~  
14 ~~biennium; and~~

15 ~~(f)(h)~~ Shall be subject to challenge pursuant to  
16 chapter 120.

17 Section 10. (1) The Agency for Health Care  
18 Administration shall conduct or contract for a study to  
19 determine what information is most feasible to provide to the  
20 public comparing state-licensed hospitals on certain inpatient  
21 quality indicators developed by the federal Agency for  
22 Healthcare Research and Quality. Such indicators shall be  
23 designed to identify information about specific procedures  
24 performed in hospitals for which there is strong evidence of a  
25 link to quality of care. The Agency for Health Care  
26 Administration or the study contractor shall refer to the  
27 hospital quality reports published in New York and Texas as  
28 guides during the evaluation.

29 (2) The following concepts shall be specifically  
30 addressed in the study report:

31

1       (a) Whether hospital discharge data about services can  
2 be translated into understandable and meaningful information  
3 for the public.

4       (b) Whether the following measures are useful consumer  
5 guides relating to care provided in state-licensed hospitals:

6           1. Inpatient mortality for medical conditions;

7           2. Inpatient mortality for procedures;

8           3. Utilization of procedures for which there are  
9 questions of overuse, underuse, or misuse; and

10           4. Volume of procedures for which there is evidence  
11 that a higher volume of procedures is associated with lower  
12 mortality.

13       (c) Whether there are quality indicators that are  
14 particularly useful relative to the state's unique  
15 demographics.

16       (d) Whether all hospitals should be included in the  
17 comparison.

18       (e) The criteria for comparison.

19       (f) Whether comparisons are best within metropolitan  
20 statistical areas or some other geographic configuration.

21       (g) Identify several websites to which such a report  
22 should be published to achieve the broadest dissemination of  
23 the information.

24       (3) The Agency for Health Care Administration shall  
25 consider the input of all interested parties, including  
26 hospitals, physicians, consumer organizations, and patients,  
27 and submit the final report to the Governor and the presiding  
28 officers of the Legislature by January 1, 2004.

29       Section 11. Section 395.1051, Florida Statutes, is  
30 created to read:

31

1           395.1051 Duty to notify patients.--The risk manager,  
2 or his or her designee, of each licensed facility shall inform  
3 each patient, or an individual identified pursuant to s.  
4 765.401(1), in person about adverse incidents that result in  
5 serious harm to the patient. Notification of outcomes of care  
6 that result in harm to the patient under this section shall  
7 not constitute an acknowledgement or admission of liability,  
8 nor can it be introduced as evidence.

9           Section 12. Section 456.0575, Florida Statutes, is  
10 created to read:

11           456.0575 Duty to notify patients.--Every licensed  
12 health care practitioner shall inform each patient, or an  
13 individual identified pursuant to s. 765.401(1), in person  
14 about adverse incidents that result in serious harm to the  
15 patient. Notification of outcomes of care that result in harm  
16 to the patient under this section shall not constitute an  
17 acknowledgement of admission of liability, nor can such  
18 notifications be introduced as evidence.

19           Section 13. Section 456.026, Florida Statutes, is  
20 amended to read:

21           456.026 Annual report concerning finances,  
22 administrative complaints, disciplinary actions, and  
23 recommendations.--The department is directed to prepare and  
24 submit a report to the President of the Senate and the Speaker  
25 of the House of Representatives by November 1 of each year.  
26 The department shall publish the report to its website  
27 simultaneously with delivery to the President of the Senate  
28 and the Speaker of the House of Representatives. The report  
29 must be directly accessible on the department's Internet  
30 homepage highlighted by easily identifiable links and buttons.

31 In addition to finances and any other information the



1 Legislature may require, the report shall include statistics  
2 and relevant information, profession by profession, detailing:

3       (1) The number of health care practitioners licensed  
4 by the Division of Medical Quality Assurance or otherwise  
5 authorized to provide services in the state, if known to the  
6 department.

7       ~~(2)(1)~~ The revenues, expenditures, and cash balances  
8 for the prior year, and a review of the adequacy of existing  
9 fees.

10       ~~(3)(2)~~ The number of complaints received and  
11 investigated.

12       ~~(4)(3)~~ The number of findings of probable cause made.

13       ~~(5)(4)~~ The number of findings of no probable cause  
14 made.

15       ~~(6)(5)~~ The number of administrative complaints filed.

16       ~~(7)(6)~~ The disposition of all administrative  
17 complaints.

18       ~~(8)(7)~~ A description of disciplinary actions taken.

19       (9) For licensees under chapter 458, chapter 459,  
20 chapter 461, or chapter 466, the professional liability claims  
21 and actions reported by insurers, as provided in s. 627.912.  
22 This information must be provided in a separate section of the  
23 report restricted to providing professional liability claims  
24 and actions data.

25       ~~(10)(8)~~ A description of any effort by the department  
26 to reduce or otherwise close any investigation or disciplinary  
27 proceeding not before the Division of Administrative Hearings  
28 under chapter 120 or otherwise not completed within 1 year  
29 after the initial filing of a complaint under this chapter.

30  
31

1           (11)~~(9)~~ The status of the development and  
2 implementation of rules providing for disciplinary guidelines  
3 pursuant to s. 456.079.

4           (12)~~(10)~~ Such recommendations for administrative and  
5 statutory changes necessary to facilitate efficient and  
6 cost-effective operation of the department and the various  
7 boards.

8           Section 14. Paragraph (a) of subsection (1) of section  
9 456.039, Florida Statutes, is amended to read:

10           456.039 Designated health care professionals;  
11 information required for licensure.--

12           (1) Each person who applies for initial licensure as a  
13 physician under chapter 458, chapter 459, chapter 460, or  
14 chapter 461, except a person applying for registration  
15 pursuant to ss. 458.345 and 459.021, must, at the time of  
16 application, and each physician who applies for license  
17 renewal under chapter 458, chapter 459, chapter 460, or  
18 chapter 461, except a person registered pursuant to ss.  
19 458.345 and 459.021, must, in conjunction with the renewal of  
20 such license and under procedures adopted by the Department of  
21 Health, and in addition to any other information that may be  
22 required from the applicant, furnish the following information  
23 to the Department of Health:

24           (a)1. The name of each medical school that the  
25 applicant has attended, with the dates of attendance and the  
26 date of graduation, and a description of all graduate medical  
27 education completed by the applicant, excluding any coursework  
28 taken to satisfy medical licensure continuing education  
29 requirements.

30           2. The name of each hospital at which the applicant  
31 has privileges.

1           3. The address at which the applicant will primarily  
2 conduct his or her practice.

3           4. Any certification that the applicant has received  
4 from a specialty board that is recognized by the board to  
5 which the applicant is applying.

6           5. The year that the applicant began practicing  
7 medicine.

8           6. Any appointment to the faculty of a medical school  
9 which the applicant currently holds and an indication as to  
10 whether the applicant has had the responsibility for graduate  
11 medical education within the most recent 10 years.

12           7. A description of any criminal offense of which the  
13 applicant has been found guilty, regardless of whether  
14 adjudication of guilt was withheld, or to which the applicant  
15 has pled guilty or nolo contendere. A criminal offense  
16 committed in another jurisdiction which would have been a  
17 felony or misdemeanor if committed in this state must be  
18 reported. If the applicant indicates that a criminal offense  
19 is under appeal and submits a copy of the notice for appeal of  
20 that criminal offense, the department must state that the  
21 criminal offense is under appeal if the criminal offense is  
22 reported in the applicant's profile. If the applicant  
23 indicates to the department that a criminal offense is under  
24 appeal, the applicant must, upon disposition of the appeal,  
25 submit to the department a copy of the final written order of  
26 disposition.

27           8. A description of any final disciplinary action  
28 taken within the previous 10 years against the applicant by  
29 the agency regulating the profession that the applicant is or  
30 has been licensed to practice, whether in this state or in any  
31 other jurisdiction, by a specialty board that is recognized by

1 the American Board of Medical Specialties, the American  
2 Osteopathic Association, or a similar national organization,  
3 or by a licensed hospital, health maintenance organization,  
4 prepaid health clinic, ambulatory surgical center, or nursing  
5 home. Disciplinary action includes resignation from or  
6 nonrenewal of medical staff membership or the restriction of  
7 privileges at a licensed hospital, health maintenance  
8 organization, prepaid health clinic, ambulatory surgical  
9 center, or nursing home taken in lieu of or in settlement of a  
10 pending disciplinary case related to competence or character.  
11 If the applicant indicates that the disciplinary action is  
12 under appeal and submits a copy of the document initiating an  
13 appeal of the disciplinary action, the department must state  
14 that the disciplinary action is under appeal if the  
15 disciplinary action is reported in the applicant's profile.

16 9. Relevant professional qualifications as defined by  
17 the applicable board.

18 Section 15. Section 456.041, Florida Statutes, is  
19 amended to read:

20 456.041 Practitioner profile; creation.--

21 (1)(a) ~~Beginning July 1, 1999,~~The Department of  
22 Health shall compile the information submitted pursuant to s.  
23 456.039 into a practitioner profile of the applicant  
24 submitting the information, except that the Department of  
25 Health shall ~~may~~ develop a format to compile uniformly any  
26 information submitted under s. 456.039(4)(b). Beginning July  
27 1, 2001, the Department of Health may compile the information  
28 submitted pursuant to s. 456.0391 into a practitioner profile  
29 of the applicant submitting the information.

30  
31

1           (b) The department shall take no longer than 45  
2 business days to update the practitioner's profile in  
3 accordance with the requirements of subsection (7).

4           (2) On the profile published under subsection (1), the  
5 department shall indicate if the information provided under s.  
6 456.039(1)(a)7. or s. 456.0391(1)(a)7. is or is not  
7 corroborated by a criminal history check conducted according  
8 to this subsection. ~~If the information provided under s.~~  
9 ~~456.039(1)(a)7. or s. 456.0391(1)(a)7. is corroborated by the~~  
10 ~~criminal history check, the fact that the criminal history~~  
11 ~~check was performed need not be indicated on the profile.~~The  
12 department, or the board having regulatory authority over the  
13 practitioner acting on behalf of the department, shall  
14 investigate any information received by the department or the  
15 board ~~when it has reasonable grounds to believe that the~~  
16 ~~practitioner has violated any law that relates to the~~  
17 ~~practitioner's practice.~~

18           (3) The Department of Health shall ~~may~~ include in each  
19 practitioner's practitioner profile that criminal information  
20 that directly relates to the practitioner's ability to  
21 competently practice his or her profession. The department  
22 must include in each practitioner's practitioner profile the  
23 following statement: "The criminal history information, if  
24 any exists, may be incomplete; federal criminal history  
25 information is not available to the public." The department  
26 shall provide in each practitioner profile, for every final  
27 disciplinary action taken against the practitioner, an  
28 easy-to-read narrative description that explains the  
29 administrative complaint filed against the practitioner and  
30 the final disciplinary action imposed on the practitioner. The  
31 department shall include a hyperlink to each final order

1 listed in its website report of dispositions of recent  
2 disciplinary actions taken against practitioners.

3 (4) The Department of Health shall include, with  
4 respect to a practitioner licensed under chapter 458 or  
5 chapter 459, a statement of how the practitioner has elected  
6 to comply with the financial responsibility requirements of s.  
7 458.320 or s. 459.0085. The department shall include, with  
8 respect to practitioners subject to s. 456.048, a statement of  
9 how the practitioner has elected to comply with the financial  
10 responsibility requirements of that section. The department  
11 shall include, with respect to practitioners licensed under  
12 ~~chapter 458, chapter 459, or~~ chapter 461, information relating  
13 to liability actions which has been reported under s. 456.049  
14 or s. 627.912 within the previous 10 years for any paid claim  
15 that exceeds \$5,000. The department shall include, with  
16 respect to practitioners licensed under chapter 458 or chapter  
17 459, information relating to liability actions which has been  
18 reported under s. 456.049 or s. 627.912 within the previous 10  
19 years for any paid claim that exceeds \$50,000.Such claims  
20 information shall be reported in the context of comparing an  
21 individual practitioner's claims to the experience of other  
22 practitioners within the same specialty, or profession if the  
23 practitioner is not a specialist, ~~to the extent such~~  
24 ~~information is available to the Department of Health.~~ The  
25 department must provide a hyperlink in such practitioner's  
26 profile to all such comparison reports.If information  
27 relating to a liability action is included in a practitioner's  
28 practitioner profile, the profile must also include the  
29 following statement: "Settlement of a claim may occur for a  
30 variety of reasons that do not necessarily reflect negatively  
31 on the professional competence or conduct of the practitioner.

1 A payment in settlement of a medical malpractice action or  
2 claim should not be construed as creating a presumption that  
3 medical malpractice has occurred."

4 (5) The Department of Health shall ~~may not~~ include the  
5 date of a hospital or ambulatory surgical center disciplinary  
6 action taken by a licensed hospital or an ambulatory surgical  
7 center, in accordance with the requirements of s. 395.0193, in  
8 the practitioner profile. The department shall state whether  
9 the action related to professional competence and whether it  
10 related to the delivery of services to a patient.

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

18 (7) Upon the completion of a practitioner profile  
19 under this section, the Department of Health shall furnish the  
20 practitioner who is the subject of the profile a copy of it  
21 for review and verification. The practitioner has a period of  
22 30 days in which to review and verify the contents of the  
23 profile and to correct any factual inaccuracies in it. The  
24 Department of Health shall make the profile available to the  
25 public at the end of the 30-day period regardless of whether  
26 the practitioner has provided verification of the profile  
27 content. A practitioner shall be subject to a fine of up to  
28 \$100 per day for failure to verify the profile contents and to  
29 correct any factual errors in his or her profile within the  
30 30-day period.The department shall make the profiles  
31 available to the public through the World Wide Web and other

1 commonly used means of distribution. The department must  
2 include the following statement, in boldface type, in each  
3 profile that has not been reviewed by the practitioner to  
4 which it applies: "The practitioner has not verified the  
5 information contained in this profile."

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

9 (9) The Department of Health may provide one link in  
10 each profile to a practitioner's professional website if the  
11 practitioner requests that such a link be included in his or  
12 her profile.

13 (10)(8) Making a practitioner profile available to the  
14 public under this section does not constitute agency action  
15 for which a hearing under s. 120.57 may be sought.

16 Section 16. Section 456.042, Florida Statutes, is  
17 amended to read:

18 456.042 Practitioner profiles; update.--A practitioner  
19 must submit updates of required information within 15 days  
20 after the final activity that renders such information a fact.  
21 The Department of Health shall update each practitioner's  
22 practitioner profile periodically. An updated profile is  
23 subject to the same requirements as an original profile ~~with~~  
24 ~~respect to the period within which the practitioner may review~~  
25 ~~the profile for the purpose of correcting factual~~  
26 ~~inaccuracies.~~

27 Section 17. Subsection (1) of section 456.049, Florida  
28 Statutes, is amended, and subsection (3) is added to that  
29 section, to read:

30 456.049 Health care practitioners; reports on  
31 professional liability claims and actions.--



1           (1) Any practitioner of medicine licensed pursuant to  
2 the provisions of chapter 458, practitioner of osteopathic  
3 medicine licensed pursuant to the provisions of chapter 459,  
4 podiatric physician licensed pursuant to the provisions of  
5 chapter 461, or dentist licensed pursuant to the provisions of  
6 chapter 466 shall report to the department any claim or action  
7 for damages for personal injury alleged to have been caused by  
8 error, omission, or negligence in the performance of such  
9 licensee's professional services or based on a claimed  
10 performance of professional services without consent if the  
11 claim was not covered by an insurer required to report under  
12 s. 627.912 and the claim resulted in:

13           (a) A final judgment in any amount.

14           (b) A settlement in any amount.

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

17

18 If the practitioner is licensed under chapter 458, chapter  
19 459, or chapter 461 and the final judgment or settlement  
20 amount was \$50,000 or more, or if the practitioner is licensed  
21 under chapter 466 and the final judgment or settlement amount  
22 was \$25,000 or more, the report ~~Reports~~ shall be filed with  
23 the department no later than 60 days following the occurrence  
24 of any event listed in paragraph (a) ~~or~~ paragraph (b), ~~or~~  
25 ~~paragraph (c)~~.

26           (3) The department must forward the information  
27 collected under this section to the Office of Insurance  
28 Regulation.

29           Section 18. Section 456.051, Florida Statutes, is  
30 amended to read:

31

1           456.051 Reports of professional liability actions;  
2 bankruptcies; Department of Health's responsibility to  
3 provide.--

4           (1) The report of a claim or action for damages for  
5 personal injury which is required to be provided to the  
6 Department of Health under s. 456.049 or s. 627.912 is public  
7 information except for the name of the claimant or injured  
8 person, which remains confidential as provided in ss.  
9 456.049(2)(d) and 627.912(2)(e). The Department of Health  
10 shall, upon request, make such report available to any person.  
11 The department shall make such report available as a part of  
12 the practitioner's profile within 45 calendar days after  
13 receipt.

14           (2) Any information in the possession of the  
15 Department of Health which relates to a bankruptcy proceeding  
16 by a practitioner of medicine licensed under chapter 458, a  
17 practitioner of osteopathic medicine licensed under chapter  
18 459, a podiatric physician licensed under chapter 461, or a  
19 dentist licensed under chapter 466 is public information. The  
20 Department of Health shall, upon request, make such  
21 information available to any person. The department shall make  
22 such report available as a part of the practitioner's profile  
23 within 45 calendar days after receipt.

24           Section 19. Paragraph (a) of subsection (7) of section  
25 456.057, Florida Statutes, is amended to read:

26           456.057 Ownership and control of patient records;  
27 report or copies of records to be furnished.--

28           (7)(a)1. The department may obtain patient records  
29 pursuant to a subpoena without written authorization from the  
30 patient if the department and the probable cause panel of the  
31 appropriate board, if any, find reasonable cause to believe

1 that a health care practitioner has excessively or  
2 inappropriately prescribed any controlled substance specified  
3 in chapter 893 in violation of this chapter or any  
4 professional practice act or that a health care practitioner  
5 has practiced his or her profession below that level of care,  
6 skill, and treatment required as defined by this chapter or  
7 any professional practice act and also find that appropriate,  
8 reasonable attempts were made to obtain a patient release.

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

17           3. The department may obtain patient records, billing  
18 records, insurance information, provider contracts, and all  
19 attachments thereto pursuant to a subpoena without written  
20 authorization from the patient if the department and probable  
21 cause panel of the appropriate board, if any, find reasonable  
22 cause to believe that a health care practitioner has submitted  
23 a claim, statement, or bill using a billing code that would  
24 result in payment greater in amount than would be paid using a  
25 billing code that accurately describes the services performed,  
26 requested payment for services that were not performed by that  
27 health care practitioner, used information derived from a  
28 written report of an automobile accident generated pursuant to  
29 chapter 316 to solicit or obtain patients personally or  
30 through an agent regardless of whether the information is  
31 derived directly from the report or a summary of that report

1 or from another person, solicited patients fraudulently,  
2 received a kickback as defined in s. 456.054, violated the  
3 patient brokering provisions of s. 817.505, or presented or  
4 caused to be presented a false or fraudulent insurance claim  
5 within the meaning of s. 817.234(1)(a), and also find that,  
6 within the meaning of s. 817.234(1)(a), patient authorization  
7 cannot be obtained because the patient cannot be located or is  
8 deceased, incapacitated, or suspected of being a participant  
9 in the fraud or scheme, and if the subpoena is issued for  
10 specific and relevant records. For purposes of this  
11 subsection, if the patient refuses to cooperate, is  
12 unavailable, or fails to execute a patient release, the  
13 department may obtain patient records pursuant to a subpoena  
14 without written authorization from the patient.

15 Section 20. Subsection (4) is added to section  
16 456.063, Florida Statutes, to read:

17 456.063 Sexual misconduct; disqualification for  
18 license, certificate, or registration.--

19 (4) Each board, or the department if there is no  
20 board, may adopt rules to implement the requirements for  
21 reporting allegations of sexual misconduct, including rules to  
22 determine the sufficiency of the allegations.

23 Section 21. Each board within the Department of Health  
24 which has jurisdiction over health care practitioners who are  
25 authorized to prescribe drugs may adopt by rule standards of  
26 practice for practitioners who are under that board's  
27 jurisdiction for the safe and ethical prescription of drugs to  
28 patients via the Internet or other electronic means.

29 Section 22. Subsection (4) of section 456.072, Florida  
30 Statutes, is amended, and subsection (7) is added to that  
31 section to read:

1           456.072 Grounds for discipline; penalties;  
2 enforcement.--

3           (4) In addition to any other discipline imposed  
4 through final order, or citation, entered on or after July 1,  
5 2001, pursuant to this section or discipline imposed through  
6 final order, or citation, entered on or after July 1, 2001,  
7 for a violation of any practice act, the board, or the  
8 department when there is no board, shall assess costs related  
9 to the investigation and prosecution of the case. Such costs  
10 related to the investigation and prosecution include, but are  
11 not limited to, salaries and benefits of personnel, costs  
12 related to the time spent by the attorney and other personnel  
13 working on the case, and any other expenses incurred by the  
14 department for the case. The board, or the department when  
15 there is no board, shall determine the amount of costs to be  
16 assessed after its consideration of an affidavit of itemized  
17 costs and any written objections thereto.In any case where  
18 the board or the department imposes a fine or assessment and  
19 the fine or assessment is not paid within a reasonable time,  
20 such reasonable time to be prescribed in the rules of the  
21 board, or the department when there is no board, or in the  
22 order assessing such fines or costs, the department or the  
23 Department of Legal Affairs may contract for the collection  
24 of, or bring a civil action to recover, the fine or  
25 assessment.

26           (7) In any formal administrative hearing conducted  
27 under s. 120.57(1), the department shall establish grounds for  
28 the discipline of a licensee by the greater weight of the  
29 evidence.

1           Section 23. Subsections (1) and (5) of section  
2 456.073, Florida Statutes, as amended by section 1 of chapter  
3 2003-27, Laws of Florida, are amended to read:

4           456.073 Disciplinary proceedings.--Disciplinary  
5 proceedings for each board shall be within the jurisdiction of  
6 the department.

7           (1) The department, for the boards under its  
8 jurisdiction, shall cause to be investigated any complaint  
9 that is filed before it if the complaint is in writing, signed  
10 by the complainant, and legally sufficient. A complaint filed  
11 by a state prisoner against a health care practitioner  
12 employed by or otherwise providing health care services within  
13 a facility of the Department of Corrections is not legally  
14 sufficient unless there is a showing that the prisoner  
15 complainant has exhausted all available administrative  
16 remedies within the state correctional system before filing  
17 the complaint. However, if the Department of Health determines  
18 after a preliminary inquiry of a state prisoner's complaint  
19 that the practitioner may present a serious threat to the  
20 health and safety of any individual who is not a state  
21 prisoner, the Department of Health may determine legal  
22 sufficiency and proceed with discipline. The Department of  
23 Health shall be notified within 15 days after the Department  
24 of Corrections disciplines or allows a health care  
25 practitioner to resign for an offense related to the practice  
26 of his or her profession. A complaint is legally sufficient if  
27 it contains ultimate facts that show that a violation of this  
28 chapter, of any of the practice acts relating to the  
29 professions regulated by the department, or of any rule  
30 adopted by the department or a regulatory board in the  
31 department has occurred. In order to determine legal

1 sufficiency, the department may require supporting information  
2 or documentation. The department may investigate, and the  
3 department or the appropriate board may take appropriate final  
4 action on, a complaint even though the original complainant  
5 withdraws it or otherwise indicates a desire not to cause the  
6 complaint to be investigated or prosecuted to completion. The  
7 department may investigate an anonymous complaint if the  
8 complaint is in writing and is legally sufficient, if the  
9 alleged violation of law or rules is substantial, and if the  
10 department has reason to believe, after preliminary inquiry,  
11 that the violations alleged in the complaint are true. The  
12 department may investigate a complaint made by a confidential  
13 informant if the complaint is legally sufficient, if the  
14 alleged violation of law or rule is substantial, and if the  
15 department has reason to believe, after preliminary inquiry,  
16 that the allegations of the complainant are true. The  
17 department may initiate an investigation if it has reasonable  
18 cause to believe that a licensee or a group of licensees has  
19 violated a Florida statute, a rule of the department, or a  
20 rule of a board. The department may investigate information  
21 filed pursuant to s. 456.041(4) relating to liability actions  
22 with respect to practitioners licensed under chapter 458 or  
23 chapter 459 which have been reported under s. 456.049 or s.  
24 627.912 within the previous 10 years for any paid claim that  
25 exceeds \$50,000. Except as provided in ss. 458.331(9),  
26 459.015(9), 460.413(5), and 461.013(6), when an investigation  
27 of any subject is undertaken, the department shall promptly  
28 furnish to the subject or the subject's attorney a copy of the  
29 complaint or document that resulted in the initiation of the  
30 investigation. The subject may submit a written response to  
31 the information contained in such complaint or document within

1 20 days after service to the subject of the complaint or  
2 document. The subject's written response shall be considered  
3 by the probable cause panel. The right to respond does not  
4 prohibit the issuance of a summary emergency order if  
5 necessary to protect the public. However, if the secretary, or  
6 the secretary's designee, and the chair of the respective  
7 board or the chair of its probable cause panel agree in  
8 writing that such notification would be detrimental to the  
9 investigation, the department may withhold notification. The  
10 department may conduct an investigation without notification  
11 to any subject if the act under investigation is a criminal  
12 offense.

13 (5) A formal hearing before an administrative law  
14 judge from the Division of Administrative Hearings shall be  
15 held pursuant to chapter 120 if there are any disputed issues  
16 of material fact. The administrative law judge shall issue a  
17 recommended order pursuant to chapter 120. Notwithstanding s.  
18 120.569(2), the department shall notify the division within 45  
19 days after receipt of a petition or request for a formal  
20 hearing.~~If any party raises an issue of disputed fact during~~  
21 ~~an informal hearing, the hearing shall be terminated and a~~  
22 ~~formal hearing pursuant to chapter 120 shall be held.~~

23 Section 24. Subsection (1) of section 456.077, Florida  
24 Statutes, is amended to read:

25 456.077 Authority to issue citations.--

26 (1) Notwithstanding s. 456.073, the board, or the  
27 department if there is no board, shall adopt rules to permit  
28 the issuance of citations. The citation shall be issued to the  
29 subject and shall contain the subject's name and address, the  
30 subject's license number if applicable, a brief factual  
31 statement, the sections of the law allegedly violated, and the



1 penalty imposed. The citation must clearly state that the  
2 subject may choose, in lieu of accepting the citation, to  
3 follow the procedure under s. 456.073. If the subject disputes  
4 the matter in the citation, the procedures set forth in s.  
5 456.073 must be followed. However, if the subject does not  
6 dispute the matter in the citation with the department within  
7 30 days after the citation is served, the citation becomes a  
8 final order and does not constitute ~~constitutes~~ discipline for  
9 a first offense. The penalty shall be a fine or other  
10 conditions as established by rule.

11 Section 25. Subsection (1) of section 456.078, Florida  
12 Statutes, is amended to read:

13 456.078 Mediation.--

14 (1) Notwithstanding the provisions of s. 456.073, the  
15 board, or the department when there is no board, shall adopt  
16 rules to designate which violations of the applicable  
17 professional practice act, including standard-of-care  
18 violations, are appropriate for mediation. The board, or the  
19 department when there is no board, must ~~may~~ designate as  
20 mediation offenses those complaints where harm caused by the  
21 licensee is economic in nature or can be remedied by the  
22 licensee.

23 Section 26. Effective upon this act becoming a law and  
24 applying to claims accruing on or after that date, section  
25 458.320, Florida Statutes, is amended to read:

26 458.320 Financial responsibility.--

27 (1) As a condition of licensing and maintaining an  
28 active license, and prior to the issuance or renewal of an  
29 active license or reactivation of an inactive license for the  
30 practice of medicine, an applicant must ~~shall~~ by one of the  
31 following methods demonstrate to the satisfaction of the board

1 and the department financial responsibility to pay claims and  
2 costs ancillary thereto arising out of the rendering of, or  
3 the failure to render, medical care or services:

4 (a) Establishing and maintaining an escrow account  
5 consisting of cash or assets eligible for deposit in  
6 accordance with s. 625.52 in the per claim amounts specified  
7 in paragraph (b). The required escrow amount set forth in this  
8 paragraph may not be used for litigation costs or attorney's  
9 fees for the defense of any medical malpractice claim.

10 (b) Obtaining and maintaining professional liability  
11 coverage in an amount not less than \$100,000 per claim, with a  
12 minimum annual aggregate of not less than \$300,000, from an  
13 authorized insurer as defined under s. 624.09, from a surplus  
14 lines insurer as defined under s. 626.914(2), from a risk  
15 retention group as defined under s. 627.942, from the Joint  
16 Underwriting Association established under s. 627.351(4), or  
17 through a plan of self-insurance as provided in s. 627.357.  
18 The required coverage amount set forth in this paragraph may  
19 not be used for litigation costs or attorney's fees for the  
20 defense of any medical malpractice claim.

21 (c) Obtaining and maintaining an unexpired,  
22 irrevocable letter of credit, established pursuant to chapter  
23 675, in an amount not less than \$100,000 per claim, with a  
24 minimum aggregate availability of credit of not less than  
25 \$300,000. The letter of credit must ~~shall~~ be payable to the  
26 physician as beneficiary upon presentment of a final judgment  
27 indicating liability and awarding damages to be paid by the  
28 physician or upon presentment of a settlement agreement signed  
29 by all parties to such agreement when such final judgment or  
30 settlement is a result of a claim arising out of the rendering  
31 of, or the failure to render, medical care and services. The

1 letter of credit may not be used for litigation costs or  
2 attorney's fees for the defense of any medical malpractice  
3 claim. The ~~Such~~ letter of credit must ~~shall~~ be nonassignable  
4 and nontransferable. Such letter of credit must ~~shall~~ be  
5 issued by any bank or savings association organized and  
6 existing under the laws of this state or any bank or savings  
7 association organized under the laws of the United States  
8 which ~~that~~ has its principal place of business in this state  
9 or has a branch office that ~~which~~ is authorized under the laws  
10 of this state or of the United States to receive deposits in  
11 this state.

12 (2) Physicians who perform surgery in an ambulatory  
13 surgical center licensed under chapter 395, and as a  
14 continuing condition of hospital staff privileges, physicians  
15 who have ~~with~~ staff privileges must ~~shall~~ also ~~be required to~~  
16 establish financial responsibility by one of the following  
17 methods:

18 (a) Establishing and maintaining an escrow account  
19 consisting of cash or assets eligible for deposit in  
20 accordance with s. 625.52 in the per claim amounts specified  
21 in paragraph (b). The required escrow amount set forth in this  
22 paragraph may not be used for litigation costs or attorney's  
23 fees for the defense of any medical malpractice claim.

24 (b) Obtaining and maintaining professional liability  
25 coverage in an amount not less than \$250,000 per claim, with a  
26 minimum annual aggregate of not less than \$750,000 from an  
27 authorized insurer as defined under s. 624.09, from a surplus  
28 lines insurer as defined under s. 626.914(2), from a risk  
29 retention group as defined under s. 627.942, from the Joint  
30 Underwriting Association established under s. 627.351(4),  
31 through a plan of self-insurance as provided in s. 627.357, or

1 through a plan of self-insurance which meets the conditions  
2 specified for satisfying financial responsibility in s.  
3 766.110. The required coverage amount set forth in this  
4 paragraph may not be used for litigation costs or attorney's  
5 fees for the defense of any medical malpractice claim.

6 (c) Obtaining and maintaining an unexpired irrevocable  
7 letter of credit, established pursuant to chapter 675, in an  
8 amount not less than \$250,000 per claim, with a minimum  
9 aggregate availability of credit of not less than \$750,000.  
10 The letter of credit must ~~shall~~ be payable to the physician as  
11 beneficiary upon presentment of a final judgment indicating  
12 liability and awarding damages to be paid by the physician or  
13 upon presentment of a settlement agreement signed by all  
14 parties to such agreement when such final judgment or  
15 settlement is a result of a claim arising out of the rendering  
16 of, or the failure to render, medical care and services. The  
17 letter of credit may not be used for litigation costs or  
18 attorney's fees for the defense of any medical malpractice  
19 claim. The ~~Such~~ letter of credit must ~~shall~~ be nonassignable  
20 and nontransferable. The ~~Such~~ letter of credit must ~~shall~~ be  
21 issued by any bank or savings association organized and  
22 existing under the laws of this state or any bank or savings  
23 association organized under the laws of the United States  
24 which ~~that~~ has its principal place of business in this state  
25 or has a branch office that ~~which~~ is authorized under the laws  
26 of this state or of the United States to receive deposits in  
27 this state.

28  
29 This subsection shall be inclusive of the coverage in  
30 subsection (1).  
31

1           ~~(3)(a) The financial responsibility requirements of~~  
2 ~~subsections (1) and (2) shall apply to claims for incidents~~  
3 ~~that occur on or after January 1, 1987, or the initial date of~~  
4 ~~licensure in this state, whichever is later.~~

5           ~~(b)~~ Meeting the financial responsibility requirements  
6 of this section or the criteria for any exemption from such  
7 requirements must ~~shall~~ be established at the time of issuance  
8 or renewal of a license ~~on or after January 1, 1987.~~

9           ~~(b)(c)~~ Any person may, at any time, submit to the  
10 department a request for an advisory opinion regarding such  
11 person's qualifications for exemption.

12           (4)(a) Each insurer, self-insurer, risk retention  
13 group, or Joint Underwriting Association must ~~shall~~ promptly  
14 notify the department of cancellation or nonrenewal of  
15 insurance required by this section. Unless the physician  
16 demonstrates that he or she is otherwise in compliance with  
17 the requirements of this section, the department shall suspend  
18 the license of the physician pursuant to ss. 120.569 and  
19 120.57 and notify all health care facilities licensed under  
20 chapter 395 of such action. Any suspension under this  
21 subsection remains ~~shall remain~~ in effect until the physician  
22 demonstrates compliance with the requirements of this section.  
23 If any judgments or settlements are pending at the time of  
24 suspension, those judgments or settlements must be paid in  
25 accordance with this section unless otherwise mutually agreed  
26 to in writing by the parties. This paragraph does not abrogate  
27 a judgment debtor's obligation to satisfy the entire amount of  
28 any judgment, ~~except that a license suspended under paragraph~~  
29 ~~(5)(g) shall not be reinstated until the physician~~  
30 ~~demonstrates compliance with the requirements of that~~  
31 ~~provision.~~

1           (b) If financial responsibility requirements are met  
2 by maintaining an escrow account or letter of credit as  
3 provided in this section, upon the entry of an adverse final  
4 judgment arising from a medical malpractice arbitration award,  
5 from a claim of medical malpractice either in contract or  
6 tort, or from noncompliance with the terms of a settlement  
7 agreement arising from a claim of medical malpractice either  
8 in contract or tort, the licensee shall pay the entire amount  
9 of the judgment together with all accrued interest, or the  
10 amount maintained in the escrow account or provided in the  
11 letter of credit as required by this section, whichever is  
12 less, within 60 days after the date such judgment became final  
13 and subject to execution, unless otherwise mutually agreed to  
14 in writing by the parties. If timely payment is not made by  
15 the physician, the department shall suspend the license of the  
16 physician pursuant to procedures set forth in subparagraphs  
17 (5)(g)3., 4., and 5. Nothing in this paragraph shall abrogate  
18 a judgment debtor's obligation to satisfy the entire amount of  
19 any judgment.

20           (5) The requirements of subsections (1), (2), and (3)  
21 do ~~shall~~ not apply to:

22           (a) Any person licensed under this chapter who  
23 practices medicine exclusively as an officer, employee, or  
24 agent of the Federal Government or of the state or its  
25 agencies or its subdivisions. For the purposes of this  
26 subsection, an agent of the state, its agencies, or its  
27 subdivisions is a person who is eligible for coverage under  
28 any self-insurance or insurance program authorized by the  
29 provisions of s. 768.28(15).

30           (b) Any person whose license has become inactive under  
31 this chapter and who is not practicing medicine in this state.

1 Any person applying for reactivation of a license must show  
2 either that such licensee maintained tail insurance coverage  
3 which provided liability coverage for incidents that occurred  
4 on or after January 1, 1987, or the initial date of licensure  
5 in this state, whichever is later, and incidents that occurred  
6 before the date on which the license became inactive; or such  
7 licensee must submit an affidavit stating that such licensee  
8 has no unsatisfied medical malpractice judgments or  
9 settlements at the time of application for reactivation.

10 (c) Any person holding a limited license pursuant to  
11 s. 458.317 and practicing under the scope of such limited  
12 license.

13 (d) Any person licensed or certified under this  
14 chapter who practices only in conjunction with his or her  
15 teaching duties at an accredited medical school or in its main  
16 teaching hospitals. Such person may engage in the practice of  
17 medicine to the extent that such practice is incidental to and  
18 a necessary part of duties in connection with the teaching  
19 position in the medical school.

20 (e) Any person holding an active license under this  
21 chapter who is not practicing medicine in this state. If such  
22 person initiates or resumes any practice of medicine in this  
23 state, he or she must notify the department of such activity  
24 and fulfill the financial responsibility requirements of this  
25 section before resuming the practice of medicine in this  
26 state.

27 (f) Any person holding an active license under this  
28 chapter who meets all of the following criteria:

29 1. The licensee has held an active license to practice  
30 in this state or another state or some combination thereof for  
31 more than 15 years.

1           2. The licensee has either retired from the practice  
2 of medicine or maintains a part-time practice of no more than  
3 1,000 patient contact hours per year.

4           3. The licensee has had no more than two claims for  
5 medical malpractice resulting in an indemnity exceeding  
6 \$25,000 within the previous 5-year period.

7           4. The licensee has not been convicted of, or pled  
8 guilty or nolo contendere to, any criminal violation specified  
9 in this chapter or the medical practice act of any other  
10 state.

11           5. The licensee has not been subject within the last  
12 10 years of practice to license revocation or suspension for  
13 any period of time; probation for a period of 3 years or  
14 longer; or a fine of \$500 or more for a violation of this  
15 chapter or the medical practice act of another jurisdiction.  
16 The regulatory agency's acceptance of a physician's  
17 relinquishment of a license, stipulation, consent order, or  
18 other settlement, offered in response to or in anticipation of  
19 the filing of administrative charges against the physician's  
20 license, constitutes ~~shall be construed as~~ action against the  
21 physician's license for the purposes of this paragraph.

22           6. The licensee has submitted a form supplying  
23 necessary information as required by the department and an  
24 affidavit affirming compliance with ~~the provisions of~~ this  
25 paragraph.

26           7. The licensee must ~~shall~~ submit biennially to the  
27 department certification stating compliance with the  
28 provisions of this paragraph. The licensee must ~~shall~~, upon  
29 request, demonstrate to the department information verifying  
30 compliance with this paragraph.

31



1 A licensee who meets the requirements of this paragraph must  
2 ~~shall be required either to post notice in the form of a sign~~  
3 ~~prominently displayed in the reception area and clearly~~  
4 ~~noticeable by all patients or provide a written statement to~~  
5 ~~any person to whom medical services are being provided. The~~  
6 ~~Such sign or statement must read as follows shall state that:~~  
7 "Under Florida law, physicians are generally required to carry  
8 medical malpractice insurance or otherwise demonstrate  
9 financial responsibility to cover potential claims for medical  
10 malpractice. However, certain part-time physicians who meet  
11 state requirements are exempt from the financial  
12 responsibility law. YOUR DOCTOR MEETS THESE REQUIREMENTS AND  
13 HAS DECIDED NOT TO CARRY MEDICAL MALPRACTICE INSURANCE. This  
14 notice is provided pursuant to Florida law."

15 ~~(g) Any person holding an active license under this~~  
16 ~~chapter who agrees to meet all of the following criteria:~~

17 ~~(6)†. Upon the entry of an adverse final judgment~~  
18 ~~arising from a medical malpractice arbitration award, from a~~  
19 ~~claim of medical malpractice either in contract or tort, or~~  
20 ~~from noncompliance with the terms of a settlement agreement~~  
21 ~~arising from a claim of medical malpractice either in contract~~  
22 ~~or tort, the licensee shall pay the judgment creditor the~~  
23 ~~lesser of the entire amount of the judgment with all accrued~~  
24 ~~interest or either \$100,000, if the physician is licensed~~  
25 ~~pursuant to this chapter but does not maintain hospital staff~~  
26 ~~privileges, or \$250,000, if the physician is licensed pursuant~~  
27 ~~to this chapter and maintains hospital staff privileges,~~  
28 ~~within 60 days after the date such judgment became final and~~  
29 ~~subject to execution, unless otherwise mutually agreed to in~~  
30 ~~writing by the parties. Such adverse final judgment shall~~  
31 ~~include any cross-claim, counterclaim, or claim for indemnity~~

1 or contribution arising from the claim of medical malpractice.  
2 Upon notification of the existence of an unsatisfied judgment  
3 or payment pursuant to this subparagraph, the department shall  
4 notify the licensee by certified mail that he or she shall be  
5 subject to disciplinary action unless, within 30 days from the  
6 date of mailing, he or she either:

7 (a)~~a.~~ Shows proof that the unsatisfied judgment has  
8 been paid in the amount specified in this subparagraph; or

9 (b)~~b.~~ Furnishes the department with a copy of a timely  
10 filed notice of appeal and either:

11 1.~~(I)~~ A copy of a supersedeas bond properly posted in  
12 the amount required by law; or

13 2.~~(II)~~ An order from a court of competent jurisdiction  
14 staying execution on the final judgment pending disposition of  
15 the appeal.

16 (c)~~c.~~ The Department of Health shall issue an  
17 emergency order suspending the license of any licensee who,  
18 after 30 days following receipt of a notice from the  
19 Department of Health, has failed to: satisfy a medical  
20 malpractice claim against him or her; furnish the Department  
21 of Health a copy of a timely filed notice of appeal; furnish  
22 the Department of Health a copy of a supersedeas bond properly  
23 posted in the amount required by law; or furnish the  
24 Department of Health an order from a court of competent  
25 jurisdiction staying execution on the final judgment pending  
26 disposition of the appeal.

27 (d)~~d.~~ Upon the next meeting of the probable cause  
28 panel of the board following 30 days after the date of mailing  
29 the notice of disciplinary action to the licensee, the panel  
30 shall make a determination of whether probable cause exists to  
31

1 take disciplinary action against the licensee pursuant to this  
2 subsection subparagraph 1.

3 (e)4. If the board determines that the factual  
4 requirements of this subsection subparagraph 1 are met, it  
5 shall take disciplinary action as it deems appropriate against  
6 the licensee. Such disciplinary action shall include, at a  
7 minimum, probation of the license with the restriction that  
8 the licensee must make payments to the judgment creditor on a  
9 schedule determined by the board to be reasonable and within  
10 the financial capability of the physician. Notwithstanding any  
11 other disciplinary penalty imposed, the disciplinary penalty  
12 may include suspension of the license for a period not to  
13 exceed 5 years. In the event that an agreement to satisfy a  
14 judgment has been met, the board shall remove any restriction  
15 on the license.

16 (f)5. The licensee has completed a form supplying  
17 necessary information as required by the department.

18  
19 ~~A licensee who meets the requirements of this paragraph shall~~  
20 ~~be required either to post notice in the form of a sign~~  
21 ~~prominently displayed in the reception area and clearly~~  
22 ~~noticeable by all patients or to provide a written statement~~  
23 ~~to any person to whom medical services are being provided.~~  
24 ~~Such sign or statement shall state: "Under Florida law,~~  
25 ~~physicians are generally required to carry medical malpractice~~  
26 ~~insurance or otherwise demonstrate financial responsibility to~~  
27 ~~cover potential claims for medical malpractice. YOUR DOCTOR~~  
28 ~~HAS DECIDED NOT TO CARRY MEDICAL MALPRACTICE INSURANCE. This~~  
29 ~~is permitted under Florida law subject to certain conditions.~~  
30 ~~Florida law imposes penalties against noninsured physicians~~  
31 ~~who fail to satisfy adverse judgments arising from claims of~~

1 ~~medical malpractice. This notice is provided pursuant to~~  
2 ~~Florida law."~~

3 (7)~~(6)~~ Any deceptive, untrue, or fraudulent  
4 representation by the licensee with respect to any provision  
5 of this section shall result in permanent disqualification  
6 from any exemption to mandated financial responsibility as  
7 provided in this section and shall constitute grounds for  
8 disciplinary action under s. 458.331.

9 (8)~~(7)~~ Any licensee who relies on any exemption from  
10 the financial responsibility requirement shall notify the  
11 department, in writing, of any change of circumstance  
12 regarding his or her qualifications for such exemption and  
13 shall demonstrate that he or she is in compliance with the  
14 requirements of this section.

15 (9) Notwithstanding any other provision of this  
16 section, the department shall suspend the license of any  
17 physician against whom has been entered a final judgment,  
18 arbitration award, or other order or who has entered into a  
19 settlement agreement to pay damages arising out of a claim for  
20 medical malpractice, if all appellate remedies have been  
21 exhausted and payment up to the amounts required by this  
22 section has not been made within 30 days after the entering of  
23 such judgment, award, or order or agreement, until proof of  
24 payment is received by the department or a payment schedule  
25 has been agreed upon by the physician and the claimant and  
26 presented to the department. This subsection does not apply to  
27 a physician who has met the financial responsibility  
28 requirements in paragraphs (1)(b) and (2)(b).

29 (10)~~(8)~~ The board shall adopt rules to implement the  
30 provisions of this section.

31

1           Section 27. Effective upon this act becoming a law and  
2 applying to claims accruing on or after that date, section  
3 459.0085, Florida Statutes, is amended to read:

4           459.0085 Financial responsibility.--

5           (1) As a condition of licensing and maintaining an  
6 active license, and prior to the issuance or renewal of an  
7 active license or reactivation of an inactive license for the  
8 practice of osteopathic medicine, an applicant must ~~shall~~ by  
9 one of the following methods demonstrate to the satisfaction  
10 of the board and the department financial responsibility to  
11 pay claims and costs ancillary thereto arising out of the  
12 rendering of, or the failure to render, medical care or  
13 services:

14           (a) Establishing and maintaining an escrow account  
15 consisting of cash or assets eligible for deposit in  
16 accordance with s. 625.52 in the per-claim amounts specified  
17 in paragraph (b).

18           (b) Obtaining and maintaining professional liability  
19 coverage for the current year and for each of the prior years  
20 that the applicant or licensee has been in the active practice  
21 of medicine, up to a maximum of 4 prior years, in an amount  
22 not less than \$100,000 per claim, with a minimum annual  
23 aggregate of not less than \$300,000, from an authorized  
24 insurer as defined under s. 624.09, from a surplus lines  
25 insurer as defined under s. 626.914(2), from a risk retention  
26 group as defined under s. 627.942, from the Joint Underwriting  
27 Association established under s. 627.351(4), or through a plan  
28 of self-insurance as provided in s. 627.357. The required  
29 coverage amount set forth in this paragraph may not be used  
30 for litigation costs or attorney's fees for the defense of any  
31 medical malpractice claim.

1 (c) Obtaining and maintaining an unexpired,  
2 irrevocable letter of credit, established pursuant to chapter  
3 675, for the current year and for each of the prior years that  
4 the applicant or licensee has been in the active practice of  
5 medicine, up to a maximum of 4 prior years, in an amount not  
6 less than \$100,000 per claim, with a minimum aggregate  
7 availability of credit of not less than \$300,000. The letter  
8 of credit must ~~shall~~ be payable to the osteopathic physician  
9 as beneficiary upon presentment of a final judgment indicating  
10 liability and awarding damages to be paid by the osteopathic  
11 physician or upon presentment of a settlement agreement signed  
12 by all parties to such agreement when such final judgment or  
13 settlement is a result of a claim arising out of the rendering  
14 of, or the failure to render, medical care and services. Such  
15 letter of credit must ~~shall~~ be nonassignable and  
16 nontransferable. Such letter of credit must ~~shall~~ be issued by  
17 any bank or savings association organized and existing under  
18 the laws of this state or any bank or savings association  
19 organized under the laws of the United States which ~~that~~ has  
20 its principal place of business in this state or has a branch  
21 office that ~~which~~ is authorized under the laws of this state  
22 or of the United States to receive deposits in this state.

23 (2) Osteopathic physicians who perform surgery in an  
24 ambulatory surgical center licensed under chapter 395, and, as  
25 a continuing condition of hospital staff privileges,  
26 osteopathic physicians who have ~~with~~ staff privileges must  
27 ~~shall also be required to~~ establish financial responsibility  
28 by one of the following methods:

29 (a) Establishing and maintaining an escrow account  
30 consisting of cash or assets eligible for deposit in  
31

1 accordance with s. 625.52 in the per-claim amounts specified  
2 in paragraph (b).

3 (b) Obtaining and maintaining professional liability  
4 coverage for the current year and for each of the prior years  
5 that the applicant or licensee has been in the active practice  
6 of medicine, up to a maximum of 4 prior years, in an amount  
7 not less than \$250,000 per claim, with a minimum annual  
8 aggregate of not less than \$750,000 from an authorized insurer  
9 as defined under s. 624.09, from a surplus lines insurer as  
10 defined under s. 626.914(2), from a risk retention group as  
11 defined under s. 627.942, from the Joint Underwriting  
12 Association established under s. 627.351(4), through a plan of  
13 self-insurance as provided in s. 627.357, or through a plan of  
14 self-insurance that ~~which~~ meets the conditions specified for  
15 satisfying financial responsibility in s. 766.110.

16 (c) Obtaining and maintaining an unexpired,  
17 irrevocable letter of credit, established pursuant to chapter  
18 675, for the current year and for each of the prior years that  
19 the applicant or licensee has been in the active practice of  
20 medicine, up to a maximum of 4 prior years, in an amount not  
21 less than \$250,000 per claim, with a minimum aggregate  
22 availability of credit of not less than \$750,000. The letter  
23 of credit must ~~shall~~ be payable to the osteopathic physician  
24 as beneficiary upon presentment of a final judgment indicating  
25 liability and awarding damages to be paid by the osteopathic  
26 physician or upon presentment of a settlement agreement signed  
27 by all parties to such agreement when such final judgment or  
28 settlement is a result of a claim arising out of the rendering  
29 of, or the failure to render, medical care and services. The  
30 ~~Such~~ letter of credit must ~~shall~~ be nonassignable and  
31 nontransferable. The ~~Such~~ letter of credit must ~~shall~~ be

1 issued by any bank or savings association organized and  
2 existing under the laws of this state or any bank or savings  
3 association organized under the laws of the United States  
4 which ~~that~~ has its principal place of business in this state  
5 or has a branch office that ~~which~~ is authorized under the laws  
6 of this state or of the United States to receive deposits in  
7 this state.

8  
9 This subsection shall be inclusive of the coverage in  
10 subsection (1).

11 ~~(3)(a) The financial responsibility requirements of~~  
12 ~~subsections (1) and (2) shall apply to claims for incidents~~  
13 ~~that occur on or after January 1, 1987, or the initial date of~~  
14 ~~licensure in this state, whichever is later.~~

15 ~~(b)~~ Meeting the financial responsibility requirements  
16 of this section or the criteria for any exemption from such  
17 requirements must ~~shall~~ be established at the time of issuance  
18 or renewal of a license ~~on or after January 1, 1987.~~

19 ~~(b)(c)~~ Any person may, at any time, submit to the  
20 department a request for an advisory opinion regarding such  
21 person's qualifications for exemption.

22 (4)(a) Each insurer, self-insurer, risk retention  
23 group, or joint underwriting association must ~~shall~~ promptly  
24 notify the department of cancellation or nonrenewal of  
25 insurance required by this section. Unless the osteopathic  
26 physician demonstrates that he or she is otherwise in  
27 compliance with the requirements of this section, the  
28 department shall suspend the license of the osteopathic  
29 physician pursuant to ss. 120.569 and 120.57 and notify all  
30 health care facilities licensed under chapter 395, part IV of  
31 chapter 394, or part I of chapter 641 of such action. Any



1 suspension under this subsection remains ~~shall remain~~ in  
2 effect until the osteopathic physician demonstrates compliance  
3 with the requirements of this section. If any judgments or  
4 settlements are pending at the time of suspension, those  
5 judgments or settlements must be paid in accordance with  
6 section (6) unless otherwise mutually agreed to in writing by  
7 the parties. This paragraph does not abrogate a judgment  
8 debtor's obligation to satisfy the entire amount of any  
9 judgment ~~except that a license suspended under paragraph~~  
10 ~~(5)(g) shall not be reinstated until the osteopathic physician~~  
11 ~~demonstrates compliance with the requirements of that~~  
12 ~~provision.~~

13 (b) If financial responsibility requirements are met  
14 by maintaining an escrow account or letter of credit as  
15 provided in this section, upon the entry of an adverse final  
16 judgment arising from a medical malpractice arbitration award,  
17 from a claim of medical malpractice either in contract or  
18 tort, or from noncompliance with the terms of a settlement  
19 agreement arising from a claim of medical malpractice either  
20 in contract or tort, the licensee shall pay the entire amount  
21 of the judgment together with all accrued interest or the  
22 amount maintained in the escrow account or provided in the  
23 letter of credit as required by this section, whichever is  
24 less, within 60 days after the date such judgment became final  
25 and subject to execution, unless otherwise mutually agreed to  
26 in writing by the parties. If timely payment is not made by  
27 the osteopathic physician, the department shall suspend the  
28 license of the osteopathic physician pursuant to procedures  
29 set forth in subparagraphs (5)(g)3., 4., and 5. Nothing in  
30 this paragraph shall abrogate a judgment debtor's obligation  
31 to satisfy the entire amount of any judgment.

1           (5) The requirements of subsections (1), (2), and (3)  
2 do ~~shall~~ not apply to:

3           (a) Any person licensed under this chapter who  
4 practices medicine exclusively as an officer, employee, or  
5 agent of the Federal Government or of the state or its  
6 agencies or its subdivisions. For the purposes of this  
7 subsection, an agent of the state, its agencies, or its  
8 subdivisions is a person who is eligible for coverage under  
9 any self-insurance or insurance program authorized by the  
10 provisions of s. 768.28(15).

11           (b) Any person whose license has become inactive under  
12 this chapter and who is not practicing medicine in this state.  
13 Any person applying for reactivation of a license must show  
14 either that such licensee maintained tail insurance coverage  
15 that ~~which~~ provided liability coverage for incidents that  
16 occurred on or after January 1, 1987, or the initial date of  
17 licensure in this state, whichever is later, and incidents  
18 that occurred before the date on which the license became  
19 inactive; or such licensee must submit an affidavit stating  
20 that such licensee has no unsatisfied medical malpractice  
21 judgments or settlements at the time of application for  
22 reactivation.

23           (c) Any person holding a limited license pursuant to  
24 s. 459.0075 and practicing under the scope of such limited  
25 license.

26           (d) Any person licensed or certified under this  
27 chapter who practices only in conjunction with his or her  
28 teaching duties at a college of osteopathic medicine. Such  
29 person may engage in the practice of osteopathic medicine to  
30 the extent that such practice is incidental to and a necessary  
31

1 part of duties in connection with the teaching position in the  
2 college of osteopathic medicine.

3 (e) Any person holding an active license under this  
4 chapter who is not practicing osteopathic medicine in this  
5 state. If such person initiates or resumes any practice of  
6 osteopathic medicine in this state, he or she must notify the  
7 department of such activity and fulfill the financial  
8 responsibility requirements of this section before resuming  
9 the practice of osteopathic medicine in this state.

10 (f) Any person holding an active license under this  
11 chapter who meets all of the following criteria:

12 1. The licensee has held an active license to practice  
13 in this state or another state or some combination thereof for  
14 more than 15 years.

15 2. The licensee has either retired from the practice  
16 of osteopathic medicine or maintains a part-time practice of  
17 osteopathic medicine of no more than 1,000 patient contact  
18 hours per year.

19 3. The licensee has had no more than two claims for  
20 medical malpractice resulting in an indemnity exceeding  
21 \$25,000 within the previous 5-year period.

22 4. The licensee has not been convicted of, or pled  
23 guilty or nolo contendere to, any criminal violation specified  
24 in this chapter or the practice act of any other state.

25 5. The licensee has not been subject within the last  
26 10 years of practice to license revocation or suspension for  
27 any period of time, probation for a period of 3 years or  
28 longer, or a fine of \$500 or more for a violation of this  
29 chapter or the medical practice act of another jurisdiction.  
30 The regulatory agency's acceptance of an osteopathic  
31 physician's relinquishment of a license, stipulation, consent

1 order, or other settlement, offered in response to or in  
2 anticipation of the filing of administrative charges against  
3 the osteopathic physician's license, constitutes ~~shall be~~  
4 ~~construed as~~ action against the physician's license for the  
5 purposes of this paragraph.

6 6. The licensee has submitted a form supplying  
7 necessary information as required by the department and an  
8 affidavit affirming compliance with ~~the provisions of this~~  
9 paragraph.

10 7. The licensee must ~~shall~~ submit biennially to the  
11 department a certification stating compliance with ~~the~~  
12 ~~provisions of this~~ paragraph. The licensee must ~~shall~~, upon  
13 request, demonstrate to the department information verifying  
14 compliance with this paragraph.

15  
16 A licensee who meets the requirements of this paragraph must  
17 ~~shall be required either to~~ post notice in the form of a sign  
18 prominently displayed in the reception area and clearly  
19 noticeable by all patients or ~~to~~ provide a written statement  
20 to any person to whom medical services are being provided. The  
21 ~~Such~~ sign or statement must read as follows ~~shall state that:~~  
22 "Under Florida law, osteopathic physicians are generally  
23 required to carry medical malpractice insurance or otherwise  
24 demonstrate financial responsibility to cover potential claims  
25 for medical malpractice. However, certain part-time  
26 osteopathic physicians who meet state requirements are exempt  
27 from the financial responsibility law. YOUR OSTEOPATHIC  
28 PHYSICIAN MEETS THESE REQUIREMENTS AND HAS DECIDED NOT TO  
29 CARRY MEDICAL MALPRACTICE INSURANCE. This notice is provided  
30 pursuant to Florida law."  
31

1           ~~(g)~~ Any person holding an active license under this  
2 chapter who agrees to meet all of the following criteria:

3           (6)~~1.~~ Upon the entry of an adverse final judgment  
4 arising from a medical malpractice arbitration award, from a  
5 claim of medical malpractice either in contract or tort, or  
6 from noncompliance with the terms of a settlement agreement  
7 arising from a claim of medical malpractice either in contract  
8 or tort, the licensee shall pay the judgment creditor the  
9 lesser of the entire amount of the judgment with all accrued  
10 interest or either \$100,000, if the osteopathic physician is  
11 licensed pursuant to this chapter but does not maintain  
12 hospital staff privileges, or \$250,000, if the osteopathic  
13 physician is licensed pursuant to this chapter and maintains  
14 hospital staff privileges, within 60 days after the date such  
15 judgment became final and subject to execution, unless  
16 otherwise mutually agreed to in writing by the parties. Such  
17 adverse final judgment shall include any cross-claim,  
18 counterclaim, or claim for indemnity or contribution arising  
19 from the claim of medical malpractice. Upon notification of  
20 the existence of an unsatisfied judgment or payment pursuant  
21 to this subparagraph, the department shall notify the licensee  
22 by certified mail that he or she shall be subject to  
23 disciplinary action unless, within 30 days from the date of  
24 mailing, the licensee either:

25           (a)~~a.~~ Shows proof that the unsatisfied judgment has  
26 been paid in the amount specified in this subparagraph; or

27           (b)~~b.~~ Furnishes the department with a copy of a timely  
28 filed notice of appeal and either:

29           1.~~(1)~~ A copy of a supersedeas bond properly posted in  
30 the amount required by law; or

31

1           2.~~(H)~~ An order from a court of competent jurisdiction  
2 staying execution on the final judgment, pending disposition  
3 of the appeal.

4           (c)~~2.~~ The Department of Health shall issue an  
5 emergency order suspending the license of any licensee who,  
6 after 30 days following receipt of a notice from the  
7 Department of Health, has failed to: satisfy a medical  
8 malpractice claim against him or her; furnish the Department  
9 of Health a copy of a timely filed notice of appeal; furnish  
10 the Department of Health a copy of a supersedeas bond properly  
11 posted in the amount required by law; or furnish the  
12 Department of Health an order from a court of competent  
13 jurisdiction staying execution on the final judgment pending  
14 disposition of the appeal.

15           (d)~~3.~~ Upon the next meeting of the probable cause  
16 panel of the board following 30 days after the date of mailing  
17 the notice of disciplinary action to the licensee, the panel  
18 shall make a determination of whether probable cause exists to  
19 take disciplinary action against the licensee pursuant to this  
20 subsection ~~subparagraph 1.~~

21           (e)~~4.~~ If the board determines that the factual  
22 requirements of this subsection ~~subparagraph 1.~~ are met, it  
23 shall take disciplinary action as it deems appropriate against  
24 the licensee. Such disciplinary action shall include, at a  
25 minimum, probation of the license with the restriction that  
26 the licensee must make payments to the judgment creditor on a  
27 schedule determined by the board to be reasonable and within  
28 the financial capability of the osteopathic physician.  
29 Notwithstanding any other disciplinary penalty imposed, the  
30 disciplinary penalty may include suspension of the license for  
31 a period not to exceed 5 years. In the event that an

1 agreement to satisfy a judgment has been met, the board shall  
2 remove any restriction on the license.

3 (f)~~5~~. The licensee has completed a form supplying  
4 necessary information as required by the department.

5  
6 ~~A licensee who meets the requirements of this paragraph shall  
7 be required either to post notice in the form of a sign  
8 prominently displayed in the reception area and clearly  
9 noticeable by all patients or to provide a written statement  
10 to any person to whom medical services are being provided.  
11 Such sign or statement shall state: "Under Florida law,  
12 osteopathic physicians are generally required to carry medical  
13 malpractice insurance or otherwise demonstrate financial  
14 responsibility to cover potential claims for medical  
15 malpractice. YOUR OSTEOPATHIC PHYSICIAN HAS DECIDED NOT TO  
16 CARRY MEDICAL MALPRACTICE INSURANCE. This is permitted under  
17 Florida law subject to certain conditions. Florida law  
18 imposes strict penalties against noninsured osteopathic  
19 physicians who fail to satisfy adverse judgments arising from  
20 claims of medical malpractice. This notice is provided  
21 pursuant to Florida law."~~

22 (7)~~(6)~~ Any deceptive, untrue, or fraudulent  
23 representation by the licensee with respect to any provision  
24 of this section shall result in permanent disqualification  
25 from any exemption to mandated financial responsibility as  
26 provided in this section and shall constitute grounds for  
27 disciplinary action under s. 459.015.

28 (8)~~(7)~~ Any licensee who relies on any exemption from  
29 the financial responsibility requirement shall notify the  
30 department in writing of any change of circumstance regarding  
31 his or her qualifications for such exemption and shall

1 demonstrate that he or she is in compliance with the  
2 requirements of this section.

3 (9)~~(8)~~ If a physician is either a resident physician,  
4 assistant resident physician, or intern in an approved  
5 postgraduate training program, as defined by the board's  
6 rules, and is supervised by a physician who is participating  
7 in the Florida Birth-Related Neurological Injury Compensation  
8 Plan, such resident physician, assistant resident physician,  
9 or intern is deemed to be a participating physician without  
10 the payment of the assessment set forth in s. 766.314(4).

11 (10) Notwithstanding any other provision of this  
12 section, the department shall suspend the license of any  
13 osteopathic physician against whom has been entered a final  
14 judgment, arbitration award, or other order or who has entered  
15 into a settlement agreement to pay damages arising out of a  
16 claim for medical malpractice, if all appellate remedies have  
17 been exhausted and payment up to the amounts required by this  
18 section has not been made within 30 days after the entering of  
19 such judgment, award, or order or agreement, until proof of  
20 payment is received by the department or a payment schedule  
21 has been agreed upon by the osteopathic physician and the  
22 claimant and presented to the department. This subsection does  
23 not apply to an osteopathic physician who has met the  
24 financial responsibility requirements in paragraphs (1)(b) and  
25 (2)(b).

26 (11)~~(9)~~ The board shall adopt rules to implement the  
27 provisions of this section.

28 Section 28. Civil immunity for members of or  
29 consultants to certain boards, committees, or other  
30 entities.--

31



1           (1) Each member of, or health care professional  
2 consultant to, any committee, board, group, commission, or  
3 other entity shall be immune from civil liability for any act,  
4 decision, omission, or utterance done or made in performance  
5 of his duties while serving as a member of or consultant to  
6 such committee, board, group, commission, or other entity  
7 established and operated for purposes of quality improvement  
8 review, evaluation, and planning in a state-licensed health  
9 care facility. Such entities must function primarily to  
10 review, evaluate, or make recommendations relating to:  
11           (a) The duration of patient stays in health care  
12 facilities;  
13           (b) The professional services furnished with respect  
14 to the medical, dental, psychological, podiatric,  
15 chiropractic, or optometric necessity for such services;  
16           (c) The purpose of promoting the most efficient use of  
17 available health care facilities and services;  
18           (d) The adequacy or quality of professional services;  
19           (e) The competency and qualifications for professional  
20 staff privileges;  
21           (f) The reasonableness or appropriateness of charges  
22 made by or on behalf of health care facilities; or  
23           (g) Patient safety, including entering into contracts  
24 with patient safety organizations.  
25           (2) Such committee, board, group, commission, or other  
26 entity must be established in accordance with state law or in  
27 accordance with requirements of the Joint Commission on  
28 Accreditation of Healthcare Organizations, established and  
29 duly constituted by one or more public or licensed private  
30 hospitals or behavioral health agencies, or established by a  
31 governmental agency. To be protected by this section, the act,

1 decision, omission, or utterance may not be made or done in  
2 bad faith or with malicious intent.

3 Section 29. Patient safety data privilege.--

4 (1) As used in this section, the term:

5 (a) "Patient safety data" means reports made to  
6 patient safety organizations, including all health care data,  
7 interviews, memoranda, analyses, root cause analyses, products  
8 of quality assurance or quality improvement processes,  
9 corrective action plans, or information collected or created  
10 by a health care facility licensed under chapter 395 or a  
11 health care practitioner as defined in section 456.001(4),  
12 Florida Statutes, as a result of an occurrence related to the  
13 provision of health care services which exacerbates an  
14 existing medical condition or could result in injury, illness,  
15 or death.

16 (b) "Patient safety organization" means any  
17 organization, group, or other entity that collects and  
18 analyzes patient safety data for the purpose of improving  
19 patient safety and health care outcomes and that is  
20 independent and not under the control of the entity that  
21 reports patient safety data.

22 (2) Patient safety data shall not be subject to  
23 discovery or introduction into evidence in any civil or  
24 administrative action. However, information, documents, or  
25 records otherwise available from original sources are not  
26 immune from discovery or use in any civil or administrative  
27 action merely because they were also collected, analyzed, or  
28 presented to a patient safety organization. Any person who  
29 testifies before a patient safety organization or who is a  
30 member of such a group may not be prevented from testifying as  
31 to matters within his or her knowledge, but he or she may not

1 be asked about his or her testimony before a patient safety  
2 organization or the opinions formed by him or her as a result  
3 of the hearings.

4 (3) Unless otherwise provided by law, a patient safety  
5 organization shall promptly remove all patient-identifying  
6 information after receipt of a complete patient safety data  
7 report unless such organization is otherwise permitted by  
8 state or federal law to maintain such information. Patient  
9 safety organizations shall maintain the confidentiality of all  
10 patient-identifying information and may not disseminate such  
11 information, except as permitted by state or federal law.

12 (4) The exchange of patient safety data among health  
13 care facilities licensed under chapter 395 or health care  
14 practitioners as defined in section 456.001 (4), Florida  
15 Statutes, or patient safety organizations which does not  
16 identify any patient shall not constitute a waiver of any  
17 privilege established in this section.

18 (5) Reports of patient safety data to patient safety  
19 organizations does not abrogate obligations to make reports to  
20 the Department of Health, the Agency for Health Care  
21 Administration, or other state or federal regulatory agencies.

22 (6) An employer may not take retaliatory action  
23 against an employee who in good faith makes a report of  
24 patient safety data to a patient safety organization.

25 Section 30. Each final settlement statement relating  
26 to medical malpractice shall include the following statement:

27 "The decision to settle a case may reflect the economic  
28 practicalities pertaining to the cost of litigation and is  
29 not, alone, an admission that the insured failed to meet the  
30 required standard of care applicable to the patient's  
31 treatment. The decision to settle a case may be made by the

1 insurance company without consulting its client for input,  
2 unless otherwise provided by the insurance policy."

3 Section 31. Office of Insurance Regulation; closed  
4 claim forms; report required.--The Office of Insurance  
5 Regulation shall revise its closed claim form for readability  
6 at the 9th grade level. The office shall compile annual  
7 statistical reports that provide data summaries of all closed  
8 claims, including, but not limited to, the number of closed  
9 claims on file pertaining to the referent health care  
10 professional or health care entity, the nature of the errant  
11 conduct, the size of payments, and the frequency and size of  
12 noneconomic damage awards. The office shall develop annualized  
13 historical statistical summaries beginning with the 1976 state  
14 fiscal year and publish these reports on its website no later  
15 than the 2005 state fiscal year. The form must accommodate the  
16 following minimum requirements:

17 (1) A practitioner of medicine licensed pursuant to  
18 chapter 458, Florida Statutes, a practitioner of osteopathic  
19 medicine licensed pursuant to chapter 459, Florida Statutes, a  
20 practitioner of podiatric medicine licensed pursuant to  
21 chapter 461, Florida Statutes, or a dentist licensed pursuant  
22 to chapter 466, Florida Statutes, shall report to the Office  
23 of Insurance Regulation and the Department of Health any claim  
24 or action for damages for personal injury alleged to have been  
25 caused by error, omission, or negligence in the performance of  
26 such licensee's professional services or based on a claimed  
27 performance of professional services without consent if the  
28 claim was not covered by an insurer required to report under  
29 section 627.912, Florida Statutes, and the claim resulted in:

30 (a) A final judgment in any amount.

31 (b) A settlement in any amount.

1  
2 Reports shall be filed with the Office of Insurance Regulation  
3 no later than 60 days following the occurrence of any event  
4 listed in this subsection.  
5 (2) Health professional reports must contain:  
6 (a) The name and address of the licensee.  
7 (b) The alleged occurrence.  
8 (c) The date of the alleged occurrence.  
9 (d) The date the claim or action was reported to the  
10 licensee.  
11 (e) The name and address of the opposing party.  
12 (f) The date of suit, if filed.  
13 (g) The injured person's age and sex.  
14 (h) The total number and names of all defendants  
15 involved in the claim.  
16 (i) The date and amount of judgment or settlement, if  
17 any, including the itemization of the verdict, together with a  
18 copy of the settlement or judgment.  
19 (j) In the case of a settlement, any information  
20 required by the Office of Insurance Regulation concerning the  
21 injured person's incurred and anticipated medical expense,  
22 wage loss, and other expenses.  
23 (k) The loss adjustment expense paid to defense  
24 counsel, and all other allocated loss adjustment expense paid.  
25 (l) The date and reason for final disposition, if  
26 there was no judgment or settlement.  
27 (m) A summary of the occurrence that created the  
28 claim, which must include:  
29 1. The name of the institution, if any, and the  
30 location within such institution, at which the injury  
31 occurred.

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

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

5           4. The operation or the diagnostic or treatment  
6 procedure causing the injury.

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

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

12           (n) Any other information required by the Office of  
13 Insurance Regulation to analyze and evaluate the nature,  
14 causes, location, cost, and damages involved in professional  
15 liability cases.

16           Section 32. Paragraph (t) of subsection (1) and  
17 subsections (3) and (6) of section 458.331, Florida Statutes,  
18 are amended to read:

19           458.331 Grounds for disciplinary action; action by the  
20 board and department.--

21           (1) The following acts constitute grounds for denial  
22 of a license or disciplinary action, as specified in s.  
23 456.072(2):

24           (t) Gross or repeated malpractice or the failure to  
25 practice medicine with that level of care, skill, and  
26 treatment which is recognized by a reasonably prudent similar  
27 physician as being acceptable under similar conditions and  
28 circumstances. The board shall give great weight to the  
29 provisions of s. 766.102 when enforcing this paragraph. As  
30 used in this paragraph, "repeated malpractice" includes, but  
31 is not limited to, three or more claims for medical

1 malpractice within the previous 5-year period resulting in  
2 indemnities being paid in excess of \$50,000~~\$25,000~~ each to  
3 the claimant in a judgment or settlement and which incidents  
4 involved negligent conduct by the physician. As used in this  
5 paragraph, "gross malpractice" or "the failure to practice  
6 medicine with that level of care, skill, and treatment which  
7 is recognized by a reasonably prudent similar physician as  
8 being acceptable under similar conditions and circumstances,"  
9 shall not be construed so as to require more than one  
10 instance, event, or act. Nothing in this paragraph shall be  
11 construed to require that a physician be incompetent to  
12 practice medicine in order to be disciplined pursuant to this  
13 paragraph. A recommended order by an administrative law judge  
14 or a final order of the board finding a violation under this  
15 paragraph shall specify whether the licensee was found to have  
16 committed "gross malpractice," "repeated malpractice," or  
17 "failure to practice medicine with that level of care, skill,  
18 and treatment which is recognized as being acceptable under  
19 similar conditions and circumstances," or any combination  
20 thereof, and any publication by the board must so specify.

21 (3) In any administrative action against a physician  
22 ~~which does not involve revocation or suspension of license,~~  
23 the division shall have the burden, by the greater weight of  
24 the evidence, to establish the existence of grounds for  
25 disciplinary action. ~~The division shall establish grounds for~~  
26 ~~revocation or suspension of license by clear and convincing~~  
27 ~~evidence.~~

28 (6) Upon the department's receipt from an insurer or  
29 self-insurer of a report of a closed claim against a physician  
30 pursuant to s. 627.912 or from a health care practitioner of a  
31 report pursuant to s. 456.049, or upon the receipt from a

1 claimant of a presuit notice against a physician pursuant to  
2 s. 766.106, the department shall review each report and  
3 determine whether it potentially involved conduct by a  
4 licensee that is subject to disciplinary action, in which case  
5 the provisions of s. 456.073 shall apply. However, if it is  
6 reported that a physician has had three or more claims with  
7 indemnities exceeding \$50,000~~\$25,000~~ each within the previous  
8 5-year period, the department shall investigate the  
9 occurrences upon which the claims were based and determine if  
10 action by the department against the physician is warranted.

11 Section 33. Paragraph (x) of subsection (1) and  
12 subsections (3) and (6) of section 459.015, Florida Statutes,  
13 are amended to read:

14 459.015 Grounds for disciplinary action; action by the  
15 board and department.--

16 (1) The following acts constitute grounds for denial  
17 of a license or disciplinary action, as specified in s.  
18 456.072(2):

19 (x) Gross or repeated malpractice or the failure to  
20 practice osteopathic medicine with that level of care, skill,  
21 and treatment which is recognized by a reasonably prudent  
22 similar osteopathic physician as being acceptable under  
23 similar conditions and circumstances. The board shall give  
24 great weight to the provisions of s. 766.102 when enforcing  
25 this paragraph. As used in this paragraph, "repeated  
26 malpractice" includes, but is not limited to, three or more  
27 claims for medical malpractice within the previous 5-year  
28 period resulting in indemnities being paid in excess of  
29 \$50,000~~\$25,000~~ each to the claimant in a judgment or  
30 settlement and which incidents involved negligent conduct by  
31 the osteopathic physician. As used in this paragraph, "gross



1 malpractice" or "the failure to practice osteopathic medicine  
2 with that level of care, skill, and treatment which is  
3 recognized by a reasonably prudent similar osteopathic  
4 physician as being acceptable under similar conditions and  
5 circumstances" shall not be construed so as to require more  
6 than one instance, event, or act. Nothing in this paragraph  
7 shall be construed to require that an osteopathic physician be  
8 incompetent to practice osteopathic medicine in order to be  
9 disciplined pursuant to this paragraph. A recommended order  
10 by an administrative law judge or a final order of the board  
11 finding a violation under this paragraph shall specify whether  
12 the licensee was found to have committed "gross malpractice,"  
13 "repeated malpractice," or "failure to practice osteopathic  
14 medicine with that level of care, skill, and treatment which  
15 is recognized as being acceptable under similar conditions and  
16 circumstances," or any combination thereof, and any  
17 publication by the board shall so specify.

18 (3) In any administrative action against a physician  
19 ~~which does not involve revocation or suspension of license,~~  
20 the division shall have the burden, by the greater weight of  
21 the evidence, to establish the existence of grounds for  
22 disciplinary action. ~~The division shall establish grounds for~~  
23 ~~revocation or suspension of license by clear and convincing~~  
24 ~~evidence.~~

25 (6) Upon the department's receipt from an insurer or  
26 self-insurer of a report of a closed claim against an  
27 osteopathic physician pursuant to s. 627.912 or from a health  
28 care practitioner of a report pursuant to s. 456.049, or upon  
29 the receipt from a claimant of a presuit notice against an  
30 osteopathic physician pursuant to s. 766.106, the department  
31 shall review each report and determine whether it potentially

1 involved conduct by a licensee that is subject to disciplinary  
2 action, in which case the provisions of s. 456.073 shall  
3 apply. However, if it is reported that an osteopathic  
4 physician has had three or more claims with indemnities  
5 exceeding ~~\$50,000~~~~\$25,000~~ each within the previous 5-year  
6 period, the department shall investigate the occurrences upon  
7 which the claims were based and determine if action by the  
8 department against the osteopathic physician is warranted.

9 Section 34. Subsection (6) of section 460.413, Florida  
10 Statutes, is amended to read:

11 460.413 Grounds for disciplinary action; action by  
12 board or department.--

13 (6) In any administrative action against a  
14 chiropractic physician ~~which does not involve revocation or~~  
15 ~~suspension of license~~, the department shall have the burden,  
16 by the greater weight of the evidence, to establish the  
17 existence of grounds for disciplinary action. ~~The department~~  
18 ~~shall establish grounds for revocation or suspension of~~  
19 ~~license by clear and convincing evidence.~~

20 Section 35. Legislative intent.--The Legislature  
21 declares that reducing the burden of proof in medical  
22 disciplinary cases to the level of greater weight of the  
23 evidence is necessary to protect the health, safety, and  
24 welfare of medical patients in the state. The Legislature  
25 declares that there is an overwhelming public necessity to  
26 protect medical patients which far overrides any purported  
27 property interest in a license to practice in this state held  
28 by a licensed health care practitioner. Furthermore, the  
29 Legislature declares that it is a privilege, not a right, to  
30 practice as a health care professional in this state and that  
31 disciplinary action relating to scope of practice issues in

1 particular is remedial and protective, not penal, in nature.  
2 The Legislature specifically reverses case law to the  
3 contrary.

4 Section 36. The Division of Administrative Hearings  
5 shall designate at least two administrative law judges who  
6 shall specifically preside over actions involving the  
7 Department of Health or boards within the Department of Health  
8 and a health care practitioner as defined in section 456.001,  
9 Florida Statutes. Each designated administrative law judge  
10 must be a member of The Florida Bar in good standing and must  
11 have experience working in the health care industry or have  
12 attained board certification in health care law from The  
13 Florida Bar.

14 Section 37. Paragraph (s) of subsection (1) and  
15 paragraph (a) of subsection (5) of section 461.013, Florida  
16 Statutes, are amended to read:

17 461.013 Grounds for disciplinary action; action by the  
18 board; investigations by department.--

19 (1) The following acts constitute grounds for denial  
20 of a license or disciplinary action, as specified in s.  
21 456.072(2):

22 (s) Gross or repeated malpractice or the failure to  
23 practice podiatric medicine at a level of care, skill, and  
24 treatment which is recognized by a reasonably prudent  
25 podiatric physician as being acceptable under similar  
26 conditions and circumstances. The board shall give great  
27 weight to the standards for malpractice in s. 766.102 in  
28 interpreting this section. As used in this paragraph,  
29 "repeated malpractice" includes, but is not limited to, three  
30 or more claims for medical malpractice within the previous  
31 5-year period resulting in indemnities being paid in excess of

1 \$50,000~~\$10,000~~ each to the claimant in a judgment or  
2 settlement and which incidents involved negligent conduct by  
3 the podiatric physicians. As used in this paragraph, "gross  
4 malpractice" or "the failure to practice podiatric medicine  
5 with the level of care, skill, and treatment which is  
6 recognized by a reasonably prudent similar podiatric physician  
7 as being acceptable under similar conditions and  
8 circumstances" shall not be construed so as to require more  
9 than one instance, event, or act.

10 (5)(a) Upon the department's receipt from an insurer  
11 or self-insurer of a report of a closed claim against a  
12 podiatric physician pursuant to s. 627.912, or upon the  
13 receipt from a claimant of a presuit notice against a  
14 podiatric physician pursuant to s. 766.106, the department  
15 shall review each report and determine whether it potentially  
16 involved conduct by a licensee that is subject to disciplinary  
17 action, in which case the provisions of s. 456.073 shall  
18 apply. However, if it is reported that a podiatric physician  
19 has had three or more claims with indemnities exceeding  
20 \$50,000~~\$25,000~~ each within the previous 5-year period, the  
21 department shall investigate the occurrences upon which the  
22 claims were based and determine if action by the department  
23 against the podiatric physician is warranted.

24 Section 38. Paragraph (x) of subsection (1) of section  
25 466.028, Florida Statutes, is amended to read:

26 466.028 Grounds for disciplinary action; action by the  
27 board.--

28 (1) The following acts constitute grounds for denial  
29 of a license or disciplinary action, as specified in s.  
30 456.072(2):

31

1           (x) Being guilty of incompetence or negligence by  
2 failing to meet the minimum standards of performance in  
3 diagnosis and treatment when measured against generally  
4 prevailing peer performance, including, but not limited to,  
5 the undertaking of diagnosis and treatment for which the  
6 dentist is not qualified by training or experience or being  
7 guilty of dental malpractice. For purposes of this paragraph,  
8 it shall be legally presumed that a dentist is not guilty of  
9 incompetence or negligence by declining to treat an individual  
10 if, in the dentist's professional judgment, the dentist or a  
11 member of her or his clinical staff is not qualified by  
12 training and experience, or the dentist's treatment facility  
13 is not clinically satisfactory or properly equipped to treat  
14 the unique characteristics and health status of the dental  
15 patient, provided the dentist refers the patient to a  
16 qualified dentist or facility for appropriate treatment. As  
17 used in this paragraph, "dental malpractice" includes, but is  
18 not limited to, three or more claims within the previous  
19 5-year period which resulted in indemnity being paid, or any  
20 single indemnity paid in excess of \$25,000~~\$5,000~~ in a  
21 judgment or settlement, as a result of negligent conduct on  
22 the part of the dentist.

23           Section 39. Subsection (2) of section 624.462, Florida  
24 Statutes, is amended to read:

25           624.462 Commercial self-insurance funds.--

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

30           (a) Established by:

31

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

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

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

17           ~~4.3-~~ A not-for-profit group comprised of no less than  
18 10 condominium associations as defined in s. 718.103(2), which  
19 is incorporated under the laws of this state, which restricts  
20 its membership to condominium associations only, and which has  
21 been organized and maintained in good faith for a continuous  
22 period of 1 year for purposes other than that of obtaining or  
23 providing insurance.

24           (b)1. In the case of funds established pursuant to  
25 subparagraph (a)2. or subparagraph (a)4.~~subparagraph (a)3.~~,  
26 operated pursuant to a trust agreement by a board of trustees  
27 which shall have complete fiscal control over the fund and  
28 which shall be responsible for all operations of the fund.  
29 The majority of the trustees shall be owners, partners,  
30 officers, directors, or employees of one or more members of  
31 the fund. The trustees shall have the authority to approve

1 applications of members for participation in the fund and to  
2 contract with an authorized administrator or servicing company  
3 to administer the day-to-day affairs of the fund.

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

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

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

13           c. Approve payment of dividends to members;

14           d. Approve changes in corporate structure; and

15           e. Have the authority to contract with an  
16 administrator authorized under s. 626.88 to administer the  
17 day-to-day affairs of the fund including, but not limited to,  
18 marketing, underwriting, billing, collection, claims  
19 administration, safety and loss prevention, reinsurance,  
20 policy issuance, accounting, regulatory reporting, and general  
21 administration. The fees or compensation for services under  
22 such contract shall be comparable to the costs for similar  
23 services incurred by insurers writing the same lines of  
24 insurance, or where available such expenses as filed by  
25 boards, bureaus, and associations designated by insurers to  
26 file such data. A majority of the trustees or directors shall  
27 be owners, partners, officers, directors, or employees of one  
28 or more members of the fund.

29           Section 40. Paragraph (a) of subsection (6) of section  
30 627.062, Florida Statutes, is amended, and subsection (7) is  
31 added to that section, to read:

1           627.062 Rate standards.--

2           (6)(a) After any action with respect to a rate filing  
3 that constitutes agency action for purposes of the  
4 Administrative Procedure Act, except for a rate filing for  
5 medical malpractice, an insurer may, in lieu of demanding a  
6 hearing under s. 120.57, require arbitration of the rate  
7 filing. Arbitration shall be conducted by a board of  
8 arbitrators consisting of an arbitrator selected by the  
9 department, an arbitrator selected by the insurer, and an  
10 arbitrator selected jointly by the other two arbitrators. Each  
11 arbitrator must be certified by the American Arbitration  
12 Association. A decision is valid only upon the affirmative  
13 vote of at least two of the arbitrators. No arbitrator may be  
14 an employee of any insurance regulator or regulatory body or  
15 of any insurer, regardless of whether or not the employing  
16 insurer does business in this state. The department and the  
17 insurer must treat the decision of the arbitrators as the  
18 final approval of a rate filing. Costs of arbitration shall be  
19 paid by the insurer.

20           (7)(a) The provisions of this subsection apply only  
21 with respect to rates for medical malpractice insurance and  
22 shall control to the extent of any conflict with other  
23 provisions of this section.

24           (b) Any portion of a judgment entered or settlement  
25 paid as a result of a statutory or common-law, bad-faith  
26 action and any portion of a judgment entered which awards  
27 punitive damages against an insurer may not be included in the  
28 insurer's rate base, and shall not be used to justify a rate  
29 or rate change. Any common-law bad-faith action identified as  
30 such and any portion of a settlement entered as a result of a  
31 statutory or portion of a settlement wherein an insurer agrees



1 to pay specific punitive damages may not be used to justify a  
2 rate or rate change. The portion of the taxable costs and  
3 attorney's fees which is identified as being related to the  
4 bad faith and punitive damages in these judgments and  
5 settlements may not be included in the insurer's rate base and  
6 may not be utilized to justify a rate or rate change.

7 (c) Upon reviewing a rate filing and determining  
8 whether the rate is excessive, inadequate, or unfairly  
9 discriminatory, the Office of Insurance Regulation shall  
10 consider, in accordance with generally accepted and reasonable  
11 actuarial techniques, past and present prospective loss  
12 experience, either using loss experience solely for this state  
13 or giving greater credibility to this state's loss data.

14 (d) Rates shall be deemed excessive if, among other  
15 standards established by this section, the rate structure  
16 provides for replenishment of reserves or surpluses from  
17 premiums when the replenishment is attributable to investment  
18 losses.

19 (e) The insurer must apply a discount or surcharge  
20 based on the health care provider's loss experience, or shall  
21 establish an alternative method giving due consideration to  
22 the provider's loss experience. The insurer must include in  
23 the filing a copy of the surcharge or discount schedule or a  
24 description of the alternative method used, and must provide a  
25 copy of such schedule or description, as approved by the  
26 office, to policyholders at the time of renewal and to  
27 prospective policyholders at the time of application for  
28 coverage.

29 Section 41. Subsections (1) and (2) of section  
30 627.0645, Florida Statutes, are amended to read:

31 627.0645 Annual filings.--

1           (1) Each rating organization filing rates for, and  
2 each insurer writing, any line of property or casualty  
3 insurance to which this part applies, except:

4           (a) Workers' compensation and employer's liability  
5 insurance; or

6           (b) Commercial property and casualty insurance as  
7 defined in s. 627.0625(1) other than commercial multiple line,  
8 ~~and~~ commercial motor vehicle, and medical malpractice,

9  
10 shall make an annual base rate filing for each such line with  
11 the department no later than 12 months after its previous base  
12 rate filing, demonstrating that its rates are not inadequate.

13           (2)(a) Deviations, except for medical malpractice,  
14 filed by an insurer to any rating organization's base rate  
15 filing are not subject to this section.

16           (b) The department, after receiving a request to be  
17 exempted from the provisions of this section, may, for good  
18 cause due to insignificant numbers of policies in force or  
19 insignificant premium volume, exempt a company, by line of  
20 coverage, from filing rates or rate certification as required  
21 by this section.

22           Section 42. The Office of Program Policy Analysis and  
23 Government Accountability shall complete a study of the  
24 eligibility requirements for a birth to be covered under the  
25 Florida Birth-Related Neurological Injury Compensation  
26 Association and submit a report to the Legislature by January  
27 1, 2004, recommending whether or not the statutory criteria  
28 for a claim to qualify for referral to the Florida  
29 Birth-Related Neurological Injury Compensation Association  
30 under section 766.302, Florida Statutes, should be modified.

31

1           Section 43. Section 627.0662, Florida Statutes, is  
2 created to read:

3           627.0662 Excessive profits for medical liability  
4 insurance prohibited.--

5           (1) As used in this section, the term:

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

11           (b) "Medical liability insurer" means any insurance  
12 company or group of insurance companies writing medical  
13 liability insurance in this state and does not include any  
14 self-insurance fund or other nonprofit entity writing such  
15 insurance.

16           (2) Each medical liability insurer shall file with the  
17 Office of Insurance Regulation, prior to July 1 of each year  
18 on forms adopted by the Financial Services Commission, the  
19 following data for medical liability insurance business in  
20 this state. The data shall include both voluntary and joint  
21 underwriting association business, as follows:

22           (a) Calendar-year earned premium.

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

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

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

30           (3)(a) Excessive profit has been realized if there has  
31 been an underwriting gain for the 3 most recent

1 calendar-accident years combined which is greater than the  
2 anticipated underwriting profit plus 5 percent of earned  
3 premiums for those calendar-accident years.

4 (b) As used in this subsection with respect to any  
5 3-year period, the term "anticipated underwriting profit"  
6 means the sum of the dollar amounts obtained by multiplying,  
7 for each rate filing of the insurer group in effect during  
8 such period, the earned premiums applicable to such rate  
9 filing during such period by the percentage factor included in  
10 such rate filing for profit and contingencies, such percentage  
11 factor having been determined with due recognition to  
12 investment income from funds generated by business in this  
13 state. Separate calculations need not be made for consecutive  
14 rate filings containing the same percentage factor for profits  
15 and contingencies.

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

28 (5) Each insurer group's underwriting gain or loss for  
29 each calendar-accident year shall be computed as follows: the  
30 sum of the accident-year incurred losses and loss adjustment  
31 expenses as of March 31 of the following year, developed to an

1 ultimate basis, plus the administrative and selling expenses  
2 incurred in the calendar year, plus policyholder dividends  
3 applicable to the calendar year, shall be subtracted from the  
4 calendar-year earned premium to determine the underwriting  
5 gain or loss.

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

9 (7) If the medical liability insurer has realized an  
10 excessive profit, the office shall order a return of the  
11 excessive amounts to policyholders after affording the insurer  
12 an opportunity for hearing and otherwise complying with the  
13 requirements of chapter 120. Such excessive amounts shall be  
14 refunded to policyholders in all instances unless the insurer  
15 affirmatively demonstrates to the office that the refund of  
16 the excessive amounts will render the insurer or a member of  
17 the insurer group financially impaired or will render it  
18 insolvent.

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

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

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

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

31

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

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

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

9           2. If the insurer elects to make refunds in the form  
10 of a credit to renewal policies, such credits shall be applied  
11 to policy renewal premium notices which are forwarded to  
12 insureds more than 60 calendar days after entry of a final  
13 order determining that excessive profits have been realized.  
14 If an insurer has made this election but an insured thereafter  
15 cancels his or her policy or otherwise allows the policy to  
16 terminate, the insurer group shall make a cash refund not  
17 later than 60 days after termination of such coverage.

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

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

25       Section 44. Subsection (10) of section 627.357,  
26 Florida Statutes, is amended to read:

27       627.357 Medical malpractice self-insurance.--

28       (10)(a) An application to form a self-insurance fund  
29 under this section must be filed with the Office of Insurance  
30 Regulation ~~A self-insurance fund may not be formed under this~~  
31 ~~section after October 1, 1992.~~

1           (b) 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 45. Effective October 1, 2003, section  
7 627.4147, Florida Statutes, is amended to read:

8           627.4147 Medical malpractice insurance contracts.--

9           (1) In addition to any other requirements imposed by  
10 law, each self-insurance policy as authorized under s. 627.357  
11 or insurance policy providing coverage for claims arising out  
12 of the rendering of, or the failure to render, medical care or  
13 services, including those of the Florida Medical Malpractice  
14 Joint Underwriting Association, shall include:

15           (a) A clause requiring the insured to cooperate fully  
16 in the review process prescribed under s. 766.106 if a notice  
17 of intent to file a claim for medical malpractice is made  
18 against the insured.

19           (b)1. Except as provided in subparagraph 2., a clause  
20 authorizing the insurer or self-insurer to determine, to make,  
21 and to conclude, without the permission of the insured, any  
22 offer of admission of liability and for arbitration pursuant  
23 to s. 766.106, settlement offer, or offer of judgment, if the  
24 offer is within the policy limits. It is against public policy  
25 for any insurance or self-insurance policy to contain a clause  
26 giving the insured the exclusive right to veto any offer for  
27 admission of liability and for arbitration made pursuant to s.  
28 766.106, settlement offer, or offer of judgment, when such  
29 offer is within the policy limits. However, any offer of  
30 admission of liability, settlement offer, or offer of judgment

31

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 physicians licensed under chapter  
4 458 or chapter 459 or 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.



1           c. Physicians licensed under chapter 458 or chapter  
2 459 and dentists licensed under chapter 466 may purchase an  
3 insurance policy pursuant to this subparagraph if such  
4 policies are available. Insurers may offer such policies,  
5 notwithstanding any other provision of law to the contrary.

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

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

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

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

30           Section 46. Section 627.41491, Florida Statutes, is  
31 created to read:

1           627.41491 Medical malpractice rate comparison.--The  
2 Office of Insurance Regulation shall annually publish a  
3 comparison of the rate in effect for each medical malpractice  
4 insurer and self-insurer and the Florida Medical Malpractice  
5 Joint Underwriting Association. Such rate comparison shall be  
6 made available to the public through the Internet and other  
7 commonly used means of distribution no later than July 1 of  
8 each year.

9           Section 47. Section 627.41492, Florida Statutes, is  
10 created to read:

11           627.41492 Annual medical malpractice report.--The  
12 Office of Insurance Regulation shall prepare an annual report  
13 by October 1 of each year, which shall be available to the  
14 public and posted on the Internet, which includes the  
15 following information:

16           (1) A summary and analysis of the closed claim  
17 information required to be reported pursuant to s. 627.912.

18           (2) A summary and analysis of the annual and quarterly  
19 financial reports filed by each insurer writing medical  
20 malpractice insurance in this state.

21           Section 48. Section 627.41493, Florida Statutes, is  
22 created to read:

23           627.41493 Insurance rate rollback.--

24           (1) For medical malpractice insurance policies issued  
25 or renewed on or after July 1, 2003, and before July 1, 2004,  
26 every insurer, including the Florida Medical Malpractice Joint  
27 Underwriting Association, shall reduce its rates and premiums  
28 to levels that were in effect on January 1, 2002.

29           (2) For medical malpractice insurance policies issued  
30 or renewed on or after July 1, 2003, and before July 1, 2004,  
31 rates and premiums reduced pursuant to subsection (1) may only

1 be increased if the director of the Office of Insurance  
2 Regulation finds that the rate reduced pursuant to subsection  
3 (1) would result in an inadequate rate. Any such increase must  
4 be approved by the director of the Office of Insurance  
5 Regulation prior to being used.

6 (3) The provisions of this section control to the  
7 extent of any conflict with the provision of s. 627.062.

8 Section 49. If, as of July 1, 2004, the director of  
9 the Office of Insurance Regulation determines that the rates  
10 of the medical malpractice insurers with a combined market  
11 share of 50 percent or greater, as measured by net written  
12 premiums in this state for medical malpractice for the most  
13 recent calendar year, have been reduced to the level in effect  
14 on January 1, 2002, but have not remained at that level for  
15 the previous year beginning July 1, 2003, or that such medical  
16 malpractice insurers have proposed increases from the January  
17 1, 2002, level which are greater than 15 percent for either of  
18 the next 2 years beginning July 1, 2004, then the Florida  
19 Medical Malpractice Insurance Fund established by this act  
20 shall begin offering coverage.

21 Section 50. Florida Medical Malpractice Insurance  
22 Fund.--

23 (1) FINDINGS AND PURPOSES.--The Legislature finds and  
24 declares that there is a compelling state interest in  
25 maintaining the availability and affordability of health care  
26 services to the citizens of Florida. This state interest is  
27 seriously threatened by the increased cost and decreased  
28 availability of medical malpractice insurance to physicians.  
29 To the extent that the private sector is unable to maintain a  
30 viable and orderly market for medical malpractice insurance,  
31 state actions to maintain the availability and affordability

1 of medical malpractice insurance are a valid and necessary  
2 exercise of the police power.

3 (2) DEFINITIONS.--As used in this section, the term:

4 (a) "Fund" means the Florida Medical Malpractice  
5 Insurance Fund, as created pursuant to this section.

6 (b) "Physician" means a physician licensed under  
7 chapter 458 or chapter 459, Florida Statutes.

8 (3) FLORIDA MEDICAL MALPRACTICE INSURANCE FUND  
9 CREATED.--Effective October 1, 2003, there is created the  
10 Florida Medical Malpractice Insurance Fund, which shall be  
11 subject to the requirements of this section. However, the fund  
12 shall not begin providing or offering coverage until the date  
13 the director of the Office of Insurance Regulation determines  
14 that the rates of the medical malpractice insurers with a  
15 combined market share of 50 percent or greater, as measured by  
16 net written premium in this state for medical malpractice for  
17 the most recent calendar year, have been reduced to the level  
18 in effect on January 1, 2002, but have not remained at that  
19 level for the previous year beginning July 1, 2003, or that  
20 such medical malpractice insurers have proposed increases from  
21 the January 1, 2002, level which are greater than 15 percent  
22 for either of the next 2 years beginning July 1, 2004.

23 (a) The fund shall be administered by a board of  
24 governors consisting of seven members who are appointed as  
25 follows:

- 26 1. Three members by the Governor;
- 27 2. Three members by the Chief Financial Officer; and
- 28 3. One member by the other six board members.

29  
30 Board members shall serve at the pleasure of the appointing  
31 authority. Two board members must be physicians licensed in

1 this state and the Governor and the Chief Financial Officer  
2 shall each appoint one of these physicians.

3 (b) The board shall submit a plan of operation, which  
4 must be approved by the Office of Insurance Regulation of the  
5 Financial Services Commission. The plan of operation and other  
6 actions of the board shall not be considered rules subject to  
7 the requirements of chapter 120, Florida Statutes.

8 (c) Except as otherwise provided by this section, the  
9 fund shall be subject to the requirements of state law which  
10 apply to authorized insurers.

11 (d) Moneys in the fund may not be expended, loaned, or  
12 appropriated except to pay obligations of the fund arising out  
13 of medical malpractice insurance policies issued to physicians  
14 and the costs of administering the fund, including the  
15 purchase of reinsurance as the board deems prudent. The board  
16 shall enter into an agreement with the State Board of  
17 Administration, which shall invest one-third of the moneys in  
18 the fund pursuant to sections 215.44-215.52, Florida Statutes.  
19 The board shall enter into an agreement with the Division of  
20 Treasury of the Department of Financial Services, which shall  
21 invest two-thirds of the moneys in the fund pursuant to the  
22 requirements for the investment of state funds in chapter 17,  
23 Florida Statutes. Earnings from all investments shall be  
24 retained in the fund, except as otherwise provided in this  
25 section.

26 (e) The fund may employ or contract with such staff  
27 and professionals as the board deems necessary for the  
28 administration of the fund.

29 (f) There shall be no liability on the part of any  
30 member of the board, its agents, or any employee of the state  
31 for any action taken by them in the performance of their

1 powers and duties under this section. Such immunity does not  
2 apply to any willful tort or to breach of any contract or  
3 agreement.

4 (g) The fund is not a member insurer of the Florida  
5 Insurance Guaranty Association established pursuant to part II  
6 of chapter 631, Florida Statutes. The fund is not subject to  
7 sections 624.407, 624.408, 624.4095, and 624.411, Florida  
8 Statutes.

9 (4) MEDICAL MALPRACTICE INSURANCE POLICIES.--The board  
10 must offer medical malpractice insurance to any physician,  
11 regardless of his or her specialty, but may adopt underwriting  
12 requirements, as specified in its plan of operation. The fund  
13 shall offer limits of coverage of \$250,000 per claim/\$500,000  
14 annual aggregate; \$500,000 per claim/\$1 million annual  
15 aggregate; and \$1 million per claim/\$2 million annual  
16 aggregate. The fund shall also allow policyholders to select  
17 from policies with deductibles of \$100,000, \$200,000, and  
18 \$250,000; excess coverage limits of \$250,000 per claim and  
19 \$750,000 annual aggregate; \$1 million per claim and \$3 million  
20 annual aggregate; or \$2 million and \$4 million annual  
21 aggregate. The fund shall offer such other limits as specified  
22 in its plan of operation.

23 (5) PREMIUM RATES.--The premium rates for coverage  
24 offered by the fund must be actuarially sound and shall be  
25 subject to the same requirements that apply to authorized  
26 insurers issuing medical malpractice insurance, except that:

27 (a) The rates shall not include any factor for  
28 profits; and

29 (b) The anticipated future investment income of the  
30 fund, as projected in its rate filing, must be approximately  
31 equal to the actual investment income that the fund has

1 earned, on average, for the prior 7 years. For those years of  
2 the prior 7 years during which the fund was not in operation,  
3 the anticipated future investment income must be approximately  
4 equal to the actual average investment income earned by the  
5 State Board of Administration for the moneys available for  
6 investment under sections 215.44-215.53, Florida Statutes, and  
7 the average annual investment income earned by the Division of  
8 Treasury of the Department of Financial Services for the  
9 investment of state funds under chapter 17, Florida Statutes,  
10 in the same proportion as specified in paragraph (3)(d).

11 (6) TAX EXEMPTION.--The fund shall be a political  
12 subdivision of the state and is exempt from the corporate  
13 income tax under chapter 220, Florida Statutes, and the  
14 premiums shall not be subject to the premium tax imposed by  
15 section 624.509, Florida Statutes. It is also the intent of  
16 the Legislature that the fund be exempt from federal income  
17 taxation. The Financial Services Commission and the fund shall  
18 seek an opinion from the Internal Revenue Service as to the  
19 tax-exempt status of the fund and shall make such  
20 recommendations to the Legislature as the board deems  
21 necessary to obtain tax-exempt status.

22 (7) INITIAL CAPITALIZATION.--The fund shall enter into  
23 an agreement with the Florida Birth-Related Neurological  
24 Injury Compensation (NICA) Fund for a loan of \$100 million to  
25 the fund to occur when the fund is established. Repayment of  
26 the loan by the fund shall be in five equal annual payments,  
27 each made no later than December 31, commencing during the  
28 fourth year of operation of the fund after the fund begins to  
29 offer medical malpractice insurance. Interest shall accrue on  
30 the outstanding amount of the loan at an annual rate equal to  
31 the annual rate of investment income earned by the NICA Fund.

1 The moneys loaned to the fund pursuant to this subsection  
2 shall be considered admitted assets of the fund for purposes  
3 of chapter 625, Florida Statutes.

4 (8) RULES.--The Financial Services Commission may  
5 adopt rules to implement and administer the provisions of this  
6 section.

7 (9) REVERSION OF FUND ASSETS UPON TERMINATION.--The  
8 fund and the duties of the board under this section shall  
9 stand repealed on a date 10 years after the date the Florida  
10 Medical Malpractice Insurance Fund begins offering coverage  
11 pursuant to this section, unless reviewed and saved from  
12 repeal through reenactment by the Legislature. Upon  
13 termination of the fund, all assets of the fund shall revert  
14 to the General Revenue Fund.

15 Section 51. (1) Notwithstanding any law to the  
16 contrary, if the Florida Medical Malpractice Insurance Fund  
17 begins offering coverage as provided in this act, all  
18 physicians licensed under chapter 458 or chapter 459, Florida  
19 Statutes, as a condition of licensure shall be required to  
20 maintain financial responsibility by obtaining and maintaining  
21 professional liability coverage in an amount not less than  
22 \$250,000 per claim, with a minimum annual aggregate of not  
23 less than \$500,000, from an authorized insurer as defined  
24 under section 624.09, Florida Statutes, from a surplus lines  
25 insurer as defined under section 626.914(2), Florida Statutes,  
26 from a risk retention group as defined under section 627.942,  
27 Florida Statutes, from the Joint Underwriting Association  
28 established under section 627.351(4), Florida Statutes, or  
29 through a plan of self-insurance as provided in section  
30 627.357 or section 624.462, Florida Statutes, or from the  
31 Florida Medical Malpractice Insurance Fund.



1           (2) Physicians and osteopathic physicians who are  
2 exempt from the financial responsibility requirements under  
3 section 458.320(5)(a),(b),(c),(d),(e) and (f) and section  
4 459.0085(5)(a),(b),(c),(d),(e), and (f), Florida Statutes,  
5 shall not be subject to the requirements of this section.

6           Section 52. Section 627.41495, Florida Statutes, is  
7 created to read:

8           627.41495 Public hearings for medical malpractice rate  
9 filings.--

10           (1) Upon the filing of a proposed rate change by a  
11 medical malpractice insurer or self-insurance fund, which  
12 filing would result in an average statewide increase of 25  
13 percent, or more, pursuant to standards determined by the  
14 office, the insurer or self-insurance fund shall mail notice  
15 of such filing to each of its policyholders or members. The  
16 notices shall also inform the policyholders and members that a  
17 public hearing may be requested on the rate filing and the  
18 procedures for requesting a public hearing, as established by  
19 rule, by the Financial Services Commission.

20           (2) The rate filing shall be available for public  
21 inspection. If any policyholder or member of an insurer or  
22 self-insurance fund that makes a rate filing described in  
23 subsection (1) requests the Office of Insurance Regulation to  
24 hold a hearing within 30 days after the mailing of the  
25 notification of the proposed rate changes to the insureds, the  
26 office shall hold a hearing within 30 days after such request.  
27 Any policyholder or member may participate in such hearing.  
28 The commission shall adopt rules implementing the provisions  
29 of this section.

30           Section 53. (1) The Office of Insurance Regulation  
31 shall order insurers to make a rate filing effective January

1 1, 2004, for medical malpractice which reduces rates by a  
2 presumed factor that reflects the impact the changes contained  
3 in all medical malpractice legislation enacted by the Florida  
4 Legislature in 2003 will have on such rates, as determined by  
5 the Office of Insurance Regulation. In determining the  
6 presumed factor, the office shall use generally accepted  
7 actuarial techniques and standards provided in section  
8 627.062, Florida Statutes, in determining the expected impact  
9 on losses, expenses, and investment income of the insurer.  
10 Inclusion in the presumed factor of the expected impact of  
11 such legislation shall be held in abeyance during the review  
12 of such measure's validity in any proceeding by a court of  
13 competent jurisdiction.

14 (2) Any insurer or rating organization that contends  
15 that the rate provided for in subsection (1) is excessive,  
16 inadequate, or unfairly discriminatory shall separately state  
17 in its filing the rate it contends is appropriate and shall  
18 state with specificity the factors or data that it contends  
19 should be considered in order to produce such appropriate  
20 rate. The insurer or rating organization shall be permitted to  
21 use all of the generally accepted actuarial techniques, as  
22 provided in section 627.062, Florida Statutes, in making any  
23 filing pursuant to this subsection. The Office of Insurance  
24 Regulation shall review each such exception and approve or  
25 disapprove it prior to use. It shall be the insurer's burden  
26 to actuarially justify any deviations from the rates filed  
27 under subsection (1). Each insurer or rating organization  
28 shall include in the filing the expected impact of all  
29 malpractice legislation enacted by the Florida Legislature in  
30 2003 on losses, expenses, and rates. If any provision of this  
31 act is held invalid by a court of competent jurisdiction, the

1 office shall permit an adjustment of all rates filed under  
2 this section to reflect the impact of such holding on such  
3 rates, so as to ensure that the rates are not excessive,  
4 inadequate, or unfairly discriminatory.

5 Section 54. Subsections (1), (2), and (4) of section  
6 627.912, Florida Statutes, are amended to read:

7 627.912 Professional liability claims and actions;  
8 reports by insurers.--

9 (1) Each self-insurer authorized under s. 627.357 and  
10 each insurer or joint underwriting association providing  
11 professional liability insurance to a practitioner of medicine  
12 licensed under chapter 458, to a practitioner of osteopathic  
13 medicine licensed under chapter 459, to a podiatric physician  
14 licensed under chapter 461, to a dentist licensed under  
15 chapter 466, to a hospital licensed under chapter 395, to a  
16 crisis stabilization unit licensed under part IV of chapter  
17 394, to a health maintenance organization certificated under  
18 part I of chapter 641, to clinics included in chapter 390, to  
19 an ambulatory surgical center as defined in s. 395.002, or to  
20 a member of The Florida Bar shall report in duplicate to the  
21 Department of Insurance any claim or action for damages for  
22 personal injuries claimed to have been caused by error,  
23 omission, or negligence in the performance of such insured's  
24 professional services or based on a claimed performance of  
25 professional services without consent, if the claim resulted  
26 in:

27 (a) A final judgment in any amount.

28 (b) A settlement in any amount.

29  
30 Reports shall be filed with the department ~~and~~, If the  
31 insured party is licensed under chapter 458, chapter 459, or

1 chapter 461, and the final judgment or settlement amount was  
2 \$50,000 or more, or if the insured party is licensed under  
3 chapter 466 and the final judgment or settlement amount was  
4 \$25,000 or more, the report shall be filed ~~or chapter 466,~~  
5 with the Department of Health, no later than 30 days following  
6 the occurrence of any event listed in paragraph (a) or  
7 paragraph (b). The Department of Health shall review each  
8 report and determine whether any of the incidents that  
9 resulted in the claim potentially involved conduct by the  
10 licensee that is subject to disciplinary action, in which case  
11 the provisions of s. 456.073 shall apply. The Department of  
12 Health, as part of the annual report required by s. 456.026,  
13 shall publish annual statistics, without identifying  
14 licensees, on the reports it receives, including final action  
15 taken on such reports by the Department of Health or the  
16 appropriate regulatory board.

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

19 (a) The name, address, and specialty coverage of the  
20 insured.

21 (b) The insured's policy number.

22 (c) The date of the occurrence which created the  
23 claim.

24 (d) The date the claim was reported to the insurer or  
25 self-insurer.

26 (e) The name and address of the injured person. This  
27 information is confidential and exempt from the provisions of  
28 s. 119.07(1), and must not be disclosed by the department  
29 without the injured person's consent, except for disclosure by  
30 the department to the Department of Health. This information  
31 may be used by the department for purposes of identifying

1 multiple or duplicate claims arising out of the same  
2 occurrence.

3 (f) The date of suit, if filed.

4 (g) The injured person's age and sex.

5 (h) The total number and names of all defendants  
6 involved in the claim.

7 (i) The date and amount of judgment or settlement, if  
8 any, including the itemization of the verdict, together with a  
9 copy of the settlement or judgment.

10 (j) In the case of a settlement, such information as  
11 the department may require with regard to the injured person's  
12 incurred and anticipated medical expense, wage loss, and other  
13 expenses.

14 (k) The loss adjustment expense paid to defense  
15 counsel, and all other allocated loss adjustment expense paid.

16 (l) The date and reason for final disposition, if no  
17 judgment or settlement.

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

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

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

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

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

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

30  
31

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

4           (n) Any other information required by the office  
5 ~~department~~ to analyze and evaluate the nature, causes,  
6 location, cost, and damages involved in professional liability  
7 cases. The Financial Services Commission shall adopt by rule  
8 requirements for additional information to assist the office  
9 in its analysis and evaluation of the nature, causes,  
10 location, cost, and damages involved in professional liability  
11 cases reported by insurers under this section.

12           (4) There shall be no liability on the part of, and no  
13 cause of action of any nature shall arise against, any insurer  
14 reporting hereunder or its agents or employees or the  
15 department or its employees for any action taken by them under  
16 this section. The department shall ~~may~~ impose a fine of \$250  
17 per day per case, but not to exceed a total of \$10,000 ~~\$1,000~~  
18 per case, against an insurer that violates the requirements of  
19 this section. This subsection applies to claims accruing on or  
20 after October 1, 1997.

21           Section 55. Section 627.9121, Florida Statutes, is  
22 created to read:

23           627.9121 Required reporting of claims;  
24 penalties.--Each entity that makes payment under a policy of  
25 insurance, self-insurance, or otherwise in settlement or  
26 partial settlement of, or in satisfaction of a judgment in, a  
27 medical malpractice action or claim that is required to report  
28 information to the National Practitioner Data Bank under 42  
29 U.S.C. section 11131 must also report the same information to  
30 the Office of Insurance Regulation. The Office of Insurance  
31 Regulation shall include such information in the data that it

1 compiles under s. 627.912. The office must compile and review  
2 the data collected pursuant to this section and must assess an  
3 administrative fine on any entity that fails to fully comply  
4 with the requirements imposed by law.

5 Section 56. Section 766.102, Florida Statutes, is  
6 amended to read:

7 766.102 Medical negligence; standards of recovery;  
8 expert witness.--

9 (1) In any action for recovery of damages based on the  
10 death or personal injury of any person in which it is alleged  
11 that such death or injury resulted from the negligence of a  
12 health care provider as defined in s. 768.50(2)(b), the  
13 claimant shall have the burden of proving by the greater  
14 weight of evidence that the alleged actions of the health care  
15 provider represented a breach of the prevailing professional  
16 standard of care for that health care provider. The  
17 prevailing professional standard of care for a given health  
18 care provider shall be that level of care, skill, and  
19 treatment which, in light of all relevant surrounding  
20 circumstances, is recognized as acceptable and appropriate by  
21 reasonably prudent similar health care providers.

22 ~~(2)(a) If the health care provider whose negligence is~~  
23 ~~claimed to have created the cause of action is not certified~~  
24 ~~by the appropriate American board as being a specialist, is~~  
25 ~~not trained and experienced in a medical specialty, or does~~  
26 ~~not hold himself or herself out as a specialist, a "similar~~  
27 ~~health care provider" is one who:~~

28 1. ~~Is licensed by the appropriate regulatory agency of~~  
29 ~~this state;~~

30 2. ~~Is trained and experienced in the same discipline~~  
31 ~~or school of practice; and~~

1           ~~3. Practices in the same or similar medical community.~~

2           ~~(b) If the health care provider whose negligence is~~  
3 ~~claimed to have created the cause of action is certified by~~  
4 ~~the appropriate American board as a specialist, is trained and~~  
5 ~~experienced in a medical specialty, or holds himself or~~  
6 ~~herself out as a specialist, a "similar health care provider"~~  
7 ~~is one who:~~

8           ~~1. Is trained and experienced in the same specialty;~~  
9 ~~and~~

10           ~~2. Is certified by the appropriate American board in~~  
11 ~~the same specialty.~~

12

13 ~~However, if any health care provider described in this~~  
14 ~~paragraph is providing treatment or diagnosis for a condition~~  
15 ~~which is not within his or her specialty, a specialist trained~~  
16 ~~in the treatment or diagnosis for that condition shall be~~  
17 ~~considered a "similar health care provider."~~

18           ~~(c) The purpose of this subsection is to establish a~~  
19 ~~relative standard of care for various categories and~~  
20 ~~classifications of health care providers. Any health care~~  
21 ~~provider may testify as an expert in any action if he or she:~~

22           ~~1. Is a similar health care provider pursuant to~~  
23 ~~paragraph (a) or paragraph (b); or~~

24           ~~2. Is not a similar health care provider pursuant to~~  
25 ~~paragraph (a) or paragraph (b) but, to the satisfaction of the~~  
26 ~~court, possesses sufficient training, experience, and~~  
27 ~~knowledge as a result of practice or teaching in the specialty~~  
28 ~~of the defendant or practice or teaching in a related field of~~  
29 ~~medicine, so as to be able to provide such expert testimony as~~  
30 ~~to the prevailing professional standard of care in a given~~  
31 ~~field of medicine. Such training, experience, or knowledge~~



1 ~~must be as a result of the active involvement in the practice~~  
2 ~~or teaching of medicine within the 5-year period before the~~  
3 ~~incident giving rise to the claim.~~

4 (2)~~(3)~~(a) If the injury is claimed to have resulted  
5 from the negligent affirmative medical intervention of the  
6 health care provider, the claimant must, in order to prove a  
7 breach of the prevailing professional standard of care, show  
8 that the injury was not within the necessary or reasonably  
9 foreseeable results of the surgical, medicinal, or diagnostic  
10 procedure constituting the medical intervention, if the  
11 intervention from which the injury is alleged to have resulted  
12 was carried out in accordance with the prevailing professional  
13 standard of care by a reasonably prudent similar health care  
14 provider.

15 (b) The provisions of this subsection shall apply only  
16 when the medical intervention was undertaken with the informed  
17 consent of the patient in compliance with the provisions of s.  
18 766.103.

19 (3)~~(4)~~ The existence of a medical injury shall not  
20 create any inference or presumption of negligence against a  
21 health care provider, and the claimant must maintain the  
22 burden of proving that an injury was proximately caused by a  
23 breach of the prevailing professional standard of care by the  
24 health care provider. However, the discovery of the presence  
25 of a foreign body, such as a sponge, clamp, forceps, surgical  
26 needle, or other paraphernalia commonly used in surgical,  
27 examination, or diagnostic procedures, shall be prima facie  
28 evidence of negligence on the part of the health care  
29 provider.

30 (4)~~(5)~~ The Legislature is cognizant of the changing  
31 trends and techniques for the delivery of health care in this

1 state and the discretion that is inherent in the diagnosis,  
2 care, and treatment of patients by different health care  
3 providers. The failure of a health care provider to order,  
4 perform, or administer supplemental diagnostic tests shall not  
5 be actionable if the health care provider acted in good faith  
6 and with due regard for the prevailing professional standard  
7 of care.

8 (5) A person may not give expert testimony concerning  
9 the prevailing professional standard of care unless that  
10 person is a licensed health care provider and meets the  
11 following criteria:

12 (a) If the party against whom or on whose behalf the  
13 testimony is offered is a specialist, the expert witness must:

14 1. Specialize in the same specialty as the party  
15 against whom or on whose behalf the testimony is offered; or  
16 2. Specialize in a similar speciality that includes  
17 the evaluation, diagnosis, or treatment of the medical  
18 condition that is the subject of the claim and have prior  
19 experience treating similar patients.

20 (b) Have devoted professional time during the 3 years  
21 immediately preceding the date of the occurrence that is the  
22 basis for the action to:

23 1. The active clinical practice of, or consulting with  
24 respect to, the same or similar health profession as the  
25 health care provider against whom or on whose behalf the  
26 testimony is offered and, if that health care provider is a  
27 specialist, the active clinical practice of, or consulting  
28 with respect to, the same or similar specialty that includes  
29 the evaluation, diagnosis, or treatment of the medical  
30 condition that is the subject of the claim and have prior  
31 experience treating similar patients;

1           2. The instruction of students in an accredited health  
2 professional school or accredited residency program in the  
3 same or similar health profession in which the health care  
4 provider against whom or on whose behalf the testimony is  
5 offered and, if that health care provider is a specialist, an  
6 accredited health professional school or accredited residency  
7 or clinical research program in the same or similar specialty;  
8 or

9           3. A clinical research program that is affiliated with  
10 an accredited medical school or teaching hospital and that is  
11 in the same or similar health profession as the health care  
12 provider against whom or on whose behalf the testimony is  
13 offered and, if that health care provider is a specialist, a  
14 clinical research program that is affiliated with an  
15 accredited health professional school or accredited residency  
16 or clinical research program in the same or similar specialty.

17           (c) If the party against whom or on whose behalf the  
18 testimony is offered is a general practitioner, the expert  
19 witness must have devoted professional time during the 5 years  
20 immediately preceding the date of the occurrence that is the  
21 basis for the action to:

22           1. Active clinical practice or consultation as a  
23 general practitioner;

24           2. Instruction of students in an accredited health  
25 professional school or accredited residency program in the  
26 general practice of medicine; or

27           3. A clinical research program that is affiliated with  
28 an accredited medical school or teaching hospital and that is  
29 in the general practice of medicine.

30           (6) A physician licensed under chapter 458 or chapter  
31 459 who qualifies as an expert witness under subsection (5)

1 and who, by reason of active clinical practice or instruction  
2 of students, has knowledge of the applicable standard of care  
3 for nurses, nurse practitioners, certified registered nurse  
4 anesthetists, certified registered nurse midwives, physician  
5 assistants, or other medical support staff may give expert  
6 testimony in a medical malpractice action with respect to the  
7 standard of care of such medical support staff.

8 (7) Notwithstanding subsection (5), in a medical  
9 malpractice action against a hospital, a health care facility,  
10 or medical facility, a person may give expert testimony on the  
11 appropriate standard of care as to administrative and other  
12 nonclinical issues if the person has substantial knowledge, by  
13 virtue of his or her training and experience, concerning the  
14 standard of care among hospitals, health care facilities, or  
15 medical facilities of the same type as the hospital, health  
16 care facility, or medical facility whose acts or omissions are  
17 the subject of the testimony and which are located in the same  
18 or similar communities at the time of the alleged act giving  
19 rise to the cause of action.

20 (8) If a health care provider described in subsection  
21 (5), subsection (6), or subsection (7) is providing  
22 evaluation, treatment, or diagnosis for a condition that is  
23 not within his or her specialty, a specialist trained in the  
24 evaluation, treatment, or diagnosis for that condition shall  
25 be considered a similar health care provider.

26 (9)~~(6)~~(a) In any action for damages involving a claim  
27 of negligence against a physician licensed under chapter 458,  
28 osteopathic physician licensed under chapter 459, podiatric  
29 physician licensed under chapter 461, or chiropractic  
30 physician licensed under chapter 460 providing emergency  
31 medical services in a hospital emergency department, the court

1 shall admit expert medical testimony only from physicians,  
2 osteopathic physicians, podiatric physicians, and chiropractic  
3 physicians who have had substantial professional experience  
4 within the preceding 5 years while assigned to provide  
5 emergency medical services in a hospital emergency department.

6 (b) For the purposes of this subsection:

7 1. The term "emergency medical services" means those  
8 medical services required for the immediate diagnosis and  
9 treatment of medical conditions which, if not immediately  
10 diagnosed and treated, could lead to serious physical or  
11 mental disability or death.

12 2. "Substantial professional experience" shall be  
13 determined by the custom and practice of the manner in which  
14 emergency medical coverage is provided in hospital emergency  
15 departments in the same or similar localities where the  
16 alleged negligence occurred.

17 (10) In any action alleging medical malpractice, an  
18 expert witness may not testify on a contingency fee basis.

19 (11) Any attorney who proffers a person as an expert  
20 witness pursuant to this section must certify that such person  
21 has not been found guilty of fraud or perjury in any  
22 jurisdiction.

23 (12) This section does not limit the power of the  
24 trial court to disqualify or qualify an expert witness on  
25 grounds other than the qualifications in this section.

26 Section 57. Effective July 1, 2003, and applicable to  
27 any action arising from a medical malpractice claim initiated  
28 by a notice of intent to litigate received by a potential  
29 defendant in a medical malpractice case on or after that date,  
30 present subsections (5) through (12) of section 766.106,  
31 Florida Statutes, are redesignated as subsections (6) through

1 (13), respectively, and a new subsection (5) is added to that  
2 section, to read:

3 766.106 Notice before filing action for medical  
4 malpractice; presuit screening period; offers for admission of  
5 liability and for arbitration; informal discovery; review.--

6 (5)(a) With regard to insurance company bad-faith  
7 causes of action arising out of medical malpractice claims,  
8 the action shall be brought pursuant to common law and not  
9 pursuant to s. 624.155.

10 (b) An insurer shall not be held to have acted in bad  
11 faith for failure to timely pay its policy limits if it  
12 tenders its policy limits and meets the reasonable conditions  
13 of settlement prior to the conclusion of the presuit screening  
14 period provided for in subsection (4); during an extension  
15 provided for therein; during a period of 270 days thereafter;  
16 or during a 90-day period after the filing of an amended  
17 medical malpractice complaint alleging new facts previously  
18 unknown to the insurer. If a case is set for trial within 1  
19 year after the date of filing of the claim, an insurer shall  
20 not be held in bad faith if policy limits are tendered 60 days  
21 or more prior to trial.

22 (c) It is the intent of the Legislature to encourage  
23 all insurers, insureds, and their assigns and legal  
24 representatives to act in good faith during a medical  
25 negligence action, both during the presuit period and the  
26 litigation.

27 Section 58. Effective October 1, 2003, and applicable  
28 to notices of intent to litigate sent on or after that date,  
29 subsection (2), paragraphs (a) and (b) of subsection (3), and  
30 subsection (7) of section 766.106, Florida Statutes, as  
31 amended by this act, are amended, to read:

1           766.106 Notice before filing action for medical  
2 malpractice; presuit screening period; offers for admission of  
3 liability and for arbitration; informal discovery; review.--

4           (2)(a) After completion of presuit investigation  
5 pursuant to s. 766.203 and prior to filing a claim for medical  
6 malpractice, a claimant shall notify each prospective  
7 defendant by certified mail, return receipt requested, of  
8 intent to initiate litigation for medical malpractice. Notice  
9 to each prospective defendant must include, if available, a  
10 list of all known health care providers seen by the claimant  
11 for the injuries complained of subsequent to the alleged act  
12 of malpractice, all known health care providers during the  
13 2-year period prior to the alleged act of malpractice who  
14 treated or evaluated the claimant, and copies of all of the  
15 medical records relied upon by the expert in signing the  
16 affidavit. The requirement of providing the list of known  
17 health care providers may not serve as grounds for imposing  
18 sanctions for failure to provide presuit discovery.

19           (b) Following the initiation of a suit alleging  
20 medical malpractice with a court of competent jurisdiction,  
21 and service of the complaint upon a defendant, the claimant  
22 shall provide a copy of the complaint to the Department of  
23 Health and, if the complaint involves a facility licensed  
24 under chapter 395, the Agency for Health Care Administration.  
25 The requirement of providing the complaint to the Department  
26 of Health or the Agency for Health Care Administration does  
27 not impair the claimant's legal rights or ability to seek  
28 relief for his or her claim. The Department of Health or the  
29 Agency for Health Care Administration shall review each  
30 incident that is the subject of the complaint and determine  
31 whether it involved conduct by a licensee which is potentially

1 subject to disciplinary action, in which case, for a licensed  
2 health care practitioner, the provisions of s. 456.073 apply,  
3 and for a licensed facility, the provisions of part I of  
4 chapter 395 apply.

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

13 1. Internal review by a duly qualified claims  
14 adjuster;

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

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

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

25  
26 Each insurer or self-insurer shall investigate the claim in  
27 good faith, and both the claimant and prospective defendant  
28 shall cooperate with the insurer in good faith. If the  
29 insurer requires, a claimant shall appear before a pretrial  
30 screening panel or before a medical review committee and shall  
31 submit to a physical examination, if required. Unreasonable



1 failure of any party to comply with this section justifies  
2 dismissal of claims or defenses. There shall be no civil  
3 liability for participation in a pretrial screening procedure  
4 if done without intentional fraud.

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

- 7 1. Rejecting the claim;
- 8 2. Making a settlement offer; or
- 9 3. Making an offer to arbitrate in which liability is  
10 deemed admitted and arbitration will be held only of admission  
11 of liability and for arbitration on the issue of damages.  
12 This offer may be made contingent upon a limit of general  
13 damages.

14 (7) Informal discovery may be used by a party to  
15 obtain unsworn statements, the production of documents or  
16 things, and physical and mental examinations, as follows:

17 (a) Unsworn statements.--Any party may require other  
18 parties to appear for the taking of an unsworn statement. Such  
19 statements may be used only for the purpose of presuit  
20 screening and are not discoverable or admissible in any civil  
21 action for any purpose by any party. A party desiring to take  
22 the unsworn statement of any party must give reasonable notice  
23 in writing to all parties. The notice must state the time and  
24 place for taking the statement and the name and address of the  
25 party to be examined. Unless otherwise impractical, the  
26 examination of any party must be done at the same time by all  
27 other parties. Any party may be represented by counsel at the  
28 taking of an unsworn statement. An unsworn statement may be  
29 recorded electronically, stenographically, or on videotape.  
30 The taking of unsworn statements is subject to the provisions  
31

1 of the Florida Rules of Civil Procedure and may be terminated  
2 for abuses.

3 (b) Documents or things.--Any party may request  
4 discovery of documents or things. The documents or things  
5 must be produced, at the expense of the requesting party,  
6 within 20 days after the date of receipt of the request. A  
7 party is required to produce discoverable documents or things  
8 within that party's possession or control.

9 (c) Physical and mental examinations.--A prospective  
10 defendant may require an injured prospective claimant to  
11 appear for examination by an appropriate health care provider.  
12 The defendant shall give reasonable notice in writing to all  
13 parties as to the time and place for examination. Unless  
14 otherwise impractical, a prospective claimant is required to  
15 submit to only one examination on behalf of all potential  
16 defendants. The practicality of a single examination must be  
17 determined by the nature of the potential claimant's  
18 condition, as it relates to the liability of each potential  
19 defendant. Such examination report is available to the parties  
20 and their attorneys upon payment of the reasonable cost of  
21 reproduction and may be used only for the purpose of presuit  
22 screening. Otherwise, such examination report is confidential  
23 and exempt from the provisions of s. 119.07(1) and s. 24(a),  
24 Art. I of the State Constitution.

25 (d) Written questions.--Any party may request answers  
26 to written questions, which may not exceed 30, including  
27 subparts. A response must be made within 20 days after receipt  
28 of the questions.

29 Section 59. Section 766.108, Florida Statutes, is  
30 amended to read:

31

1           766.108 Mandatory mediation and mandatory settlement  
2 conference in medical malpractice actions.--

3           (1) Within 120 days after suit being filed, unless  
4 such period is extended by mutual agreement of all parties,  
5 all parties shall attend in-person mandatory mediation in  
6 accordance with s. 44.102 if binding arbitration under s.  
7 766.106 or s. 766.207 has not been agreed to by the parties.  
8 The Florida Rules of Civil Procedure shall apply to mediation  
9 held pursuant to this section.

10           (2)(a)~~(1)~~ In any action for damages based on personal  
11 injury or wrongful death arising out of medical malpractice,  
12 whether in tort or contract, the court shall require a  
13 settlement conference at least 3 weeks before the date set for  
14 trial.

15           (b)~~(2)~~ Attorneys who will conduct the trial, parties,  
16 and persons with authority to settle shall attend the  
17 settlement conference held before the court unless excused by  
18 the court for good cause.

19           Section 60. Section 766.118, Florida Statutes, is  
20 created to read:

21           766.118 Determination of noneconomic damages.--

22           (1) With respect to a cause of action for personal  
23 injury or wrongful death resulting from an occurrence of  
24 medical negligence, including actions pursuant to ss.  
25 766.207-766.212, damages recoverable for noneconomic losses to  
26 compensate for pain and suffering, inconvenience, physical  
27 impairment, mental anguish, disfigurement, loss of capacity  
28 for enjoyment of life, and all other noneconomic damages shall  
29 not exceed \$500,000 per defendant, regardless of the number of  
30 claimants involved in the action subject to the limitations  
31 set forth in subsection (2).

1           (2) Notwithstanding subsection (1), a trier of fact  
2 may award noneconomic damages under this section in excess of  
3 the limits described in subsection (1) in cases where medical  
4 negligence results in certain catastrophic injuries, including  
5 death, severe and permanent brain damage, coma, paralysis,  
6 quadriplegia, paraplegia, blindness, or a permanent vegetative  
7 state, except in those actions under ss. 766.207-766.212.

8           Section 61. Subsections (3), (5), (7), and (8) of  
9 section 766.202, Florida Statutes, are amended to read:

10           766.202 Definitions; ss. 766.201-766.212.--As used in  
11 ss. 766.201-766.212, the term:

12           (3) "Economic damages" means financial losses that  
13 ~~which~~ would not have occurred but for the injury giving rise  
14 to the cause of action, including, but not limited to, past  
15 and future medical expenses and 80 percent of wage loss and  
16 loss of earning capacity, to the extent the claimant is  
17 entitled to recover such damages under general law, including  
18 the Wrongful Death Act.

19           (5) "Medical expert" means a person duly and regularly  
20 engaged in the practice of his or her profession who holds a  
21 health care professional degree from a university or college  
22 and who meets the requirements of an expert witness as set  
23 ~~forth in s. 766.102 has had special professional training and~~  
24 ~~experience or one possessed of special health care knowledge~~  
25 ~~or skill about the subject upon which he or she is called to~~  
26 ~~testify or provide an opinion.~~

27           (7) "Noneconomic damages" means nonfinancial losses  
28 which would not have occurred but for the injury giving rise  
29 to the cause of action, including pain and suffering,  
30 inconvenience, physical impairment, mental anguish,  
31 disfigurement, loss of capacity for enjoyment of life, and

1 other nonfinancial losses, to the extent the claimant is  
2 entitled to recover such damages under general law, including  
3 the Wrongful Death Act.

4 (8) "Periodic payment" means provision for the  
5 structuring of future economic damages payments, in whole or  
6 in part, over a period of time, as follows:

7 (a) A specific finding of the dollar amount of  
8 periodic payments which will compensate for these future  
9 damages after offset for collateral sources shall be made.  
10 The total dollar amount of the periodic payments shall equal  
11 the dollar amount of all such future damages before any  
12 reduction to present value.

13 (b) The defendant shall be required to post a bond or  
14 security or otherwise to assure full payment of these damages  
15 awarded. A bond is not adequate unless it is written by a  
16 company authorized to do business in this state and is rated  
17 A+ by Best's. If the defendant is unable to adequately assure  
18 full payment of the damages, all damages, reduced to present  
19 value, shall be paid to the claimant in a lump sum. No bond  
20 may be canceled or be subject to cancellation unless at least  
21 60 days' advance written notice is filed with the court and  
22 the claimant. Upon termination of periodic payments, the  
23 security, or so much as remains, shall be returned to the  
24 defendant.

25 (c) The provision for payment of future damages by  
26 periodic payments shall specify the recipient or recipients of  
27 the payments, the dollar amounts of the payments, the interval  
28 between payments, and the number of payments or the period of  
29 time over which payments shall be made.

30 (d) Any portion of the periodic payment which is  
31 attributable to medical expenses that have not yet been

1 incurred shall terminate upon the death of the claimant. Any  
2 outstanding medical expenses incurred prior to the death of  
3 the claimant shall be paid from that portion of the periodic  
4 payment attributable to medical expenses.

5 Section 62. Effective July 1, 2003, and applicable to  
6 all causes of action accruing on or after that date, section  
7 766.206, Florida Statutes, is amended to read:

8 766.206 Presuit investigation of medical negligence  
9 claims and defenses by court.--

10 (1) After the completion of presuit investigation by  
11 the parties pursuant to s. 766.203 and any informal discovery  
12 pursuant to s. 766.106, any party may file a motion in the  
13 circuit court requesting the court to determine whether the  
14 opposing party's claim or denial rests on a reasonable basis.

15 (2) If the court finds that the notice of intent to  
16 initiate litigation mailed by the claimant is not in  
17 compliance with the reasonable investigation requirements of  
18 ss. 766.201-766.212, including a review of the claim and a  
19 verified written medical expert opinion by an expert witness  
20 as defined in s. 766.202,the court shall dismiss the claim,  
21 and the person who mailed such notice of intent, whether the  
22 claimant or the claimant's attorney, shall be personally  
23 liable for all attorney's fees and costs incurred during the  
24 investigation and evaluation of the claim, including the  
25 reasonable attorney's fees and costs of the defendant or the  
26 defendant's insurer.

27 (3) If the court finds that the response mailed by a  
28 defendant rejecting the claim is not in compliance with the  
29 reasonable investigation requirements of ss. 766.201-766.212,  
30 including a review of the claim and a verified written medical  
31 expert opinion by an expert witness as defined in s. 766.202,

1 the court shall strike the defendant's pleading~~response~~, and  
2 The person who mailed such response, whether the defendant,  
3 the defendant's insurer, or the defendant's attorney, shall be  
4 personally liable for all attorney's fees and costs incurred  
5 during the investigation and evaluation of the claim,  
6 including the reasonable attorney's fees and costs of the  
7 claimant.

8 (4) If the court finds that an attorney for the  
9 claimant mailed notice of intent to initiate litigation  
10 without reasonable investigation, or filed a medical  
11 negligence claim without first mailing such notice of intent  
12 which complies with the reasonable investigation requirements,  
13 or if the court finds that an attorney for a defendant mailed  
14 a response rejecting the claim without reasonable  
15 investigation, the court shall submit its finding in the  
16 matter to The Florida Bar for disciplinary review of the  
17 attorney. Any attorney so reported three or more times within  
18 a 5-year period shall be reported to a circuit grievance  
19 committee acting under the jurisdiction of the Supreme Court.  
20 If such committee finds probable cause to believe that an  
21 attorney has violated this section, such committee shall  
22 forward to the Supreme Court a copy of its finding.

23 (5)(a) If the court finds that the corroborating  
24 written medical expert opinion attached to any notice of claim  
25 or intent or to any response rejecting a claim lacked  
26 reasonable investigation, or that the medical expert  
27 submitting the opinion did not meet the expert witness  
28 qualifications as set forth in s. 766.202(5), the court shall  
29 report the medical expert issuing such corroborating opinion  
30 to the Division of Medical Quality Assurance or its designee.  
31 If such medical expert is not a resident of the state, the

1 division shall forward such report to the disciplining  
2 authority of that medical expert.

3 (b) The court shall ~~may~~ refuse to consider the  
4 testimony or opinion attached to any notice of intent or to  
5 any response rejecting a claim of ~~such~~ an expert who has been  
6 disqualified three times pursuant to this section.

7 Section 63. Subsection (7) of section 766.207, Florida  
8 Statutes, is amended to read:

9 766.207 Voluntary binding arbitration of medical  
10 negligence claims.--

11 (7) Arbitration pursuant to this section shall  
12 preclude recourse to any other remedy by the claimant against  
13 any participating defendant, and shall be undertaken with the  
14 understanding that damages shall be awarded as provided by  
15 general law, including the Wrongful Death Act, subject to the  
16 following limitations:

17 (a) Net economic damages shall be awardable,  
18 including, but not limited to, past and future medical  
19 expenses and 80 percent of wage loss and loss of earning  
20 capacity, offset by any collateral source payments.

21 (b) Noneconomic damages shall be limited to a maximum  
22 of \$250,000 per incident, and shall be calculated on a  
23 percentage basis with respect to capacity to enjoy life, so  
24 that a finding that the claimant's injuries resulted in a  
25 50-percent reduction in his or her capacity to enjoy life  
26 would warrant an award of not more than \$125,000 noneconomic  
27 damages.

28 (c) Damages for future economic losses shall be  
29 awarded to be paid by periodic payments pursuant to s.  
30 766.202(8) and shall be offset by future collateral source  
31 payments.



1 (d) Punitive damages shall not be awarded.

2 (e) The defendant shall be responsible for the payment  
3 of interest on all accrued damages with respect to which  
4 interest would be awarded at trial.

5 (f) The defendant shall pay the claimant's reasonable  
6 attorney's fees and costs, as determined by the arbitration  
7 panel, but in no event more than 15 percent of the award,  
8 reduced to present value.

9 (g) The defendant shall pay all the costs of the  
10 arbitration proceeding and the fees of all the arbitrators  
11 other than the administrative law judge.

12 (h) Each defendant who submits to arbitration under  
13 this section shall be jointly and severally liable for all  
14 damages assessed pursuant to this section.

15 (i) The defendant's obligation to pay the claimant's  
16 damages shall be for the purpose of arbitration under this  
17 section only. A defendant's or claimant's offer to arbitrate  
18 shall not be used in evidence or in argument during any  
19 subsequent litigation of the claim following the rejection  
20 thereof.

21 (j) The fact of making or accepting an offer to  
22 arbitrate shall not be admissible as evidence of liability in  
23 any collateral or subsequent proceeding on the claim.

24 (k) Any offer by a claimant to arbitrate must be made  
25 to each defendant against whom the claimant has made a claim.  
26 Any offer by a defendant to arbitrate must be made to each  
27 claimant who has joined in the notice of intent to initiate  
28 litigation, as provided in s. 766.106. A defendant who  
29 rejects a claimant's offer to arbitrate shall be subject to  
30 the provisions of s. 766.209(3). A claimant who rejects a  
31

1 defendant's offer to arbitrate shall be subject to the  
2 provisions of s. 766.209(4).

3 (1) The hearing shall be conducted by all of the  
4 arbitrators, but a majority may determine any question of fact  
5 and render a final decision. The chief arbitrator shall  
6 decide all evidentiary matters.

7  
8 The provisions of this subsection shall not preclude  
9 settlement at any time by mutual agreement of the parties.

10 Section 64. Subsection (4) is added to section  
11 768.041, Florida Statutes, to read:

12 768.041 Release or covenant not to sue.--

13 (4)(a) At trial pursuant to a suit filed under chapter  
14 766, or at trial pursuant to s. 766.209, if any defendant  
15 shows the court that the plaintiff, or his or her legal  
16 representative, has delivered a written release or covenant  
17 not to sue to any person in partial satisfaction of the  
18 damages sued for, the court shall set off this amount from the  
19 total amount of the damages set forth in the verdict and  
20 before entry of the final judgment.

21 (b) The amount of the setoff pursuant to this  
22 subsection shall include all sums received by the plaintiff,  
23 including economic and noneconomic damages, costs, and  
24 attorney's fees.

25 Section 65. Paragraph (c) of subsection (2) of section  
26 768.13, Florida Statutes, is amended to read:

27 768.13 Good Samaritan Act; immunity from civil  
28 liability.--

29 (2)

30 (c)1. Any health care practitioner as defined in s.  
31 456.001(4) who is in a hospital attending to a patient of his

1 or her practice or for business or personal reasons unrelated  
2 to direct patient care, and who voluntarily responds to  
3 provide care or treatment to a patient with whom at that time  
4 the practitioner does not have a then-existing health care  
5 patient-physician relationship, and when such care or  
6 treatment is necessitated by a sudden or unexpected situation  
7 or by an occurrence that demands immediate medical attention,  
8 shall not be held liable for any civil damages as a result of  
9 any act or omission relative to that care or treatment, unless  
10 that care or treatment is proven to amount to conduct that is  
11 willful and wanton and would likely result in injury so as to  
12 affect the life or health of another.

13 2. The immunity provided by this paragraph does not  
14 apply to damages as a result of any act or omission of  
15 providing medical care or treatment unrelated to the original  
16 situation that demanded immediate medical attention.

17 3. For purposes of this paragraph, the Legislature's  
18 intent is to encourage health care practitioners to provide  
19 necessary emergency care to all persons without fear of  
20 litigation as described in this paragraph.

21 ~~(c) Any person who is licensed to practice medicine,~~  
22 ~~while acting as a staff member or with professional clinical~~  
23 ~~privileges at a nonprofit medical facility, other than a~~  
24 ~~hospital licensed under chapter 395, or while performing~~  
25 ~~health screening services, shall not be held liable for any~~  
26 ~~civil damages as a result of care or treatment provided~~  
27 ~~gratuitously in such capacity as a result of any act or~~  
28 ~~failure to act in such capacity in providing or arranging~~  
29 ~~further medical treatment, if such person acts as a reasonably~~  
30 ~~prudent person licensed to practice medicine would have acted~~  
31 ~~under the same or similar circumstances.~~

1 Section 66. Section 768.77, Florida Statutes, is  
2 amended to read:

3 768.77 Itemized verdict.--

4 (1) Except as provided in subsection (2), in any  
5 action to which this part applies in which the trier of fact  
6 determines that liability exists on the part of the defendant,  
7 the trier of fact shall, as a part of the verdict, itemize the  
8 amounts to be awarded to the claimant into the following  
9 categories of damages:

10 (a)~~(1)~~ Amounts intended to compensate the claimant for  
11 economic losses;

12 (b)~~(2)~~ Amounts intended to compensate the claimant for  
13 noneconomic losses; and

14 (c)~~(3)~~ Amounts awarded to the claimant for punitive  
15 damages, if applicable.

16 (2) In any action for damages based on personal injury  
17 or wrongful death arising out of medical malpractice, whether  
18 in tort or contract, to which this part applies in which the  
19 trier of fact determines that liability exists on the part of  
20 the defendant, the trier of fact shall, as a part of the  
21 verdict, itemize the amounts to be awarded to the claimant  
22 into the following categories of damages:

23 (a) Amounts intended to compensate the claimant for:

24 1. Past economic losses; and

25 2. Future economic losses, not reduced to present  
26 value, and the number of years or part thereof which the award  
27 is intended to cover;

28 (b) Amounts intended to compensate the claimant for:

29 1. Past noneconomic losses; and

30 2. Future noneconomic losses and the number of years  
31 or part thereof which the award is intended to cover; and

1           (c) Amounts awarded to the claimant for punitive  
2 damages, if applicable.

3           Section 67. Subsection (5) of section 768.81, Florida  
4 Statutes, is amended to read:

5           768.81 Comparative fault.--

6           (5) Notwithstanding any provision of ~~anything in~~ law  
7 to the contrary, in an action for damages for personal injury  
8 or wrongful death arising out of medical malpractice, whether  
9 in contract or tort, the trier of fact shall apportion the  
10 total fault only among the claimant and all the joint  
11 tortfeasors who are parties to the action when the case is  
12 submitted to the jury for deliberation and rendition of the  
13 verdict ~~when an apportionment of damages pursuant to this~~  
14 ~~section is attributed to a teaching hospital as defined in s.~~  
15 ~~408.07, the court shall enter judgment against the teaching~~  
16 ~~hospital on the basis of such party's percentage of fault and~~  
17 ~~not on the basis of the doctrine of joint and several~~  
18 ~~liability.~~

19           Section 68. The Office of Program Policy Analysis and  
20 Government Accountability and the Office of the Auditor  
21 General must jointly conduct an audit of the Department of  
22 Health's health care practitioner disciplinary process and  
23 closed claims that are filed with the department under section  
24 627.912, Florida Statutes. The Office of Program Policy  
25 Analysis and Government Accountability and the Office of the  
26 Auditor General shall submit a report to the Legislature by  
27 January 1, 2004.

28           Section 69. Section 1004.08, Florida Statutes, is  
29 created to read:

30           1004.08 Patient safety instructional  
31 requirements.--Each public school, college, and university

1 that offers degrees in medicine, nursing, or allied health  
2 shall include in the curricula applicable to such degrees  
3 material on patient safety, including patient safety  
4 improvement. Materials shall include, but need not be limited  
5 to, effective communication and teamwork; epidemiology of  
6 patient injuries and medical errors; medical injuries;  
7 vigilance, attention and fatigue; checklists and inspections;  
8 automation, technological, and computer support; psychological  
9 factors in human error; and reporting systems.

10 Section 70. Section 1005.07, Florida Statutes, is  
11 created to read:

12 1005.07 Patient safety instructional  
13 requirements.--Each private school, college, and university  
14 that offers degrees in medicine, nursing, and allied health  
15 shall include in the curricula applicable to such degrees  
16 material on patient safety, including patient safety  
17 improvement. Materials shall include, but need not be limited  
18 to, effective communication and teamwork; epidemiology of  
19 patient injuries and medical errors; medical injuries;  
20 vigilance, attention and fatigue; checklists and inspections;  
21 automation, technological, and computer support; psychological  
22 factors in human error; and reporting systems.

23 Section 71. No later than September 1, 2003, the  
24 Department of Health shall convene a workgroup to study the  
25 current healthcare practitioner disciplinary process. The  
26 workgroup shall include a representative of the Administrative  
27 Law section of The Florida Bar, a representative of the Health  
28 Law section of The Florida Bar, a representative of the  
29 Florida Medical Association, a representative of the Florida  
30 Osteopathic Medical Association, a representative of the  
31 Florida Dental Association, a member of the Florida Board of

1 Medicine who has served on the probable cause panel, a member  
2 of the Board of Osteopathic Medicine who has served on the  
3 probable cause panel, and a member of the Board of Dentistry  
4 who has served on the probable cause panel. The workgroup  
5 shall also include one consumer member of the Board of  
6 Medicine. The Department of Health shall present the findings  
7 and recommendations to the Governor, the President of the  
8 Senate, and the Speaker of the House of Representatives no  
9 later than January 1, 2004. The sponsoring organizations shall  
10 assume the costs of their representative.

11 Section 72. Section 766.1065, Florida Statutes, is  
12 created to read:

13 766.1065 Mandatory presuit investigation.--

14 (1) Within 30 days after service of the presuit notice  
15 of intent to initiate medical malpractice litigation, each  
16 party shall provide to all other parties all medical,  
17 hospital, health care, and employment records concerning the  
18 claimant in the disclosing party's possession, custody, or  
19 control, and the disclosing party shall affirmatively certify  
20 in writing that such records constitute all records in that  
21 party's possession, custody, or control of that the party has  
22 no medical, hospital, health care, or employment records  
23 concerning the claimant.

24 (a) Subpoenas may be issued according to the Florida  
25 Rules of Civil Procedure as if suit has been filed for the  
26 limited purpose of obtaining copies of medical, hospital,  
27 health care, and employment records relating to the claimant.  
28 The party shall indicate on the subpoena that it is issued in  
29 accordance with the presuit procedures of this section and  
30 need not include a case number.

31

1           (b) This section does not limit the ability of any  
2 party to use any other presuit discovery available under this  
3 chapter or the Florida Rules of Civil Procedure.

4           (2) Within 60 days after service of the presuit notice  
5 of intent to initiate medical malpractice litigation, all  
6 parties must be made available for a sworn deposition. A  
7 deposition taken pursuant to this section may not be used in  
8 any civil action for any purpose by any party.

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

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

17           (b) An expert is deemed available for deposition if  
18 suitable accommodations can be made for appearance of the  
19 expert by real-time video technology.

20           (4) Within 150 days after service of the presuit  
21 notice of intent to initiate medical malpractice litigation,  
22 all parties must attend in-person mandatory mediation in  
23 accordance with s. 44.102, if binding arbitration under s.  
24 766.106 or s. 766.207 has not been agreed to by the parties.  
25 The Florida Rules of Civil Procedure shall apply to such  
26 mediation.

27           (5) If the parties declare an impasse during the  
28 mandatory mediation, the plaintiff shall make a request to the  
29 Office of Presuit Screening, via certified mail, for a hearing  
30 of a presuit screening panel to be convened pursuant to s.  
31 766.1066.



1           Section 73. Section 766.1066, Florida Statutes, is  
2 created to read:

3           766.1066 Office of Presuit Screening Administration;  
4 presuit screening panels.--

5           (1)(a) There is created within the Department of  
6 Health, the Office of Presuit Screening Administration. The  
7 department shall provide administrative support and service to  
8 the office to the extent requested by the director. The office  
9 is not subject to any control, supervision, or direction by  
10 the department, including, but not limited to, personnel,  
11 purchasing, transactions involving real or personal property,  
12 and budgetary matters. The director of the office shall be  
13 appointed by the Governor and the Cabinet.

14           (b) The office shall, by September 1, 2003, develop  
15 and maintain a database of physicians, attorneys, and  
16 consumers available to serve as members of presuit screening  
17 panels.

18           (c) The Department of Health and the relevant  
19 regulatory boards shall assist the office in developing the  
20 database. The office shall request the assistance of The  
21 Florida Bar in developing the database.

22           (d) Funding for the office's general expenses shall  
23 come from a service charge equal to 0.5 percent of the final  
24 judgment or arbitration award in each medical malpractice  
25 liability case in this state. All parties in such malpractice  
26 actions shall in equal parts pay the service charge at the  
27 time proceeds from a final judgment or an arbitration award  
28 are initially disbursed. Such charge shall be collected by the  
29 clerk of the circuit court in the county where the final  
30 judgment is entered or the arbitration award is made. The  
31 clerk shall remit the service charges to the Department of

1 Revenue for deposit into the Presuit Screening Administration  
2 Trust Fund. The Department of Revenue shall adopt rules to  
3 administer the service charge.

4 (e)1. A person may not be required to serve on a  
5 presuit screening panel for more than 2 days.

6 2. A person on a panel shall designate in advance any  
7 time period during which he or she will not be available to  
8 serve.

9 3. When a plaintiff requests a hearing before a panel,  
10 the office shall randomly select members for a panel from  
11 available persons in the appropriate categories who have not  
12 served on a panel in the past 12 months. If there are no other  
13 potential panelists available, a panelist may be asked to  
14 serve on another panel within 12 months.

15 (f) Panel members shall receive reimbursement from the  
16 office for their travel expenses.

17 (g) A physician who serves on a panel:

18 1. Shall receive credit for 20 hours of continuing  
19 medical education for such service;

20 2. Must reside and practice at least 50 miles from the  
21 location where the alleged injury occurred;

22 3. Must have had no more than two judgments for  
23 medical malpractice liability against him or her within the  
24 preceding 5 years and no more than 10 claims of medical  
25 malpractice filed against him or her within the preceding 3  
26 years.

27 4. Must hold an active license in good standing in  
28 this state or must have been in active practice within the  
29 5-year period prior to selection.

30  
31

1 A physician who fails to attend the designated panel hearing  
2 on two separate occasions shall be reported to his or her  
3 regulatory board for discipline and may not receive certified  
4 medical education credit for participation on the panel.

5 (h) An attorney who serves on a panel:

6 1. Should receive credit for 20 hours of continuing  
7 legal education and credit towards pro bono requirements for  
8 such service. The Legislature requests that the Supreme Court  
9 adopt rules to implement this provision.

10 2. Must reside and practice at least 50 miles from the  
11 location where the alleged injury occurred;

12 3. Must have had no judgments for filing a frivolous  
13 lawsuit within the preceding 5 years;

14 4. Must hold an active license to practice law in this  
15 state and have held an active license in good standing for at  
16 least 5 years; and

17 5. Must be a board-certified civil trial lawyer.

18  
19 An attorney who fails to attend the designated panel hearing  
20 on two separate occasions shall be reported to The Florida  
21 Bar.

22 (2)(a) A presuit screening panel shall be composed of  
23 five persons, including:

24 1. Two physicians who are board-certified in the same  
25 specialty as the defendant;

26 2. Two attorneys; and

27 3. One consumer who is neither an attorney nor a  
28 physician and who does not have a professional or financial  
29 relationship with a health care provider or an attorney that  
30 is a party or represents a party in the hearing. A consumer  
31 panel member who fails to attend the designated panel hearing

1 on two separate occasions shall be dismissed from service on  
2 the panel and barred from future service on a panel.

3 (b) If there is more than one physician defendant, the  
4 plaintiff shall designate the subject areas in which both  
5 physician members of the panel must be board-certified.

6 (c) A panel member who knowingly has a conflict of  
7 interest or potential conflict of interest must disclose it  
8 prior to the hearing.

9 (d) A plaintiff or a defendant may challenge any panel  
10 member for a conflict of interest and ask that the panelist be  
11 replaced by the office. The office must replace a challenged  
12 panel member with a panel member from the same category as the  
13 one challenged. A plaintiff or defendant may make repeated  
14 challenges to prospective panel members until the lists from  
15 which the panel members are selected are exhausted.

16 (e) The office shall provide administrative support to  
17 the panel.

18 (3) The plaintiff shall be allowed 8 hours to present  
19 his or her case. All defendants shall be allowed a total of 8  
20 hours collectively to present their case, and a hearing may  
21 not exceed a total of 16 hours; however, the panel may hear a  
22 case over the course of 2 calendar days. The panel members  
23 shall select a chair to preside at the hearing from among the  
24 panel members.

25 (4)(a) The testimony of all witnesses or parties shall  
26 be given under oath. The presiding panel member may administer  
27 oaths.

28 (b) The parties are entitled to be heard, to present  
29 relevant evidence, and to cross-examine witnesses to the  
30 extent necessary to enable the panel to render an opinion.  
31 Irrelevant, immaterial, or unduly repetitious evidence shall

1 be excluded, but all other evidence of a type commonly relied  
2 upon by reasonably prudent persons in the conduct of their  
3 affairs is admissible, whether or not such evidence would be  
4 admissible in a trial. Any part of the evidence may be  
5 received in written form. The panel may proceed with the  
6 hearing and shall render an opinion upon the evidence  
7 produced, notwithstanding the failure of a party to appear.

8 (5) A panel shall, by a majority vote for each  
9 defendant, make its findings in writing regarding reasonable  
10 grounds for liability of the defendant, based on the  
11 preponderance of the evidence. The findings of the panel are  
12 not final agency action for purposes of chapter 120, and are  
13 admissible as evidence, but not conclusive evidence, in the  
14 action brought by the plaintiff.

15 (6) Panel members are immune from civil liability for  
16 all communications, findings, opinions, and conclusions made  
17 in the course and scope of duties prescribed by this section  
18 to the extent provided in s. 768.28.

19 (7) The Administration Commission shall adopt rules to  
20 administer this section.

21 Section 74. Three positions are authorized and the sum  
22 of \$200,000 is appropriated from the General Revenue Fund to  
23 the Office of Presuit Screening Administration to implement  
24 the provisions of sections 72 and 73 of this act for the  
25 2003-2004 fiscal year. The \$200,000 includes \$147,600 in  
26 salaries and benefits, \$47,400 in expenses, and \$5,000 in OCO.  
27 The appropriations shall be continued from the Presuit  
28 Screening Trust Fund of the Department of Health in subsequent  
29 years.

30 Section 75. The sum of \$687,786 is appropriated from  
31 the Medical Quality Assurance Trust Fund to the Department of

1 Health, and seven positions are authorized, for the purpose of  
2 implementing this act during the 2003-2004 fiscal year. The  
3 sum of \$452,122 is appropriated from the General Revenue Fund  
4 to the Agency for Health Care Administration, and five  
5 positions are authorized, for the purpose of implementing this  
6 act during the 2003-2004 fiscal year.

7       Section 76. The sum of \$2,150,000 is appropriated from  
8 the Insurance Regulatory Trust Fund in the Department of  
9 Financial Services to the Office of Insurance Regulation for  
10 the purpose of implementing this act during the 2003-2004  
11 fiscal year.

12       Section 77. If any law that is amended by this act was  
13 also amended by a law enacted at the 2003 Regular Session or  
14 2003 Special Session A of the Legislature, such laws shall be  
15 construed as if they had been enacted during the same session  
16 of the Legislature, and full effect should be given to each if  
17 that is possible.

18       Section 78. If any provision of this act or its  
19 application to any person or circumstance is held invalid, the  
20 invalidity does not affect other provisions or applications of  
21 the act which can be given effect without the invalid  
22 provision or application, and to this end the provisions of  
23 this act are severable.

24       Section 79. Except as otherwise expressly provided in  
25 this act, this act shall take effect July 1, 2003, or upon  
26 becoming a law, whichever occurs later, and shall apply  
27 retroactively to July 1, 2003, with respect to any action  
28 arising from a medical malpractice claim initiated by a notice  
29 of intent to litigate received by a potential defendant in a  
30 medical malpractice case on or after that date.

31

1 STATEMENT OF SUBSTANTIAL CHANGES CONTAINED IN  
2 COMMITTEE SUBSTITUTE FOR  
3 Senate Bill 2-B

4 The bill deletes requirements for a claimant to execute a  
5 medical malpractice action to permit the taking of unsworn  
6 statements.

7 The financial responsibility requirements for medical and  
8 osteopathic physicians are revised to prohibit the use of  
9 funds set aside to meet the requirements for litigation or  
10 defense costs in a medical malpractice action. The minimum  
11 amount of professional liability claims that a medical or  
12 osteopathic physician has incurred within the previous ten  
13 years which the Department of Health must include in the  
14 practitioner profiles is revised from \$100,000 to \$50,000.

15 For purposes of the prohibition on excess underwriting profits  
16 for medical liability insurance, the bill revises the number  
17 of years in which an insurer would be deemed to have earned  
18 excess profits if its actual profit for the previous 3 instead  
19 of ten years is greater than the insurer's anticipated profit  
20 plus a specified percentage for that period.

21 The period in which an insurer may not be held to have acted  
22 in bad faith for failure to timely pay its policy limits if it  
23 tenders its policy limits and meets reasonable conditions of  
24 settlement before the conclusion of the presuit screening  
25 period for a medical malpractice action is revised.

26 A \$500,000 per defendant cap is established on noneconomic  
27 damages in personal injury or wrongful death cases resulting  
28 from an occurrence of medical negligence, including voluntary  
29 binding arbitration. Damages may be awarded in excess of the  
30 \$500,000 cap under when specified injuries are involved with  
31 exceptions.

The bill revises provisions extending immunity from civil  
liability under the Good Samaritan Act.

The bill establishes the Office of Presuit Screening  
Administration and creates presuit screening panels to  
determine whether there is a reasonable basis for claims after  
the presuit investigation by the claimant and defendant. An  
appropriation of \$200,000 is provided to implement the Office  
and its responsibilities.

The bill provides for an appropriation of \$2,150,000 to be  
transferred from the Insurance Regulatory Trust Fund to the  
Office of Insurance Regulation in order to implement the Act  
during the 2003-2004 fiscal year.