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

317-2695-03

A bill to be entitled

An act relating to medical malpractice; providing legislative findings; amending s. 46.015, F.S.; revising requirements for setoffs against damages in medical malpractice actions if there is a written release or covenant not to sue; creating s. 381.0409, F.S.; providing that creation of the Florida Center for Excellence in Health Care is contingent on the enactment of a public-records exemption; creating the Florida Center for Excellence in Health Care; providing goals and duties of the center; providing definitions; providing limitations on the center's liability for any lawful actions taken; requiring the center to issue patient safety recommendations; requiring the development of a statewide electronic infrastructure to improve patient care and the delivery and quality of health care services; providing requirements for development of a core electronic medical record; authorizing access to the electronic medical records and other data maintained by the center; providing for the use of computerized physician order entry systems; providing for the establishment of a simulation center for high technology intervention surgery and intensive care; providing for the immunity of specified information in adverse incident reports from discovery or admissibility in civil or administrative actions; providing limitations

on liability of specified health care practitioners and facilities under specified conditions; providing requirements for the appointment of a board of directors for the center; establishing a mechanism for financing the center through the assessment of specified fees; requiring the Florida Center for Excellence in Health Care to develop a business and financing plan; authorizing state agencies to contract with the center for specified projects; authorizing the use of center funds and the use of state purchasing and travel contracts for the center; requiring the center to submit an annual report and providing requirements for the annual report; providing for the center's books, records, and audits to be open to the public; requiring the center to annually furnish an audited report to the Governor and Legislature; amending s. 395.004, F.S., relating to licensure of certain health care facilities; providing for discounted medical liability insurance based on certification of programs that reduce adverse incidents; requiring the Office of Insurance Regulation to consider certain information in reviewing discounted rates; creating s. 395.0056, F.S.; requiring the Agency for Health Care Administration to review complaints submitted if the defendant is a hospital; amending s. 395.0193, F.S., relating to peer review and disciplinary actions; providing for

discipline of a physician for mental or physical abuse of staff; limiting the liability of certain participants in certain disciplinary actions at a licensed facility; amending s. 395.0197, F.S., relating to internal risk management programs; requiring a system for notifying patients that they are the subject of an adverse incident; requiring risk managers or their designees to give notice; requiring licensed facilities to annually report certain information about health care practitioners for whom they assume liability; requiring the Agency for Health Care Administration and the Department of Health to annually publish statistics about licensed facilities that assume liability for health care practitioners; requiring a licensed facility at which sexual abuse occurs to offer testing for sexually transmitted diseases at no cost to the victim; creating s. 395.1012, F.S.; requiring facilities to adopt a patient safety plan; providing requirements for a patient safety plan; requiring facilities to appoint a patient safety officer and a patient safety committee and providing duties for the patient safety officer and committee; amending s. 456.025, F.S.; eliminating certain restrictions on the setting of licensure renewal fees for health care practitioners; directing the Agency for Health Care Administration to conduct or contract for a study to determine what

information to provide to the public comparing hospitals, based on inpatient quality indicators developed by the federal Agency for Healthcare Research and Quality; creating s. 395.1051, F.S.; requiring certain facilities to notify patients about adverse incidents under specified conditions; creating s. 456.0575, F.S.; requiring licensed health care practitioners to notify patients about adverse incidents under certain conditions; amending s. 456.026, F.S., relating to an annual report published by the Department of Health; requiring that the department publish the report to its website; requiring the department to include certain detailed information; amending s. 456.039, F.S.; revising requirements for the information furnished to the Department of Health for licensure purposes; amending s. 456.041, F.S., relating to practitioner profiles; requiring the Department of Health to compile certain specified information in a practitioner profile; establishing a timeframe for certain health care practitioners to report specified information; providing for disciplinary action and a fine for untimely submissions; deleting provisions that provide that a profile need not indicate whether a criminal history check was performed to corroborate information in the profile; authorizing the department or regulatory board to investigate any information

received; requiring the department to provide an easy-to-read narrative explanation concerning final disciplinary action taken against a practitioner; requiring a hyperlink to each final order on the department's website which provides information about disciplinary actions; requiring the department to provide a hyperlink to certain comparison reports pertaining to claims experience; requiring the department to include the date that a reported disciplinary action was taken by a licensed facility and a characterization of the practitioner's conduct that resulted in the action; deleting provisions requiring the department to consult with a regulatory board before including certain information in a health care practitioner's profile; providing for a penalty for failure to comply with the timeframe for verifying and correcting a practitioner profile; requiring the department to add a statement to a practitioner profile when the profile information has not been verified by the practitioner; requiring the department to provide, in the practitioner profile, an explanation of disciplinary action taken and the reason for sanctions imposed; requiring the department to include a hyperlink to a practitioner's website when requested; providing that practitioners licensed under ch. 458 or ch. 459, F.S., shall have claim information concerning an indemnity payment

greater than a specified amount posted in the practitioner profile; amending s. 456.042, F.S.; providing for the update of practitioner profiles; designating a timeframe within which a practitioner must submit new information to update his or her profile; amending s. 456.049, F.S., relating to practitioner reports on professional liability claims and actions; revising requirements for a practitioner to report claims or actions that were not covered by an insurer; requiring the department to forward information on liability claims and actions to the Office of Insurance Regulation; amending s. 456.051, F.S.; establishing the responsibility of the Department of Health to provide reports of professional liability actions and bankruptcies; requiring the department to include such reports in a practitioner's profile within a specified period; amending s. 456.057, F.S.; allowing the department to obtain patient records by subpoena without the patient's written authorization, in specified circumstances; amending s. 456.063, F.S.; authorizing regulatory boards or the department to adopt rules to implement requirements for reporting allegations of sexual misconduct; authorizing health care practitioner regulatory boards to adopt rules to establish standards of practice for prescribing drugs to patients via the Internet; amending s. 456.072, F.S.; providing

for determining the amount of any costs to be assessed in a disciplinary proceeding; prescribing the standard of proof in certain disciplinary proceedings; amending s. 456.073, F.S.; authorizing the Department of Health to investigate certain paid claims made on behalf of practitioners licensed under ch. 458 or ch. 459, F.S.; amending procedures for certain disciplinary proceedings; providing a deadline for raising issues of material fact; providing a deadline relating to notice of receipt of a request for a formal hearing; amending s. 456.077, F.S.; providing a presumption related to an undisputed citation; amending s. 456.078, F.S.; revising standards for determining which violations of the applicable professional practice act are appropriate for mediation; amending s. 458.320, F.S., relating to financial responsibility requirements for medical physicians; requiring maintenance of financial responsibility as a condition of licensure of physicians; providing for payment of any outstanding judgments or settlements pending at the time a physician is suspended by the Department of Business and Professional Regulation; providing for an alternative method of providing financial responsibility; requiring the department to suspend the license of a medical physician who has not paid, up to the amounts required by any applicable financial responsibility provision, any

outstanding judgment, arbitration award, other order, or settlement; amending s. 459.0085, F.S., relating to financial responsibility requirements for osteopathic physicians; requiring maintenance of financial responsibility as a condition of licensure of osteopathic physicians; providing for payment of any outstanding judgments or settlements pending at the time an osteopathic physician is suspended by the Department of Business and Professional Regulation; providing for an alternative method of providing financial responsibility; requiring that the department suspend the license of an osteopathic physician who has not paid, up to the amounts required by any applicable financial responsibility provision, any outstanding judgment, arbitration award, other order, or settlement; providing civil immunity for certain participants in quality improvement processes; defining the terms "patient safety data" and "patient safety organization"; providing for use of patient safety data by a patient safety organization; providing limitations on use of patient safety data; providing for protection of patient-identifying information; providing for determination of whether the privilege applies as asserted; providing that an employer may not take retaliatory action against an employee who makes a good-faith report concerning patient safety data; requiring that

a specific statement be included in each final settlement statement relating to medical malpractice actions; providing requirements for the closed claim form of the Office of Insurance Regulation; requiring the Office of Insurance Regulation to compile annual statistical reports pertaining to closed claims; requiring historical statistical summaries; specifying certain information to be included on the closed claim form; amending s. 458.331, F.S., relating to grounds for disciplinary action against a physician; redefining the term "repeated malpractice"; revising the standards for the burden of proof in an administrative action against a physician; revising the minimum amount of a claim against a licensee which will trigger a departmental investigation; amending s. 459.015, F.S., relating to grounds for disciplinary action against an osteopathic physician; redefining the term "repeated malpractice"; revising the standards for the burden of proof in an administrative action against an osteopathic physician; amending conditions that necessitate a departmental investigation of an osteopathic physician; revising the minimum amount of a claim against a licensee which will trigger a departmental investigation; amending s. 460.413, F.S., relating to grounds for disciplinary action against a chiropractic physician; revising the

standards for the burden of proof in an administrative action against a chiropractic physician; providing a statement of legislative intent regarding the change in the standard of proof in disciplinary cases involving the suspension or revocation of a license; providing that the practice of health care is a privilege, not a right; providing that protecting patients overrides purported property interest in the license of a health care practitioner; providing that certain disciplinary actions are remedial and protective, not penal; providing that the Legislature specifically reverses case law to the contrary; requiring the Division of Administrative Hearings to designate administrative law judges who have special qualifications for hearings involving certain health care practitioners; amending s. 461.013, F.S., relating to grounds for disciplinary action against a podiatric physician; redefining the term "repeated malpractice"; amending the minimum amount of a claim against such a physician which will trigger a department investigation; amending s. 466.028, F.S., relating to grounds for disciplinary action against a dentist or a dental hygienist; redefining the term "dental malpractice"; revising the minimum amount of a claim against a dentist which will trigger a departmental investigation; amending s. 624.462, F.S.;

authorizing health care providers to form a commercial self-insurance fund; amending s. 627.062, F.S.; providing that an insurer may not require arbitration of a rate filing for medical malpractice; providing additional requirements for medical malpractice insurance rate filings; providing that portions of judgments and settlements entered against a medical malpractice insurer for bad-faith actions or for punitive damages against the insurer, as well as related taxable costs and attorney's fees, may not be included in an insurer's base rate; providing for review of rate filings by the Office of Insurance Regulation for excessive, inadequate, or unfairly discriminatory rates; requiring insurers to apply a discount based on the health care provider's loss experience; amending s. 627.0645, F.S.; excepting medical malpractice insurers from certain annual filings; requiring the Office of Program Policy Analysis and Government Accountability to study and report to the Legislature on requirements for coverage by the Florida Birth-Related Neurological Injury Compensation Association; creating s. 627.0662, F.S.; providing definitions; requiring each medical liability insurer to report certain information to the Office of Insurance Regulation; providing for determination of whether excessive profit has been realized; requiring return of excessive

amounts; amending s. 627.357, F.S.; providing guidelines for the formation and regulation of certain self-insurance funds; amending s. 627.4147, F.S.; revising certain notification criteria for medical and osteopathic physicians; requiring prior notification of a rate increase; authorizing the purchase of insurance by certain health care providers; creating s. 627.41491, F.S.; requiring the Office of Insurance Regulation to require health care providers to annually publish certain rate comparison information; creating s. 627.41492, F.S.; requiring the Office of Insurance Regulation to publish an annual medical malpractice report; creating s. 627.41493, F.S.; requiring a medical malpractice insurance rate rollback; providing for subsequent increases under certain circumstances; requiring approval for use of certain medical malpractice insurance rates; providing for a mechanism to make effective the Florida Medical Malpractice Insurance Fund in the event the rollback of medical malpractice insurance rates is not completed; creating the Florida Medical Malpractice Insurance Fund; providing purpose; providing governance by a board of governors; providing for the fund to issue medical malpractice policies to any physician regardless of specialty; providing for regulation by the Office of Insurance Regulation of the Financial Services

Commission; providing applicability; providing for initial funding; providing for tax-exempt status; providing for initial capitalization; providing for termination of the fund; providing that practitioners licensed under ch. 458 or ch. 459, F.S., must, as a licensure requirement, obtain and maintain professional liability coverage; creating s. 627.41495, F.S.; providing for consumer participation in review of medical malpractice rate changes; providing for public inspection; providing for adoption of rules by the Financial Services Commission; requiring the Office of Insurance Regulation to order insurers to make rate filings effective January 1, 2004, which reflect the impact of the act; providing criteria for such rate filing; amending s. 627.912, F.S.; amending provisions prescribing conditions under which insurers must file certain reports with the Department of Health; requiring the Financial Services Commission to adopt by rule requirements for reporting financial information; increasing the limitation on a fine imposed against insurers; creating s. 627.9121, F.S.; requiring certain claims, judgments, or settlements to be reported to the Office of Insurance Regulation; providing penalties; amending s. 766.102, F.S; revising requirements for health care providers providing expert testimony in medical negligence actions; prohibiting contingency

fees for an expert witness; amending s. 766.106, F.S.; providing for application of common law principles of good faith to an insurance company's bad-faith actions arising out of medical malpractice claims; providing that an insurer shall not be held to have acted in bad faith for certain activities during the presuit period and for a specified later period; providing legislative intent with respect to actions by insurers, insureds, and their assigns and representatives; revising requirements for presuit notice and for an insurer's or self-insurer's response to a claim; requiring that a claimant provide the Agency for Health Care Administration with a copy of the complaint alleging medical malpractice; requiring the agency to review such complaints for licensure noncompliance; permitting written questions during informal discovery; amending s. 766.108, F.S.; providing for mandatory mediation; creating s. 766.118, F.S.; providing a maximum amount to be awarded as noneconomic damages in medical negligence actions; providing exceptions; amending s. 766.202, F.S.; redefining the terms "economic damages," "medical expert," "noneconomic damages," and "periodic payment"; amending s. 766.206, F.S.; providing for dismissal of a claim under certain circumstances; requiring the court to make certain reports concerning a medical expert who fails to meet

qualifications; amending s. 766.207, F.S.; providing for the applicability of the Wrongful Death Act and general law to arbitration awards; amending s. 768.041, F.S.; revising requirements for setoffs against damages in medical malpractice actions if there is a written release or covenant not to sue; amending s. 768.13, F.S.; revising guidelines for immunity from liability under the "Good Samaritan Act"; amending s. 768.77, F.S.; prescribing a method for itemization of specific categories of damages awarded in medical malpractice actions; amending s. 768.81, F.S.; requiring the trier of fact to apportion total fault solely among the claimant and joint tortfeasors as parties to an action; requiring the Office of Program Policy Analysis and Government Accountability and the Office of the Auditor General to conduct an audit of the health care practitioner disciplinary process and closed claims and report to the Legislature; creating ss. 1004.08 and 1005.07, F.S.; requiring schools, colleges, and universities to include material on patient safety in their curricula if the institution awards specified degrees; creating a workgroup to study the health care practitioner disciplinary process; providing for workgroup membership; providing that the workgroup deliver its report by January 1, 2004; creating s. 766.1065, F.S.; providing for mandatory

presuit investigations; providing that certain records be provided to opposing parties; providing subpoena power; providing for sworn depositions of parties and medical experts; providing for mandatory in-person mediation if binding arbitration has not been agreed to; providing for a mandatory presuit screening panel hearing in the event of mediation impasse; creating s. 766.1066, F.S.; creating the Office of Presuit Screening Administration; providing for a database of volunteer panel members; prescribing qualifications for panel membership; providing a funding mechanism; providing panel procedures; providing for determination and recordation of panel findings; providing for disposition of panel findings; providing immunity from liability for panel members; providing appropriations and authorizing positions; providing for construction of the act in pari materia with laws enacted during the 2003 Regular Session or 2003 Special Session A of the Legislature; providing for severability; providing for retroactive application; providing effective dates.

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

Section 1. Findings.--

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

46.015 Release of parties.--

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

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

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

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

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

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

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

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

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

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

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

(2) The center shall directly or by contract:

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

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

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

and the delivery and quality of health care services by health care facilities and practitioners. The electronic infrastructure shall be a secure platform for communication and the sharing of clinical and other data, such as business data, among providers and between patients and providers. The electronic infrastructure shall include a "core" electronic medical record. Health care practitioners and health care facilities shall have access to individual electronic medical records subject to the consent of the individual. Each health insurer licensed under chapter 627 or chapter 641 shall have access to the electronic medical records of its policyholders and, subject to s. 381.04091, to other data if such access is for the sole purpose of conducting research to identify diagnostic tests and treatments that are medically effective. Health research entities shall have access to the electronic medical records of individuals, subject to the consent of the individual and subject to s. 381.04091, and to other data if such access is for the sole purpose of conducting research to identify diagnostic tests and treatments that are medically effective.

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

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

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

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

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

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

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

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

(6) The center shall:

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

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

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

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

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

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

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

(d) The members shall elect a chairperson.

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

(8) The center shall be financed as follows:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(e) A financial statement and balance sheet.

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

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

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

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

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

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

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

395.004 Application for license, fees; expenses.--

(3) A licensed facility may apply to the agency for certification of a quality improvement program that results in the reduction of adverse incidents at that facility. The agency, in consultation with the Office of Insurance Regulation, shall develop criteria for such certification. Insurers shall file with the Office of Insurance Regulation a discount in the rate or rates applicable for medical liability insurance coverage to reflect the implementation of a certified program. In reviewing insurance company filings with respect to rate discounts authorized under this subsection, the Office of Insurance Regulation shall consider whether, and the extent to which, the program certified under this subsection is otherwise covered under a program of risk management offered by an insurance company or self-insurance plan providing medical liability coverage.

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

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

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

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

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

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

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

(a) Incompetence.

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

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

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

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

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

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

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

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

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

395.0197 Internal risk management program.--

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

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

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

1. Risk management and risk prevention education and training of all nonphysician personnel as follows:

a. Such education and training of all nonphysician personnel as part of their initial orientation; and

b. At least 1 hour of such education and training annually for all personnel of the licensed facility working in clinical areas and providing patient care, except those persons licensed as health care practitioners who are required to complete continuing education coursework pursuant to chapter 456 or the respective practice act.

2. A prohibition, except when emergency circumstances require otherwise, against a staff member of the licensed facility attending a patient in the recovery room, unless the staff member is authorized to attend the patient in the recovery room and is in the company of at least one other person. However, a licensed facility is exempt from the two-person requirement if it has:

a. Live visual observation;

b. Electronic observation; or

c. Any other reasonable measure taken to ensure patient protection and privacy.

3. A prohibition against an unlicensed person from assisting or participating in any surgical procedure unless the facility has authorized the person to do so following a competency assessment, and such assistance or participation is done under the direct and immediate supervision of a licensed physician and is not otherwise an activity that may only be performed by a licensed health care practitioner.

4. Development, implementation, and ongoing evaluation of procedures, protocols, and systems to accurately identify patients, planned procedures, and the correct site of the

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

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

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

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

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

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

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

(a) The death of a patient;

(b) Brain or spinal damage to a patient;

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

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

(e) The performance of a wrong surgical procedure;

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

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

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

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

be available to the public pursuant to s. 119.07(1) or any other law providing access to public records, nor be discoverable or admissible in any civil or administrative action, except in disciplinary proceedings by the agency or the appropriate regulatory board, nor shall they be available to the public as part of the record of investigation for and prosecution in disciplinary proceedings made available to the public by the agency or the appropriate regulatory board. However, the agency or the appropriate regulatory board shall make available, upon written request by a health care professional against whom probable cause has been found, any such records which form the basis of the determination of probable cause. The agency may investigate, as it deems appropriate, any such incident and prescribe measures that must or may be taken in response to the incident. The agency shall review each incident and determine whether it potentially involved conduct by the health care professional who is subject to disciplinary action, in which case the provisions of s. 456.073 shall apply. <u>The agency shall forward a copy of all reports of adverse incidents submitted to the agency by hospitals and ambulatory surgical centers to the Florida Center for Excellence in Health Care, as created in s. 381.0409, for analysis by experts who may make recommendations regarding the prevention of such incidents. Such information shall remain confidential as otherwise provided by law.</u>

<u>(12) If appropriate, a licensed facility in which sexual abuse occurs must offer the victim of sexual abuse testing for sexually transmissible diseases and shall provide all such testing at no cost to the victim.</u>

Section 8. Section 395.1012, Florida Statutes, is created to read:

395.1012 Patient safety.--

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

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

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

456.025 Fees; receipts; disposition.--

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

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

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

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

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

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

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

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

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

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

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

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

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

1. Inpatient mortality for medical conditions;

2. Inpatient mortality for procedures;

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

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

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

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

(e) The criteria for comparison.

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

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

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

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

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

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

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

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

456.026 Annual report concerning finances, administrative complaints, disciplinary actions, and recommendations.--The department is directed to prepare and submit a report to the President of the Senate and the Speaker of the House of Representatives by November 1 of each year. The department shall publish the report to its website simultaneously with delivery to the President of the Senate and the Speaker of the House of Representatives. The report must be directly accessible on the department's Internet homepage highlighted by easily identifiable links and buttons. In addition to finances and any other information the

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

5. The year that the applicant began practicing medicine.

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

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

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

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

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

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

456.041 Practitioner profile; creation.--

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(a) A final judgment in any amount.

(b) A settlement in any amount.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

456.072 Grounds for discipline; penalties; enforcement.--

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

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

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

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

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

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

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

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

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

456.077 Authority to issue citations.--

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

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

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

456.078 Mediation.--

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

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

458.320 Financial responsibility.--

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(d)~~3.~~ Upon the next meeting of the probable cause panel of the board following 30 days after the date of mailing the notice of disciplinary action to the licensee, the panel shall make a determination of whether probable cause exists to

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

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

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

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

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

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

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

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

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

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

459.0085 Financial responsibility.--

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(1) Each member of, or health care professional consultant to, any committee, board, group, commission, or other entity shall be immune from civil liability for any act, decision, omission, or utterance done or made in performance of his duties while serving as a member of or consultant to such committee, board, group, commission, or other entity established and operated for purposes of quality improvement review, evaluation, and planning in a state-licensed health care facility. Such entities must function primarily to review, evaluate, or make recommendations relating to:

(a) The duration of patient stays in health care facilities;

(b) The professional services furnished with respect to the medical, dental, psychological, podiatric, chiropractic, or optometric necessity for such services;

(c) The purpose of promoting the most efficient use of available health care facilities and services;

(d) The adequacy or quality of professional services;

(e) The competency and qualifications for professional staff privileges;

(f) The reasonableness or appropriateness of charges made by or on behalf of health care facilities; or

(g) Patient safety, including entering into contracts with patient safety organizations.

(2) Such committee, board, group, commission, or other entity must be established in accordance with state law or in accordance with requirements of the Joint Commission on Accreditation of Healthcare Organizations, established and duly constituted by one or more public or licensed private hospitals or behavioral health agencies, or established by a governmental agency. To be protected by this section, the act,

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

Section 29. Patient safety data privilege.--

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

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

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

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

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

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

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

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

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

Section 30. Each final settlement statement relating to medical malpractice shall include the following statement: "The decision to settle a case may reflect the economic practicalities pertaining to the cost of litigation and is not, alone, an admission that the insured failed to meet the required standard of care applicable to the patient's treatment. The decision to settle a case may be made by the

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

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

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

(a) A final judgment in any amount.

(b) A settlement in any amount.

Reports shall be filed with the Office of Insurance Regulation no later than 60 days following the occurrence of any event listed in this subsection.

(2) Health professional reports must contain:

(a) The name and address of the licensee.

(b) The alleged occurrence.

(c) The date of the alleged occurrence.

(d) The date the claim or action was reported to the licensee.

(e) The name and address of the opposing party.

(f) The date of suit, if filed.

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

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

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

(j) In the case of a settlement, any information required by the Office of Insurance Regulation concerning the injured person's incurred and anticipated medical expense, wage loss, and other expenses.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

624.462 Commercial self-insurance funds.--

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

(a) Established by:

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

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

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

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

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

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

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

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

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

c. Approve payment of dividends to members;

d. Approve changes in corporate structure; and

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

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

627.062 Rate standards.--

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

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

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

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

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

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

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

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

627.0645 Annual filings.--

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

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

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

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

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

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

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

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

627.0662 Excessive profits for medical liability insurance prohibited.--

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

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

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

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

(a) Calendar-year earned premium.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

627.357 Medical malpractice self-insurance.--

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

(b) The Financial Services Commission must ensure that self-insurance funds remain solvent and provide insurance coverage purchased by participants. The Financial Services Commission may adopt rules pursuant to ss. 120.536(1) and 120.54 to implement this section.

Section 45. Effective October 1, 2003, section 627.4147, Florida Statutes, is amended to read:

627.4147 Medical malpractice insurance contracts.--

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

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

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

made by an insurer or self-insurer shall be made in good faith and in the best interests of the insured.

2.a. With respect to physicians licensed under chapter 458 or chapter 459 or dentists licensed under chapter 466, a clause clearly stating whether or not the insured has the exclusive right to veto any offer of admission of liability and for arbitration pursuant to s. 766.106, settlement offer, or offer of judgment if the offer is within policy limits. An insurer or self-insurer shall not make or conclude, without the permission of the insured, any offer of admission of liability and for arbitration pursuant to s. 766.106, settlement offer, or offer of judgment, if such offer is outside the policy limits. However, any offer for admission of liability and for arbitration made under s. 766.106, settlement offer, or offer of judgment made by an insurer or self-insurer shall be made in good faith and in the best interest of the insured.

b. If the policy contains a clause stating the insured does not have the exclusive right to veto any offer or admission of liability and for arbitration made pursuant to s. 766.106, settlement offer or offer of judgment, the insurer or self-insurer shall provide to the insured or the insured's legal representative by certified mail, return receipt requested, a copy of the final offer of admission of liability and for arbitration made pursuant to s. 766.106, settlement offer or offer of judgment and at the same time such offer is provided to the claimant. A copy of any final agreement reached between the insurer and claimant shall also be provided to the insurer or his or her legal representative by certified mail, return receipt requested not more than 10 days after affecting such agreement.

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

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

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

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

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

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

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

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

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

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

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

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

627.41493 Insurance rate rollback.--

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

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

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

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

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

Section 50. Florida Medical Malpractice Insurance Fund.--

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

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

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

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

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

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

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

1. Three members by the Governor;

2. Three members by the Chief Financial Officer; and

3. One member by the other six board members.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

627.41495 Public hearings for medical malpractice rate filings.--

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

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

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

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

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

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

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

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

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

(a) A final judgment in any amount.

(b) A settlement in any amount.

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

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

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

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

(b) The insured's policy number.

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

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

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

multiple or duplicate claims arising out of the same occurrence.

(f) The date of suit, if filed.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1. Specialize in the same specialty as the party against whom or on whose behalf the testimony is offered; or

2. Specialize in a similar speciality that includes the evaluation, diagnosis, or treatment of the medical condition that is the subject of the claim and have prior experience treating similar patients.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(b) For the purposes of this subsection:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1. Internal review by a duly qualified claims adjuster;

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

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

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

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

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

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

1. Rejecting the claim;

2. Making a settlement offer; or

3. Making an offer to arbitrate in which liability is deemed admitted and arbitration will be held only ~~of admission of liability and for arbitration~~ on the issue of damages. This offer may be made contingent upon a limit of general damages.

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

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

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

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

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

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

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

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

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

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

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

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

766.118 Determination of noneconomic damages.--

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

766.207 Voluntary binding arbitration of medical negligence claims.--

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

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

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

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

(d) Punitive damages shall not be awarded.

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

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

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

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

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

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

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

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

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

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

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

768.041 Release or covenant not to sue.--

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

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

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

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

(2)

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

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

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

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

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

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

768.77 Itemized verdict.--

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

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

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

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

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

(a) Amounts intended to compensate the claimant for:

1. Past economic losses; and

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

(b) Amounts intended to compensate the claimant for:

1. Past noneconomic losses; and

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

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

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

768.81 Comparative fault.--

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

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

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

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

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

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

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

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

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

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

766.1065 Mandatory presuit investigation.--

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(g) A physician who serves on a panel:

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

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

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

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

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

(h) An attorney who serves on a panel:

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

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

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

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

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

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

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

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

2. Two attorneys; and

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

The bill deletes requirements for a claimant to execute a medical release pursuant to informal discovery as part of a medical malpractice action to permit the taking of unsworn statements.

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

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

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

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