

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

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

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

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

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

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

1 for determining the amount of any costs to be
2 assessed in a disciplinary proceeding;
3 prescribing the standard of proof in certain
4 disciplinary proceedings; amending s. 456.073,
5 F.S.; authorizing the Department of Health to
6 investigate certain paid claims made on behalf
7 of practitioners licensed under ch. 458 or ch.
8 459, F.S.; amending procedures for certain
9 disciplinary proceedings; providing a deadline
10 for raising issues of material fact; providing
11 a deadline relating to notice of receipt of a
12 request for a formal hearing; amending s.
13 456.077, F.S.; providing a presumption related
14 to an undisputed citation; amending s. 456.078,
15 F.S.; revising standards for determining which
16 violations of the applicable professional
17 practice act are appropriate for mediation;
18 amending ss. 458.311 and 459.0055, F.S.;
19 requiring that specified information be
20 provided to the Department of Health; amending
21 s. 458.320, F.S., relating to financial
22 responsibility requirements for medical
23 physicians; requiring maintenance of financial
24 responsibility as a condition of licensure of
25 physicians; providing for payment of any
26 outstanding judgments or settlements pending at
27 the time a physician is suspended by the
28 Department of Business and Professional
29 Regulation; requiring the department to suspend
30 the license of a medical physician who has not
31 paid, up to the amounts required by any

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

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

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

1 commercial self-insurance fund; amending s.
2 627.062, F.S.; providing that an insurer may
3 not require arbitration of a rate filing for
4 medical malpractice; providing additional
5 requirements for medical malpractice insurance
6 rate filings; providing that portions of
7 judgments and settlements entered against a
8 medical malpractice insurer for bad-faith
9 actions or for punitive damages against the
10 insurer, as well as related taxable costs and
11 attorney's fees, may not be included in an
12 insurer's base rate; providing for review of
13 rate filings by the Office of Insurance
14 Regulation for excessive, inadequate, or
15 unfairly discriminatory rates; requiring
16 insurers to apply a discount based on the
17 health care provider's loss experience;
18 amending s. 627.0645, F.S.; excepting medical
19 malpractice insurers from certain annual
20 filings; requiring the Office of Program Policy
21 Analysis and Government Accountability to study
22 and report to the Legislature on requirements
23 for coverage by the Florida Birth-Related
24 Neurological Injury Compensation Association;
25 creating s. 627.0662, F.S.; providing
26 definitions; requiring each medical liability
27 insurer to report certain information to the
28 Office of Insurance Regulation; providing for
29 determination of whether excessive profit has
30 been realized; requiring return of excessive
31 amounts; amending s. 627.357, F.S.; providing

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

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

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

1 "noneconomic damages," and "periodic payment";
2 amending s. 766.206, F.S.; providing for
3 dismissal of a claim under certain
4 circumstances; requiring the court to make
5 certain reports concerning a medical expert who
6 fails to meet qualifications; amending s.
7 766.207, F.S.; providing for the applicability
8 of the Wrongful Death Act and general law to
9 arbitration awards; amending s. 768.041, F.S.;
10 revising requirements for setoffs against
11 damages in medical malpractice actions if there
12 is a written release or covenant not to sue;
13 amending s. 768.13, F.S.; revising guidelines
14 for immunity from liability under the "Good
15 Samaritan Act"; amending s. 768.77, F.S.;
16 prescribing a method for itemization of
17 specific categories of damages awarded in
18 medical malpractice actions; amending s.
19 768.81, F.S.; requiring the trier of fact to
20 apportion total fault solely among the claimant
21 and joint tortfeasors as parties to an action;
22 preserving sovereign immunity and the
23 abrogation of certain joint and several
24 liability; requiring the Office of Program
25 Policy Analysis and Government Accountability
26 and the Office of the Auditor General to
27 conduct an audit of the health care
28 practitioner disciplinary process and closed
29 claims and report to the Legislature; creating
30 ss. 1004.08 and 1005.07, F.S.; requiring
31 schools, colleges, and universities to include

1 material on patient safety in their curricula
2 if the institution awards specified degrees;
3 amending s. 1006.20, F.S.; requiring completion
4 of a uniform participation physical evaluation
5 and history form incorporating recommendations
6 of the American Heart Association; deleting
7 revisions to procedures for students' physical
8 examinations; creating a workgroup to study the
9 health care practitioner disciplinary process;
10 providing for workgroup membership; providing
11 that the workgroup deliver its report by
12 January 1, 2004; creating s. 766.1065, F.S.;
13 providing for mandatory presuit investigations;
14 providing that certain records be provided to
15 opposing parties; providing subpoena power;
16 providing for sworn depositions of parties and
17 medical experts; providing for mandatory
18 in-person mediation if binding arbitration has
19 not been agreed to; providing for a mandatory
20 presuit screening panel hearing in the event of
21 mediation impasse; creating s. 766.1066, F.S.;
22 creating the Office of Presuit Screening
23 Administration; providing for a database of
24 volunteer panel members; prescribing
25 qualifications for panel membership; providing
26 a funding mechanism; providing panel
27 procedures; providing for determination and
28 recordation of panel findings; providing for
29 disposition of panel findings; providing
30 immunity from liability for panel members;
31 creating s. 624.156, F.S.; providing that

1 certain consumer protection laws apply to the
2 business of insurance; amending s. 456.013,
3 F.S.; requiring, as a condition of licensure
4 and license renewal, that physicians and
5 physician assistants complete a continuing
6 education course relating to misdiagnosed
7 conditions; amending s. 766.209, F.S.; revising
8 applicable damages available in voluntary
9 binding arbitration relating to claims of
10 medical negligence; providing appropriations
11 and authorizing positions; providing for
12 construction of the act in pari materia with
13 laws enacted during the 2003 Regular Session or
14 2003 Special Session A of the Legislature;
15 providing for severability; providing for
16 retroactive application; providing effective
17 dates.

18

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

20

21 Section 1. Findings.--

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

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

28 (3) The Legislature finds that the rapidly growing
29 population and the changing demographics of Florida make it
30 imperative that students continue to choose Florida as the

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1 place they will receive their medical educations and practice
2 medicine.

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

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

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

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

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

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

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

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

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

4 (13) The Legislature finds, based upon the findings
5 and recommendations of the Governor's Select Task Force on
6 Healthcare Professional Liability Insurance, the findings and
7 recommendations of various study groups throughout the nation,
8 and the experience of other states, that the overwhelming
9 public necessities of making quality health care available to
10 the citizens of this state, of ensuring that physicians
11 continue to practice in Florida, and of ensuring that those
12 physicians have the opportunity to purchase affordable
13 professional liability insurance cannot be met unless a cap on
14 noneconomic damages is imposed under certain circumstances.

15 (14) The Legislature finds that the high cost of
16 medical malpractice claims can be substantially alleviated, in
17 the short term, by imposing a limitation on noneconomic
18 damages in medical malpractice actions under certain
19 circumstances.

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

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

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

30 46.015 Release of parties.--

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

19 (6) The center shall:

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

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

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

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

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

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

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

11 (d) The members shall elect a chairperson.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

4 (e) A financial statement and balance sheet.

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

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

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

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

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

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

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

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

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

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

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

27 (2) Review the incident that is the subject of the
28 complaint and determine whether it involved conduct by a
29 licensee which is potentially subject to disciplinary action.
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1 Section 6. Subsection (3) and paragraph (a) of
2 subsection (9) of section 395.0193, Florida Statutes, are
3 amended to read:

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

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

18 (a) Incompetence.

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

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

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

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

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

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

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

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

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

20 395.0197 Internal risk management program.--

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

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

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

31

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

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

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

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

18 a. Live visual observation;

19 b. Electronic observation; or

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

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

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

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

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

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

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

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

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

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

11 (a) The death of a patient;

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

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

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

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

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

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

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

27

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

1 be available to the public pursuant to s. 119.07(1) or any
2 other law providing access to public records, nor be
3 discoverable or admissible in any civil or administrative
4 action, except in disciplinary proceedings by the agency or
5 the appropriate regulatory board, nor shall they be available
6 to the public as part of the record of investigation for and
7 prosecution in disciplinary proceedings made available to the
8 public by the agency or the appropriate regulatory board.
9 However, the agency or the appropriate regulatory board shall
10 make available, upon written request by a health care
11 professional against whom probable cause has been found, any
12 such records which form the basis of the determination of
13 probable cause. The agency may investigate, as it deems
14 appropriate, any such incident and prescribe measures that
15 must or may be taken in response to the incident. The agency
16 shall review each incident and determine whether it
17 potentially involved conduct by the health care professional
18 who is subject to disciplinary action, in which case the
19 provisions of s. 456.073 shall apply. The agency shall forward
20 a copy of all reports of adverse incidents submitted to the
21 agency by hospitals and ambulatory surgical centers to the
22 Florida Center for Excellence in Health Care, as created in s.
23 381.0409, for analysis by experts who may make recommendations
24 regarding the prevention of such incidents. Such information
25 shall remain confidential as otherwise provided by law.

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

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

1 395.1012 Patient safety.--

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

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

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

16 456.025 Fees; receipts; disposition.--

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

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

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

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

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

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

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

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

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

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

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

31

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

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

6 1. Inpatient mortality for medical conditions;

7 2. Inpatient mortality for procedures;

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

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

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

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

18 (e) The criteria for comparison.

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

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

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

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

31

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

20 456.041 Practitioner profile; creation.--

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

30
31

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

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

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

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

3 (4) The Department of Health shall include, with
4 respect to a practitioner licensed under chapter 458 or
5 chapter 459, a statement of how the practitioner has elected
6 to comply with the financial responsibility requirements of s.
7 458.320 or s. 459.0085. The department shall include, with
8 respect to practitioners subject to s. 456.048, a statement of
9 how the practitioner has elected to comply with the financial
10 responsibility requirements of that section. The department
11 shall include, with respect to practitioners licensed under
12 ~~chapter 458, chapter 459, or~~ chapter 461, information relating
13 to liability actions which has been reported under s. 456.049
14 or s. 627.912 within the previous 10 years for any paid claim
15 that exceeds \$5,000. The department shall include, with
16 respect to practitioners licensed under chapter 458 or chapter
17 459, information relating to liability actions which has been
18 reported under s. 456.049 or s. 627.912 within the previous 10
19 years for any paid claim that exceeds \$100,000.Such claims
20 information shall be reported in the context of comparing an
21 individual practitioner's claims to the experience of other
22 practitioners within the same specialty, or profession if the
23 practitioner is not a specialist, ~~to the extent such~~
24 ~~information is available to the Department of Health.~~ The
25 department must provide a hyperlink in such practitioner's
26 profile to all such comparison reports.If information
27 relating to a liability action is included in a practitioner's
28 practitioner profile, the profile must also include the
29 following statement: "Settlement of a claim may occur for a
30 variety of reasons that do not necessarily reflect negatively
31 on the professional competence or conduct of the practitioner.

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

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

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

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

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

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

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

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

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

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

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

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

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

13 (a) A final judgment in any amount.

14 (b) A settlement in any amount.

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

17
18 If the practitioner is licensed under chapter 458, chapter
19 459, or chapter 461 and the final judgment or settlement
20 amount was \$50,000 or more, or if the practitioner is licensed
21 under chapter 466 and the final judgment or settlement amount
22 was \$25,000 or more, the report ~~Reports~~ shall be filed with
23 the department no later than 60 days following the occurrence
24 of any event listed in paragraph (a) or ~~paragraph (b), or~~
25 ~~paragraph (c).~~

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

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

31

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

30
31

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

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

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

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

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

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

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

25 456.077 Authority to issue citations.--

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

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

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

13 456.078 Mediation.--

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

23 Section 26. Subsection (9) is added to section
24 458.311, Florida Statutes, to read:

25 458.311 Licensure by examination; requirements;
26 fees.--

27 (9) In addition to other information required under
28 this section, an applicant for licensure or relicensure must
29 submit the following information to the department:

30 (a) The name of the applicant's insurance carrier;
31

- 1 (b) If the applicant is self-insured, a description of
- 2 how, such as a certificate of deposit;
- 3 (c) The dates of insurance coverage;
- 4 (d) The cost of insurance coverage;
- 5 (e) The terms and limits of insurance coverage,
- 6 including policy changes;
- 7 (f) The identity of the hospital or group name if
- 8 coverage is provided by an entity other than the licensee;
- 9 (g) Whether the licensee is covered by insurance;
- 10 (h) The applicant's specialty of practice; and
- 11 (i) The name of the county or counties in which the
- 12 licensee practices medicine.

13

14 A licensee seeking a renewal license must include the

15 specified information for the 2 years prior to the renewal

16 date. The department shall include the information provided on

17 the application form in its computer database.

18 Section 27. Subsection (5) is added to section

19 459.0055, Florida Statutes, to read:

20 459.0055 General licensure requirements.--

21 (5) In addition to other information required under

22 this section, an applicant for licensure or relicensure must

23 submit the following information to the department:

- 24 (a) The name of the applicant's insurance carrier;
- 25 (b) If the applicant is self-insured, a description of
- 26 how, such as a certificate of deposit;
- 27 (c) The dates of insurance coverage;
- 28 (d) The cost of insurance coverage;
- 29 (e) The terms and limits of insurance coverage,
- 30 including policy changes;

31

1 (f) The identity of the hospital or group name if
2 coverage is provided by an entity other than the licensee;

3 (g) Whether the licensee is covered by insurance;

4 (h) The applicant's specialty of practice; and

5 (i) The name of the county or counties in which the
6 licensee practices medicine.

7
8 A licensee seeking a renewal license must include the
9 specified information for the 2 years prior to the renewal
10 date. The department shall include the information provided on
11 the application form in its computer database.

12 Section 28. Effective upon this act becoming a law and
13 applying to claims accruing on or after that date, section
14 458.320, Florida Statutes, is amended to read:

15 458.320 Financial responsibility.--

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

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

30 (b) Obtaining and maintaining professional liability
31 coverage in an amount not less than \$100,000 per claim, with a

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

10 (c) Obtaining and maintaining an unexpired,
11 irrevocable letter of credit, established pursuant to chapter
12 675, in an amount not less than \$100,000 per claim, with a
13 minimum aggregate availability of credit of not less than
14 \$300,000. The letter of credit must ~~shall~~ be payable to the
15 physician as beneficiary upon presentment of a final judgment
16 indicating liability and awarding damages to be paid by the
17 physician or upon presentment of a settlement agreement signed
18 by all parties to such agreement when such final judgment or
19 settlement is a result of a claim arising out of the rendering
20 of, or the failure to render, medical care and services. The
21 letter of credit may not be used for litigation costs or
22 attorney's fees for the defense of any medical malpractice
23 claim. The ~~Such~~ letter of credit must ~~shall~~ be nonassignable
24 and nontransferable. Such letter of credit must ~~shall~~ be
25 issued by any bank or savings association organized and
26 existing under the laws of this state or any bank or savings
27 association organized under the laws of the United States
28 which ~~that~~ has its principal place of business in this state
29 or has a branch office that ~~which~~ is authorized under the laws
30 of this state or of the United States to receive deposits in
31 this state.

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

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

13 (b) Obtaining and maintaining professional liability
14 coverage in an amount not less than \$250,000 per claim, with a
15 minimum annual aggregate of not less than \$750,000 from an
16 authorized insurer as defined under s. 624.09, from a surplus
17 lines insurer as defined under s. 626.914(2), from a risk
18 retention group as defined under s. 627.942, from the Joint
19 Underwriting Association established under s. 627.351(4),
20 through a plan of self-insurance as provided in s. 627.357, or
21 through a plan of self-insurance which meets the conditions
22 specified for satisfying financial responsibility in s.
23 766.110. The required coverage amount set forth in this
24 paragraph may not be used for litigation costs or attorney's
25 fees for the defense of any medical malpractice claim.

26 (c) Obtaining and maintaining an unexpired irrevocable
27 letter of credit, established pursuant to chapter 675, in an
28 amount not less than \$250,000 per claim, with a minimum
29 aggregate availability of credit of not less than \$750,000.
30 The letter of credit must ~~shall~~ be payable to the physician as
31 beneficiary upon presentment of a final judgment indicating

1 liability and awarding damages to be paid by the physician or
2 upon presentment of a settlement agreement signed by all
3 parties to such agreement when such final judgment or
4 settlement is a result of a claim arising out of the rendering
5 of, or the failure to render, medical care and services. The
6 letter of credit may not be used for litigation costs or
7 attorney's fees for the defense of any medical malpractice
8 claim. The ~~Such~~ letter of credit must ~~shall~~ be nonassignable
9 and nontransferable. The ~~Such~~ letter of credit must ~~shall~~ be
10 issued by any bank or savings association organized and
11 existing under the laws of this state or any bank or savings
12 association organized under the laws of the United States
13 which ~~that~~ has its principal place of business in this state
14 or has a branch office that ~~which~~ is authorized under the laws
15 of this state or of the United States to receive deposits in
16 this state.

17

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

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

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

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

31

1 (4)(a) Each insurer, self-insurer, risk retention
2 group, or Joint Underwriting Association must ~~shall~~ promptly
3 notify the department of cancellation or nonrenewal of
4 insurance required by this section. Unless the physician
5 demonstrates that he or she is otherwise in compliance with
6 the requirements of this section, the department shall suspend
7 the license of the physician pursuant to ss. 120.569 and
8 120.57 and notify all health care facilities licensed under
9 chapter 395 of such action. Any suspension under this
10 subsection remains ~~shall remain~~ in effect until the physician
11 demonstrates compliance with the requirements of this section.
12 If any judgments or settlements are pending at the time of
13 suspension, those judgments or settlements must be paid in
14 accordance with this section unless otherwise mutually agreed
15 to in writing by the parties. This paragraph does not abrogate
16 a judgment debtor's obligation to satisfy the entire amount of
17 any judgment, except that a license suspended under paragraph
18 ~~(5)(g) shall not be reinstated until the physician~~
19 ~~demonstrates compliance with the requirements of that~~
20 ~~provision.~~

21 (b) If financial responsibility requirements are met
22 by maintaining an escrow account or letter of credit as
23 provided in this section, upon the entry of an adverse final
24 judgment arising from a medical malpractice arbitration award,
25 from a claim of medical malpractice either in contract or
26 tort, or from noncompliance with the terms of a settlement
27 agreement arising from a claim of medical malpractice either
28 in contract or tort, the licensee shall pay the entire amount
29 of the judgment together with all accrued interest, or the
30 amount maintained in the escrow account or provided in the
31 letter of credit as required by this section, whichever is

1 less, within 60 days after the date such judgment became final
2 and subject to execution, unless otherwise mutually agreed to
3 in writing by the parties. If timely payment is not made by
4 the physician, the department shall suspend the license of the
5 physician pursuant to procedures set forth in subparagraphs
6 (5)(g)3., 4., and 5. Nothing in this paragraph shall abrogate
7 a judgment debtor's obligation to satisfy the entire amount of
8 any judgment.

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

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

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

30
31

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

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

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

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

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

23 2. The licensee has either retired from the practice
24 of medicine or maintains a part-time practice of no more than
25 1,000 patient contact hours per year.

26 3. The licensee has had no more than two claims for
27 medical malpractice resulting in an indemnity exceeding
28 \$25,000 within the previous 5-year period.

29 4. The licensee has not been convicted of, or pled
30 guilty or nolo contendere to, any criminal violation specified
31

1 in this chapter or the medical practice act of any other
2 state.

3 5. The licensee has not been subject within the last
4 10 years of practice to license revocation or suspension for
5 any period of time; probation for a period of 3 years or
6 longer; or a fine of \$500 or more for a violation of this
7 chapter or the medical practice act of another jurisdiction.
8 The regulatory agency's acceptance of a physician's
9 relinquishment of a license, stipulation, consent order, or
10 other settlement, offered in response to or in anticipation of
11 the filing of administrative charges against the physician's
12 license, constitutes ~~shall be construed as~~ action against the
13 physician's license for the purposes of this paragraph.

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

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

23
24 A licensee who meets the requirements of this paragraph must
25 ~~shall be required either to~~ post notice in the form of a sign
26 prominently displayed in the reception area and clearly
27 noticeable by all patients or provide a written statement to
28 any person to whom medical services are being provided. The
29 ~~Such~~ sign or statement must read as follows ~~shall state~~ that:
30 "Under Florida law, physicians are generally required to carry
31 medical malpractice insurance or otherwise demonstrate

1 financial responsibility to cover potential claims for medical
2 malpractice. However, certain part-time physicians who meet
3 state requirements are exempt from the financial
4 responsibility law. YOUR DOCTOR MEETS THESE REQUIREMENTS AND
5 HAS DECIDED NOT TO CARRY MEDICAL MALPRACTICE INSURANCE. This
6 notice is provided pursuant to Florida law."

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

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

30 a. Shows proof that the unsatisfied judgment has been
31 paid in the amount specified in this subparagraph; or

1 b. Furnishes the department with a copy of a timely
2 filed notice of appeal and either:

3 (I) A copy of a supersedeas bond properly posted in
4 the amount required by law; or

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

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

18 3. Upon the next meeting of the probable cause panel
19 of the board following 30 days after the date of mailing the
20 notice of disciplinary action to the licensee, the panel shall
21 make a determination of whether probable cause exists to take
22 disciplinary action against the licensee pursuant to
23 subparagraph 1.

24 4. If the board determines that the factual
25 requirements of subparagraph 1. are met, it shall take
26 disciplinary action as it deems appropriate against the
27 licensee. Such disciplinary action shall include, at a
28 minimum, probation of the license with the restriction that
29 the licensee must make payments to the judgment creditor on a
30 schedule determined by the board to be reasonable and within
31 the financial capability of the physician. Notwithstanding any

1 other disciplinary penalty imposed, the disciplinary penalty
2 may include suspension of the license for a period not to
3 exceed 5 years. In the event that an agreement to satisfy a
4 judgment has been met, the board shall remove any restriction
5 on the license.

6 5. The licensee has completed a form supplying
7 necessary information as required by the department.

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

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

30 (7) Any licensee who relies on any exemption from the
31 financial responsibility requirement shall notify the

1 department, in writing, of any change of circumstance
2 regarding his or her qualifications for such exemption and
3 shall demonstrate that he or she is in compliance with the
4 requirements of this section.

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

19 ~~(9)(8)~~ The board shall adopt rules to implement the
20 provisions of this section.

21 Section 29. Effective upon this act becoming a law and
22 applying to claims accruing on or after that date, section
23 459.0085, Florida Statutes, is amended to read:

24 459.0085 Financial responsibility.--

25 (1) As a condition of licensing and maintaining an
26 active license,and prior to the issuance or renewal of an
27 active license or reactivation of an inactive license for the
28 practice of osteopathic medicine, an applicant must ~~shall~~ by
29 one of the following methods demonstrate to the satisfaction
30 of the board and the department financial responsibility to
31 pay claims and costs ancillary thereto arising out of the

1 rendering of, or the failure to render, medical care or
2 services:

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

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

21 (c) Obtaining and maintaining an unexpired,
22 irrevocable letter of credit, established pursuant to chapter
23 675, for the current year and for each of the prior years that
24 the applicant or licensee has been in the active practice of
25 medicine, up to a maximum of 4 prior years, in an amount not
26 less than \$100,000 per claim, with a minimum aggregate
27 availability of credit of not less than \$300,000. The letter
28 of credit must ~~shall~~ be payable to the osteopathic physician
29 as beneficiary upon presentment of a final judgment indicating
30 liability and awarding damages to be paid by the osteopathic
31 physician or upon presentment of a settlement agreement signed

1 by all parties to such agreement when such final judgment or
2 settlement is a result of a claim arising out of the rendering
3 of, or the failure to render, medical care and services. Such
4 letter of credit must ~~shall~~ be nonassignable and
5 nontransferable. Such letter of credit must ~~shall~~ be issued by
6 any bank or savings association organized and existing under
7 the laws of this state or any bank or savings association
8 organized under the laws of the United States which ~~that~~ has
9 its principal place of business in this state or has a branch
10 office that ~~which~~ is authorized under the laws of this state
11 or of the United States to receive deposits in this state.

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

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

22 (b) Obtaining and maintaining professional liability
23 coverage for the current year and for each of the prior years
24 that the applicant or licensee has been in the active practice
25 of medicine, up to a maximum of 4 prior years, in an amount
26 not less than \$250,000 per claim, with a minimum annual
27 aggregate of not less than \$750,000 from an authorized insurer
28 as defined under s. 624.09, from a surplus lines insurer as
29 defined under s. 626.914(2), from a risk retention group as
30 defined under s. 627.942, from the Joint Underwriting
31 Association established under s. 627.351(4), through a plan of

1 self-insurance as provided in s. 627.357, or through a plan of
2 self-insurance that ~~which~~ meets the conditions specified for
3 satisfying financial responsibility in s. 766.110.

4 (c) Obtaining and maintaining an unexpired,
5 irrevocable letter of credit, established pursuant to chapter
6 675, for the current year and for each of the prior years that
7 the applicant or licensee has been in the active practice of
8 medicine, up to a maximum of 4 prior years, in an amount not
9 less than \$250,000 per claim, with a minimum aggregate
10 availability of credit of not less than \$750,000. The letter
11 of credit must ~~shall~~ be payable to the osteopathic physician
12 as beneficiary upon presentment of a final judgment indicating
13 liability and awarding damages to be paid by the osteopathic
14 physician or upon presentment of a settlement agreement signed
15 by all parties to such agreement when such final judgment or
16 settlement is a result of a claim arising out of the rendering
17 of, or the failure to render, medical care and services. The
18 ~~Such~~ letter of credit must ~~shall~~ be nonassignable and
19 nontransferable. The ~~Such~~ letter of credit must ~~shall~~ be
20 issued by any bank or savings association organized and
21 existing under the laws of this state or any bank or savings
22 association organized under the laws of the United States
23 which ~~that~~ has its principal place of business in this state
24 or has a branch office that ~~which~~ is authorized under the laws
25 of this state or of the United States to receive deposits in
26 this state.

27
28 This subsection shall be inclusive of the coverage in
29 subsection (1).

30 (3)(a) ~~The financial responsibility requirements of~~
31 ~~subsections (1) and (2) shall apply to claims for incidents~~

1 ~~that occur on or after January 1, 1987, or the initial date of~~
2 ~~licensure in this state, whichever is later.~~

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

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

10 (4)(a) Each insurer, self-insurer, risk retention
11 group, or joint underwriting association must ~~shall~~ promptly
12 notify the department of cancellation or nonrenewal of
13 insurance required by this section. Unless the osteopathic
14 physician demonstrates that he or she is otherwise in
15 compliance with the requirements of this section, the
16 department shall suspend the license of the osteopathic
17 physician pursuant to ss. 120.569 and 120.57 and notify all
18 health care facilities licensed under chapter 395, part IV of
19 chapter 394, or part I of chapter 641 of such action. Any
20 suspension under this subsection remains ~~shall remain~~ in
21 effect until the osteopathic physician demonstrates compliance
22 with the requirements of this section. If any judgments or
23 settlements are pending at the time of suspension, those
24 judgments or settlements must be paid in accordance with this
25 section unless otherwise mutually agreed to in writing by the
26 parties. This paragraph does not abrogate a judgment debtor's
27 obligation to satisfy the entire amount of any judgment ~~except~~
28 ~~that a license suspended under paragraph (5)(g) shall not be~~
29 ~~reinstated until the osteopathic physician demonstrates~~
30 ~~compliance with the requirements of that provision.~~

31

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

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

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

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

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

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

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

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

28 (f) Any person holding an active license under this
29 chapter who meets all of the following criteria:
30
31

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

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

8 3. The licensee has had no more than two claims for
9 medical malpractice resulting in an indemnity exceeding
10 \$25,000 within the previous 5-year period.

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

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

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

30 7. The licensee must ~~shall~~ submit biennially to the
31 department a certification stating compliance with ~~the~~

1 ~~provisions of~~ this paragraph. The licensee must ~~shall~~, upon
2 request, demonstrate to the department information verifying
3 compliance with this paragraph.

4
5 A licensee who meets the requirements of this paragraph must
6 ~~shall be required either to~~ post notice in the form of a sign
7 prominently displayed in the reception area and clearly
8 noticeable by all patients or ~~to~~ provide a written statement
9 to any person to whom medical services are being provided. The
10 ~~Such~~ sign or statement must read as follows ~~shall state that:~~

11 "Under Florida law, osteopathic physicians are generally
12 required to carry medical malpractice insurance or otherwise
13 demonstrate financial responsibility to cover potential claims
14 for medical malpractice. However, certain part-time
15 osteopathic physicians who meet state requirements are exempt
16 from the financial responsibility law. YOUR OSTEOPATHIC
17 PHYSICIAN MEETS THESE REQUIREMENTS AND HAS DECIDED NOT TO
18 CARRY MEDICAL MALPRACTICE INSURANCE. This notice is provided
19 pursuant to Florida law."

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

22 1. Upon the entry of an adverse final judgment arising
23 from a medical malpractice arbitration award, from a claim of
24 medical malpractice either in contract or tort, or from
25 noncompliance with the terms of a settlement agreement arising
26 from a claim of medical malpractice either in contract or
27 tort, the licensee shall pay the judgment creditor the lesser
28 of the entire amount of the judgment with all accrued interest
29 or either \$100,000, if the osteopathic physician is licensed
30 pursuant to this chapter but does not maintain hospital staff
31 privileges, or \$250,000, if the osteopathic physician is

1 licensed pursuant to this chapter and maintains hospital staff
2 privileges, within 60 days after the date such judgment became
3 final and subject to execution, unless otherwise mutually
4 agreed to in writing by the parties. Such adverse final
5 judgment shall include any cross-claim, counterclaim, or claim
6 for indemnity or contribution arising from the claim of
7 medical malpractice. Upon notification of the existence of an
8 unsatisfied judgment or payment pursuant to this subparagraph,
9 the department shall notify the licensee by certified mail
10 that he or she shall be subject to disciplinary action unless,
11 within 30 days from the date of mailing, the licensee either:

12 a. Shows proof that the unsatisfied judgment has been
13 paid in the amount specified in this subparagraph; or

14 b. Furnishes the department with a copy of a timely
15 filed notice of appeal and either:

16 (I) A copy of a supersedeas bond properly posted in
17 the amount required by law; or

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

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

31

1 3. Upon the next meeting of the probable cause panel
2 of the board following 30 days after the date of mailing the
3 notice of disciplinary action to the licensee, the panel shall
4 make a determination of whether probable cause exists to take
5 disciplinary action against the licensee pursuant to
6 subparagraph 1.

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

20 5. The licensee has completed a form supplying
21 necessary information as required by the department.

22
23 A licensee who meets the requirements of this paragraph shall
24 be required either to post notice in the form of a sign
25 prominently displayed in the reception area and clearly
26 noticeable by all patients or to provide a written statement
27 to any person to whom medical services are being provided.
28 Such sign or statement shall state: "Under Florida law,
29 osteopathic physicians are generally required to carry medical
30 malpractice insurance or otherwise demonstrate financial
31 responsibility to cover potential claims for medical

1 malpractice. YOUR OSTEOPATHIC PHYSICIAN HAS DECIDED NOT TO
2 CARRY MEDICAL MALPRACTICE INSURANCE. This is permitted under
3 Florida law subject to certain conditions. Florida law
4 imposes strict penalties against noninsured osteopathic
5 physicians who fail to satisfy adverse judgments arising from
6 claims of medical malpractice. This notice is provided
7 pursuant to Florida law."

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

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

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

28 (9) Notwithstanding any other provision of this
29 section, the department shall suspend the license of any
30 osteopathic physician against whom has been entered a final
31 judgment, arbitration award, or other order or who has entered

1 into a settlement agreement to pay damages arising out of a
2 claim for medical malpractice, if all appellate remedies have
3 been exhausted and payment up to the amounts required by this
4 section has not been made within 30 days after the entering of
5 such judgment, award, or order or agreement, until proof of
6 payment is received by the department or a payment schedule
7 has been agreed upon by the osteopathic physician and the
8 claimant and presented to the department. This subsection does
9 not apply to an osteopathic physician who has met the
10 financial responsibility requirements in paragraphs (1)(b) and
11 (2)(b).

12 (10)(9) The board shall adopt rules to implement the
13 provisions of this section.

14 Section 30. Civil immunity for members of or
15 consultants to certain boards, committees, or other
16 entities.--

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

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

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

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

3 (d) The adequacy or quality of professional services;

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

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

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

10 (2) Such committee, board, group, commission, or other
11 entity must be established in accordance with state law or in
12 accordance with requirements of the Joint Commission on
13 Accreditation of Healthcare Organizations, established and
14 duly constituted by one or more public or licensed private
15 hospitals or behavioral health agencies, or established by a
16 governmental agency. To be protected by this section, the act,
17 decision, omission, or utterance may not be made or done in
18 bad faith or with malicious intent.

19 Section 31. Patient safety data privilege.--

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

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

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

7 (2) Patient safety data shall not be subject to
8 discovery or introduction into evidence in any civil or
9 administrative action. However, information, documents, or
10 records otherwise available from original sources are not
11 immune from discovery or use in any civil or administrative
12 action merely because they were also collected, analyzed, or
13 presented to a patient safety organization. Any person who
14 testifies before a patient safety organization or who is a
15 member of such a group may not be prevented from testifying as
16 to matters within his or her knowledge, but he or she may not
17 be asked about his or her testimony before a patient safety
18 organization or the opinions formed by him or her as a result
19 of the hearings.

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

28 (4) The exchange of patient safety data among health
29 care facilities licensed under chapter 395 or health care
30 practitioners as defined in section 456.001 (4), Florida
31 Statutes, or patient safety organizations which does not

1 identify any patient shall not constitute a waiver of any
2 privilege established in this section.

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

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

10 Section 32. Each final settlement statement relating
11 to medical malpractice shall include the following statement:

12 "The decision to settle a case may reflect the economic
13 practicalities pertaining to the cost of litigation and is
14 not, alone, an admission that the insured failed to meet the
15 required standard of care applicable to the patient's
16 treatment. The decision to settle a case may be made by the
17 insurance company without consulting its client for input,
18 unless otherwise provided by the insurance policy."

19 Section 33. Office of Insurance Regulation; closed
20 claim forms; report required.--The Office of Insurance
21 Regulation shall revise its closed claim form for readability
22 at the 9th grade level. The office shall compile annual
23 statistical reports that provide data summaries of all closed
24 claims, including, but not limited to, the number of closed
25 claims on file pertaining to the referent health care
26 professional or health care entity, the nature of the errant
27 conduct, the size of payments, and the frequency and size of
28 noneconomic damage awards. The office shall develop annualized
29 historical statistical summaries beginning with the 1976 state
30 fiscal year and publish these reports on its website no later

31

1 than the 2005 state fiscal year. The form must accommodate the
2 following minimum requirements:

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

16 (a) A final judgment in any amount.

17 (b) A settlement in any amount.

18
19 Reports shall be filed with the Office of Insurance Regulation
20 no later than 60 days following the occurrence of any event
21 listed in this subsection.

22 (2) Health professional reports must contain:

23 (a) The name and address of the licensee.

24 (b) The alleged occurrence.

25 (c) The date of the alleged occurrence.

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

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

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

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

31

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

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

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

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

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

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

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

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

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

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

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

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

30 (n) Any other information required by the Office of
31 Insurance Regulation to analyze and evaluate the nature,

1 causes, location, cost, and damages involved in professional
2 liability cases.

3 Section 34. Paragraph (t) of subsection (1) and
4 subsections (3) and (6) of section 458.331, Florida Statutes,
5 are amended to read:

6 458.331 Grounds for disciplinary action; action by the
7 board and department.--

8 (1) The following acts constitute grounds for denial
9 of a license or disciplinary action, as specified in s.
10 456.072(2):

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

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

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

15 (6) Upon the department's receipt from an insurer or
16 self-insurer of a report of a closed claim against a physician
17 pursuant to s. 627.912 or from a health care practitioner of a
18 report pursuant to s. 456.049, or upon the receipt from a
19 claimant of a presuit notice against a physician pursuant to
20 s. 766.106, the department shall review each report and
21 determine whether it potentially involved conduct by a
22 licensee that is subject to disciplinary action, in which case
23 the provisions of s. 456.073 shall apply. However, if it is
24 reported that a physician has had three or more claims with
25 indemnities exceeding ~~\$25,000~~ \$50,000 each within the previous
26 5-year period, the department shall investigate the
27 occurrences upon which the claims were based and determine if
28 action by the department against the physician is warranted.

29 Section 35. Paragraph (x) of subsection (1) and
30 subsections (3) and (6) of section 459.015, Florida Statutes,
31 are amended to read:

1 459.015 Grounds for disciplinary action; action by the
2 board and department.--

3 (1) The following acts constitute grounds for denial
4 of a license or disciplinary action, as specified in s.
5 456.072(2):

6 (x) Gross or repeated malpractice or the failure to
7 practice osteopathic medicine with that level of care, skill,
8 and treatment which is recognized by a reasonably prudent
9 similar osteopathic physician as being acceptable under
10 similar conditions and circumstances. The board shall give
11 great weight to the provisions of s. 766.102 when enforcing
12 this paragraph. As used in this paragraph, "repeated
13 malpractice" includes, but is not limited to, three or more
14 claims for medical malpractice within the previous 5-year
15 period resulting in indemnities being paid in excess of
16 \$50,000~~\$25,000~~ each to the claimant in a judgment or
17 settlement and which incidents involved negligent conduct by
18 the osteopathic physician. As used in this paragraph, "gross
19 malpractice" or "the failure to practice osteopathic medicine
20 with that level of care, skill, and treatment which is
21 recognized by a reasonably prudent similar osteopathic
22 physician as being acceptable under similar conditions and
23 circumstances" shall not be construed so as to require more
24 than one instance, event, or act. Nothing in this paragraph
25 shall be construed to require that an osteopathic physician be
26 incompetent to practice osteopathic medicine in order to be
27 disciplined pursuant to this paragraph. A recommended order
28 by an administrative law judge or a final order of the board
29 finding a violation under this paragraph shall specify whether
30 the licensee was found to have committed "gross malpractice,"
31 "repeated malpractice," or "failure to practice osteopathic

1 medicine with that level of care, skill, and treatment which
2 is recognized as being acceptable under similar conditions and
3 circumstances," or any combination thereof, and any
4 publication by the board shall so specify.

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

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

27 Section 36. Subsection (6) of section 460.413, Florida
28 Statutes, is amended to read:

29 460.413 Grounds for disciplinary action; action by
30 board or department.--

31

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

8 Section 37. Legislative intent.--The Legislature
9 declares that reducing the burden of proof in medical
10 disciplinary cases to the level of greater weight of the
11 evidence is necessary to protect the health, safety, and
12 welfare of medical patients in the state. The Legislature
13 declares that there is an overwhelming public necessity to
14 protect medical patients which far overrides any purported
15 property interest in a license to practice in this state held
16 by a licensed health care practitioner. Furthermore, the
17 Legislature declares that it is a privilege, not a right, to
18 practice as a health care professional in this state and that
19 disciplinary action relating to scope of practice issues in
20 particular is remedial and protective, not penal, in nature.
21 The Legislature specifically reverses case law to the
22 contrary.

23 Section 38. The Division of Administrative Hearings
24 shall designate at least two administrative law judges who
25 shall specifically preside over actions involving the
26 Department of Health or boards within the Department of Health
27 and a health care practitioner as defined in section 456.001,
28 Florida Statutes. Each designated administrative law judge
29 must be a member of The Florida Bar in good standing and must
30 have experience working in the health care industry or have
31

1 attained board certification in health care law from The
2 Florida Bar.

3 Section 39. Paragraph (s) of subsection (1) and
4 paragraph (a) of subsection (5) of section 461.013, Florida
5 Statutes, are amended to read:

6 461.013 Grounds for disciplinary action; action by the
7 board; investigations by department.--

8 (1) The following acts constitute grounds for denial
9 of a license or disciplinary action, as specified in s.
10 456.072(2):

11 (s) Gross or repeated malpractice or the failure to
12 practice podiatric medicine at a level of care, skill, and
13 treatment which is recognized by a reasonably prudent
14 podiatric physician as being acceptable under similar
15 conditions and circumstances. The board shall give great
16 weight to the standards for malpractice in s. 766.102 in
17 interpreting this section. As used in this paragraph,
18 "repeated malpractice" includes, but is not limited to, three
19 or more claims for medical malpractice within the previous
20 5-year period resulting in indemnities being paid in excess of
21 ~~\$50,000~~\$10,000 each to the claimant in a judgment or
22 settlement and which incidents involved negligent conduct by
23 the podiatric physicians. As used in this paragraph, "gross
24 malpractice" or "the failure to practice podiatric medicine
25 with the level of care, skill, and treatment which is
26 recognized by a reasonably prudent similar podiatric physician
27 as being acceptable under similar conditions and
28 circumstances" shall not be construed so as to require more
29 than one instance, event, or act.

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

1 podiatric physician pursuant to s. 627.912, or upon the
2 receipt from a claimant of a presuit notice against a
3 podiatric physician pursuant to s. 766.106, the department
4 shall review each report and determine whether it potentially
5 involved conduct by a licensee that is subject to disciplinary
6 action, in which case the provisions of s. 456.073 shall
7 apply. However, if it is reported that a podiatric physician
8 has had three or more claims with indemnities exceeding
9 \$50,000~~\$25,000~~ each within the previous 5-year period, the
10 department shall investigate the occurrences upon which the
11 claims were based and determine if action by the department
12 against the podiatric physician is warranted.

13 Section 40. Paragraph (x) of subsection (1) of section
14 466.028, Florida Statutes, is amended to read:

15 466.028 Grounds for disciplinary action; action by the
16 board.--

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

20 (x) Being guilty of incompetence or negligence by
21 failing to meet the minimum standards of performance in
22 diagnosis and treatment when measured against generally
23 prevailing peer performance, including, but not limited to,
24 the undertaking of diagnosis and treatment for which the
25 dentist is not qualified by training or experience or being
26 guilty of dental malpractice. For purposes of this paragraph,
27 it shall be legally presumed that a dentist is not guilty of
28 incompetence or negligence by declining to treat an individual
29 if, in the dentist's professional judgment, the dentist or a
30 member of her or his clinical staff is not qualified by
31 training and experience, or the dentist's treatment facility

1 is not clinically satisfactory or properly equipped to treat
2 the unique characteristics and health status of the dental
3 patient, provided the dentist refers the patient to a
4 qualified dentist or facility for appropriate treatment. As
5 used in this paragraph, "dental malpractice" includes, but is
6 not limited to, three or more claims within the previous
7 5-year period which resulted in indemnity being paid, or any
8 single indemnity paid in excess of \$25,000~~\$5,000~~ in a
9 judgment or settlement, as a result of negligent conduct on
10 the part of the dentist.

11 Section 41. Subsection (2) of section 624.462, Florida
12 Statutes, is amended to read:

13 624.462 Commercial self-insurance funds.--

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

18 (a) Established by:

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

26 2. A self-insurance trust fund organized pursuant to
27 s. 627.357 and maintained in good faith for a continuous
28 period of 1 year for purposes other than that of obtaining or
29 providing insurance pursuant to this section. Each member of
30 a commercial self-insurance trust fund established pursuant to

31

1 this subsection must maintain membership in the self-insurance
2 trust fund organized pursuant to s. 627.357; ~~or~~

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

5 ~~4.3.~~ A not-for-profit group comprised of no less than
6 10 condominium associations as defined in s. 718.103(2), which
7 is incorporated under the laws of this state, which restricts
8 its membership to condominium associations only, and which has
9 been organized and maintained in good faith for a continuous
10 period of 1 year for purposes other than that of obtaining or
11 providing insurance.

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

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

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

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

1 c. Approve payment of dividends to members;
2 d. Approve changes in corporate structure; and
3 e. Have the authority to contract with an
4 administrator authorized under s. 626.88 to administer the
5 day-to-day affairs of the fund including, but not limited to,
6 marketing, underwriting, billing, collection, claims
7 administration, safety and loss prevention, reinsurance,
8 policy issuance, accounting, regulatory reporting, and general
9 administration. The fees or compensation for services under
10 such contract shall be comparable to the costs for similar
11 services incurred by insurers writing the same lines of
12 insurance, or where available such expenses as filed by
13 boards, bureaus, and associations designated by insurers to
14 file such data. A majority of the trustees or directors shall
15 be owners, partners, officers, directors, or employees of one
16 or more members of the fund.

17 Section 42. Paragraph (a) of subsection (6) of section
18 627.062, Florida Statutes, is amended, and subsection (7) is
19 added to that section, to read:

20 627.062 Rate standards.--

21 (6)(a) After any action with respect to a rate filing
22 that constitutes agency action for purposes of the
23 Administrative Procedure Act, except for a rate filing for
24 medical malpractice, an insurer may, in lieu of demanding a
25 hearing under s. 120.57, require arbitration of the rate
26 filing. Arbitration shall be conducted by a board of
27 arbitrators consisting of an arbitrator selected by the
28 department, an arbitrator selected by the insurer, and an
29 arbitrator selected jointly by the other two arbitrators. Each
30 arbitrator must be certified by the American Arbitration
31 Association. A decision is valid only upon the affirmative

1 vote of at least two of the arbitrators. No arbitrator may be
2 an employee of any insurance regulator or regulatory body or
3 of any insurer, regardless of whether or not the employing
4 insurer does business in this state. The department and the
5 insurer must treat the decision of the arbitrators as the
6 final approval of a rate filing. Costs of arbitration shall be
7 paid by the insurer.

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

12 (b) Any portion of a judgment entered or settlement
13 paid as a result of a statutory or common-law, bad-faith
14 action and any portion of a judgment entered which awards
15 punitive damages against an insurer may not be included in the
16 insurer's rate base, and shall not be used to justify a rate
17 or rate change. Any common-law bad-faith action identified as
18 such and any portion of a settlement entered as a result of a
19 statutory or portion of a settlement wherein an insurer agrees
20 to pay specific punitive damages may not be used to justify a
21 rate or rate change. The portion of the taxable costs and
22 attorney's fees which is identified as being related to the
23 bad faith and punitive damages in these judgments and
24 settlements may not be included in the insurer's rate base and
25 may not be utilized to justify a rate or rate change.

26 (c) Upon reviewing a rate filing and determining
27 whether the rate is excessive, inadequate, or unfairly
28 discriminatory, the Office of Insurance Regulation shall
29 consider, in accordance with generally accepted and reasonable
30 actuarial techniques, past and present prospective loss
31

1 experience, either using loss experience solely for this state
2 or giving greater credibility to this state's loss data.

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

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

18 Section 43. Subsections (1) and (2) of section
19 627.0645, Florida Statutes, are amended to read:

20 627.0645 Annual filings.--

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

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

26 (b) Commercial property and casualty insurance as
27 defined in s. 627.0625(1) other than commercial multiple line,
28 ~~and~~ commercial motor vehicle, and medical malpractice,
29
30
31

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

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

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

13 Section 44. The Office of Program Policy Analysis and
14 Government Accountability shall complete a study of the
15 eligibility requirements for a birth to be covered under the
16 Florida Birth-Related Neurological Injury Compensation
17 Association and submit a report to the Legislature by January
18 1, 2004, recommending whether or not the statutory criteria
19 for a claim to qualify for referral to the Florida
20 Birth-Related Neurological Injury Compensation Association
21 under section 766.302, Florida Statutes, should be modified.

22 Section 45. Section 627.0662, Florida Statutes, is
23 created to read:

24 627.0662 Excessive profits for medical liability
25 insurance prohibited.--

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

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

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

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

12 (a) Calendar-year earned premium.

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

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

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

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

25 (b) As used in this subsection with respect to any
26 3-year period, the term "anticipated underwriting profit"
27 means the sum of the dollar amounts obtained by multiplying,
28 for each rate filing of the insurer group in effect during
29 such period, the earned premiums applicable to such rate
30 filing during such period by the percentage factor included in
31 such rate filing for profit and contingencies, such percentage

1 factor having been determined with due recognition to
2 investment income from funds generated by business in this
3 state. Separate calculations need not be made for consecutive
4 rate filings containing the same percentage factor for profits
5 and contingencies.

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

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

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

30 (7) If the medical liability insurer has realized an
31 excessive profit, the office shall order a return of the

1 excessive amounts to policyholders after affording the insurer
2 an opportunity for hearing and otherwise complying with the
3 requirements of chapter 120. Such excessive amounts shall be
4 refunded to policyholders in all instances unless the insurer
5 affirmatively demonstrates to the office that the refund of
6 the excessive amounts will render the insurer or a member of
7 the insurer group financially impaired or will render it
8 insolvent.

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

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

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

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

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

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

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

29 2. If the insurer elects to make refunds in the form
30 of a credit to renewal policies, such credits shall be applied
31 to policy renewal premium notices which are forwarded to

1 insureds more than 60 calendar days after entry of a final
2 order determining that excessive profits have been realized.
3 If an insurer has made this election but an insured thereafter
4 cancels his or her policy or otherwise allows the policy to
5 terminate, the insurer group shall make a cash refund not
6 later than 60 days after termination of such coverage.

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

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

14 Section 46. Subsection (10) of section 627.357,
15 Florida Statutes, is amended to read:

16 627.357 Medical malpractice self-insurance.--

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

21 (b) The Financial Services Commission must ensure that
22 self-insurance funds remain solvent and provide insurance
23 coverage purchased by participants. The Financial Services
24 Commission may adopt rules pursuant to ss. 120.536(1) and
25 120.54 to implement this section.

26 Section 47. Effective October 1, 2003, section
27 627.4147, Florida Statutes, is amended to read:

28 627.4147 Medical malpractice insurance contracts.--

29 (1) In addition to any other requirements imposed by
30 law, each self-insurance policy as authorized under s. 627.357
31 or insurance policy providing coverage for claims arising out

1 of the rendering of, or the failure to render, medical care or
2 services, including those of the Florida Medical Malpractice
3 Joint Underwriting Association, shall include:

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

8 (b)1. Except as provided in subparagraph 2., a clause
9 authorizing the insurer or self-insurer to determine, to make,
10 and to conclude, without the permission of the insured, any
11 offer of admission of liability and for arbitration pursuant
12 to s. 766.106, settlement offer, or offer of judgment, if the
13 offer is within the policy limits. It is against public policy
14 for any insurance or self-insurance policy to contain a clause
15 giving the insured the exclusive right to veto any offer for
16 admission of liability and for arbitration made pursuant to s.
17 766.106, settlement offer, or offer of judgment, when such
18 offer is within the policy limits. However, any offer of
19 admission of liability, settlement offer, or offer of judgment
20 made by an insurer or self-insurer shall be made in good faith
21 and in the best interests of the insured.

22 2.a. With respect to physicians licensed under chapter
23 458 or chapter 459 or dentists licensed under chapter 466, a
24 clause clearly stating whether or not the insured has the
25 exclusive right to veto any offer of admission of liability
26 and for arbitration pursuant to s. 766.106, settlement offer,
27 or offer of judgment if the offer is within policy limits. An
28 insurer or self-insurer shall not make or conclude, without
29 the permission of the insured, any offer of admission of
30 liability and for arbitration pursuant to s. 766.106,
31 settlement offer, or offer of judgment, if such offer is

1 outside the policy limits. However, any offer for admission of
2 liability and for arbitration made under s. 766.106,
3 settlement offer, or offer of judgment made by an insurer or
4 self-insurer shall be made in good faith and in the best
5 interest of the insured.

6 b. If the policy contains a clause stating the insured
7 does not have the exclusive right to veto any offer or
8 admission of liability and for arbitration made pursuant to s.
9 766.106, settlement offer or offer of judgment, the insurer or
10 self-insurer shall provide to the insured or the insured's
11 legal representative by certified mail, return receipt
12 requested, a copy of the final offer of admission of liability
13 and for arbitration made pursuant to s. 766.106, settlement
14 offer or offer of judgment and at the same time such offer is
15 provided to the claimant. A copy of any final agreement
16 reached between the insurer and claimant shall also be
17 provided to the insurer or his or her legal representative by
18 certified mail, return receipt requested not more than 10 days
19 after affecting such agreement.

20 c. Physicians licensed under chapter 458 or chapter
21 459 and dentists licensed under chapter 466 may purchase an
22 insurance policy pursuant to this subparagraph if such
23 policies are available. Insurers may offer such policies,
24 notwithstanding any other provision of law to the contrary.

25 (c) A clause requiring the insurer or self-insurer to
26 notify the insured no less than 90 ~~60~~ days prior to the
27 effective date of cancellation of the policy or contract and,
28 in the event of a determination by the insurer or self-insurer
29 not to renew the policy or contract, to notify the insured no
30 less than 90 ~~60~~ days prior to the end of the policy or
31

1 contract period. If cancellation or nonrenewal is due to
2 nonpayment or loss of license, 10 days' notice is required.

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

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

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

19 Section 48. Section 627.41491, Florida Statutes, is
20 created to read:

21 627.41491 Medical malpractice rate comparison.--The
22 Office of Insurance Regulation shall annually publish a
23 comparison of the rate in effect for each medical malpractice
24 insurer and self-insurer and the Florida Medical Malpractice
25 Joint Underwriting Association. Such rate comparison shall be
26 made available to the public through the Internet and other
27 commonly used means of distribution no later than July 1 of
28 each year.

29 Section 49. Section 627.41492, Florida Statutes, is
30 created to read:

31

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

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

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

11 Section 50. Section 627.41493, Florida Statutes, is
12 created to read:

13 627.41493 Insurance rate rollback.--

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

19 (2) For medical malpractice insurance policies issued
20 or renewed on or after July 1, 2003, and before July 1, 2004,
21 rates and premiums reduced pursuant to subsection (1) may only
22 be increased if the director of the Office of Insurance
23 Regulation finds that the rate reduced pursuant to subsection
24 (1) would result in an inadequate rate. Any such increase must
25 be approved by the director of the Office of Insurance
26 Regulation prior to being used.

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

29 Section 51. If, as of July 1, 2004, the director of
30 the Office of Insurance Regulation determines that the rates
31 of the medical malpractice insurers with a combined market

1 share of 50 percent or greater, as measured by net written
2 premiums in this state for medical malpractice for the most
3 recent calendar year, have been reduced to the level in effect
4 on January 1, 2002, but have not remained at that level for
5 the previous year beginning July 1, 2003, or that such medical
6 malpractice insurers have proposed increases from the January
7 1, 2002, level which are greater than 15 percent for either of
8 the next 2 years beginning July 1, 2004, then the Florida
9 Medical Malpractice Insurance Fund established by this act
10 shall begin offering coverage.

11 Section 52. Florida Medical Malpractice Insurance
12 Fund.--

13 (1) FINDINGS AND PURPOSES.--The Legislature finds and
14 declares that there is a compelling state interest in
15 maintaining the availability and affordability of health care
16 services to the citizens of Florida. This state interest is
17 seriously threatened by the increased cost and decreased
18 availability of medical malpractice insurance to physicians.
19 To the extent that the private sector is unable to maintain a
20 viable and orderly market for medical malpractice insurance,
21 state actions to maintain the availability and affordability
22 of medical malpractice insurance are a valid and necessary
23 exercise of the police power.

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

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

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

29 (3) FLORIDA MEDICAL MALPRACTICE INSURANCE FUND
30 CREATED.--Effective October 1, 2003, there is created the
31 Florida Medical Malpractice Insurance Fund, which shall be

1 subject to the requirements of this section. However, the fund
2 shall not begin providing or offering coverage until the date
3 the director of the Office of Insurance Regulation determines
4 that the rates of the medical malpractice insurers with a
5 combined market share of 50 percent or greater, as measured by
6 net written premium in this state for medical malpractice for
7 the most recent calendar year, have been reduced to the level
8 in effect on January 1, 2002, but have not remained at that
9 level for the previous year beginning July 1, 2003, or that
10 such medical malpractice insurers have proposed increases from
11 the January 1, 2002, level which are greater than 15 percent
12 for either of the next 2 years beginning July 1, 2004.

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

- 16 1. Three members by the Governor;
- 17 2. Three members by the Chief Financial Officer; and
- 18 3. One member by the other six board members.

19
20 Board members shall serve at the pleasure of the appointing
21 authority. Two board members must be physicians licensed in
22 this state and the Governor and the Chief Financial Officer
23 shall each appoint one of these physicians.

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

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

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

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

19 (f) There shall be no liability on the part of any
20 member of the board, its agents, or any employee of the state
21 for any action taken by them in the performance of their
22 powers and duties under this section. Such immunity does not
23 apply to any willful tort or to breach of any contract or
24 agreement.

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

30 (4) MEDICAL MALPRACTICE INSURANCE POLICIES.--The board
31 must offer medical malpractice insurance to any physician,

1 regardless of his or her specialty, but may adopt underwriting
2 requirements, as specified in its plan of operation. The fund
3 shall offer limits of coverage of \$250,000 per claim/\$500,000
4 annual aggregate; \$500,000 per claim/\$1 million annual
5 aggregate; and \$1 million per claim/\$2 million annual
6 aggregate. The fund shall also allow policyholders to select
7 from policies with deductibles of \$100,000, \$200,000, and
8 \$250,000; excess coverage limits of \$250,000 per claim and
9 \$750,000 annual aggregate; \$1 million per claim and \$3 million
10 annual aggregate; or \$2 million and \$4 million annual
11 aggregate. The fund shall offer such other limits as specified
12 in its plan of operation.

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

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

19 (b) The anticipated future investment income of the
20 fund, as projected in its rate filing, must be approximately
21 equal to the actual investment income that the fund has
22 earned, on average, for the prior 7 years. For those years of
23 the prior 7 years during which the fund was not in operation,
24 the anticipated future investment income must be approximately
25 equal to the actual average investment income earned by the
26 State Board of Administration for the moneys available for
27 investment under sections 215.44-215.53, Florida Statutes, and
28 the average annual investment income earned by the Division of
29 Treasury of the Department of Financial Services for the
30 investment of state funds under chapter 17, Florida Statutes,
31 in the same proportion as specified in paragraph (3)(d).

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

12 (7) INITIAL CAPITALIZATION.--By July 1, 2004, the
13 Legislature shall provide by law for adequate initial
14 capitalization of the Florida Medical Malpractice Insurance
15 Fund to occur on the date that the Office of Insurance
16 Regulation notifies the Legislature that it has made the
17 determination necessary for the fund to begin providing or
18 offering coverage pursuant to subsection (3).

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

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

30 Section 53. (1) Notwithstanding any law to the
31 contrary, if the Florida Medical Malpractice Insurance Fund

1 begins offering coverage as provided in this act, all
2 physicians licensed under chapter 458 or chapter 459, Florida
3 Statutes, as a condition of licensure shall be required to
4 maintain financial responsibility by obtaining and maintaining
5 professional liability coverage in an amount not less than
6 \$250,000 per claim, with a minimum annual aggregate of not
7 less than \$500,000, from an authorized insurer as defined
8 under section 624.09, Florida Statutes, from a surplus lines
9 insurer as defined under section 626.914(2), Florida Statutes,
10 from a risk retention group as defined under section 627.942,
11 Florida Statutes, from the Joint Underwriting Association
12 established under section 627.351(4), Florida Statutes, or
13 through a plan of self-insurance as provided in section
14 627.357 or section 624.462, Florida Statutes, or from the
15 Florida Medical Malpractice Insurance Fund.

16 (2) Physicians and osteopathic physicians who are
17 exempt from the financial responsibility requirements under
18 section 458.320(5)(a),(b),(c),(d),(e) and (f) and section
19 459.0085(5)(a),(b),(c),(d),(e), and (f), Florida Statutes,
20 shall not be subject to the requirements of this section.

21 Section 54. Section 627.41495, Florida Statutes, is
22 created to read:

23 627.41495 Public hearings for medical malpractice rate
24 filings.--

25 (1) Upon the filing of a proposed rate change by a
26 medical malpractice insurer or self-insurance fund, which
27 filing would result in an average statewide increase of 25
28 percent, or more, pursuant to standards determined by the
29 office, the insurer or self-insurance fund shall mail notice
30 of such filing to each of its policyholders or members. The
31 notices shall also inform the policyholders and members that a

1 public hearing may be requested on the rate filing and the
2 procedures for requesting a public hearing, as established by
3 rule, by the Financial Services Commission.

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

14 Section 55. (1) The Office of Insurance Regulation
15 shall order insurers to make a rate filing effective January
16 1, 2004, for medical malpractice which reduces rates by a
17 presumed factor that reflects the impact the changes contained
18 in all medical malpractice legislation enacted by the Florida
19 Legislature in 2003 will have on such rates, as determined by
20 the Office of Insurance Regulation. In determining the
21 presumed factor, the office shall use generally accepted
22 actuarial techniques and standards provided in section
23 627.062, Florida Statutes, in determining the expected impact
24 on losses, expenses, and investment income of the insurer.
25 Inclusion in the presumed factor of the expected impact of
26 such legislation shall be held in abeyance during the review
27 of such measure's validity in any proceeding by a court of
28 competent jurisdiction.

29 (2) Any insurer or rating organization that contends
30 that the rate provided for in subsection (1) is excessive,
31 inadequate, or unfairly discriminatory shall separately state

1 in its filing the rate it contends is appropriate and shall
2 state with specificity the factors or data that it contends
3 should be considered in order to produce such appropriate
4 rate. The insurer or rating organization shall be permitted to
5 use all of the generally accepted actuarial techniques, as
6 provided in section 627.062, Florida Statutes, in making any
7 filing pursuant to this subsection. The Office of Insurance
8 Regulation shall review each such exception and approve or
9 disapprove it prior to use. It shall be the insurer's burden
10 to actuarially justify any deviations from the rates filed
11 under subsection (1). Each insurer or rating organization
12 shall include in the filing the expected impact of all
13 malpractice legislation enacted by the Florida Legislature in
14 2003 on losses, expenses, and rates. If any provision of this
15 act is held invalid by a court of competent jurisdiction, the
16 office shall permit an adjustment of all rates filed under
17 this section to reflect the impact of such holding on such
18 rates, so as to ensure that the rates are not excessive,
19 inadequate, or unfairly discriminatory.

20 Section 56. Subsections (1), (2), and (4) of section
21 627.912, Florida Statutes, are amended to read:

22 627.912 Professional liability claims and actions;
23 reports by insurers.--

24 (1) Each self-insurer authorized under s. 627.357 and
25 each insurer or joint underwriting association providing
26 professional liability insurance to a practitioner of medicine
27 licensed under chapter 458, to a practitioner of osteopathic
28 medicine licensed under chapter 459, to a podiatric physician
29 licensed under chapter 461, to a dentist licensed under
30 chapter 466, to a hospital licensed under chapter 395, to a
31 crisis stabilization unit licensed under part IV of chapter

1 394, to a health maintenance organization certificated under
2 part I of chapter 641, to clinics included in chapter 390, to
3 an ambulatory surgical center as defined in s. 395.002, or to
4 a member of The Florida Bar shall report in duplicate to the
5 Department of Insurance any claim or action for damages for
6 personal injuries claimed to have been caused by error,
7 omission, or negligence in the performance of such insured's
8 professional services or based on a claimed performance of
9 professional services without consent, if the claim resulted
10 in:

11 (a) A final judgment in any amount.

12 (b) A settlement in any amount.

13

14 Reports shall be filed with the department, ~~and~~, If the
15 insured party is licensed under chapter 458, chapter 459, or
16 chapter 461, and the final judgment or settlement amount was
17 \$50,000 or more, or if the insured party is licensed under
18 chapter 466 and the final judgment or settlement amount was
19 \$25,000 or more, the report shall be filed ~~or chapter 466,~~
20 with the Department of Health, no later than 30 days following
21 the occurrence of any event listed in paragraph (a) or
22 paragraph (b). The Department of Health shall review each
23 report and determine whether any of the incidents that
24 resulted in the claim potentially involved conduct by the
25 licensee that is subject to disciplinary action, in which case
26 the provisions of s. 456.073 shall apply. The Department of
27 Health, as part of the annual report required by s. 456.026,
28 shall publish annual statistics, without identifying
29 licensees, on the reports it receives, including final action
30 taken on such reports by the Department of Health or the
31 appropriate regulatory board.

- 1 (2) The reports required by subsection (1) shall
2 contain:
- 3 (a) The name, address, and specialty coverage of the
4 insured.
- 5 (b) The insured's policy number.
- 6 (c) The date of the occurrence which created the
7 claim.
- 8 (d) The date the claim was reported to the insurer or
9 self-insurer.
- 10 (e) The name and address of the injured person. This
11 information is confidential and exempt from the provisions of
12 s. 119.07(1), and must not be disclosed by the department
13 without the injured person's consent, except for disclosure by
14 the department to the Department of Health. This information
15 may be used by the department for purposes of identifying
16 multiple or duplicate claims arising out of the same
17 occurrence.
- 18 (f) The date of suit, if filed.
- 19 (g) The injured person's age and sex.
- 20 (h) The total number and names of all defendants
21 involved in the claim.
- 22 (i) The date and amount of judgment or settlement, if
23 any, including the itemization of the verdict, together with a
24 copy of the settlement or judgment.
- 25 (j) In the case of a settlement, such information as
26 the department may require with regard to the injured person's
27 incurred and anticipated medical expense, wage loss, and other
28 expenses.
- 29 (k) The loss adjustment expense paid to defense
30 counsel, and all other allocated loss adjustment expense paid.
31

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

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

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

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

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

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

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

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

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

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

1 per case, against an insurer that violates the requirements of
2 this section. This subsection applies to claims accruing on or
3 after October 1, 1997.

4 Section 57. Section 627.9121, Florida Statutes, is
5 created to read:

6 627.9121 Required reporting of claims;
7 penalties.--Each entity that makes payment under a policy of
8 insurance, self-insurance, or otherwise in settlement or
9 partial settlement of, or in satisfaction of a judgment in, a
10 medical malpractice action or claim that is required to report
11 information to the National Practitioner Data Bank under 42
12 U.S.C. section 11131 must also report the same information to
13 the Office of Insurance Regulation. The Office of Insurance
14 Regulation shall include such information in the data that it
15 compiles under s. 627.912. The office must compile and review
16 the data collected pursuant to this section and must assess an
17 administrative fine on any entity that fails to fully comply
18 with the requirements imposed by law.

19 Section 58. Section 766.102, Florida Statutes, is
20 amended to read:

21 766.102 Medical negligence; standards of recovery;
22 expert witness.--

23 (1) In any action for recovery of damages based on the
24 death or personal injury of any person in which it is alleged
25 that such death or injury resulted from the negligence of a
26 health care provider as defined in s. 768.50(2)(b), the
27 claimant shall have the burden of proving by the greater
28 weight of evidence that the alleged actions of the health care
29 provider represented a breach of the prevailing professional
30 standard of care for that health care provider. The
31 prevailing professional standard of care for a given health

1 care provider shall be that level of care, skill, and
2 treatment which, in light of all relevant surrounding
3 circumstances, is recognized as acceptable and appropriate by
4 reasonably prudent similar health care providers.

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

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

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

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

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

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

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

26
27 ~~However, if any health care provider described in this~~
28 ~~paragraph is providing treatment or diagnosis for a condition~~
29 ~~which is not within his or her specialty, a specialist trained~~
30 ~~in the treatment or diagnosis for that condition shall be~~
31 ~~considered a "similar health care provider."~~

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

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

7 ~~2. Is not a similar health care provider pursuant to~~
8 ~~paragraph (a) or paragraph (b) but, to the satisfaction of the~~
9 ~~court, possesses sufficient training, experience, and~~
10 ~~knowledge as a result of practice or teaching in the specialty~~
11 ~~of the defendant or practice or teaching in a related field of~~
12 ~~medicine, so as to be able to provide such expert testimony as~~
13 ~~to the prevailing professional standard of care in a given~~
14 ~~field of medicine. Such training, experience, or knowledge~~
15 ~~must be as a result of the active involvement in the practice~~
16 ~~or teaching of medicine within the 5-year period before the~~
17 ~~incident giving rise to the claim.~~

18 ~~(2)(3)~~(a) If the injury is claimed to have resulted
19 from the negligent affirmative medical intervention of the
20 health care provider, the claimant must, in order to prove a
21 breach of the prevailing professional standard of care, show
22 that the injury was not within the necessary or reasonably
23 foreseeable results of the surgical, medicinal, or diagnostic
24 procedure constituting the medical intervention, if the
25 intervention from which the injury is alleged to have resulted
26 was carried out in accordance with the prevailing professional
27 standard of care by a reasonably prudent similar health care
28 provider.

29 (b) The provisions of this subsection shall apply only
30 when the medical intervention was undertaken with the informed
31

1 consent of the patient in compliance with the provisions of s.
2 766.103.

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

14 ~~(4)(5)~~ The Legislature is cognizant of the changing
15 trends and techniques for the delivery of health care in this
16 state and the discretion that is inherent in the diagnosis,
17 care, and treatment of patients by different health care
18 providers. The failure of a health care provider to order,
19 perform, or administer supplemental diagnostic tests shall not
20 be actionable if the health care provider acted in good faith
21 and with due regard for the prevailing professional standard
22 of care.

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

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

29 1. Specialize in the same specialty as the party
30 against whom or on whose behalf the testimony is offered; or
31

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

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

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

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

25 3. A clinical research program that is affiliated with
26 an accredited medical school or teaching hospital and that is
27 in the same or similar health profession as the health care
28 provider against whom or on whose behalf the testimony is
29 offered and, if that health care provider is a specialist, a
30 clinical research program that is affiliated with an
31

1 accredited health professional school or accredited residency
2 or clinical research program in the same or similar specialty.

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

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

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

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

16 (6) A physician licensed under chapter 458 or chapter
17 459 who qualifies as an expert witness under subsection (5)
18 and who, by reason of active clinical practice or instruction
19 of students, has knowledge of the applicable standard of care
20 for nurses, nurse practitioners, certified registered nurse
21 anesthetists, certified registered nurse midwives, physician
22 assistants, or other medical support staff may give expert
23 testimony in a medical malpractice action with respect to the
24 standard of care of such medical support staff.

25 (7) Notwithstanding subsection (5), in a medical
26 malpractice action against a hospital, a health care facility,
27 or medical facility, a person may give expert testimony on the
28 appropriate standard of care as to administrative and other
29 nonclinical issues if the person has substantial knowledge, by
30 virtue of his or her training and experience, concerning the
31 standard of care among hospitals, health care facilities, or

1 medical facilities of the same type as the hospital, health
2 care facility, or medical facility whose acts or omissions are
3 the subject of the testimony and which are located in the same
4 or similar communities at the time of the alleged act giving
5 rise to the cause of action.

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

12 (9)(6)(a) In any action for damages involving a claim
13 of negligence against a physician licensed under chapter 458,
14 osteopathic physician licensed under chapter 459, podiatric
15 physician licensed under chapter 461, or chiropractic
16 physician licensed under chapter 460 providing emergency
17 medical services in a hospital emergency department, the court
18 shall admit expert medical testimony only from physicians,
19 osteopathic physicians, podiatric physicians, and chiropractic
20 physicians who have had substantial professional experience
21 within the preceding 5 years while assigned to provide
22 emergency medical services in a hospital emergency department.

23 (b) For the purposes of this subsection:

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

29 2. "Substantial professional experience" shall be
30 determined by the custom and practice of the manner in which
31 emergency medical coverage is provided in hospital emergency

1 departments in the same or similar localities where the
2 alleged negligence occurred.

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

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

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

12 Section 59. Effective July 1, 2003, and applicable to
13 any action arising from a medical malpractice claim initiated
14 by a notice of intent to litigate received by a potential
15 defendant in a medical malpractice case on or after that date,
16 present subsections (5) through (12) of section 766.106,
17 Florida Statutes, are redesignated as subsections (6) through
18 (13), respectively, and a new subsection (5) is added to that
19 section, to read:

20 766.106 Notice before filing action for medical
21 malpractice; presuit screening period; offers for admission of
22 liability and for arbitration; informal discovery; review.--

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

27 (b) An insurer shall not be held to have acted in bad
28 faith for failure to timely pay its policy limits if it
29 tenders its policy limits and meets the reasonable conditions
30 of settlement prior to the conclusion of the presuit screening
31 period provided for in subsection (4); during an extension

1 provided for therein; during a period of 210 days thereafter;
2 or during a 90-day period after the filing of an amended
3 medical malpractice complaint alleging new facts previously
4 unknown to the insurer. If a case is set for trial within 1
5 year after the date of filing the claim, an insurer shall not
6 be held in bad faith if policy limits are tendered 60 days or
7 more prior to the initial trial date. This paragraph does not
8 apply when, based upon information known earlier to the
9 insurance company or its representatives, the insurance
10 company could and should have settled the claim within policy
11 limits if it had been acting fairly and honestly toward the
12 insured and with due regard for the insured's interests during
13 the 210-day period after the 90-day presuit period or in
14 circumstances when a case is set for trial within 1 year after
15 the date of filing the claim, 60 days or more prior to the
16 initial trial date, whichever is earlier.

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

22 (d) This subsection is repealed effective September 1,
23 2006, but shall continue to apply with respect to incidents
24 that occur prior to that date.

25 Section 60. Effective October 1, 2003, and applicable
26 to notices of intent to litigate sent on or after that date,
27 subsection (2), paragraphs (a) and (b) of subsection (3), and
28 subsection (7) of section 766.106, Florida Statutes, as
29 amended by this act, are amended, to read:

30
31

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

29 Section 61. Section 766.108, Florida Statutes, is
30 amended to read:

31

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

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

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

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

19 Section 62. Section 766.118, Florida Statutes, is
20 created to read:

21 766.118 Determination of noneconomic damages.--

22 (1) With respect to a cause of action for personal
23 injury or wrongful death resulting from an occurrence of
24 medical negligence, damages recoverable for noneconomic losses
25 to compensate for pain and suffering, inconvenience, physical
26 impairment, mental anguish, disfigurement, loss of capacity
27 for enjoyment of life, and all other noneconomic damages shall
28 not exceed \$500,000 aggregate for all defendant practitioners,
29 \$500,000 aggregate for all defendant facilities, and \$500,000
30 aggregate for all other defendants regardless of the number of
31

1 claimants involved in the action subject to the limitations
2 set forth in subsection (2).

3 (2) Notwithstanding subsection (1), the trier of fact
4 may award noneconomic damages under this section in an amount
5 not to exceed \$2 million per incident in cases where medical
6 negligence results in certain catastrophic injuries including
7 death, coma, severe and permanent brain damage, mastectomy,
8 loss of reproductive capabilities, hemiplegia, quadriplegia,
9 paraplegia, blindness, or a permanent vegetative state.
10 Regardless of the number of individual claimants, the total
11 noneconomic damages that may be awarded for all claims arising
12 out of the same incident, shall be limited to a maximum of \$2
13 million aggregate for all defendant practitioners, \$2 million
14 aggregate for all defendant facilities, and \$2 million
15 aggregate for all other defendants.

16 (3) The maximum amount of noneconomic damages which
17 may be awarded under this section must be adjusted each year
18 on July 1 to reflect the rate of inflation or deflation as
19 indicated in the Consumer Price Index for All Urban Consumers
20 published by the United States Department of Labor. However,
21 the maximum amount of noneconomic damages which may be awarded
22 may not be less than \$500,000.

23 (4) Notwithstanding any law to the contrary, the caps
24 on noneconomic damages provided in subsection (1) of this
25 section do not apply to any incident involving a physician or
26 osteopathic physician who is not in compliance with the
27 financial responsibility requirements set forth in sections
28 458.320 and 459.0085, Florida Statutes, respectively.

29 (5) This section is repealed effective September 1,
30 2006, but shall continue to apply with respect to incidents
31 that occur prior to that date.

1 Section 63. Subsections (3), (5), (7), and (8) of
2 section 766.202, Florida Statutes, are amended to read:

3 766.202 Definitions; ss. 766.201-766.212.--As used in
4 ss. 766.201-766.212, the term:

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

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

20 (7) "Noneconomic damages" means nonfinancial losses
21 which would not have occurred but for the injury giving rise
22 to the cause of action, including pain and suffering,
23 inconvenience, physical impairment, mental anguish,
24 disfigurement, loss of capacity for enjoyment of life, and
25 other nonfinancial losses, to the extent the claimant is
26 entitled to recover such damages under general law, including
27 the Wrongful Death Act.

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

31

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

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

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

24 (d) Any portion of the periodic payment which is
25 attributable to medical expenses that have not yet been
26 incurred shall terminate upon the death of the claimant. Any
27 outstanding medical expenses incurred prior to the death of
28 the claimant shall be paid from that portion of the periodic
29 payment attributable to medical expenses.

30
31

1 Section 64. Effective July 1, 2003, and applicable to
2 all causes of action accruing on or after that date, section
3 766.206, Florida Statutes, is amended to read:

4 766.206 Presuit investigation of medical negligence
5 claims and defenses by court.--

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

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

23 (3) If the court finds that the response mailed by a
24 defendant rejecting the claim is not in compliance with the
25 reasonable investigation requirements of ss. 766.201-766.212,
26 including a review of the claim and a verified written medical
27 expert opinion by an expert witness as defined in s. 766.202,
28 the court shall strike the defendant's pleading~~response, and~~
29 The person who mailed such response, whether the defendant,
30 the defendant's insurer, or the defendant's attorney, shall be
31 personally liable for all attorney's fees and costs incurred

1 during the investigation and evaluation of the claim,
2 including the reasonable attorney's fees and costs of the
3 claimant.

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

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

30 (b) The court shall ~~may~~ refuse to consider the
31 testimony or opinion attached to any notice of intent or to

1 any response rejecting a claim of ~~such~~ an expert who has been
2 disqualified three times pursuant to this section.

3 Section 65. Subsection (7) of section 766.207, Florida
4 Statutes, is amended to read:

5 766.207 Voluntary binding arbitration of medical
6 negligence claims.--

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

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

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

24 (c) Damages for future economic losses shall be
25 awarded to be paid by periodic payments pursuant to s.
26 766.202(8) and shall be offset by future collateral source
27 payments.

28 (d) Punitive damages shall not be awarded.

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

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

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

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

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

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

20 (k) Any offer by a claimant to arbitrate must be made
21 to each defendant against whom the claimant has made a claim.
22 Any offer by a defendant to arbitrate must be made to each
23 claimant who has joined in the notice of intent to initiate
24 litigation, as provided in s. 766.106. A defendant who
25 rejects a claimant's offer to arbitrate shall be subject to
26 the provisions of s. 766.209(3). A claimant who rejects a
27 defendant's offer to arbitrate shall be subject to the
28 provisions of s. 766.209(4).

29 (l) The hearing shall be conducted by all of the
30 arbitrators, but a majority may determine any question of fact
31

1 and render a final decision. The chief arbitrator shall
2 decide all evidentiary matters.

3
4 The provisions of this subsection shall not preclude
5 settlement at any time by mutual agreement of the parties.

6 Section 66. Subsection (4) is added to section
7 768.041, Florida Statutes, to read:

8 768.041 Release or covenant not to sue.--

9 (4)(a) At trial pursuant to a suit filed under chapter
10 766, or at trial pursuant to s. 766.209, if any defendant
11 shows the court that the plaintiff, or his or her legal
12 representative, has delivered a written release or covenant
13 not to sue to any person in partial satisfaction of the
14 damages sued for, the court shall set off this amount from the
15 total amount of the damages set forth in the verdict and
16 before entry of the final judgment.

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

21 Section 67. Paragraph (c) of subsection (2) of section
22 768.13, Florida Statutes, is amended to read:

23 768.13 Good Samaritan Act; immunity from civil
24 liability.--

25 (2)

26 (c)1. Any health care practitioner as defined in s.
27 456.001(4) who is in a hospital attending to a patient of his
28 or her practice or for business or personal reasons unrelated
29 to direct patient care, and who voluntarily responds to
30 provide care or treatment to a patient with whom at that time
31 the practitioner does not have a then-existing health care

1 patient-physician relationship, and when such care or
2 treatment is necessitated by a sudden or unexpected situation
3 or by an occurrence that demands immediate medical attention,
4 shall not be held liable for any civil damages as a result of
5 any act or omission relative to that care or treatment, unless
6 that care or treatment is proven to amount to conduct that is
7 willful and wanton and would likely result in injury so as to
8 affect the life or health of another.

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

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

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

28 Section 68. Section 768.77, Florida Statutes, is
29 amended to read:

30 768.77 Itemized verdict.--

31

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

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

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

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

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

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

21 1. Past economic losses; and

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

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

26 1. Past noneconomic losses; and

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

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

31

1 Section 69. Subsection (5) of section 768.81, Florida
2 Statutes, is amended to read:

3 768.81 Comparative fault.--

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

17 Section 70. Nothing in this act constitutes a waiver
18 of sovereign immunity under section 768.28, Florida Statutes,
19 or contravenes the abrogation of joint and several liability
20 contained in section 766.112, Florida Statutes.

21 Section 71. The Office of Program Policy Analysis and
22 Government Accountability and the Office of the Auditor
23 General must jointly conduct an audit of the Department of
24 Health's health care practitioner disciplinary process and
25 closed claims that are filed with the department under section
26 627.912, Florida Statutes. The Office of Program Policy
27 Analysis and Government Accountability and the Office of the
28 Auditor General shall submit a report to the Legislature by
29 January 1, 2004.

30 Section 72. Section 1004.08, Florida Statutes, is
31 created to read:

1 1004.08 Patient safety instructional
2 requirements.--Each public school, college, and university
3 that offers degrees in medicine, nursing, or allied health
4 shall include in the curricula applicable to such degrees
5 material on patient safety, including patient safety
6 improvement. Materials shall include, but need not be limited
7 to, effective communication and teamwork; epidemiology of
8 patient injuries and medical errors; medical injuries;
9 vigilance, attention and fatigue; checklists and inspections;
10 automation, technological, and computer support; psychological
11 factors in human error; and reporting systems.

12 Section 73. Section 1005.07, Florida Statutes, is
13 created to read:

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

25 Section 74. Paragraph (c) of subsection (2) of section
26 1006.20, Florida Statutes, as amended by section 2 of chapter
27 2003-129, Laws of Florida, is amended to read:

28 1006.20 Athletics in public K-12 schools.--

29 (2) ADOPTION OF BYLAWS.--

30 (c) The organization shall adopt bylaws that require
31 all students participating in interscholastic athletic

1 competition or who are candidates for an interscholastic
2 athletic team to satisfactorily pass a medical evaluation each
3 year prior to participating in interscholastic athletic
4 competition or engaging in any practice, tryout, workout, or
5 other physical activity associated with the student's
6 candidacy for an interscholastic athletic team. Such medical
7 evaluation can only be administered by a practitioner licensed
8 under the provisions of chapter 458, chapter 459, chapter 460,
9 or s. 464.012, and in good standing with the practitioner's
10 regulatory board. The bylaws shall establish requirements for
11 eliciting a student's medical history and performing the
12 medical evaluation required under this paragraph, which shall
13 include a physical assessment of the student's physical
14 capabilities to participate in interscholastic athletic
15 competition as contained in a uniform preparticipation
16 physical evaluation and history form. The evaluation form
17 shall incorporate the recommendations of the American Heart
18 Association for participation cardiovascular screening and
19 shall provide a place for the signature of the practitioner
20 performing the evaluation with an attestation that each
21 examination procedure listed on the form was performed by the
22 practitioner or by someone under the direct supervision of the
23 practitioner. The form shall also contain a place for the
24 practitioner to indicate if a referral to another practitioner
25 was made in lieu of completion of a certain examination
26 procedure. The form shall provide a place for the practitioner
27 to whom the student was referred to complete the remaining
28 sections and attest to that portion of the examination. The
29 preparticipation physical evaluation form shall advise
30 students to complete a cardiovascular assessment and shall
31 include information concerning alternative cardiovascular

1 evaluation and diagnostic tests. ~~Practitioners administering~~
2 ~~medical evaluations pursuant to this subsection must, at a~~
3 ~~minimum, solicit all information required by, and perform a~~
4 ~~physical assessment according to, the uniform preparticipation~~
5 ~~form referred to in this paragraph and must certify, based on~~
6 ~~the information provided and the physical assessment, that the~~
7 ~~student is physically capable of participating in~~
8 ~~interscholastic athletic competition. If the practitioner~~
9 ~~determines that there are any abnormal findings in the~~
10 ~~cardiovascular system, the student may not participate until a~~
11 ~~further cardiovascular assessment, which may include an EKG,~~
12 ~~is performed which indicates that the student is physically~~
13 ~~capable of participating in interscholastic athletic~~
14 ~~competition.~~Results of such medical evaluation must be
15 provided to the school. No student shall be eligible to
16 participate in any interscholastic athletic competition or
17 engage in any practice, tryout, workout, or other physical
18 activity associated with the student's candidacy for an
19 interscholastic athletic team until the results of the medical
20 evaluation ~~clearing the student for participation~~ has been
21 received and approved by the school.

22 Section 75. No later than September 1, 2003, the
23 Department of Health shall convene a workgroup to study the
24 current healthcare practitioner disciplinary process. The
25 workgroup shall include a representative of the Administrative
26 Law section of The Florida Bar, a representative of the Health
27 Law section of The Florida Bar, a representative of the
28 Florida Medical Association, a representative of the Florida
29 Osteopathic Medical Association, a representative of the
30 Florida Dental Association, a member of the Florida Board of
31 Medicine who has served on the probable cause panel, a member

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

10 Section 76. Section 766.1065, Florida Statutes, is
11 created to read:

12 766.1065 Mandatory presuit investigation.--

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

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

28 (3) Within 90 days after service of the presuit notice
29 of intent to initiate medical malpractice litigation, all
30 parties must attend in-person mandatory mediation in
31 accordance with s. 44.102, if binding arbitration under s.

1 766.106 or s. 766.207 has not been agreed to by the parties.
2 The Florida Rules of Civil Procedure shall apply to such
3 mediation.

4 (4) If the parties declare an impasse during the
5 mandatory mediation, and if the plaintiff or the defendants so
6 request within 10 days of the impasse, via certified mail to
7 Office of Presuit Screening Administration for a presuit
8 screening panel, then the Office of Presuit Screening
9 Administration shall convene such a panel pursuant to s.
10 766.1066. Notwithstanding any other provision of law, the
11 parties may stipulate to waive any proceedings under this
12 section.

13 Section 77. Section 766.1066, Florida Statutes, is
14 created to read:

15 766.1066 Office of Presuit Screening Administration;
16 presuit screening panels.--

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

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

30 (c) The Department of Health shall request the
31 relevant regulatory boards to assist the office in developing

1 the database. The office shall request the assistance of The
2 Florida Bar in developing the database.

3 (d) Funding for the office's general expenses shall
4 come from a service charge equal to 0.5 percent of the final
5 judgment or arbitration award in each medical malpractice
6 liability case in this state. All parties in such malpractice
7 actions shall in equal parts pay the service charge at the
8 time proceeds from a final judgment or an arbitration award
9 are initially disbursed. Such charge shall be collected by the
10 clerk of the circuit court in the county where the final
11 judgment is entered or the arbitration award is made. The
12 clerk shall remit the service charges to the Department of
13 Revenue for deposit into the Department of Health
14 Administrative Trust Fund. The Department of Revenue shall
15 adopt rules to administer the service charge.

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

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

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

27 (4) The office shall establish a panel no later than
28 15 days after the receipt of the request for hearing. The
29 office shall set a hearing no later than 30 days after the
30 receipt of the request for hearing.

31

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

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

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

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

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

13 4. Must hold an active license in good standing in
14 this state and must have been in active practice within the
15 5-year period prior to selection.

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

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

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

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

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

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

1 5. Must be a board-certified civil trial lawyer.
2 An attorney who fails to attend the designated panel hearing
3 on two separate occasions shall be reported to The Florida
4 Bar.

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

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

9 2. Two attorneys; and

10 3. One certified mediator obtained from a list
11 provided by the Clerk of the Court in the Judicial circuit
12 where a prospective defendant physician resides. The mediator
13 shall serve as the presiding officer of the panel.

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

17 (c) A panel member who knowingly has a conflict of
18 interest or potential conflict of interest must disclose it
19 prior to the hearing. The office must replace the conflicted
20 panel member with a panel member from the same category as the
21 member removed because of a conflict of interest. Failure of a
22 panel member to report a conflict of interest shall result in
23 dismissal from the panel and from further service. A physician
24 member who does not report a conflict of interest shall also
25 be reported to his or her regulatory board for disciplinary
26 action. An attorney member who does not report a conflict of
27 interest shall be reported to the Florida Bar and the office
28 is to request disciplinary action be taken against the
29 attorney.

30 (d) The office shall provide administrative support to
31 the panel.

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

6 (4)(a) In addition to any other information that may
7 be disclosed under this section and no later than two weeks
8 prior to the hearing of the screening panel, the claimant
9 shall provide to the panel and opposing parties a detailed
10 report, supported by one or more verified written medical
11 expert opinion reports from medical experts as defined in this
12 chapter, including a detailed description of the expert
13 witness's qualifications, the precise nature of the witness's
14 opinions regarding each instance in which each defendant is
15 alleged to breached the prevailing professional standard of
16 care, and a description of the factual basis for each such
17 opinion of negligence. The report shall also include a
18 description of all elements of damages claimed.

19 (b) In addition to any other information that may be
20 disclosed under this section and no later than one week prior
21 to the hearing of the screening panel, each defendant shall
22 provide to the panel and opposing parties a detailed report,
23 supported by one or more verified written medical expert
24 opinion reports from medical experts as defined in this
25 chapter, including a detailed description of the expert
26 witness's qualifications, the precise nature of the witness's
27 opinions and a description of the factual basis for each such
28 opinion. If a party fails to comply with the requirements of
29 this section without good cause, the court upon motion shall
30 impose sanctions, including as award of attorney's fees and
31 other costs, against the party failing to comply.

1 (5) All documentary evidence of a type commonly relied
2 upon by reasonably prudent persons in the conduct of their
3 affairs is admissible, whether or not such evidence would be
4 admissible in a trial. The panel may proceed with the hearing
5 and shall render an opinion upon the evidence produced,
6 notwithstanding the failure of a party to appear.

7 (6) A panel shall, by a majority vote for each
8 defendant, determine whether reasonable grounds exists to
9 support a claim of medical negligence. The findings of the
10 panel are not final agency action for purposes of chapter 120.

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

15 (8) Unless excluded by the judge for good cause shown,
16 the proceedings and findings of a presuit screening panel
17 shall be discoverable and admissible in any subsequent trial
18 arising out of the claim, and the members of the panel may be
19 deposed and called to testify at trial. If the panel's
20 findings, or any testimony or evidence related to the panel's
21 findings or proceedings, are admitted into evidence, the court
22 shall instruct the jury that the findings are not binding and
23 shall be considered by the jury equally with all other
24 evidence presented at trial.

25 (9) The statute of limitations as to all potential
26 defendants shall be tolled from the date that any party serves
27 upon the Office of Presuit Screening Administration the
28 request for a medical review panel until the date that the
29 plaintiff receives the panel's findings. These tolling
30 provisions shall be in addition to any other tolling
31 provision.

1 (10) Upon the plaintiff receipt of the presuit
2 screening panel's determination, the plaintiff has 60 days or
3 the remainder of the period of the statute of limitations,
4 whichever period is greater, in which to file suit.

5 (11) The Administration Commission shall adopt rules
6 to administer this section.

7 (12) This section is repealed effective September 1,
8 2006, but shall continue to apply with respect to incidents
9 that occur prior to that date.

10 Section 78. Section 624.156, Florida Statutes, is
11 created to read:

12 624.156 Applicability of consumer protection laws to
13 the business of insurance.--

14 (1) Notwithstanding any provision of law to the
15 contrary, the business of insurance shall be subject to the
16 laws of this state applicable to any other business,
17 including, but not limited to, the Florida Civil Rights Act of
18 1992 set forth in part I of chapter 760, the Florida Antitrust
19 Act of 1980 set forth in chapter 542, the Florida Deceptive
20 and Unfair Trade Practices Act set forth in part II of chapter
21 501, and the consumer protection provisions contained in
22 chapter 540. The protections afforded consumers by chapters
23 501, 540, 542, and 760 shall apply to insurance consumers.

24 (2) Nothing in this section shall be construed to
25 prohibit:

26 (a) Any agreement to collect, compile, and disseminate
27 historical data on paid claims or reserves for reported
28 claims, provided such data is contemporaneously transmitted to
29 the Office of Insurance Regulation and made available for
30 public inspection.

31

1 (b) Participation in any joint arrangement established
2 by law or the Office of Insurance Regulation to assure
3 availability of insurance.

4 (c) Any agent or broker, representing one or more
5 insurers, from obtaining from any insurer such agent or broker
6 represents information relative to the premium for any policy
7 or risk to be underwritten by that insurer.

8 (d) Any agent or broker from disclosing to an insurer
9 the agent or broker represents any quoted rate or charge
10 offered by another insurer represented by that agent or broker
11 for the purpose of negotiating a lower rate, charge, or term
12 from the insurer to whom the disclosure is made.

13 (e) Any agents, brokers, or insurers from using, or
14 participating with multiple insurers or reinsurers for
15 underwriting, a single risk or group of risks.

16 Section 79. Subsection (7) of section 456.013, Florida
17 Statutes, is amended to read:

18 456.013 Department; general licensing provisions.--

19 (7) The boards, or the department when there is no
20 board, shall require the completion of a 2-hour course
21 relating to prevention of medical errors as part of the
22 licensure and renewal process. The 2-hour course shall count
23 towards the total number of continuing education hours
24 required for the profession. The course shall be approved by
25 the board or department, as appropriate, and shall include a
26 study of root-cause analysis, error reduction and prevention,
27 and patient safety. If the course is being offered by a
28 facility licensed pursuant to chapter 395 for its employees,
29 the board may approve up to 1 hour of the 2-hour course to be
30 specifically related to error reduction and prevention methods
31 used in that facility. The Board of Medicine and the Board of

1 Osteopathic Medicine shall also require as a condition of
2 licensure and license renewal that each physician and
3 physician assistant complete a 2-hour board-approved
4 continuing education course relating to the five most
5 misdiagnosed conditions, as determined by the board, during
6 the previous biennium. This continuing education course shall
7 count towards the total number of continuing education hours
8 required for those physicians and physician assistants.

9 Section 80. Paragraph (a) of subsection (3) of section
10 766.209, Florida Statutes, is amended to read:

11 766.209 Effects of failure to offer or accept
12 voluntary binding arbitration.--

13 (3) If the defendant refuses a claimant's offer of
14 voluntary binding arbitration:

15 (a) The claim shall proceed to trial ~~without~~
16 ~~limitation on damages~~, and the claimant, upon proving medical
17 negligence, shall be entitled to recover prejudgment interest,
18 and reasonable attorney's fees up to 25 percent of the award
19 reduced to present value.

20 Section 81. Seven positions are authorized and the sum
21 of \$454,766 is appropriated from the General Revenue Fund to
22 the Department of Health, Office of Presuit Screening
23 Administration, to implement the provisions of this act for
24 the 2003-2004 fiscal year.

25 Section 82. The sum of \$687,786 is appropriated from
26 the Medical Quality Assurance Trust Fund to the Department of
27 Health, and seven positions are authorized, for the purpose of
28 implementing this act during the 2003-2004 fiscal year. The
29 sum of \$452,122 is appropriated from the General Revenue Fund
30 to the Agency for Health Care Administration, and five

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1 positions are authorized, for the purpose of implementing this
2 act during the 2003-2004 fiscal year.

3 Section 83. The sum of \$2,150,000 is appropriated from
4 the Insurance Regulatory Trust Fund in the Department of
5 Financial Services to the Office of Insurance Regulation for
6 the purpose of implementing this act during the 2003-2004
7 fiscal year.

8 Section 84. If any law that is amended by this act was
9 also amended by a law enacted at the 2003 Regular Session or
10 2003 Special Session A of the Legislature, such laws shall be
11 construed as if they had been enacted during the same session
12 of the Legislature, and full effect should be given to each if
13 that is possible.

14 Section 85. If any provision of this act or its
15 application to any person or circumstance is held invalid, the
16 invalidity does not affect other provisions or applications of
17 the act which can be given effect without the invalid
18 provision or application, and to this end the provisions of
19 this act are severable.

20 Section 86. Except as otherwise expressly provided in
21 this act, this act shall take effect July 1, 2003, or upon
22 becoming a law, whichever occurs later, and shall apply
23 retroactively to July 1, 2003, with respect to any action
24 arising from a medical malpractice claim initiated by a notice
25 of intent to litigate received by a potential defendant in a
26 medical malpractice case on or after that date.

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