A bill to be entitled

An act relating to medical malpractice insurance, liability, and litigation reform; providing a popular name; providing findings; amending s. 120.65, F.S.; requiring the Division of Administrative Hearings to designate administrative law judges to preside over actions involving a health care practitioner; providing qualifications for such administrative law judges; creating s. 381.0409, F.S.; creating the Florida Center for Excellence in Health Care as a not-for-profit corporation; providing goals; providing definitions; providing limitations on the center's liability for any lawful actions taken; requiring the center to issue patient safety recommendations; requiring the development of a statewide electronic infrastructure to improve patient care and the delivery and quality of health care services; providing requirements for development of a core electronic medical record; authorizing access to the electronic medical records and other data maintained by the center; providing for the use of computerized physician medication ordering systems; providing for the establishment of a simulation center for high technology intervention surgery and intensive care; providing for the immunity of specified information in adverse incident reports from discovery or admissibility in civil or administrative actions; providing limitations on liability of specified health care practitioners and facilities under specified conditions; providing an exception to confidentiality requirements; providing for a board of directors to be appointed by the Governor; providing for

the assessment, payment, and collection of fees on certain health insurance policies; providing that health maintenance organizations and prepaid clinics and patients served by certain health care facilities are a funding source for the center; providing penalties for late payments of assessed fees; requiring the Florida Center for Excellence in Health Care to develop a business and financing plan; authorizing state agencies to contract with the center for specified projects; authorizing the use of center funds and the use of state purchasing and travel contracts for the center; requiring annual reports to the Legislature and the Governor; providing for the transfer of assets upon the dissolution of the center; amending s. 395.004, F.S., relating to licensure of certain health care facilities; providing for discounted medical liability insurance based on certification of programs that reduce adverse incidents; requiring the Office of Insurance Regulation to consider certain information in reviewing discounted rates; creating s. 395.0056, F.S.; requiring the Agency for Health Care Administration to review complaints submitted if the defendant is a hospital; amending s. 395.0191, F.S.; providing certain immunity from suit, including actions for injunctive relief, for actions relating to staff membership and clinical privileges; deleting requirement that persons act in good faith to avoid liability or discipline for their actions regarding the awarding of staff membership or clinical privileges; amending s. 395.0193, F.S., relating to peer review and disciplinary actions; providing for discipline of a physician for

mental or physical abuse of staff; limiting liability of certain participants in certain disciplinary actions at a licensed facility; providing that a defendant's monetary liability shall not exceed $250,000 on any action brought under this section; creating s. 395.0194, F.S.; authorizing the governing boards of hospitals to reject or modify medical staff recommendations or to take action where the medical staff has failed to act under certain circumstances; providing procedures for corrective or disciplinary actions, including referral of such matters to a joint committee appointed by the governing board and the medical staff; providing for review and consideration of the recommendations of the joint committee by the governing board; amending s. 395.0197, F.S., relating to internal risk management programs; requiring certain training components in internal risk management programs; requiring a system for notifying patients that they are victims of an adverse incident; requiring risk managers or their designees to give notice; requiring internal risk management programs to address methods for reducing medication errors; requiring licensed facilities to annually report certain information about health care practitioners for whom they assume liability; requiring the Agency for Health Care Administration and the Department of Health to annually publish statistics about licensed facilities that assume liability for health care practitioners; providing for analysis of reports of adverse incidents; providing for confidentiality; requiring a licensed facility at which sexual abuse occurs to offer testing for sexually transmitted disease at no

cost to the victim; creating s. 395.1012, F.S.; requiring hospitals, ambulatory surgical centers, and mobile surgical facilities to establish patient safety plans and committees; providing for discount on medical malpractice insurance premiums for certain health care facilities that implement certain programs recommended by the Florida Center for Excellence in Health Care; creating s. 395.1051, F.S.; requiring certain facilities to notify patients about adverse incidents under specified conditions; amending s. 456.026, F.S.; requiring the Department of Health to publish its annual report to the Legislature concerning finances, administrative complaints, disciplinary actions, and recommendations on its website; requiring additional information in such report including the number of licensed health care practitioners and the claims reported against certain health care practitioners; amending s. 456.039, F.S.; amending the information required to be furnished to the Department of Health for licensure purposes; amending s. 456.041, F.S.; requiring additional information to be included in health care practitioner profiles; providing for fines; revising requirements for the reporting of paid liability claims; amending s. 456.042, F.S.; requiring health care practitioner profiles to be updated within a specific time period; amending s. 456.049, F.S.; revising requirements for the reporting of paid liability claims; amending s. 456.051, F.S.; requiring the Department of Health to provide reports of professional liability actions and bankruptcies in a practitioner's profile within a specified period; amending s. 456.057, F.S.;

authorizing the Department of Health to utilize subpoenas to obtain patient records without patients' consent under certain circumstances; creating s. 456.0575, F.S.; requiring licensed health care practitioners to notify patients about adverse incidents under certain conditions; amending s. 456.063, F.S.; providing for adopting rules to implement requirements for reporting allegations of sexual misconduct; amending s. 456.072, F.S.; authorizing the Department of Health to determine and assess administrative costs, including attorney's fees in disciplinary actions; changing the burden of proof in certain administrative hearings; amending s. 456.073, F.S.; authorizing the Department of Health to investigate certain paid claims made on behalf of health care practitioners licensed under ch. 458 or ch. 459, F.S.; providing a deadline relating to notice of receipt of a request for a formal hearing; amending s. 456.077, F.S.; revising provisions relating to designation of certain citation violations; amending s. 456.078, F.S.; revising provisions relating to designation of certain mediation offenses; providing civil immunity for certain participants in quality improvement processes; providing a patient safety data privilege; defining the terms "patient safety data" and "patient safety organization"; providing for use of patient safety data by patient safety organizations; providing limitations on use of patient safety data; providing for protection of patient-identifying information; providing for determination of whether privilege applies as asserted; providing that an employer may not take retaliatory action against an

employee who makes a good faith report concerning patient safety data; providing that certain regulatory boards may adopt rules governing the safe and ethical prescription of drugs to patients via the Internet or other electronic means; requiring the Office of Program Policy Analysis and Government Accountability and the Office of the Auditor General to jointly conduct an audit of the Department of Health's health care practitioner disciplinary process and closed claims, requiring a report; amending s. 458.320, F.S., relating to financial responsibility requirements for medical physicians; requiring the department to suspend the license of a medical physician who has not paid, up to the amounts required by any applicable financial responsibility provision, any outstanding judgment, arbitration award, other order, or settlement; amending s. 458.331, F.S., relating to grounds for disciplinary action of a physician; redefining the term "repeated malpractice"; revising the standards for the burden of proof in an administrative action against a physician; revising the minimum amount of a claim against a licensee which will trigger a departmental investigation; creating s. 458.3311, F.S.; establishing emergency procedures for disciplinary actions; amending s. 459.0085, F.S., relating to financial responsibility requirements for osteopathic physicians; requiring that the department suspend the license of an osteopathic physician who has not paid, up to the amounts required by any applicable financial responsibility provision, any outstanding judgment, arbitration award, other order, or settlement; amending s. 459.015, F.S., relating to grounds

for disciplinary action against an osteopathic physician; redefining the term "repeated malpractice"; revising the standards for the burden of proof in an administrative action against an osteopathic physician; amending conditions that necessitate a departmental investigation of an osteopathic physician; revising the minimum amount of a claim against a licensee which will trigger a departmental investigation; creating s. 459.0151, F.S.; establishing emergency procedures for disciplinary actions; amending s. 461.013, F.S.; increasing the amount of paid liability claims requiring investigation by the Department of Health; revising the definition of "repeated malpractice" to conform; amending s. 466.028, F.S.; redefining "dental malpractice"; amending s. 624.462, F.S.; authorizing health care providers to form a commercial self-insurance fund; amending s. 627.062, F.S.; providing additional requirements for medical malpractice insurance rate filings; providing that portions of judgments and settlements entered against a medical malpractice insurer for bad faith actions or for punitive damages against the insurer, as well as related taxable costs and attorney's fees, may not be included in an insurer's base rate; providing for review of rate filings by the Office of Insurance Regulation for excessive, inadequate, or unfairly discriminatory rates; requiring insurers to apply a discount based on the health care provider's loss experience; creating s. 627.0662, F.S.; providing definitions; requiring each medical liability insurer to report certain information to the Office of Insurance Regulation; providing for determination of

whether excessive profit has been realized; requiring return of excessive amounts; amending s. 627.357, F.S.; deleting the prohibition against formation of medical malpractice self-insurance funds; providing requirements to form a self-insurance fund; providing rulemaking authority to the Financial Services Commission; creating s. 627.3575, F.S.; creating the Health Care Professional Liability Insurance Facility; providing purpose; providing for governance and powers; providing for eligibility and termination; providing for premiums and assessments; providing for regulation; providing applicability; specifying duties of the Department of Health; providing for debt and regulation thereof; creating s. 627.358, F.S.; authorizing the issuance of reduced premium medical malpractice insurance policies to certain part-time or retired health care professionals; providing eligibility requirements; creating s. 627.359, F.S.; providing for discounts on medical malpractice premiums for health care professionals who enter medication orders electronically using certain approved computer software; amending s. 627.4147, F.S.; revising certain notification criteria for medical and osteopathic physicians; requiring prior notification of a rate increase; creating s. 627.41491, F.S.; requiring the Office of Insurance Regulation to require health care providers to annually publish certain rate comparison information; creating s. 627.41492, F.S.; requiring the Office of Insurance Regulation to prepare and publish an annual comparison of rates for malpractice insurance; creating s. 627.41493, F.S.; requiring a medical malpractice insurance rate rollback; providing for

subsequent increases under certain circumstances; providing authority for the Insurance Regulatory Commission to adopt rules relating to discounts authorized by this act; requiring the Office of Program Policy Analysis and Government Accountability to study and report to the Legislature on requirements for coverage by the Florida Birth-Related Neurological Injury Compensation Association; amending s. 627.912, F.S.; requiring certain claims information to be filed with the Office of Insurance Regulation and the Department of Health; providing for rulemaking by the Financial Services Commission; increasing the limit on and making mandatory a fine against insurers for certain actions; creating s. 627.9121, F.S.; requiring certain information relating to medical malpractice to be reported to the Office of Insurance Regulation; providing for enforcement; amending s. 766.102, F.S; revising requirements for health care providers providing expert testimony in medical negligence actions; prohibiting contingency fees for an expert witness; requiring attorneys proffering expert witness testimony from a medical expert to certify that the witness has not been found guilty of fraud or perjury in any jurisdiction; providing an hourly cap on certain expert witness fees; amending s. 766.106, F.S.; requiring additional information to be provided in presuit notices; requiring that certain complaints alleging medical malpractice be provided by the claimant to the Agency for Health Care Administration; increasing certain timeframes for the conduct of presuit investigations; establishing the date from which the time for filing certain actions is

measured; revising standards for determination of bad faith by an insurer to timely pay its policy limits; providing that failure to cooperate during a presuit investigation is grounds to strike claims or defenses; revising the standards for determining when an insurer has acted in bad faith; creating s. 766.1065, F.S.; providing for presuit discovery in medical malpractice actions; requiring mandatory mediation of medical malpractice claims; creating s. 766.1066, F.S.; creating the Office of Presuit Screening Administration; requiring the office to maintain a database of physicians, attorneys, and consumers willing to serve on presuit screening panels; providing for the assessment of certain fees to fund the office; providing requirements for eligibility to serve on presuit screening panels; providing powers and duties of the panels; providing for the makeup and appointment of such panels; requiring panelist to disclose conflicts of interest and providing for challenge of such panelists; providing for impact of decisions of panels; creating s. 766.1067, F.S.; providing for structured judgments in medical malpractice actions; creating s. 766.1068, F.S.; providing that offers of settlement may be made at any time following the filing of suit; creating s. 766.110, F.S.; providing limitations on liability for certain medical staff, public family practice teaching hospitals, or medical school faculty members for the performance of emergency services prior to the patient being sufficiently stable; providing limitations on liability for certain medical facility staff when providing services following a subsequent injury in the facility prior to the patient

again becoming sufficiently stable; amending s. 766.112, F.S.; eliminating the application of the doctrine of joint and several liability to medical malpractice actions; estopping plaintiffs from denying that a defendant or prospective defendant with whom the plaintiff settled contributed to the injury alleged; creating s. 766.118, F.S.; revising the method for determining and reviewing awards of noneconomic damages; authorizing judges to alter certain awards; providing an exception; providing the right to appeal such awards and establishing the standard for review; defining the term "sufficiently stable"; creating s. 766.185, F.S.; requiring joinder of certain parties; prohibiting the assignment of fault to such parties if not joined; amending s. 766.202, F.S.; revising the definition of "medical expert"; amending s. 766.203, F.S.; providing that presuit expert opinions in medical malpractice actions are subject to discovery; amending s. 766.206, F.S.; providing for dismissal of a claim or the striking of a defense under certain circumstances; requiring the court to make certain reports concerning a medical expert who fails to meet qualifications; requiring the court to refuse to consider testimony from certain expert witnesses; amending s. 766.207, F.S.; providing that voluntary binding arbitration shall be authorized only after the hearing of a presuit screening panel; providing a limitation on damages, including certain economic and noneconomic damages under certain circumstances; deleting an exception to the time limitation for agreeing to arbitration; providing that the Florida Rules of Civil Procedure shall govern discovery;

providing exceptions; providing that discovery disputes shall be resolved by an administrative law judge; revising the makeup of arbitration panels; revising the compensation of the arbitrators; providing limitations on damages which may be awarded under certain circumstances; deleting the provision that defendants who agree to arbitration are jointly and severally liable for all damages awarded in arbitration; providing that claimant's may recover additional damages and costs at trial if a defendant refuses an offer of voluntary binding arbitration; providing a limitation on certain damages which may be awarded at trial if a plaintiff refuses an offer of voluntary binding arbitration; providing for an award and allocation of damages in arbitration; providing for periodic payment of certain damages; providing for extinguishing liability to claimants and for contribution; providing for a right of contribution against defendants not in arbitration; providing that physicians not carrying medical malpractice insurance require no relief provided by this act; creating s. 766.25, F.S.; prescribing a method for itemization of specific categories of damages awarded in medical malpractice actions; creating s. 766.26, F.S.; requiring the Agency for Health Care Administration to maintain a jury verdict database regarding malpractice actions; requiring the Clerks of the Court to report all such future verdicts to the agency; creating s. 766.27, F.S.; providing sanctions against certain attorneys who file frivolous medical malpractice lawsuits; requiring the Office of Insurance Regulation to compile annual statistical reports of closed claims on

files relating to health care providers; requiring physicians to report certain claims or actions for medical malpractice against the physician to the Office of Insurance Regulation and the Department of Health; providing requirements for such reports; amending s. 768.21, F.S.; providing that certain adult beneficiaries of estates are entitled to damages in wrongful death actions; amending s. 768.81, F.S.; eliminating the application of the doctrine of joint and several liability to medical malpractice actions; estopping plaintiffs from denying that a defendant or prospective defendant with whom the plaintiff settled contributed to the injury alleged; creating s. 1004.08, F.S.; requiring patient safety instruction for certain students in public schools, colleges, and universities; creating s. 1004.085, F.S.; requiring certain public schools to assist the Agency for Health Care Administration in the development of information to be provided to patients and their families on risks of treatment options to assist in receiving informed consent; creating s. 1005.07, F.S.; requiring patient safety instruction for certain students in nonpublic schools, colleges, and universities; creating s. 1005.075, F.S.; requiring certain nonpublic schools to assist the Agency for Health Care Administration in the development of information to be provided to patients and their families on risks of treatment options to assist in receiving informed consent; directing the Agency for Health Care Administration to conduct or contract for a study to determine what information to provide to the public comparing hospitals, based on inpatient quality

indicators developed by the federal Agency for Healthcare Research and Quality; creating a workgroup to study the health care practitioner disciplinary process; providing for workgroup membership; providing that the workgroup deliver its report by January 1, 2004; providing severability; providing for construction of the act in pari materia with laws enacted during the 2003 Regular Session or the 2003 Special Session A of the Legislature; providing for future repeal of the act; providing for applicability; providing an effective date.

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

Section 1. Popular name.-- This act may be cited as the "Malpractice Insurance, Liability, and Litigation Reform Act" (MILLRA).

Section 2. Findings.--

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

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

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

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

nation.

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

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

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

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

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

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

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

(12) The Legislature finds that ensuring that physicians

continue to practice in Florida is an overwhelming public necessity.

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

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

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

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

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

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

medical malpractice insurance.

Section 3. A new subsection (11) is added to section 120.65, Florida Statutes, to read:

120.65 Administrative law judges.--

(11) The Division of Administrative Hearings shall designate at least two administrative law judges who will specifically preside over actions involving a health care practitioner as defined in s. 456.001(4). Each designated administrative law judge shall be a member of The Florida Bar in good standing and shall be a health care practitioner or have experience in health care. The Division of Administrative Hearings and the Department of Health shall work cooperatively to enhance the effectiveness of disciplinary actions involving a health care practitioner as defined in s. 456.001(4).

Section 4. Section 381.0409, Florida Statutes, is created to read:

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

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

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

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

(c) "Health care practitioner" means any health care practitioner as defined in s. 456.001(4).

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

(e) “Medication error” is any preventable event that may cause or lead to inappropriate medication use or patient harm while the medication is in the control of the health care professional, patient, or consumer. Such events may be related to professional practice, health care products, health care procedures, and health care systems, each of which may include the prescribing of medications and order communications; product labeling; product packaging; the nomenclature, compounding, dispensing, distribution, administration, and use of medications; and education and monitoring related thereto.

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

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

(2) The center shall, either directly or by contract:

(a) Analyze patient safety data for the purpose of

recommending changes in practices and procedures which may be implemented by health care practitioners and health care facilities to prevent future adverse incidents.

(b) Collect, analyze, and evaluate patient safety data submitted voluntarily by a health care practitioner or health care facility. The center shall establish a series of baseline assessments in order to, at a minimum annual frequency, review the effectiveness of patient safety initiatives and enacted recommendations. The center shall recommend to health care practitioners and health care facilities changes in practices and procedures that may be implemented for the purpose of improving patient safety and preventing patient safety events.

(c) Foster the development of a statewide electronic infrastructure, which may be implemented in phases over a multiyear period, that is designed to improve patient care and the delivery and quality of health care services by health care facilities and practitioners. The electronic infrastructure shall be a secure platform for communication and the sharing of clinical and other data, including, but not limited to, business data, among providers and between patients and providers. The electronic infrastructure shall include a core electronic medical record. Health care practitioners and health care facilities shall have access to individual electronic medical records subject to the consent of the individual. Health insurers licensed under chapter 627 or chapter 641 shall have access to the electronic medical records of their policyholders and to other data if such access is for the sole purpose of conducting research to identify diagnostic tests and treatments that are medically effective. Health research entities shall have access to the electronic medical records of individuals

subject to the consent of the individual and to other data if such access is for the sole purpose of conducting research to identify diagnostic tests and treatments that are medically effective.

(d) Inventory hospitals to determine the current status of implementation of computerized physician medication ordering systems, barcode point of care systems, or other technological patient safety implementation, and recommend a plan for expediting implementation statewide or, in hospitals where the center determines that implementation of such systems is not practicable, alternative methods to reduce medication errors. The center shall identify in its plan any barriers to statewide implementation and shall include recommendations to the Legislature of statutory changes that may be necessary to eliminate those barriers. The center will review newly developed plans for compliance with statewide initiatives and to determine both the commitment of the health care facility staff and the capability of the facility to successfully coordinate and implement these plans, especially from a technological perspective.

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

(f) Establish a pilot review program in Dade, Hillsborough, and Clay Counties to evaluate the effectiveness of technological implementations of Computerized Physician Order Entry (CPOE) and Barcode Point of Care (BPOC) as they relate to the patient safety initiatives outlined in the Malpractice Insurance, Liability, and Litigation Reform Act. After a 6-month evaluation, a series of recommendations will be produced,

including considerations regarding appropriate financial terms to allow health care practitioners and health care facilities to absorb the costs associated with these technological solutions. Incorporated in this evaluation will be a recommendation for two commercial patient safety technology solutions. These recommendations are designed to assist health care practitioners and health care facilities in their individual patient safety plan development.

(g) Identify best practices and share this information with health care providers. Nothing in this section shall serve to limit the scope of services provided by the center with regard to engaging in other activities that improve health care quality, improve the diagnosis and treatment of diseases and medical conditions, increase the efficiency of the delivery of health care services, increase administrative efficiency, or increase access to quality health care services.

(3) The center may release deidentified information contained in patient safety data to any health care practitioner or health care facility when recommending changes in practices and procedures which may be implemented by such practitioner or facility to prevent patient safety events or adverse incidents.

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

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

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

(6) The center shall:

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

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

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

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

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

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

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

(d) The members shall elect from the membership a chairperson.

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

(8) The center shall be financed as follows:

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

If payment has not been received within 60 days after interest is charged, the center shall notify the Office of Insurance Regulation that payment has not been received pursuant to the requirements of this paragraph. An insurer that refuses to comply with the requirements of this paragraph is subject to the forfeiture of its certificate of authority.

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

paragraph is subject to the forfeiture of its certificate of authority.

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

(d) Notwithstanding any law to the contrary, each nursing home, assisted living facility, home health agency, hospice, prescribed pediatric extended care center, and health care services pool licensed under chapter 400 shall, as a condition of licensure, make payment to the center on April 1 of each year, in the amount of $1 for each individual served by each aforementioned entity during the previous 12 months.

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

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

(f) The center shall develop a business and financing plan to obtain funds through other means if funds beyond those that are provided for in this subsection are needed to accomplish the objectives of the center.

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

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

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

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

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

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

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

(b) The status report on the implementation of technology designed to reduce medication error.

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

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

(e) A financial statement and balance sheet. The initial report shall include any recommendations that the center deems appropriate regarding revisions in the definition of adverse incidents in s. 395.0197 and the reporting of such adverse

incidents by licensed facilities.

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

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

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

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

(19) In carrying out this section, the center shall consult with and develop partnerships, as appropriate, with all segments of the health care industry, including, but not limited to, health care practitioners, health care facilities, health care consumers, professional organizations, agencies, health care practitioner licensing boards, and educational institutions.

Section 5. Subsection (3) is added to section 395.004, Florida Statutes, to read:

395.004 Application for license, fees; expenses.--

(3) A licensed facility may apply to the agency for certification of a quality improvement program that results in the reduction of adverse incidents at that facility. The agency, in consultation with the Office of Insurance Regulation, shall develop criteria for such certification. Insurers shall file with the Office of Insurance Regulation a discount in the rate or rates applicable for medical liability insurance coverage to

reflect the implementation of a certified program. In reviewing insurance company filings with respect to rate discounts authorized under this subsection, the Office of Insurance Regulation shall consider whether, and the extent to which, the program certified under this subsection is otherwise covered under a program of risk management offered by an insurance company or self-insurance plan providing medical liability insurance coverage.

Section 6. Section 395.0056, Florida Statutes, is created to read:

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

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

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

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

395.0191 Staff membership and clinical privileges.--

(7) There shall be no monetary liability on the part of, and no cause of action for injunctive relief or damages shall arise against, any licensed facility, its governing board or governing board members, medical staff, or disciplinary board or against its agents, investigators, witnesses, or employees, or against any other person, for any action arising out of or

related to carrying out the provisions of this section, absent ~~taken in good faith and without~~ intentional fraud ~~in carrying out the provisions of this section~~.

Section 8. Subsections (3) and (9) of section 395.0193, Florida Statutes, are amended to read:

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

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

(a) Incompetence.

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

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

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

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

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

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

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

(9)(a) If the defendant prevails in an action brought by a staff member or physician who delivers health care services at the licensed facility against any person or entity that initiated, participated in, was a witness in, or conducted any review as authorized by this section, the court shall award reasonable attorney's fees and costs to the defendant.

(b) As a condition of any staff member or physician bringing any action against any person or entity that initiated, participated in, was a witness in, or conducted any review as authorized by this section and before any responsive pleading is due, the staff member or physician shall post a bond or other security, as set by the court having jurisdiction of the action, in an amount sufficient to pay the costs and attorney's fees. A defendant's monetary liability under this section shall not exceed $250,000.

Section 9. Section 395.0194, Florida Statutes, is created to read:

395.0194 Licensed facilities; quality assurance responsibilities of governing board.--

(1) A governing board's authority for the administration of the hospital is not limited by the authority of its medical staff. Therefore, a governing board may reject or modify a

medical staff recommendation or may, if the medical staff has failed to act, take action independent of the medical staff concerning medical staff membership, clinical privileges, peer review, patient safety, and quality assurance.

(2) To the extent a governing board seeks to modify a medical staff recommendation, or where a medical staff has failed to act within 75 days after a request from the governing board to take action against, or with regard to, an individual physician concerning medical staff membership, clinical privileges, peer review, or quality assurance, a governing board may take action independent of the actions of the medical staff. If no existing bylaw provision exists and if, after any informal interview, the governing board determines that corrective or disciplinary action is necessary, it shall recommend such action to a six-member joint conference committee composed of three members of the governing board, to be appointed by the chair of the governing board, and three members of the medical staff, to be appointed by the chair or president of the medical staff. The joint conference committee shall, within 15 days after the governing board's decision, conduct a fair hearing in which the physician is entitled to be represented by counsel, to be afforded an opportunity to present oral and written argument in response to the corrective or disciplinary action proposed, and to comment upon and cross-examine witnesses and evidence against such physician and notify the governing board that the joint conference committee accepts, rejects, or cannot reach a majority consensus concerning the governing board's recommendation. If the joint conference committee's recommendation is to accept the governing board's recommendation, the governing board's decision shall be final.

If the joint conference committee rejects the governing board's recommendation and suggests an alternative corrective or disciplinary action, or finds that no corrective or disciplinary action is warranted, the governing board shall not unreasonably reject the joint conference committee's recommendation. If the joint conference committee cannot reach a majority consensus to either accept or reject the governing board's action concerning the fair hearing decision, the governing board's action shall be final. The governing board shall give full and complete consideration to the joint conference committee’s recommendations.

Section 10. Subsections (12) through (20) of section 395.0197, Florida Statutes, are renumbered as subsections (13) through (21), respectively, subsections (1), (3), (7), and (8) of said section are amended, and a new subsection (12) is added to said section, to read:

395.0197 Internal risk management program.--

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

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

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

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

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

b. At least 1 hour of such education and training annually for all personnel of the licensed facility working in clinical areas and providing patient care, except those persons licensed as health care practitioners who are required to complete continuing education coursework pursuant to chapter 456 or the respective practice act, which education and training shall include components designed to assisting physicians and hospital personnel in providing constructive advice to patients when there is an adverse outcome.

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

a. Live visual observation;

b. Electronic observation; or

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

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

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

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

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

(d) A system for informing a patient or a proxy authorized by law to make health care decisions on behalf of a patient that the patient was the subject of an adverse incident as defined in subsection (5). Such notice shall be given by the risk manager, or his or her designee, as soon as practicable to allow the patient an opportunity to minimize damage or injury.

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

(f) The development of a facilitywide plan for reducing medication errors, which shall include:

1. The development of effective reporting mechanisms to ensure that medication-related errors are reviewed.

2. The establishment of a baseline assessment and a review to be conducted at least annually of the effectiveness of the plan to reduce medication-related errors.

3. The use of technology.

Pertinent literature related to the reduction of medication-related errors shall be reviewed and utilized in the development

and ongoing review of the plan developed pursuant to this paragraph.

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

(7) The licensed facility shall notify the agency no later than 7 calendar days ~~1 business day~~ after the risk manager or his or her designee has received a report pursuant to paragraph (1)(d) and can determine within 7 calendar days ~~1 business day~~ that any of the following adverse incidents has occurred, whether occurring in the licensed facility or arising from health care prior to admission in the licensed facility:

(a) The death of a patient;

(b) Brain or spinal damage to a patient;

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

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

(e) The performance of a wrong surgical procedure.

The notification must be made in writing and be provided by facsimile device or overnight mail delivery. The notification must include information regarding the identity of the affected patient, the type of adverse incident, the initiation of an investigation by the facility, and whether the events causing or resulting in the adverse incident represent a potential risk to other patients.

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

(a) The death of a patient;

(b) Brain or spinal damage to a patient;

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

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

(e) The performance of a wrong surgical procedure;

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

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

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

The agency may grant extensions to this reporting requirement for more than 15 days upon justification submitted in writing by the facility administrator to the agency. The agency may require an additional, final report. These reports shall not be available to the public pursuant to s. 119.07(1) or any other law providing access to public records, nor be discoverable or admissible in any civil or administrative action, except in disciplinary proceedings by the agency or the appropriate regulatory board, nor shall they be available to the public as part of the record of investigation for and prosecution in disciplinary proceedings made available to the public by the agency or the appropriate regulatory board. However, the agency or the appropriate regulatory board shall make available, upon written request by a health care professional against whom probable cause has been found, any such records which form the basis of the determination of probable cause. The agency may investigate, as it deems appropriate, any such incident and prescribe measures that must or may be taken in response to the incident. The agency shall review each incident and determine whether it potentially involved conduct by the health care professional who is subject to disciplinary action, in which case the provisions of s. 456.073 shall apply. Copies of all reports of adverse incidents submitted to the agency by hospitals and ambulatory surgical centers shall be forwarded to the Florida Center for Excellence in Health Care, as defined in s. 381.0409, for analysis by experts who may make recommendations regarding the prevention of such incidents. Such information shall remain confidential as otherwise provided by law.

(12) If appropriate, a licensed facility in which sexual

abuse occurs must offer the victim of sexual abuse testing for sexually transmissible diseases and shall provide all such testing at no cost to the victim.

Section 11. Section 395.1012, Florida Statutes, is created to read:

395.1012 Patient safety.--

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

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

Section 12. Section 395.1051, Florida Statutes, is created to read:

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

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

456.026 Annual report concerning finances, administrative complaints, disciplinary actions, and recommendations.-- The

department is directed to prepare and submit a report to the President of the Senate and the Speaker of the House of Representatives by November 1 of each year. The department shall publish the report on its website simultaneously with delivery to the President of the Senate and the Speaker of the House of Representatives. The report must be directly accessible on the department's Internet homepage highlighted by easily identifiable links and buttons. In addition to finances and any other information the Legislature may require, the report shall include statistics and relevant information, profession by profession, detailing:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(a)1. The name of each medical school that the applicant has attended, with the dates of attendance and the date of graduation, and a description of all graduate medical education

completed by the applicant, excluding any coursework taken to satisfy medical licensure continuing education requirements.

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

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

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

5. The year that the applicant began practicing medicine.

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

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

8. A description of any final disciplinary action taken within the previous 10 years against the applicant by the agency

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

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

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

456.041 Practitioner profile; creation.--

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

submitted pursuant to s. 456.0391 into a practitioner profile of the applicant submitting the information.

(b) Each practitioner licensed under chapter 458 or chapter 459 must report to the Department of Health and the Board of Medicine or the Board of Osteopathic Medicine, respectively, all final disciplinary actions, sanctions by a governmental agency or a facility or entity licensed under state law, and claims or actions, as provided under s. 456.051, to which he or she is subject no later than 15 calendar days after such action or sanction is imposed. Failure to submit the requisite information within 15 calendar days in accordance with this paragraph shall subject the practitioner to discipline by the Board of Medicine or the Board of Osteopathic Medicine and a fine of $100 for each day that the information is not submitted after the expiration of the 15-day reporting period.

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

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

practitioner has violated any law that relates to the practitioner's practice.

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

(4) The Department of Health shall include, with respect to a practitioner licensed under chapter 458 or chapter 459, a statement of how the practitioner has elected to comply with the financial responsibility requirements of s. 458.320 or s. 459.0085. The department shall include, with respect to practitioners subject to s. 456.048, a statement of how the practitioner has elected to comply with the financial responsibility requirements of that section. The department shall include, with respect to practitioners licensed under chapter 458, chapter 459, or chapter 461, information relating to liability actions which has been reported under s. 456.049 or s. 627.912 within the previous 10 years for any paid claim of

$50,000 or more ~~that exceeds $5,000~~. Such claims information shall be reported in the context of comparing an individual practitioner's claims to the experience of other practitioners within the same specialty, or profession if the practitioner is not a specialist~~, to the extent such information is available to the Department of Health~~. The department shall include a hyperlink to all such comparison reports in such practitioner's profile on its Internet website. If information relating to a liability action is included in a practitioner's practitioner profile, the profile must also include the following statement: "Settlement of a claim may occur for a variety of reasons that do not necessarily reflect negatively on the professional competence or conduct of the practitioner. A payment in settlement of a medical malpractice action or claim should not be construed as creating a presumption that medical malpractice has occurred."

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

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

having regulatory authority over the practitioner before such information is included in his or her profile.

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

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

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

Section 15. Section 456.042, Florida Statutes, is amended to read:

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

Section 16. Subsection (1) of section 456.049, Florida Statutes, is amended, and subsection (3) is added to said section, to read:

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

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

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

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

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

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

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

Section 17. Section 456.051, Florida Statutes, is amended to read:

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

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

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

Section 18. Paragraph (a) of subsection (7) of section 456.057, Florida Statutes, is amended to read:

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

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

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

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

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

the report or a summary of that report or from another person, solicited patients fraudulently, received a kickback as defined in s. 456.054, violated the patient brokering provisions of s. 817.505, or presented or caused to be presented a false or fraudulent insurance claim within the meaning of s. 817.234(1)(a), and also find that, within the meaning of s. 817.234(1)(a), patient authorization cannot be obtained because the patient cannot be located or is deceased, incapacitated, or suspected of being a participant in the fraud or scheme, and if the subpoena is issued for specific and relevant records.

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

Section 19. Section 456.0575, Florida Statutes, is created to read:

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

Section 20. Patient safety discount.-- A health care facility licensed pursuant to chapter 395, Florida Statutes, may

apply to the Department of Financial Services for certification of any program that is recommended by the Florida Center for Excellence in Health Care to reduce adverse incidents, as defined in s. 395.0197, Florida Statutes, which result in the reduction of serious events at that facility. The department shall develop criteria for such certification. Insurers shall file with the department a discount in the rate or rates applicable for insurance coverage to reflect the effect of a certified program. A health care facility shall receive a discount in the rate or rates applicable for mandated basic insurance coverage required by law. In reviewing filings under this section, the department shall consider whether, and the extent to which, the program certified under this section is otherwise covered under a program of risk management offered by an insurance company or exchange or self-insurance plan providing medical professional liability coverage.

Section 21. Subsection (4) is added to section 456.063, Florida Statutes, to read:

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

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

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

456.072 Grounds for discipline; penalties; enforcement.--

(4) In any ~~addition to any other discipline imposed through~~ final order, or citation, entered on or after July 1,

2001, that imposes a penalty or other form of discipline pursuant to this section or ~~discipline imposed through final order, or citation, entered on or after July 1, 2001,~~ for a violation of any practice act, the board, or the department when there is no board, shall assess costs related to the investigation and prosecution of the case, including costs associated with an attorney's time. The amount of costs to be assessed shall be determined by the board, or the department when there is no board, following its consideration of an affidavit of itemized costs and any written objections thereto. In any case in which ~~where the board or the department imposes~~ a fine or assessment of costs imposed by the board or department ~~and the fine or assessment~~ is not paid within a reasonable time, such reasonable time to be prescribed in the rules of the board, or the department when there is no board, or in the order assessing such fines or costs, the department or the Department of Legal Affairs may contract for the collection of, or bring a civil action to recover, the fine or assessment.

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

Section 23. Subsections (1) and (5) of section 456.073, Florida Statutes, are amended to read:

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

(1) The department, for the boards under its jurisdiction, shall cause to be investigated any complaint that is filed before it if the complaint is in writing, signed by the

complainant, and legally sufficient. A complaint is legally sufficient if it contains ultimate facts that show that a violation of this chapter, of any of the practice acts relating to the professions regulated by the department, or of any rule adopted by the department or a regulatory board in the department has occurred. In order to determine legal sufficiency, the department may require supporting information or documentation. The department may investigate, and the department or the appropriate board may take appropriate final action on, a complaint even though the original complainant withdraws it or otherwise indicates a desire not to cause the complaint to be investigated or prosecuted to completion. The department may investigate an anonymous complaint if the complaint is in writing and is legally sufficient, if the alleged violation of law or rules is substantial, and if the department has reason to believe, after preliminary inquiry, that the violations alleged in the complaint are true. The department may investigate a complaint made by a confidential informant if the complaint is legally sufficient, if the alleged violation of law or rule is substantial, and if the department has reason to believe, after preliminary inquiry, that the allegations of the complainant are true. The department may initiate an investigation if it has reasonable cause to believe that a licensee or a group of licensees has violated a Florida statute, a rule of the department, or a rule of a board. The department may investigate information filed pursuant to s. 456.041(4) relating to liability actions with respect to health care practitioners licensed under chapter 458 and chapter 459 which have been reported under s. 456.049 or s. 627.912 within the previous 5 years for any paid claim that exceeds $50,000.

Except as provided in ss. 458.331(9), 459.015(9), 460.413(5), and 461.013(6), when an investigation of any subject is undertaken, the department shall promptly furnish to the subject or the subject's attorney a copy of the complaint or document that resulted in the initiation of the investigation. The subject may submit a written response to the information contained in such complaint or document within 20 days after service to the subject of the complaint or document. The subject's written response shall be considered by the probable cause panel. The right to respond does not prohibit the issuance of a summary emergency order if necessary to protect the public. However, if the secretary, or the secretary's designee, and the chair of the respective board or the chair of its probable cause panel agree in writing that such notification would be detrimental to the investigation, the department may withhold notification. The department may conduct an investigation without notification to any subject if the act under investigation is a criminal offense.

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

(b) Notwithstanding s. 120.569(2), the department shall notify the Division of Administrative Hearings within 45 days after receipt of a petition or request for a hearing that the

department has determined requires a formal hearing before an administrative law judge.

Section 24. Subsections (1) and (2) of section 456.077, Florida Statutes, are amended to read:

456.077 Authority to issue citations.--

(1) Notwithstanding s. 456.073, the board, or the department if there is no board, shall adopt rules to permit the issuance of citations. The citation shall be issued to the subject and shall contain the subject's name and address, the subject's license number if applicable, a brief factual statement, the sections of the law allegedly violated, and the penalty imposed. The citation must clearly state that the subject may choose, in lieu of accepting the citation, to follow the procedure under s. 456.073. If the subject disputes the matter in the citation, the procedures set forth in s. 456.073 must be followed. However, if the subject does not dispute the matter in the citation with the department within 30 days after the citation is served, the citation becomes a public final order and does not constitute ~~constitutes~~ discipline for a first offense, but does constitute discipline for a second or subsequent offense. The penalty shall be a fine or other conditions as established by rule.

(2) The board, or the department if there is no board, shall adopt rules designating violations for which a citation may be issued. Such rules shall designate as citation violations those violations for which there is no substantial threat to the public health, safety, and welfare or no violation of standard of care involving injury to a patient. Violations for which a citation may be issued shall include violations of continuing education requirements; failure to timely pay required fees and

fines; failure to comply with the requirements of ss. 381.026 and 381.0261 regarding the dissemination of information regarding patient rights; failure to comply with advertising requirements; failure to timely update practitioner profile and credentialing files; failure to display signs, licenses, and permits; failure to have required reference books available; and all other violations that do not pose a direct and serious threat to the health and safety of the patient or involve a violation of standard of care that has resulted in injury to a patient.

Section 25. Subsections (1) and (2) of section 456.078, Florida Statutes, are amended to read:

456.078 Mediation.--

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

(a) The death of a patient;

(b) Brain or spinal damage to a patient;

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

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

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

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

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

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

(2) After the department determines a complaint is legally sufficient and the alleged violations are defined as mediation offenses, the department or any agent of the department may conduct informal mediation to resolve the complaint. If the complainant and the subject of the complaint agree to a resolution of a complaint within 14 days after contact by the mediator, the mediator shall notify the department of the terms of the resolution. The department or board shall take no further action unless the complainant and the subject each fail to record with the department an acknowledgment of satisfaction of the terms of mediation within 60 days of the mediator's notification to the department. A successful mediation which results in an award of $50,000 or less shall not constitute discipline. In the event the complainant and subject fail to reach settlement terms or to record the required acknowledgment, the department shall process the complaint according to the provisions of s. 456.073.

Section 26. Civil immunity for members of or consultants to certain boards, committees, or other entities.--

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

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

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

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

(d) The adequacy or quality of professional services;

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

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

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

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

agency. To be protected by this section, the act, decision, omission, or utterance may not be made or done in bad faith or with malicious intent.

Section 27. Patient safety data privilege.--

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

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

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

(2) Patient safety data shall not be subject to discovery or introduction into evidence in any civil or administrative action.

(3) Unless otherwise provided by law, a patient safety organization shall promptly remove all patient-identifying information after receipt of a complete patient safety data report unless such organization is otherwise permitted by state or federal law to maintain such information. Patient safety organizations shall maintain the confidentiality of all patient-

identifying information and may not disseminate such information, except as permitted by state or federal law.

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

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

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

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

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

Section 30. Subsection (10) is added to section 458.320,

Florida Statutes, subsection (8) of said section is renumbered as subsection (9), and a new subsection (8) is added to said section, to read:

458.320 Financial responsibility.--

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

(10) Nothing in this section shall be construed as creating a civil cause of action against any hospital as a result of the failure of any physician with staff privileges to comply with the requirements of this section.

Section 31. Paragraph (t) of subsection (1) and subsections (3) and (6) of section 458.331, Florida Statutes, are amended to read:

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

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

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

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

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

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

Section 32. Section 458.3311, Florida Statutes, is created to read:

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

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

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

Section 33. Subsection (11) is added to section 459.0085, Florida Statutes, subsection (9) of said section is renumbered as subsection (10), and a new subsection (9) is added to said section, to read:

459.0085 Financial responsibility.--

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

(11) Nothing in this section shall be construed as creating a civil cause of action against any hospital as a result of the failure of any physician with staff privileges to comply with the requirements of this section.

Section 34. Paragraph (x) of subsection (1) and subsections (3) and (6) of section 459.015, Florida Statutes, are amended to read:

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

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

(x) Gross or repeated malpractice or the failure to practice osteopathic medicine with that level of care, skill, and treatment which is recognized by a reasonably prudent similar osteopathic physician as being acceptable under similar

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

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

action. ~~The division shall establish grounds for revocation or suspension of license by clear and convincing evidence.~~

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

Section 35. Section 459.0151, Florida Statutes, is created to read:

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

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

(2) No later than 30 days after an osteopathic physician has, within a 60-month period, made three reports as required by subsection (1), the Department of Health shall initiate an

emergency investigation and the Board of Osteopathic Medicine shall conduct an emergency probable cause hearing to determine whether the physician should be disciplined for a violation of s. 459.015(1)(x) or any other relevant provision of law.

Section 36. Paragraph (s) of subsection (1) and paragraph (a) of subsection (5) of section 461.013, Florida Statutes, are amended to read:

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

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

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

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

Section 37. Paragraph (x) of subsection (1) of section 466.028, Florida Statutes, is amended to read:

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

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

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

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

Section 38. Subsection (2) of section 624.462, Florida Statutes, is amended to read:

624.462 Commercial self-insurance funds.--

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

(a) Established by:

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

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

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

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

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

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

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

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

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

c. Approve payment of dividends to members;

d. Approve changes in corporate structure; and

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

Section 39. Paragraph (a) of subsection (6) of section 627.062, Florida Statutes, is amended and subsections (7), (8), (9), and (10) are added to said section, to read:

627.062 Rate standards.--

(6)(a) After any action with respect to a rate filing that constitutes agency action for purposes of the Administrative Procedure Act, except for a rate filing for medical malpractice insurance, an insurer may, in lieu of demanding a hearing under s. 120.57, require arbitration of the rate filing. Arbitration shall be conducted by a board of arbitrators consisting of an arbitrator selected by the department, an arbitrator selected by the insurer, and an arbitrator selected jointly by the other two arbitrators. Each arbitrator must be certified by the American

Arbitration Association. A decision is valid only upon the affirmative vote of at least two of the arbitrators. No arbitrator may be an employee of any insurance regulator or regulatory body or of any insurer, regardless of whether or not the employing insurer does business in this state. The department and the insurer must treat the decision of the arbitrators as the final approval of a rate filing. Costs of arbitration shall be paid by the insurer.

(7) Notwithstanding any other provision of this section, in matters relating to professional liability insurance coverage for medical negligence, any portion of a judgment entered as a result of a statutory or common-law bad faith action and any portion of a judgment entered that awards punitive damages against an insurer may not be included in the insurer's rate base and may not be used to justify a rate or rate change. In matters relating to professional liability insurance coverage for medical negligence, any portion of a settlement entered as a result of a statutory or common-law bad faith action identified as such and any portion of a settlement wherein an insurer agrees to pay specific punitive damages may not be used to justify a rate or rate change. The portion of the taxable costs and attorney's fees that is identified as being related to the bad faith and punitive damages in these judgments and settlements may not be included in the insurer's rate base and may not be utilized to justify a rate or rate change.

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

(9) Medical malpractice insurance companies shall submit a

rate filing to the Office of Insurance Regulation no earlier than 30 days, but no later than 120 days, after the date upon which this act becomes law.

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

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

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

(d) Rates shall be deemed excessive if, among other standards established by this section, the rate structure

provides for replenishment of reserves or surpluses from premiums when the replenishment is attributable to investment losses.

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

Section 40. Section 627.0662, Florida Statutes, is created to read:

627.0662 Excessive profits for medical liability insurance prohibited.--

(1) As used in this section:

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

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

(2) Each medical liability insurer shall file with the Office of Insurance Regulation, prior to July 1 of each year on forms prescribed by the office, the following data for medical liability insurance business in this state. The data shall

include both voluntary and joint underwriting association business, as follows:

(a) Calendar-year earned premium.

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

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

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

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

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

(4) Each medical liability insurer shall also file a schedule of medical liability insurance loss in this state and loss adjustment experience for each of the 3 most recent accident years. The incurred losses and loss adjustment expenses shall be valued as of March 31 of the year following the close

of the accident year, developed to an ultimate basis, and at two 12-month intervals thereafter, each developed to an ultimate basis, to the extent that a total of three evaluations is provided for each accident year. The first year to be so reported shall be accident year 2004, such that the reporting of 3 accident years will not take place until accident years 2005 and 2006 have become available.

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

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

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

(8) The excessive amount shall be refunded to policyholders on a pro rata basis in relation to the final

compilation year earned premiums to the voluntary medical liability insurance policyholders of record of the insurer group on December 31 of the final compilation year.

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

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

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

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

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

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

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

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

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

Section 41. Subsection (10) of section 627.357, Florida Statutes, is amended to read:

627.357 Medical malpractice self-insurance.--

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

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

Section 42. Section 627.3575, Florida Statutes, is created to read:

627.3575 Health Care Professional Liability Insurance Facility.--

(1) FACILITY CREATED; PURPOSE; STATUS.-- There is created the Health Care Professional Liability Insurance Facility. The facility is intended to meet ongoing availability and affordability problems relating to liability insurance for health care professionals by providing an affordable, self-supporting source of excess insurance coverage for those professionals who are willing and able to self-insure for smaller losses. The facility shall operate on a not-for-profit basis. The facility is self-funding and is intended to serve a

public purpose but is not a state agency or program, and no activity of the facility shall create any state liability.

(2) GOVERNANCE; POWERS.--

(a) The facility shall operate under a seven-member board of governors consisting of the Secretary of Health, three members appointed by the Governor, and three members appointed by the Chief Financial Officer. The board shall be chaired by the Secretary of Health. The secretary shall serve by virtue of his or her office, and the other members of the board shall serve terms concurrent with the term of office of the official who appointed them. Any vacancy on the board shall be filled in the same manner as the original appointment. Members serve at the pleasure of the official who appointed them. Members are not eligible for compensation for their service on the board, but the facility may reimburse them for per diem and travel expenses at the same levels as are provided in s. 112.061 for state employees.

(b) The facility shall have such powers as are necessary to operate as an insurer, including the power to:

1. Sue and be sued.

2. Hire such employees and retain such consultants, attorneys, actuaries, and other professionals as it deems appropriate.

3. Contract with such service providers as it deems appropriate.

4. Maintain offices appropriate to the conduct of its business.

5. Take such other actions as are necessary or appropriate in fulfillment of its responsibilities under this section.

(3) COVERAGE PROVIDED.-- The facility shall provide

liability insurance coverage for health care professionals. The facility shall allow policyholders to select from policies with deductibles of $25,000 per claim, $50,000 per claim, and $100,000 per claim and with coverage limits of $250,000 per claim and $750,000 annual aggregate and $1 million per claim and $3 million annual aggregate. To the greatest extent possible, the terms and conditions of the policies shall be consistent with terms and conditions commonly used by professional liability insurers. The facility shall offer policies to cover health care professionals who have retired from practice or maintain a part-time practice as set forth herein. For health care professionals who meet the following requirements, the premiums for such policies shall be no more than 50% of the cost of premiums for similar specialties for health care professionals who meet each of the following requirements:

(a) The health care professional has held an active license to practice in this state or another state or some combination thereof for more than 15 years.

(b) The health care professional has either retired from the practice of medicine or maintains a part-time practice of no more than 1,000 patient contact hours per year.

(c) The health care professional has had no more than two claims for medical malpractice resulting in an indemnity exceeding $50,000 each within the previous 5-year period.

(d) The health care professional has not been convicted of, or pled guilty or nolo contendere to, any criminal violation specified in this chapter or the medical practice act of any other state.

(e) The health care professional has not been subject within the last 10 years of practice to license revocation or

suspension for any period of time; probation for a period of 3 years or longer; or a fine of $500 or more for a violation of this chapter or the medical practice act of another jurisdiction. The regulatory agency's acceptance of a health care professional's relinquishment of a license, stipulation, consent order, or other settlement, offered in response to or in anticipation of the filing of administrative charges against the health care professional's license, shall be construed as action against the health care professional's license for the purposes of this paragraph.

(f) The health care professional has submitted a form supplying necessary information as required by the department and an affidavit affirming compliance with the provisions of this subsection.

(g) The health care professional submits biennially to the facility certification stating compliance with the provisions of this subsection. The health care professional shall, upon request, demonstrate to the facility information verifying compliance with this subsection.

(4) ELIGIBILITY; TERMINATION.--

(a) Any health care professional is eligible for coverage provided by the facility if the professional at all times maintains either:

1. An escrow account consisting of cash or assets eligible for deposit under s. 625.52 in an amount equal to the deductible amount of the policy; or

2. An unexpired, irrevocable letter of credit, established pursuant to chapter 675, in an amount not less than the deductible amount of the policy. The letter of credit shall be payable to the health care professional as beneficiary upon

presentment of a final judgment indicating liability and awarding damages to be paid by the health care professional or upon presentment of a settlement agreement signed by all parties to such agreement when such final judgment or settlement is a result of a claim arising out of the rendering of, or the failure to render, medical care and services. Such letter of credit shall be nonassignable and nontransferable. Such letter of credit shall be issued by any bank or savings association organized and existing under the laws of this state or any bank or savings association organized under the laws of the United States that has its principal place of business in this state or has a branch office which is authorized under the laws of this state or of the United States to receive deposits in this state.

(b) The eligibility of a health care professional for coverage terminates upon:

1. The failure of the professional to comply with paragraph (a);

2. The failure of the professional to timely pay premiums or assessments; or

3. The commission of any act of fraud in connection with the policy, as determined by the board of governors.

(c) The board of governors, in its discretion, may reinstate the eligibility of a health care professional whose eligibility has terminated pursuant to paragraph (b) upon determining that the professional has subsequently complied with paragraph (a) or has paid the overdue premiums or assessments. Eligibility may be reinstated in the case of fraud only if the board determines that its initial determination of fraud was in error.

(5) PREMIUMS; ASSESSMENTS.--

(a) The facility shall charge the actuarially indicated premium for the coverage provided and shall retain the services of consulting actuaries to prepare its rate filings. The facility shall not provide dividends to policyholders, and, to the extent that premiums are more than the amount required to cover claims and expenses, such excess shall be retained by the facility for payment of future claims. In the event of dissolution of the facility, any amounts not required as a reserve for outstanding claims shall be transferred to the policyholders of record as of the last day of operation.

(b) To ensure that the facility has the funds to pay claims, the facility shall receive:

1. From each judgment awarded and settlement agreed to from which a claim will be paid in whole or in part by the facility, the facility shall retain one percent of its portion of the award or settlement for deposit into a separate account for guaranteeing payment of claims.

2. A surcharge of $100 on each medical malpractice policy issued or renewed after July 1, 2003.

(6) REGULATION; APPLICABILITY OF OTHER STATUTES.--

(a) The facility shall operate pursuant to a plan of operation approved by order of the Office of Insurance Regulation of the Financial Services Commission. The board of governors may at any time adopt amendments to the plan of operation and submit the amendments to the Office of Insurance Regulation for approval.

(b) The facility is subject to regulation by the Office of Insurance Regulation of the Financial Services Commission in the same manner as other insurers, except that, in recognition of the fact that its ability to levy assessments against its own

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

(c) The facility is not subject to part II of chapter 631, relating to the Florida Insurance Guaranty Association.

(7) STARTUP PROVISIONS.--

(a) It is the intent of the Legislature that the facility begin providing coverage no later than January 1, 2004.

(b) The Governor and the Chief Financial Officer shall make their appointments to the board of governors of the facility no later than August 1, 2003. Until the board is appointed, the Secretary of Health may perform ministerial acts on behalf of the facility as chair of the board of governors.

(c) Until the facility is able to hire permanent staff and enter into contracts for professional services, the office of the Secretary of Health shall provide support services to the facility.

(d) In order to provide startup funds for the facility, the board of governors may incur debt or enter into agreements for lines of credit, provided that the sole source of funds for repayment of any debt is future premium revenues of the facility. The amount of such debt or lines of credit may not exceed $10 million.

Section 43. Section 627.358, Florida Statutes, is created to read:

627.358 Medical malpractice insurance; part-time coverage.-- Insurance carriers shall be permitted to offer policies to cover health care professionals who have retired from practice or maintain a part-time practice as set forth

herein. For health care professionals who meet each of the following requirements, the premiums for such policies shall be no more than 50 percent of the cost of premiums for similar specialties for health care professionals who do meet each of the following requirements:

(1) The health care professional has held an active license to practice in this state or another state or some combination thereof for more than 15 years.

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

(3) The health care professional has had no more than two claims for medical malpractice resulting in an indemnity exceeding $50,000 each within the previous 5-year period.

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

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

(6) The health care professional has submitted a form supplying necessary information as required by the department and an affidavit affirming compliance with the provisions of this section.

(7) The health care professional submits biennially to his or her insurance provider certification stating compliance with the provisions of this section. The health care professional shall, upon request, demonstrate to the Office of Insurance Regulation information verifying compliance with this section.

Section 44. Section 627.359, Florida Statutes, is created to read:

627.359 Discounts on medical malpractice liability insurance.--

(1)(a) Medical malpractice insurance providers, including the Health Care Professional Liability Insurance Facility, shall provide a 20 percent discount on premiums for health care professionals who implement a system wherein the professional enters medication orders using a computer linked to prescribing error prevention software.

(b) The Office of Insurance Regulation shall designate software vendors who meet the requirements of paragraph (a).

(2)(a) Medical malpractice insurance providers, including the Health Care Professional Liability Insurance Facility, shall provide a 10 percent discount on premiums for health care professionals who implement a system wherein patients are only referred to a hospital based on scientifically valid criteria.

(b) The Agency for Health Care Administration shall develop criteria that meet the requirements of paragraph (a).

Section 45. Paragraph (c) of subsection (1) and subsection (3) of section 627.4147, Florida Statutes, are amended, and

paragraph (d) is added to subsection (1) of said section, to read:

627.4147 Medical malpractice insurance contracts.--

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

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

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

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

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

627.41491 Medical malpractice rate comparison.-- The Office of Insurance Regulation shall annually publish a comparison of the rate in effect for each medical malpractice

insurer and self-insurer and the Florida Medical Malpractice Joint Underwriting Association. Such rate comparison shall be made available to the public through the Internet and other commonly used means of distribution no later than July 1 of each year.

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

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

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

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

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

627.41493 Insurance rate rollback.--

(1) For medical malpractice insurance policies issued or renewed on or after July 1, 2003, and before July 1, 2004, every insurer, including the Florida Medical Malpractice Joint Underwriting Association, shall reduce its rates and premiums by 25 percent. The lower rates must be in effect for at least 12 months and may not be raised by more than 15 percent after the expiration of those 12 months. Thereafter, there will be consideration for a physician, hospital, other health care professional, or other health care facility to receive a credit against the rate or rates applicable to their medical

malpractice insurance, consistent with the level of such discount set in rule by the Financial Services Commission. In developing such rules, the commission may consider whether, and the extent to which, the types of programs approved under this act are otherwise covered under a program of risk management offered by the insurer.

(2) The Financial Services Commission may adopt rules to implement the provisions of this section.

Section 49. The Office of Program Policy Analysis and Government Accountability shall complete a study of the eligibility requirements for a birth to be covered under the Florida Birth-Related Neurological Injury Compensation Association and submit a report to the Legislature by January 1, 2004, recommending whether the statutory criteria for a claim to qualify for referral to the Florida Birth-Related Neurological Injury Compensation Association under s. 766.302, Florida Statutes, should be modified.

Section 50. Subsections (1) and (4) and paragraph (n) of subsection (2) of section 627.912, Florida Statutes, are amended to read:

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

(1)(a) Each self-insurer authorized under s. 627.357 and each insurer or joint underwriting association providing professional liability insurance to a practitioner of medicine licensed under chapter 458, to a practitioner of osteopathic medicine licensed under chapter 459, to a podiatric physician licensed under chapter 461, to a dentist licensed under chapter 466, to a hospital licensed under chapter 395, to a crisis stabilization unit licensed under part IV of chapter 394, to a

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

1.~~(a)~~ A final judgment in any amount.

2.~~(b)~~ A settlement in any amount.

Reports shall be filed with the department.

(b) In addition to the requirements of paragraph (a), if the insured party is licensed under chapter 395, chapter 458, chapter 459, chapter 461, or chapter 466, the insurer shall report in duplicate to the Office of Insurance Regulation any other disposition of the claim, including, but not limited to, a dismissal. If the insured is licensed under chapter 458, chapter 459, or chapter 461, any claim that resulted in a final judgment or settlement in the amount of $50,000 or more shall be reported to the Department of Health no later than 30 days following the occurrence of that event. If the insured is licensed under chapter 466, any claim that resulted in a final judgment or settlement in the amount of $25,000 or more shall be reported to the Department of Health no later than 30 days following the occurrence of that event ~~and, if the insured party is licensed under chapter 458, chapter 459, chapter 461, or chapter 466, with the Department of Health, no later than 30 days following the occurrence of any event listed in paragraph (a) or paragraph~~

~~(b)~~. The Department of Health shall review each report and determine whether any of the incidents that resulted in the claim potentially involved conduct by the licensee that is subject to disciplinary action, in which case the provisions of s. 456.073 shall apply. The Department of Health, as part of the annual report required by s. 456.026, shall publish annual statistics, without identifying licensees, on the reports it receives, including final action taken on such reports by the Department of Health or the appropriate regulatory board.

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

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

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

Section 51. Section 627.9121, Florida Statutes, is created to read:

627.9121 Required reporting of claims; penalties.-- Each

entity that makes payment under a policy of insurance, self-insurance, or otherwise in settlement, partial settlement, or satisfaction of a judgment in a medical malpractice action or claim that is required to report information to the National Practitioner Data Bank under 42 U.S.C. s. 11131 must also report the same information to the Office of Insurance Regulation. The office shall include such information in the data that it compiles under s. 627.912. The office must compile and review the data collected pursuant to this section and must assess an administrative fine on any entity that fails to fully comply with such reporting requirements.

Section 52. Section 766.102, Florida Statutes, is amended to read:

766.102 Medical negligence; standards of recovery.--

(1) In any action for recovery of damages based on the death or personal injury of any person in which it is alleged that such death or injury resulted from the negligence of a health care provider as defined in s. 766.101(1)(b) ~~s. 768.50(2)(b)~~, the claimant shall have the burden of proving by the greater weight of evidence that the alleged actions of the health care provider represented a breach of the prevailing professional standard of care for that health care provider. The prevailing professional standard of care for a given health care provider shall be that level of care, skill, and treatment which, in light of all relevant surrounding circumstances, is recognized as acceptable and appropriate by reasonably prudent similar health care providers.

~~(2)(a) If the health care provider whose negligence is claimed to have created the cause of action is not certified by the appropriate American board as being a specialist, is not~~

~~trained and experienced in a medical specialty, or does not hold himself or herself out as a specialist, a "similar health care provider" is one who:~~

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

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

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

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

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

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

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

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

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

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

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

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

(3)~~(4)~~ The existence of a medical injury shall not create any inference or presumption of negligence against a health care provider, and the claimant must maintain the burden of proving that an injury was proximately caused by a breach of the prevailing professional standard of care by the health care

provider. However, the discovery of the presence of a foreign body, such as a sponge, clamp, forceps, surgical needle, or other paraphernalia commonly used in surgical, examination, or diagnostic procedures, shall be prima facie evidence of negligence on the part of the health care provider.

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

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

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

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

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

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

1. The active clinical practice of, or consulting with respect to, the same or similar health profession as the health care provider against whom or on whose behalf the testimony is

offered and, if that health care provider is a specialist, the active clinical practice of, or consulting with respect to, the same or similar specialty that includes the evaluation, diagnosis, or treatment of the medical condition that is the subject of the claim and have prior experience treating similar patients;

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

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

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

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

2. Instruction of students in an accredited health professional school or accredited residency program in the

general practice of medicine; or

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

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

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

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

similar health care provider.

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

(b) For the purposes of this subsection:

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

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

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

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

(12) Any person who serves as an expert witness under

subsection (5) may not receive remuneration in excess of $300 per hour.

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

Section 53. Subsections (2), (3), and (4) and paragraph (a) of subsection (10) of section 766.106, Florida Statutes, are amended, and subsections (13), (14), and (15) are added to said section, to read:

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

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

(b) Following the initiation of a suit alleging medical malpractice with a court of competent jurisdiction, and service of the complaint upon a defendant, the claimant shall provide a

copy of the complaint to the Department of Health and, if the complaint involves a facility licensed under chapter 395, the Agency for Health Care Administration. The requirement of providing the complaint to the Department of Health or the Agency for Health Care Administration does not impair the claimant's legal rights or ability to seek relief for his or her claim. The Department of Health or the Agency for Health Care Administration shall review each incident that is the subject of the complaint and determine whether it involved conduct by a licensee which is potentially subject to disciplinary action, in which case the provisions of s. 456.073 or s. 395.1046 apply.

(3)(a) No suit may be filed for a period of 150 ~~90~~ days after notice is mailed to any prospective defendant. During the 150-day ~~90-day~~ period, the prospective defendant's insurer or self-insurer shall conduct a review to determine the liability of the defendant. Each insurer or self-insurer shall have a procedure for the prompt investigation, review, and evaluation of claims during the 150-day ~~90-day~~ period. This procedure shall include one or more of the following:

1. Internal review by a duly qualified claims adjuster;

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

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

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

Each insurer or self-insurer shall investigate the claim in good faith, and both the claimant and prospective defendant shall cooperate with the insurer in good faith. If the insurer requires, a claimant shall appear before a pretrial screening panel or before a medical review committee and shall submit to a physical examination, if required. Unreasonable failure of any party to comply with this section justifies dismissal of claims or defenses. There shall be no civil liability for participation in a pretrial screening procedure if done without intentional fraud.

(b) At or before the end of the 150 ~~90~~ days, the insurer or self-insurer shall provide the claimant with a response:

1. Rejecting the claim;

2. Making a settlement offer; or

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

(c) The response shall be delivered to the claimant if not represented by counsel or to the claimant's attorney, by certified mail, return receipt requested. Failure of the prospective defendant or insurer or self-insurer to reply to the notice within 150 ~~90~~ days after receipt shall be deemed a final rejection of the claim for purposes of this section.

(d) Within 30 days after ~~of~~ receipt of a response by a prospective defendant, insurer, or self-insurer to a claimant represented by an attorney, the attorney shall advise the claimant in writing of the response, including:

1. The exact nature of the response under paragraph (b).

2. The exact terms of any settlement offer, or admission of liability and offer of arbitration on damages.

3. The legal and financial consequences of acceptance or rejection of any settlement offer, or admission of liability, including the provisions of this section.

4. An evaluation of the time and likelihood of ultimate success at trial on the merits of the claimant's action.

5. An estimation of the costs and attorney's fees of proceeding through trial.

(4) The notice of intent to initiate litigation shall be served within the time limits set forth in s. 95.11. However, during the 150-day ~~90-day~~ period, the statute of limitations is tolled as to all potential defendants. Upon stipulation by the parties, the 150-day ~~90-day~~ period may be extended and the statute of limitations is tolled during any such extension. Upon receiving notice of termination of negotiations in an extended period, the claimant shall have 60 days or the remainder of the period of the statute of limitations, whichever is greater, within which to file suit.

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

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

(13) In matters relating to professional liability insurance coverage for medical negligence, an insurer shall not be held in bad faith for failure to timely pay its policy limits if it tenders its policy limits and meets all other conditions of settlement prior to the conclusion of the presuit screening period.

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

(15) In all matters relating to professional liability insurance coverage for medical negligence, and in determining whether the insurer has acted in good faith, the following factors may be considered, along with all of the other circumstances of the case:

(a) Whether the damages recoverable against the insured are large or small.

(b) Whether the liability against the insured is relatively clear.

(c) Whether the insurance companies or its agents were negligent in handling the claim.

(d) Whether the carrier acted as a reasonable person would

who was facing the prospect of paying the entire loss.

(e) Whether the insurance company made a fair offer as soon as a reasonable investigation would reveal that liability was reasonably clear and that the damages were greater than the policy limits.

(f) Whether the insurer violated the unfair claims practice standards.

(g) Whether the insurer's communications with its insureds were actually honest, candid, and complete.

(h) Whether the insurer violated the adjuster's code of ethics in handling the claim.

(i) Whether the insurer fully documented its claims handling activities and the reasons for its decisions.

(j) Whether the insurer or its agents properly trained its adjusters and provided adequate written standards for the adjustment of claims.

(k) Whether the insurer used the policy benefits available to the insurer to extinguish as much of the insured's liability as possible.

(l) Whether the attorney appointed by the insurer to defend the insured was competent, independent, and faithfully representing the interests of the insured.

Section 54. Section 766.1065, Florida Statutes, is created to read:

766.1065 Mandatory staging of presuit investigation; mandatory mediation.--

(1) Within 30 days after service of the presuit notice of intent to initiate medical malpractice litigation, each party shall voluntarily produce to all other parties, without being requested, any and all medical, hospital, health care, and

employment records concerning the claimant in the disclosing party's possession, custody, or control, and the disclosing party shall affirmatively certify in writing that the records produced include all records in that party's possession, custody, or control or that the disclosing party has no medical, hospital, health care, or employment records concerning the claimant.

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

(b) Nothing in this section shall limit the ability of any party to use any other available form of presuit discovery available under this chapter or the Florida Rules of Civil Procedure.

(2) Within 60 days after service of the presuit notice of intent to initiate medical malpractice litigation, all parties must be made available for a sworn deposition. Such deposition may not be used in a civil suit for medical negligence.

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

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

(b) An expert shall be deemed available for deposition if suitable accommodations can be made for appearance of said expert via real-time video technology.

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

(5) If the parties declare an impasse during the mandatory mediation required in subsection (4), the plaintiff shall request, via certified mail, a hearing of a presuit screening panel which shall be convened pursuant to s. 766.1066.

Section 55. Section 766.1066, Florida Statutes, is created to read:

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

(1)(a) There is created within the Department of Health the Office of Presuit Screening Administration, which shall be responsible for administering the presuit screening program.

(b) The Office of Presuit Screening Administration shall develop and maintain a database of physicians, attorneys, and consumers to serve as members of presuit screening panels as described in this section.

(c) The Office of Presuit Screening Administration shall develop an application by September 1, 2003, that can be submitted in writing and via the Internet for physicians, attorneys, and consumers to volunteer for the panels.

(d) Funding for the Office of Presuit Screening

Administration shall come from:

1. A fee equal to 0.5 percent of, and assessed against, all judgments and settlements in medical malpractice liability cases. The defendant shall remit such fee to the Office of Presuit Administration.

2. An annual fee of $1 on all medical malpractice liability insurance policies issued to physicians licensed by the Department of Health, which shall be collected by the insurer and submitted by the insurer to the Office of Presuit Administration.

(e)1. Physicians, attorneys, and consumers who volunteer for the panels shall be obligated to serve on a panel for no longer than 2 calendar days per selection.

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

3. When a plaintiff requests a hearing of a presuit screening panel, the Office of Presuit Screening Administration shall randomly select members for a panel as provided in subsection (2) from among the available persons in the appropriate categories who have not served on a panel in the past 12 months. If there are no other potential panelists available, a panelist may be asked to serve on another panel within 12 months.

(f) If a physician, attorney, or consumer is selected to serve on a panel, he or she shall not be obligated to serve for a period exceeding 2 days.

(g) All persons serving on a panel shall receive reimbursement for their travel expenses.

(h) Physicians who are selected to serve on a panel:

1. Shall receive credit for 20 hours of continuing medical education for his or her service.

2. Must reside and practice at least 50 miles from the location of the injury alleged by the plaintiff.

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

4. Must have an active license with the Department of Health and be in good standing.

(i) Attorneys who are selected to serve on a panel:

1. Shall receive credit for 20 hours of continuing legal education and credit towards pro bono requirements for his or her service.

2. Must reside and practice at least 50 miles from the location of the injury alleged by the plaintiff.

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

4. Must have an active license with The Florida Bar and be in good standing.

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

1. One physician board certified in the same specialty as the defendant physician.

2. One physician who is a general practitioner, family practitioner, or an internist or one physician who serves as a full-time member in the faculty of an accredited public or private medical school in the state.

3. One attorney who has served as a plaintiff’s attorney, with 5 years' experience in medical malpractice liability cases

including at least one jury trial.

4. One attorney who has served as a defendant's attorney, with 5 years' experience in medical malpractice liability cases including at least one jury trial.

5. One consumer who shall not have a professional or financial relationship with either a health care provider or an attorney.

(b) In cases with more than one physician defendant, the plaintiff shall designate the subject areas in which both physician members of the panel shall be board certified.

(c) Any panelist who knowingly has a conflict of interest or potential conflict of interest must disclose such conflict of interest prior to the hearing.

(d) A plaintiff or a defendant may challenge any panel member for a conflict of interest and ask that the panelist be replaced by the Office of Presuit Screening Administration.

(3) The Office of Presuit Screening Administration shall provide an administrator for the panel.

(4) The plaintiff shall be allowed 8 hours to present his or her case. The defendants shall be allowed a total of 8 hours to present their case. No hearing shall exceed a total of 16 hours; however, the panel may hear the case over the course of 2 calendar days.

(5) A presuit screening panel shall, by a majority vote for each defendant, make its findings in regards to reasonable grounds for liability of the defendant based on the preponderance of the evidence.

(a) If a panel finds that there are no reasonable grounds for liability on the part of a defendant for the injury alleged, the defendant may, within 10 days, request voluntary binding

arbitration pursuant to s. 766.207.

(b) If a panel finds that there are reasonable grounds for liability on the part of a defendant for the injury alleged, the parties may elect to have damages determined by voluntary binding arbitration pursuant to s. 766.207.

(c) If a panel finds that there are no reasonable grounds for liability on the part of a defendant for the injury alleged and the defendant does not request arbitration, or if a panel finds that there are reasonable grounds for liability on the part of a defendant for the injury alleged and either a defendant or the plaintiff do not agree to voluntary binding arbitration pursuant to s. 766.207, the claim shall proceed to trial or to any available legal alternative such as offer of judgment and demand for judgment under s. 768.79 or offer of settlement under s. 45.061. The damages that may be awarded during such trial are subject to the limitations included in s. 766.118.

Section 56. Section 766.1067, Florida Statutes, is created to read:

766.1067 Structured judgments.-- For cases that are decided in a trial, the judgment may be structured as follows:

(1) If the noneconomic damages awarded to the plaintiff are equal to or greater than $500,000 and the jury finds the life expectancy of the plaintiff to be 20 years or greater, the defendant may compel a structured judgment for 50 percent of the noneconomic damages to be paid over the remaining life of the plaintiff. Such payments shall terminate upon the plaintiff’s death.

(2) If the economic damages awarded to the plaintiff are equal to or greater than $250,000 and the jury finds the

plaintiff would otherwise have been able to work for 20 years or more, the defendant may compel a structured judgment for 75 percent of the future economic damages to be paid over the years in which the jury finds the plaintiff would otherwise have been able to work. Any unpaid portion of a structured judgment made under this subsection which is attributable to medical expenses that have not yet been incurred shall terminate upon the death of the plaintiff. Any outstanding medical expenses incurred prior to the death of the plaintiff shall be paid from that portion of the structured judgment attributable to medical expenses.

Section 57. Section 766.1068, Florida Statutes, is created to read:

766.1068 Proposal for settlement; timing.--Notwithstanding any other provision of law, any party may serve another party in a medical malpractice suit with a proposal for settlement at any time after the filing of the complaint. If a claimant rejects the proposal for settlement, then either loses at trial or prevails at trial while receiving an award for damages less than the most recent proposal for settlement, the court may require the claimant to pay the attorney's fees and costs of the defendant from whom the claimant will receive the award. If a defendant rejects the proposal for settlement, then loses at trial while receiving a judgment greater than the most resent proposal for settlement, the court may require the defendant to pay the attorney's fees and costs of the claimant to whom the judgment is awarded.

Section 58. Subsections (3), (4), (5), and (6) are added to section 766.110, Florida Statutes, to read:

766.110 Liability of health care facilities.--

(3)(a) Members of the medical staff of a hospital licensed under chapter 395 and any professional group comprised of such persons shall be immune from liability for noneconomic damages in excess of $250,000 per emergency room admission arising from medical injuries to a patient resulting from negligent acts or omissions of such medical staff members in the performance of emergency medical services as defined in s. 768.13(2) prior to the patient's condition being sufficiently stable, and no member of the medical staff of a hospital and no professional group comprised of such persons shall be liable to pay noneconomic damages in excess of $250,000 to any person or persons for any single incident of medical negligence that causes injuries to a patient or patients in the performance of emergency medical services.

(b) For the purposes of paragraph (a), a patient's condition shall be deemed to be sufficiently stable when that patient could reasonably be transferred to another health care facility without causing further injury, whether or not the patient is in fact transferred.

(4)(a) No person or persons may recover damages from a public family practice teaching hospital licensed under chapter 395 and designated under s. 398.806, or its insurer, or any health care professional who is a full-time member of the faculty of an accredited public medical school, or his or her insurer, in excess of $250,000 per emergency room admission arising from medical injuries to a patient or patients caused by negligent acts or omissions on the part of the hospital or members of the hospital's medical staff in the performance of emergency medical services as defined in s. 768.13(2) prior to the patient's condition being sufficiently stable.

(b) For the purposes of paragraph (a), a patient's condition shall be deemed to be sufficiently stable when that patient could reasonably be transferred to another health care facility without causing further injury, whether or not the patient is in fact transferred.

(5)(a) Other than as provided in paragraph (c), when a subsequent injury occurs after a patient's condition is sufficiently stable, no person or persons may recover noneconomic damages from any health care professional who is a member of the medical staff of such facility, or his or her insurer, in excess of $250,000 per injury arising from medical injury to a patient caused by negligent acts or omissions on the part of the hospital or members of the hospital's medical staff in the performance of emergency medical services as defined in s. 768.13(2) until the patient's condition returns to sufficiently stable.

(b) For the purposes of paragraph (a), a patient's condition shall be deemed to be sufficiently stable when that patient could reasonably be transferred to another health care facility without causing further injury, whether or not the patient is in fact transferred.

(c) A person or persons may recover damages from the health care professional who caused the subsequent injury in paragraph (a) and the hospital licensed under chapter 395, or its insurer, where the injury occurred.

(6) The limits established in this section shall be adjusted annually in accordance with the changes in the Consumer Price Index as issued by the United States Department of Labor Bureau of Labor Statistics. The Agency for Health Care Administration shall establish by rule the new limits on July 1

of each year.

Section 59. Section 766.118, Florida Statutes, is created to read:

766.118 Determination of noneconomic damages.-- With respect to a cause of action for personal injury or wrongful death resulting from an occurrence of medical negligence, including actions pursuant to s. 766.209, damages recoverable for noneconomic losses to compensate for pain and suffering, inconvenience, physical impairment, mental anguish, disfigurement, loss of capacity for enjoyment of life, and all other noneconomic damages shall be determined as follows:

(1) The award for noneconomic damages from the jury shall be reviewed by the judge to determine the appropriateness of the award.

(2) In reviewing the award, the judge shall utilize the Florida Jury Verdict Database as provided in s. 766.26.

(3)(a) The judge shall examine all cases where the injuries alleged and the economic damages awarded are substantially similar.

(b) The judge shall adopt a presumptively reasonable range of similar awards that shall be one standard deviation above and below the mean award for similar cases. The judge shall then subtract the economic damages awarded by the jury from the valid range to find the valid range for noneconomic damages.

(c) If the award for noneconomic damages is outside of the presumptively reasonable range for noneconomic damages based on similar cases, the judge may elect to change the award so that it falls within said range, which is subject to appeal based on abuse of discretion standards, or the judge may elect to leave the amount as awarded by providing findings of fact on the

record, which shall be subject to appeal based on clear and convincing evidence standards.

(4) If a health care professional does not meet his or her financial responsibility requirements as provided in s. 458.320 or 459.0085, as applicable, by July 1, 2004, the limits established in this section shall not apply and awards for economic and noneconomic damages shall not be limited.

Section 60. Section 766.185, Florida Statutes, is created to read:

766.185 Apportionment of fault in medical negligence actions.--

(1) In an action for damages for personal injury or wrongful death arising out of medical negligence, whether in contract or tort, when a defendant asserts an affirmative defense that one or more nonparties is liable, in whole or in part, for damages arising out of medical negligence, such defendant must join the nonparties into the action by means of a third-party complaint asserting a cause of action for comparative fault in medical negligence against the nonparties, except with respect to a nonparty who meets one of the following criteria:

(a) The nonparty has entered into a settlement with each of the plaintiffs;

(b) The nonparty has complete immunity from suit;

(c) The statute of limitations involving the nonparty expired prior to filing of the presuit notice of intent to initiate medical malpractice litigation; or

(d) The nonparty cannot be otherwise legally joined to the suit.

(2) If the defendant has reasonable grounds to believe

during the presuit investigation that one or more nonparties are liable, in whole or in part, for damages arising out of medical negligence and that such nonparties would be joinable into the action under this section, the defendant must notify the claimant in writing of the identity and reasonable grounds for inclusions of such nonparty in the action within 10 days after obtaining such information.

(3) If the defendant fails to comply with the provisions set forth in this section, then the defendant shall be estopped from asserting the negligence of the nonparty who should have otherwise been joined into the action.

(4) Any third party joined into the action under the provisions of this section shall be liable to the plaintiff for any damages adjudicated by the trier of fact subject to the provisions of this chapter.

Section 61. Subsection (5) of section 766.202, Florida Statutes, is amended to read:

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

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

Section 62. Subsections (2) and (3) of section 766.203, Florida Statutes, are amended to read:

766.203 Presuit investigation of medical negligence claims

and defenses by prospective parties.--

(2) Prior to issuing notification of intent to initiate medical malpractice litigation pursuant to s. 766.106, the claimant shall conduct an investigation to ascertain that there are reasonable grounds to believe that:

(a) Any named defendant in the litigation was negligent in the care or treatment of the claimant; and

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

Corroboration of reasonable grounds to initiate medical negligence litigation shall be provided by the claimant's submission of a verified written medical expert opinion from a medical expert as defined in s. 766.202(5), at the time the notice of intent to initiate litigation is mailed, which statement shall corroborate reasonable grounds to support the claim of medical negligence. <u>This opinion and statement are subject to discovery.</u>

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

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

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

Corroboration of lack of reasonable grounds for medical negligence litigation shall be provided with any response rejecting the claim by the defendant's submission of a verified

written medical expert opinion from a medical expert as defined in s. 766.202(5), at the time the response rejecting the claim is mailed, which statement shall corroborate reasonable grounds for lack of negligent injury sufficient to support the response denying negligent injury. This opinion and statement are subject to discovery.

Section 63. Subsections (2), (3), and (5) of section 766.206, Florida Statutes, are amended to read:

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

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

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

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

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

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

Section 64. Section 766.207, Florida Statutes, is amended to read:

766.207 Voluntary binding arbitration of medical negligence claims.--

(1) Voluntary binding arbitration pursuant to this section and ss. 766.208-766.212 shall not apply to rights of action involving the state or its agencies or subdivisions, or the officers, employees, or agents thereof, pursuant to s. 768.28.

(2)(a) Upon the completion of the hearing of a presuit screening panel pursuant to s. 706.1066 ~~investigation with preliminary reasonable grounds for a medical negligence claim intact~~, the parties may elect to have damages determined by an arbitration panel. Such election may be initiated by either party by serving a request for voluntary binding arbitration of

damages within 10 ~~90~~ days after the hearing of a presuit screening panel ~~service of the claimant's notice of intent to initiate litigation upon the defendant~~. The evidentiary standards for voluntary binding arbitration of medical negligence claims shall be as provided in ss. 120.569(2)(g) and 120.57(1)(c).

(b) If the presuit screening panel pursuant to s. 766.1066 found that the defendant was not liable by unanimous vote and the plaintiff refuses arbitration, damages that can be awarded during a trial shall not exceed a total of $350,000, as adjusted herein, per defendant for both future economic and all noneconomic damages. If the presuit screening panel pursuant to s. 766.1066 found that the defendant was not liable by majority vote and the plaintiff refuses arbitration, damages that can be awarded during a trial for all noneconomic damages shall not exceed a total of $350,000, as adjusted herein, per defendant.

(3) Upon receipt of a party's request for such arbitration, the opposing party may accept the offer of voluntary binding arbitration within 30 days, and such arbitration shall be held within 120 days of acceptance of the offer of voluntary binding arbitration. ~~However, in no event shall the defendant be required to respond to the request for arbitration sooner than 90 days after service of the notice of intent to initiate litigation under s. 766.106.~~ Such acceptance within the time period provided by this subsection shall be a binding commitment to comply with the decision of the arbitration panel. The liability of any insurer shall be subject to any applicable insurance policy limits.

(4) The arbitration panel shall be a presuit screening panel selected by the Office of Presuit Screening as provided in

s. 766.1066. The Florida Rules of Civil Procedure shall apply to discovery, except as follows:

(a) Any 30-day deadline provided in such rules shall be shortened to 10 business days.

(b) Depositions of expert witnesses shall be permitted for no more than five experts per side.

Discovery disputes shall be resolved by an administrative law judge assigned by the Division of Administrative Hearings until arbitration is completed ~~composed of three arbitrators, one selected by the claimant, one selected by the defendant, and one an administrative law judge furnished by the Division of Administrative Hearings who shall serve as the chief arbitrator. In the event of multiple plaintiffs or multiple defendants, the arbitrator selected by the side with multiple parties shall be the choice of those parties. If the multiple parties cannot reach agreement as to their arbitrator, each of the multiple parties shall submit a nominee, and the director of the Division of Administrative Hearings shall appoint the arbitrator from among such nominees~~.

(5) The panel ~~arbitrators~~ shall be independent of all parties, witnesses, and legal counsel, and no officer, director, affiliate, subsidiary, or employee of a party, witness, or legal counsel may serve as a panelist ~~an arbitrator~~ in the proceeding.

(6) The rate of compensation for arbitration panelists shall be the same as for members of a presuit screening panel as outlined in s. 766.1066 ~~medical negligence claims arbitrators other than the administrative law judge shall be set by the chief judge of the appropriate circuit court by schedule providing for compensation of not less than $250 per day nor~~

~~more than $750 per day or as agreed by the parties. In setting the schedule, the chief judge shall consider the prevailing rates charged for the delivery of professional services in the community~~.

(7) Arbitration pursuant to this section shall preclude recourse to any other remedy by the claimant against any participating defendant, and shall be undertaken with the understanding that:

(a) If the presuit screening panel pursuant to s. 766.1066 found that the defendant was not liable by unanimous vote, the damages that can be awarded during arbitration shall not exceed a total of $250,000, as adjusted herein, per defendant for both future economic and all noneconomic damages. If the presuit screening panel established pursuant to s. 766.1066 found that the defendant was not liable by majority vote, the damages that can be awarded during arbitration for all noneconomic damages shall not exceed a total of $250,000, as adjusted herein, per defendant.

(b) If the presuit screening panel established pursuant to s. 766.1066 found that the defendant was liable, the following conditions shall apply:

1.~~(a)~~ Net economic damages shall be awardable, including, but not limited to, past and future medical expenses and 80 percent of wage loss and loss of earning capacity, offset by any collateral source payments, beginning at the time the injury occurred and extended to a work-life expectancy as determined by the jury. Net economic damages shall also include interest on all economic damages occurring prior to trial.

2.~~(b)~~ Noneconomic damages shall be limited to a maximum of $250,000, as adjusted herein, per incident, and shall be

calculated on a percentage basis with respect to capacity to enjoy life, so that a finding that the claimant's injuries resulted in a 50-percent reduction in his or her capacity to enjoy life would warrant an award of not more than $125,000 noneconomic damages. The limits on damages established in this paragraph shall be adjusted annually in accordance with the changes in the Consumer Price Index as issued by the United States Department of Labor Bureau of Labor Statistics. The Agency for Health Care Administration shall establish by rule the new limits on July 1 of each year.

3.~~(c)~~ Damages for future economic losses shall be awarded to be paid by periodic payments pursuant to s. 766.1067(2) ~~s. 766.202(8)~~ and shall be offset by future collateral source payments.

4.~~(d)~~ Punitive damages shall not be awarded.

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

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

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

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

7.~~(i)~~ The defendant's obligation to pay the claimant's damages shall be for the purpose of arbitration under this

section only. A defendant's or claimant's offer to arbitrate shall not be used in evidence or in argument during any subsequent litigation of the claim following the rejection thereof.

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

9.~~(k)~~ Any offer by a claimant to arbitrate must be made to each defendant against whom the claimant has made a claim. Any offer by a defendant to arbitrate must be made to each claimant who has joined in the notice of intent to initiate litigation, as provided in s. 766.106. A defendant who rejects a claimant's offer to arbitrate shall be subject to the provisions of subsection (11) ~~s. 766.209(3)~~. A claimant who rejects a defendant's offer to arbitrate shall be subject to the provisions of subsection (12) ~~s. 766.209(4)~~.

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

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

(8) Any issue between the defendant and the defendant's insurer or self-insurer as to who shall control the defense of the claim and any responsibility for payment of an arbitration award, shall be determined under existing principles of law; provided that the insurer or self-insurer shall not offer to arbitrate or accept a claimant's offer to arbitrate without the written consent of the defendant.

(9) The Division of Administrative Hearings is authorized to promulgate rules to effect the orderly and efficient processing of the arbitration procedures of ss. 766.201-766.212.

(10) Rules promulgated by the Division of Administrative Hearings pursuant to this section, s. 120.54, or s. 120.65 may authorize any reasonable sanctions except contempt for violation of the rules of the division or failure to comply with a reasonable order issued by an administrative law judge, which is not under judicial review.

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

(a) The claim shall proceed to trial without limitation on damages and the claimant, upon proving medical negligence, shall be entitled to recover prejudgment interest and reasonable attorney's fees up to 25 percent of the award reduced to present value.

(b) The claimant's award at trial shall be reduced by any damages recovered by the claimant from arbitrating codefendants following arbitration.

(c) The claimant shall be entitled to recover prejudgement interest on economic damages incurred prior to trial.

(12) If the claimant rejects a defendant's offer to enter voluntary binding arbitration:

(a) The damages awardable at trial shall be limited to net economic damages, plus noneconomic damages not to exceed $350,000, as adjusted herein, per incident. The Legislature expressly finds that such conditional limit on noneconomic damages is warranted by the claimant's refusal to accept arbitration, and represents an appropriate balance between the interests of all patients who ultimately pay for medical

negligence losses and the interests of those patients who are injured as a result of medical negligence. The limits on damages established in this paragraph shall be adjusted annually in accordance with the changes in the Consumer Price Index as issued by the United States Department of Labor Bureau of Labor Statistics. The Agency for Health Care Administration shall establish by rule the new limits on July 1 of each year. Net economic damages shall also include interest on all economic damages occurring prior to trial.

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

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

(13) The arbitration panel shall allocate financial responsibility among all defendants named in the notice of intent to initiate litigation, regardless of whether the defendant has submitted to arbitration. The defendants in the arbitration proceeding shall pay their proportionate share of the economic and noneconomic damages awarded by the arbitration panel. All defendants in the arbitration proceeding shall be jointly and severally liable for any damages assessed in arbitration. The determination of the percentage of fault of any defendant not in the arbitration case shall neither be binding against that defendant, nor shall it be admissible in any subsequent legal proceeding.

(14) Payment by the defendants of the damages awarded by the arbitration panel shall extinguish those defendants'

liability to the claimant and shall also extinguish those defendants' liability for contribution to any defendants who did not participate in arbitration.

(15) Any defendant paying damages assessed pursuant to this section shall have an action for contribution against any nonarbitrating person whose negligence contributed to the injury.

(16)(a) If a health care professional does not meet his or her financial responsibility requirements as provided in s. 458.320(1)(b) or s. 459.0085(1)(b), as applicable, by July 1, 2004, the limits on damages established in this section shall not apply and awards for economic and noneconomic damages shall not be limited during arbitration or jury trial.

(b) It is the intent of the Legislature to provide relief from rising medical malpractice insurance premiums to those physicians who pay premiums on medical malpractice liability insurance. Physicians who do not carry medical malpractice liability insurance and hence do not pay premiums require no relief from the crisis referred to in the findings provided in this act.

(17) Jury trials shall proceed in accordance with existing principles of law.

Section 65. Sections 766.208 and 766.209, Florida Statutes, are repealed.

Section 66. Subsection (1) of section 766.112, Florida Statutes, is amended to read:

766.112 Comparative fault.--

(1) Notwithstanding any provision of ~~anything in~~ law to the contrary, in an action for damages for personal injury or wrongful death arising out of medical malpractice, whether in

contract or tort, ~~when an apportionment of damages pursuant to this section is attributed to a teaching hospital as defined in s. 408.07,~~ the court shall enter judgment ~~against the teaching hospital~~ on the basis of ~~such~~ party's percentage of fault and not on the basis of the doctrine of joint and several liability. In the trial of any action for medical malpractice which follows a settlement between the plaintiff and one or more defendants or potential defendants for the same injury, the plaintiff shall be estopped from denying that the fault on the part of any such settled defendant or prospective defendant contributed to causing the plaintiff’s injuries with respect to any such settled defendant or prospective defendant who has been identified by way of affirmative defense or joined by a nonsettling defendant as a party who is liable, in whole or in part, for the plaintiff's damages.

Section 67. Section 766.25, Florida Statutes, is created to read:

766.25 Itemized verdict.--

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

(a) Amounts intended to compensate the claimant for:

1. Past economic losses; and

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

(b) Amounts intended to compensate the claimant for:

1. Past noneconomic losses;

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

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

Section 68. Section 766.26, Florida Statutes, is created to read:

766.26 Florida Jury Verdict Database.--

(1) The Agency for Health Care Administration shall maintain the Florida Jury Verdict Database. For the initial database, the department shall utilize information and categories provided by a nationwide jury verdict research database of plaintiff and defense verdicts and settlements resulting from medical malpractice claims. The data to be used must be reported, tabulated, and analyzed to determine values, trends, and deviations for injuries and liabilities including medical malpractice.

(2) Beginning September 1, 2003, all awards under subsection (1) shall be reported by the Clerk of the Court in the circuit in which the judgment was entered to the agency within 3 business days for compilation into the Florida Jury Verdict Data Base. The agency, in conjunction with the Clerks of the Court, shall develop a format for the clerks to use in reporting the information required for the categories utilized by the database in subsection (1).

(3) Beginning July 1, 2007, the department shall only utilize reports concerning cases within the state in the Florida Jury Verdict Database.

(4) The awards reported by the Clerks of the Court shall

be adjusted annually in accordance with the changes in the Consumer Price Index as issued by the United States Department of Labor Bureau of Labor Statistics. The Agency for Health Care Administration shall adjust all previously reported awards in the Florida Jury Verdict Database as provided herein prior to July 1 of each year. Only those awards reported from courts in this state after September 1, 2003, shall be adjusted.

Section 69. Section 766.27, Florida Statutes, is created to read:

766.27 Sanctions for frivolous medical malpractice lawsuits.-- Any attorney who receives three judgments of filing a frivolous medical malpractice lawsuit in any 5-year period shall be precluded from filing a medical malpractice lawsuit for 3 years. Such preclusion shall prohibit him or her from serving as co-counsel on any medical malpractice lawsuit.

Section 70. Office of Insurance Regulation; closed claim forms; report required.-- The Office of Insurance Regulation shall revise its closed claim form for readability at the ninth-grade level. The office shall compile annual statistical reports that provide data summaries of all closed claims, including, but not limited to, the number of closed claims on file pertaining to the referent health care professional or health care entity, the nature of the errant conduct, the size of payments, and the frequency and size of noneconomic damage awards. The office shall develop annualized historical statistical summaries beginning with the 1976 state fiscal year and publish these reports on its website no later than the 2005 state fiscal year. The form must accommodate the following minimum requirements:

(1) A practitioner of medicine licensed pursuant to chapter 458, Florida Statutes, or a practitioner of osteopathic

medicine licensed pursuant to chapter 459, Florida Statutes, shall report to the Office of Insurance Regulation and the Department of Health any claim or action for damages for personal injury alleged to have been caused by error, omission, or negligence in the performance of such licensee's professional services or based on a claimed performance of professional services without consent if the claim was not covered by an insurer required to report under s. 627.912, Florida Statutes, is not a claim for medical malpractice that is subject to the provisions of s. 766.106, Florida Statutes, and the claim resulted in:

(a) A final judgment in any amount.

(b) A settlement in any amount.

(c) A final disposition not resulting in payment on behalf of the licensee. Reports shall be filed with the Office of Insurance Regulation no later than 60 days following the occurrence of any event listed in this subsection.

(2) Health professional reports must contain:

(a) The name and address of the licensee.

(b) The alleged occurrence.

(c) The date of the alleged occurrence.

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

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

(f) The date of suit, if filed.

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

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

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

of the settlement or judgment.

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

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

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

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

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

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

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

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

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

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

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

Section 71. Subsection (8) of section 768.21, Florida Statutes, is amended to read:

768.21 Damages.-- All potential beneficiaries of a recovery for wrongful death, including the decedent's estate, shall be identified in the complaint, and their relationships to the decedent shall be alleged. Damages may be awarded as follows:

(8) Notwithstanding any other provision of law to the contrary, for purposes of a wrongful death action arising out of medical negligence, adult individuals named as beneficiaries under a testamentary estate may recover noneconomic damages as though they were within that class of survivors identified in this section when a health care practitioner commits an intentional tort or is convicted of a crime which resulted in the death of the benefactor. The personal representative of the estate shall be entitled to assert a cause of action on behalf of the class of beneficiaries for the noneconomic damages of such beneficiaries which shall be in addition to any other damages that the estate would otherwise be entitled to assert. However, in no event shall the total amount of noneconomic damages for the entire class of beneficiaries exceed any limitation on noneconomic damages imposed under s. 766.118 ~~The damages specified in subsection (3) shall not be recoverable by adult children and the damages specified in subsection (4) shall not be recoverable by parents of an adult child with respect to claims for medical malpractice as defined by s. 766.106(1)~~.

Section 72. Subsection (5) of section 768.81, Florida Statutes, is amended to read:

768.81 Comparative fault.--

(5) Notwithstanding any provision of ~~anything in~~ law to the contrary, in an action for damages for personal injury or wrongful death arising out of medical malpractice, whether in

contract or tort, ~~when an apportionment of damages pursuant to this section is attributed to a teaching hospital as defined in s. 408.07,~~ the court shall enter judgment ~~against the teaching hospital~~ on the basis of each ~~such~~ party's percentage of fault and not on the basis of the doctrine of joint and several liability. In the trial of any action for medical malpractice which follows a settlement between the plaintiff and one or more defendants or potential defendants for the same injury, the plaintiff shall be estopped from denying that the fault on the part of any such settled defendant or prospective defendant contributed to causing the plaintiff’s injuries with respect to any such settled defendant or prospective defendant who has been identified by way of affirmative defense or joined by a nonsettling defendant as a party who is liable, in whole or in part, for the plaintiff's damages.

Section 73. Section 1004.08, Florida Statutes, is created to read:

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

Section 74. Section 1004.085, Florida Statutes, is created to read:

1004.085 Informed consent standardization project.-- Every

public school, college, and university that offers degrees in medicine, nursing, and allied health shall work with the Agency for Health Care Administration to develop bilingual, multimedia methods for communicating the risks of treatment options for medical procedures. Such materials shall be provided to patients and their families in an effort to educate them and to obtain the informed consent to prescribe a treatment procedure. The agency shall develop a list of treatment procedures based on significance of risk and frequency of performance.

Section 75. Section 1005.07, Florida Statutes, is created to read:

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

Section 76. Section 1005.075, Florida Statutes, is created to read:

1005.075 Informed consent standardization project.-- Every nonpublic school, college, and university that offers degrees in medicine, nursing, and allied health shall work with the Agency for Health Care Administration to develop bilingual, multimedia methods for communicating the risks of treatment options for medical procedures. Such materials shall be provided to patients and their families in an effort to educate them and to obtain

the informed consent to prescribe a treatment procedure. The agency shall develop a list of treatment procedures based on significance of risk and frequency of performance.

Section 77. (1) The Agency for Health Care Administration shall conduct or contract for a study to determine what information is most feasible to provide to the public comparing state-licensed hospitals on certain inpatient quality indicators developed by the federal Agency for Healthcare Research and Quality. Such indicators shall be designed to identify information about specific procedures performed in hospitals for which there is strong evidence of a link to quality of care. The Agency for Health Care Administration or the study contractor shall refer to the hospital quality reports published in New York and Texas as guides during the evaluation.

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

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

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

1. Inpatient mortality for medical conditions.

2. Inpatient mortality for procedures.

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

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

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

(d) Whether all hospitals should be included in the

comparison.

(e) The criteria for comparison.

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

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

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

Section 78. No later than September 1, 2003, the Department of Health shall convene a workgroup to study the current healthcare practitioner disciplinary process. The workgroup shall include a representative of the Administrative Law section of The Florida Bar, a representative of the Health Law section of The Florida Bar, a representative of the Florida Medical Association, a representative of the Florida Osteopathic Medical Association, a representative of the Florida Dental Association, a member of the Florida Board of Medicine who has served on the probable cause panel, a member of the Board of Osteopathic Medicine who has served on the probable cause panel, and a member of the Board of Dentistry who has served on the probable cause panel. The workgroup shall also include one consumer member of the Board of Medicine. The Department of Health shall present the findings and recommendations to the Governor, the President of the Senate, and the Speaker of the House of Representatives no later than January 1, 2004. The sponsoring organizations shall assume the costs of their

representative.

Section 79. The sum of $687,786 is appropriated from the Medical Quality Assurance Trust Fund to the Department of Health, and seven positions are authorized for the purpose of implementing this act during the 2003-2004 fiscal year. The sum of $452,122 is appropriated from the General Revenue Fund to the Agency for Health Care Administration, and five positions are authorized for the purpose of implementing this act during the 2003-2004 fiscal year.

Section 80. If any provision of this act or the application thereof to any person or circumstance is held invalid, the invalidity does not affect other provisions or applications of the act which can be given effect without the invalid provision or application, and to this end the provisions of this act are declared severable.

Section 81. All provisions of this act shall be repealed on July 1, 2007, unless the Legislature otherwise directs.

Section 82. If any law amended by this act was also amended by a law enacted at the 2003 Regular Session of the Legislature or at the 2003 Special Session A of the Legislature, such laws shall be construed as if they had been enacted at the same session of the Legislature, and full effect shall be given to each if possible.

Section 83. This act shall take effect upon becoming a law and shall apply to all actions filed after the effective date of the act.