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1                                   A bill to be entitled  
2           An act relating to medical malpractice insurance,  
3           liability, and litigation reform; providing a popular  
4           name; providing findings; amending s. 120.65, F.S.;  
5           requiring the Division of Administrative Hearings to  
6           designate administrative law judges to preside over  
7           actions involving a health care practitioner; providing  
8           qualifications for such administrative law judges;  
9           creating s. 381.0409, F.S.; creating the Florida Center  
10          for Excellence in Health Care as a not-for-profit  
11          corporation; providing goals; providing definitions;  
12          providing limitations on the center's liability for any  
13          lawful actions taken; requiring the center to issue  
14          patient safety recommendations; requiring the development  
15          of a statewide electronic infrastructure to improve  
16          patient care and the delivery and quality of health care  
17          services; providing requirements for development of a core  
18          electronic medical record; authorizing access to the  
19          electronic medical records and other data maintained by  
20          the center; providing for the use of computerized  
21          physician medication ordering systems; providing for the  
22          establishment of a simulation center for high technology  
23          intervention surgery and intensive care; providing for the  
24          immunity of specified information in adverse incident  
25          reports from discovery or admissibility in civil or  
26          administrative actions; providing limitations on liability  
27          of specified health care practitioners and facilities  
28          under specified conditions; providing an exception to  
29          confidentiality requirements; providing for a board of  
30          directors to be appointed by the Governor; providing for



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31 the assessment, payment, and collection of fees on certain  
32 health insurance policies; providing that health  
33 maintenance organizations and prepaid clinics and patients  
34 served by certain health care facilities are a funding  
35 source for the center; providing penalties for late  
36 payments of assessed fees; requiring the Florida Center  
37 for Excellence in Health Care to develop a business and  
38 financing plan; authorizing state agencies to contract  
39 with the center for specified projects; authorizing the  
40 use of center funds and the use of state purchasing and  
41 travel contracts for the center; requiring annual reports  
42 to the Legislature and the Governor; providing for the  
43 transfer of assets upon the dissolution of the center;  
44 amending s. 395.004, F.S., relating to licensure of  
45 certain health care facilities; providing for discounted  
46 medical liability insurance based on certification of  
47 programs that reduce adverse incidents; requiring the  
48 Office of Insurance Regulation to consider certain  
49 information in reviewing discounted rates; creating s.  
50 395.0056, F.S.; requiring the Agency for Health Care  
51 Administration to review complaints submitted if the  
52 defendant is a hospital; amending s. 395.0191, F.S.;  
53 providing certain immunity from suit, including actions  
54 for injunctive relief, for actions relating to staff  
55 membership and clinical privileges; deleting requirement  
56 that persons act in good faith to avoid liability or  
57 discipline for their actions regarding the awarding of  
58 staff membership or clinical privileges; amending s.  
59 395.0193, F.S., relating to peer review and disciplinary  
60 actions; providing for discipline of a physician for



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61 mental or physical abuse of staff; limiting liability of  
62 certain participants in certain disciplinary actions at a  
63 licensed facility; providing that a defendant's monetary  
64 liability shall not exceed \$250,000 on any action brought  
65 under this section; creating s. 395.0194, F.S.;

66 authorizing the governing boards of hospitals to reject or  
67 modify medical staff recommendations or to take action  
68 where the medical staff has failed to act under certain  
69 circumstances; providing procedures for corrective or  
70 disciplinary actions, including referral of such matters  
71 to a joint committee appointed by the governing board and  
72 the medical staff; providing for review and consideration  
73 of the recommendations of the joint committee by the  
74 governing board; amending s. 395.0197, F.S., relating to  
75 internal risk management programs; requiring certain  
76 training components in internal risk management programs;  
77 requiring a system for notifying patients that they are  
78 victims of an adverse incident; requiring risk managers or  
79 their designees to give notice; requiring internal risk  
80 management programs to address methods for reducing  
81 medication errors; requiring licensed facilities to  
82 annually report certain information about health care  
83 practitioners for whom they assume liability; requiring  
84 the Agency for Health Care Administration and the  
85 Department of Health to annually publish statistics about  
86 licensed facilities that assume liability for health care  
87 practitioners; providing for analysis of reports of  
88 adverse incidents; providing for confidentiality;  
89 requiring a licensed facility at which sexual abuse occurs  
90 to offer testing for sexually transmitted disease at no



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91 cost to the victim; creating s. 395.1012, F.S.; requiring  
92 hospitals, ambulatory surgical centers, and mobile  
93 surgical facilities to establish patient safety plans and  
94 committees; providing for discount on medical malpractice  
95 insurance premiums for certain health care facilities that  
96 implement certain programs recommended by the Florida  
97 Center for Excellence in Health Care; creating s.  
98 395.1051, F.S.; requiring certain facilities to notify  
99 patients about adverse incidents under specified  
100 conditions; amending s. 456.026, F.S.; requiring the  
101 Department of Health to publish its annual report to the  
102 Legislature concerning finances, administrative  
103 complaints, disciplinary actions, and recommendations on  
104 its website; requiring additional information in such  
105 report including the number of licensed health care  
106 practitioners and the claims reported against certain  
107 health care practitioners; amending s. 456.039, F.S.;  
108 amending the information required to be furnished to the  
109 Department of Health for licensure purposes; amending s.  
110 456.041, F.S.; requiring additional information to be  
111 included in health care practitioner profiles; providing  
112 for fines; revising requirements for the reporting of paid  
113 liability claims; amending s. 456.042, F.S.; requiring  
114 health care practitioner profiles to be updated within a  
115 specific time period; amending s. 456.049, F.S.; revising  
116 requirements for the reporting of paid liability claims;  
117 amending s. 456.051, F.S.; requiring the Department of  
118 Health to provide reports of professional liability  
119 actions and bankruptcies in a practitioner's profile  
120 within a specified period; amending s. 456.057, F.S.;



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



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151 employee who makes a good faith report concerning patient  
152 safety data; providing that certain regulatory boards may  
153 adopt rules governing the safe and ethical prescription of  
154 drugs to patients via the Internet or other electronic  
155 means; requiring the Office of Program Policy Analysis and  
156 Government Accountability and the Office of the Auditor  
157 General to jointly conduct an audit of the Department of  
158 Health's health care practitioner disciplinary process and  
159 closed claims, requiring a report; amending s. 458.320,  
160 F.S., relating to financial responsibility requirements  
161 for medical physicians; requiring the department to  
162 suspend the license of a medical physician who has not  
163 paid, up to the amounts required by any applicable  
164 financial responsibility provision, any outstanding  
165 judgment, arbitration award, other order, or settlement;  
166 amending s. 458.331, F.S., relating to grounds for  
167 disciplinary action of a physician; redefining the term  
168 "repeated malpractice"; revising the standards for the  
169 burden of proof in an administrative action against a  
170 physician; revising the minimum amount of a claim against  
171 a licensee which will trigger a departmental  
172 investigation; creating s. 458.3311, F.S.; establishing  
173 emergency procedures for disciplinary actions; amending s.  
174 459.0085, F.S., relating to financial responsibility  
175 requirements for osteopathic physicians; requiring that  
176 the department suspend the license of an osteopathic  
177 physician who has not paid, up to the amounts required by  
178 any applicable financial responsibility provision, any  
179 outstanding judgment, arbitration award, other order, or  
180 settlement; amending s. 459.015, F.S., relating to grounds



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



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211 whether excessive profit has been realized; requiring  
212 return of excessive amounts; amending s. 627.357, F.S.;  
213 deleting the prohibition against formation of medical  
214 malpractice self-insurance funds; providing requirements  
215 to form a self-insurance fund; providing rulemaking  
216 authority to the Financial Services Commission; creating  
217 s. 627.3575, F.S.; creating the Health Care Professional  
218 Liability Insurance Facility; providing purpose; providing  
219 for governance and powers; providing for eligibility and  
220 termination; providing for premiums and assessments;  
221 providing for regulation; providing applicability;  
222 specifying duties of the Department of Health; providing  
223 for debt and regulation thereof; creating s. 627.358,  
224 F.S.; authorizing the issuance of reduced premium medical  
225 malpractice insurance policies to certain part-time or  
226 retired health care professionals; providing eligibility  
227 requirements; creating s. 627.359, F.S.; providing for  
228 discounts on medical malpractice premiums for health care  
229 professionals who enter medication orders electronically  
230 using certain approved computer software; amending s.  
231 627.4147, F.S.; revising certain notification criteria for  
232 medical and osteopathic physicians; requiring prior  
233 notification of a rate increase; creating s. 627.41491,  
234 F.S.; requiring the Office of Insurance Regulation to  
235 require health care providers to annually publish certain  
236 rate comparison information; creating s. 627.41492, F.S.;  
237 requiring the Office of Insurance Regulation to prepare  
238 and publish an annual comparison of rates for malpractice  
239 insurance; creating s. 627.41493, F.S.; requiring a  
240 medical malpractice insurance rate rollback; providing for





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241 subsequent increases under certain circumstances;  
242 providing authority for the Insurance Regulatory  
243 Commission to adopt rules relating to discounts authorized  
244 by this act; requiring the Office of Program Policy  
245 Analysis and Government Accountability to study and report  
246 to the Legislature on requirements for coverage by the  
247 Florida Birth-Related Neurological Injury Compensation  
248 Association; amending s. 627.912, F.S.; requiring certain  
249 claims information to be filed with the Office of  
250 Insurance Regulation and the Department of Health;  
251 providing for rulemaking by the Financial Services  
252 Commission; increasing the limit on and making mandatory a  
253 fine against insurers for certain actions; creating s.  
254 627.9121, F.S.; requiring certain information relating to  
255 medical malpractice to be reported to the Office of  
256 Insurance Regulation; providing for enforcement; amending  
257 s. 766.102, F.S.; revising requirements for health care  
258 providers providing expert testimony in medical negligence  
259 actions; prohibiting contingency fees for an expert  
260 witness; requiring attorneys proffering expert witness  
261 testimony from a medical expert to certify that the  
262 witness has not been found guilty of fraud or perjury in  
263 any jurisdiction; providing an hourly cap on certain  
264 expert witness fees; amending s. 766.106, F.S.; requiring  
265 additional information to be provided in presuit notices;  
266 requiring that certain complaints alleging medical  
267 malpractice be provided by the claimant to the Agency for  
268 Health Care Administration; increasing certain timeframes  
269 for the conduct of presuit investigations; establishing  
270 the date from which the time for filing certain actions is



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271 measured; revising standards for determination of bad  
272 faith by an insurer to timely pay its policy limits;  
273 providing that failure to cooperate during a presuit  
274 investigation is grounds to strike claims or defenses;  
275 revising the standards for determining when an insurer has  
276 acted in bad faith; creating s. 766.1065, F.S.; providing  
277 for presuit discovery in medical malpractice actions;  
278 requiring mandatory mediation of medical malpractice  
279 claims; creating s. 766.1066, F.S.; creating the Office of  
280 Presuit Screening Administration; requiring the office to  
281 maintain a database of physicians, attorneys, and  
282 consumers willing to serve on presuit screening panels;  
283 providing for the assessment of certain fees to fund the  
284 office; providing requirements for eligibility to serve on  
285 presuit screening panels; providing powers and duties of  
286 the panels; providing for the makeup and appointment of  
287 such panels; requiring panelist to disclose conflicts of  
288 interest and providing for challenge of such panelists;  
289 providing for impact of decisions of panels; creating s.  
290 766.1067, F.S.; providing for structured judgments in  
291 medical malpractice actions; creating s. 766.1068, F.S.;  
292 providing that offers of settlement may be made at any  
293 time following the filing of suit; creating s. 766.110,  
294 F.S.; providing limitations on liability for certain  
295 medical staff, public family practice teaching hospitals,  
296 or medical school faculty members for the performance of  
297 emergency services prior to the patient being sufficiently  
298 stable; providing limitations on liability for certain  
299 medical facility staff when providing services following a  
300 subsequent injury in the facility prior to the patient



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301 again becoming sufficiently stable; amending s. 766.112,  
302 F.S.; eliminating the application of the doctrine of joint  
303 and several liability to medical malpractice actions;  
304 estopping plaintiffs from denying that a defendant or  
305 prospective defendant with whom the plaintiff settled  
306 contributed to the injury alleged; creating s. 766.118,  
307 F.S.; revising the method for determining and reviewing  
308 awards of noneconomic damages; authorizing judges to alter  
309 certain awards; providing an exception; providing the  
310 right to appeal such awards and establishing the standard  
311 for review; defining the term "sufficiently stable";  
312 creating s. 766.185, F.S.; requiring joinder of certain  
313 parties; prohibiting the assignment of fault to such  
314 parties if not joined; amending s. 766.202, F.S.; revising  
315 the definition of "medical expert"; amending s. 766.203,  
316 F.S.; providing that presuit expert opinions in medical  
317 malpractice actions are subject to discovery; amending s.  
318 766.206, F.S.; providing for dismissal of a claim or the  
319 striking of a defense under certain circumstances;  
320 requiring the court to make certain reports concerning a  
321 medical expert who fails to meet qualifications; requiring  
322 the court to refuse to consider testimony from certain  
323 expert witnesses; amending s. 766.207, F.S.; providing  
324 that voluntary binding arbitration shall be authorized  
325 only after the hearing of a presuit screening panel;  
326 providing a limitation on damages, including certain  
327 economic and noneconomic damages under certain  
328 circumstances; deleting an exception to the time  
329 limitation for agreeing to arbitration; providing that the  
330 Florida Rules of Civil Procedure shall govern discovery;



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331 providing exceptions; providing that discovery disputes  
332 shall be resolved by an administrative law judge; revising  
333 the makeup of arbitration panels; revising the  
334 compensation of the arbitrators; providing limitations on  
335 damages which may be awarded under certain circumstances;  
336 deleting the provision that defendants who agree to  
337 arbitration are jointly and severally liable for all  
338 damages awarded in arbitration; providing that claimant's  
339 may recover additional damages and costs at trial if a  
340 defendant refuses an offer of voluntary binding  
341 arbitration; providing a limitation on certain damages  
342 which may be awarded at trial if a plaintiff refuses an  
343 offer of voluntary binding arbitration; providing for an  
344 award and allocation of damages in arbitration; providing  
345 for periodic payment of certain damages; providing for  
346 extinguishing liability to claimants and for contribution;  
347 providing for a right of contribution against defendants  
348 not in arbitration; providing that physicians not carrying  
349 medical malpractice insurance require no relief provided  
350 by this act; creating s. 766.25, F.S.; prescribing a  
351 method for itemization of specific categories of damages  
352 awarded in medical malpractice actions; creating s.  
353 766.26, F.S.; requiring the Agency for Health Care  
354 Administration to maintain a jury verdict database  
355 regarding malpractice actions; requiring the Clerks of the  
356 Court to report all such future verdicts to the agency;  
357 creating s. 766.27, F.S.; providing sanctions against  
358 certain attorneys who file frivolous medical malpractice  
359 lawsuits; requiring the Office of Insurance Regulation to  
360 compile annual statistical reports of closed claims on



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361 files relating to health care providers; requiring  
362 physicians to report certain claims or actions for medical  
363 malpractice against the physician to the Office of  
364 Insurance Regulation and the Department of Health;  
365 providing requirements for such reports; amending s.  
366 768.21, F.S.; providing that certain adult beneficiaries  
367 of estates are entitled to damages in wrongful death  
368 actions; amending s. 768.81, F.S.; eliminating the  
369 application of the doctrine of joint and several liability  
370 to medical malpractice actions; estopping plaintiffs from  
371 denying that a defendant or prospective defendant with  
372 whom the plaintiff settled contributed to the injury  
373 alleged; creating s. 1004.08, F.S.; requiring patient  
374 safety instruction for certain students in public schools,  
375 colleges, and universities; creating s. 1004.085, F.S.;  
376 requiring certain public schools to assist the Agency for  
377 Health Care Administration in the development of  
378 information to be provided to patients and their families  
379 on risks of treatment options to assist in receiving  
380 informed consent; creating s. 1005.07, F.S.; requiring  
381 patient safety instruction for certain students in  
382 nonpublic schools, colleges, and universities; creating s.  
383 1005.075, F.S.; requiring certain nonpublic schools to  
384 assist the Agency for Health Care Administration in the  
385 development of information to be provided to patients and  
386 their families on risks of treatment options to assist in  
387 receiving informed consent; directing the Agency for  
388 Health Care Administration to conduct or contract for a  
389 study to determine what information to provide to the  
390 public comparing hospitals, based on inpatient quality



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

401

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

403

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

407 Section 2. Findings.--

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

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

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

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



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421 nation.

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

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

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

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

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

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

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

450 (12) The Legislature finds that ensuring that physicians



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451 continue to practice in Florida is an overwhelming public  
452 necessity.

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

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

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

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

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

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





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481 medical malpractice insurance.

482 Section 3. A new subsection (11) is added to section  
483 120.65, Florida Statutes, to read:

484 120.65 Administrative law judges.--

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

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

497 381.0409 Florida Center for Excellence in Health Care.--  
498 There is created the Florida Center for Excellence in Health  
499 Care, which shall be responsible for performing activities and  
500 functions that are designed to improve the quality of health  
501 care delivered by health care facilities and health care  
502 practitioners. The principal goals of the center are to improve  
503 health care quality and patient safety. The long-term goal of  
504 the center is to improve diagnostic and treatment decisions,  
505 thus further improving quality.

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

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

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



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

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

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

527 (f) "Patient safety data" means any data, reports,  
528 records, memoranda, or analyses of patient safety events and  
529 adverse incidents reported by a licensed facility pursuant to s.  
530 395.0197 which are submitted to the Florida Center for  
531 Excellence in Health Care or the corrective actions taken in  
532 response to such patient safety events or adverse incidents.

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

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

540 (a) Analyze patient safety data for the purpose of



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

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

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



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

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

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

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



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

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

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

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



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

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

648 (6) The center shall:

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

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

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

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



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661 indemnity plans, one member representing health maintenance  
662 organizations, one member representing business, and one member  
663 representing consumers. The Governor shall appoint members for  
664 2-year terms. Such members shall serve until their successors  
665 are appointed. Members are eligible to be reappointed for  
666 additional terms.

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

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

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

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

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

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



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

697 (b) Notwithstanding any law to the contrary, each health  
698 maintenance organization issued a certificate of authority under  
699 part I of chapter 641 and each prepaid clinic issued a  
700 certificate of authority under part II of chapter 641 shall, as  
701 a condition of maintaining such certificate, make payment to the  
702 center on April 1 of each year, in the amount of \$1 for each  
703 individual who is eligible to receive services pursuant to a  
704 contract with the health maintenance organization or the prepaid  
705 clinic during the previous calendar year. Accompanying any  
706 payment shall be a certification under oath by the chief  
707 executive officer that states the number of individuals on which  
708 such payment was based. The health maintenance organization or  
709 prepaid clinic may collect the \$1 from individuals eligible to  
710 receive services under contract. The center may direct the  
711 health maintenance organization or prepaid clinic to provide an  
712 independent audit of the certification that shall be furnished  
713 within 90 days. If payment is not received by the center within  
714 30 days after April 1, interest at the annualized rate of 18  
715 percent shall begin to be charged on the amount due. If payment  
716 has not been received within 60 days after interest is charged,  
717 the center shall notify the Department of Financial Services  
718 that payment has not been received pursuant to the requirements  
719 of this paragraph. A health maintenance organization or prepaid  
720 clinic that refuses to comply with the requirements of this





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

723 (c) Notwithstanding any law to the contrary, each hospital  
724 and ambulatory surgical center licensed under chapter 395 shall,  
725 as a condition of licensure, make payment to the center on April  
726 1 of each year, in the amount of \$1 for each individual during  
727 the previous 12 months who was an inpatient discharged by the  
728 hospital or who was a patient in the ambulatory surgical center.  
729 Accompanying payment shall be a certification under oath by the  
730 chief executive officer that states the number of individuals on  
731 which such payment was based. The facility may collect the \$1  
732 from patients discharged from the facility. The center may  
733 direct the facility to provide an independent audit of the  
734 certification that shall be furnished within 90 days. If payment  
735 is not received by the center within 30 days after April 1,  
736 interest at the annualized rate of 18 percent shall begin to be  
737 charged on the amount due. If payment has not been received  
738 within 60 days after interest is charged, the center shall  
739 notify the Agency for Health Care Administration that payment  
740 has not been received pursuant to the requirements of this  
741 paragraph. An entity that refuses to comply with the  
742 requirements of this paragraph is subject to the forfeiture of  
743 its license.

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



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

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

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

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



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

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

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

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

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

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

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

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

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

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



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811 incidents by licensed facilities.

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

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

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

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

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

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

833 395.004 Application for license, fees; expenses.--

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



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

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

851 395.0056 Litigation notice requirement.-- Upon receipt of  
852 a copy of a complaint filed against a hospital as a defendant in  
853 a medical malpractice action as required by s. 766.106(2), the  
854 agency shall:

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

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

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

864 395.0191 Staff membership and clinical privileges.--

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



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

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

876 395.0193 Licensed facilities; peer review; disciplinary  
877 powers; agency or partnership with physicians.--

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

890 (a) Incompetence.

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

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

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

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



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

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

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

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

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

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

926        395.0194 Licensed facilities; quality assurance  
 927 responsibilities of governing board.--

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



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

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





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

972 Section 10. Subsections (12) through (20) of section  
973 395.0197, Florida Statutes, are renumbered as subsections (13)  
974 through (21), respectively, subsections (1), (3), (7), and (8)  
975 of said section are amended, and a new subsection (12) is added  
976 to said section, to read:

977 395.0197 Internal risk management program.--

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

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

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

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

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



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

1000           2. A prohibition, except when emergency circumstances  
 1001 require otherwise, against a staff member of the licensed  
 1002 facility attending a patient in the recovery room, unless the  
 1003 staff member is authorized to attend the patient in the recovery  
 1004 room and is in the company of at least one other person.  
 1005 However, a licensed facility is exempt from the two-person  
 1006 requirement if it has:

- 1007           a. Live visual observation;
- 1008           b. Electronic observation; or
- 1009           c. Any other reasonable measure taken to ensure patient  
 1010 protection and privacy.

1011           3. A prohibition against an unlicensed person from  
 1012 assisting or participating in any surgical procedure unless the  
 1013 facility has authorized the person to do so following a  
 1014 competency assessment, and such assistance or participation is  
 1015 done under the direct and immediate supervision of a licensed  
 1016 physician and is not otherwise an activity that may only be  
 1017 performed by a licensed health care practitioner.

1018           4. Development, implementation, and ongoing evaluation of  
 1019 procedures, protocols, and systems to accurately identify  
 1020 patients, planned procedures, and the correct site of the



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1021 planned procedure so as to minimize the performance of a  
1022 surgical procedure on the wrong patient, a wrong surgical  
1023 procedure, a wrong-site surgical procedure, or a surgical  
1024 procedure otherwise unrelated to the patient's diagnosis or  
1025 medical condition.

1026 (c) The analysis of patient grievances that relate to  
1027 patient care and the quality of medical services.

1028 (d) A system for informing a patient or a proxy authorized  
1029 by law to make health care decisions on behalf of a patient that  
1030 the patient was the subject of an adverse incident as defined in  
1031 subsection (5). Such notice shall be given by the risk manager,  
1032 or his or her designee, as soon as practicable to allow the  
1033 patient an opportunity to minimize damage or injury.

1034 (e)-~~(d)~~ The development and implementation of an incident  
1035 reporting system based upon the affirmative duty of all health  
1036 care providers and all agents and employees of the licensed  
1037 health care facility to report adverse incidents to the risk  
1038 manager, or to his or her designee, within 3 business days after  
1039 their occurrence.

1040 (f) The development of a facilitywide plan for reducing  
1041 medication errors, which shall include:

1042 1. The development of effective reporting mechanisms to  
1043 ensure that medication-related errors are reviewed.

1044 2. The establishment of a baseline assessment and a review  
1045 to be conducted at least annually of the effectiveness of the  
1046 plan to reduce medication-related errors.

1047 3. The use of technology.

1048  
1049 Pertinent literature related to the reduction of medication-  
1050 related errors shall be reviewed and utilized in the development



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1051 and ongoing review of the plan developed pursuant to this  
 1052 paragraph.

1053 (3) In addition to the programs mandated by this section,  
 1054 other innovative approaches intended to reduce the frequency and  
 1055 severity of medical malpractice and patient injury claims shall  
 1056 be encouraged and their implementation and operation  
 1057 facilitated. Such additional approaches may include extending  
 1058 internal risk management programs to health care providers'  
 1059 offices and the assuming of provider liability by a licensed  
 1060 health care facility for acts or omissions occurring within the  
 1061 licensed facility. Each licensed facility shall annually report  
 1062 to the agency and the Department of Health the name and  
 1063 judgments entered against each health care practitioner for  
 1064 which the facility assumes liability. The agency and the  
 1065 Department of Health, in their respective annual reports, shall  
 1066 include statistics that report the number of licensed facilities  
 1067 that assume such liability and the number of health care  
 1068 practitioners, by profession, for whom they assume liability.

1069 (7) The licensed facility shall notify the agency no later  
 1070 than 7 calendar days ~~1 business day~~ after the risk manager or  
 1071 his or her designee has received a report pursuant to paragraph  
 1072 (1)(d) and can determine within 7 calendar days ~~1 business day~~  
 1073 that any of the following adverse incidents has occurred,  
 1074 whether occurring in the licensed facility or arising from  
 1075 health care prior to admission in the licensed facility:

- 1076 (a) The death of a patient;
- 1077 (b) Brain or spinal damage to a patient;
- 1078 (c) The performance of a surgical procedure on the wrong  
 1079 patient;
- 1080 (d) The performance of a wrong-site surgical procedure; or



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1081 (e) The performance of a wrong surgical procedure.

1082

1083 The notification must be made in writing and be provided by  
1084 facsimile device or overnight mail delivery. The notification  
1085 must include information regarding the identity of the affected  
1086 patient, the type of adverse incident, the initiation of an  
1087 investigation by the facility, and whether the events causing or  
1088 resulting in the adverse incident represent a potential risk to  
1089 other patients.

1090 (8) Any of the following adverse incidents, whether  
1091 occurring in the licensed facility or arising from health care  
1092 prior to admission in the licensed facility, shall be reported  
1093 by the facility to the agency within 15 calendar days after its  
1094 occurrence:

1095 (a) The death of a patient;

1096 (b) Brain or spinal damage to a patient;

1097 (c) The performance of a surgical procedure on the wrong  
1098 patient;

1099 (d) The performance of a wrong-site surgical procedure;

1100 (e) The performance of a wrong surgical procedure;

1101 (f) The performance of a surgical procedure that is  
1102 medically unnecessary or otherwise unrelated to the patient's  
1103 diagnosis or medical condition;

1104 (g) The surgical repair of damage resulting to a patient  
1105 from a planned surgical procedure, where the damage is not a  
1106 recognized specific risk, as disclosed to the patient and  
1107 documented through the informed-consent process; or

1108 (h) The performance of procedures to remove unplanned  
1109 foreign objects remaining from a surgical procedure.

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1111 The agency may grant extensions to this reporting requirement  
1112 for more than 15 days upon justification submitted in writing by  
1113 the facility administrator to the agency. The agency may require  
1114 an additional, final report. These reports shall not be  
1115 available to the public pursuant to s. 119.07(1) or any other  
1116 law providing access to public records, nor be discoverable or  
1117 admissible in any civil or administrative action, except in  
1118 disciplinary proceedings by the agency or the appropriate  
1119 regulatory board, nor shall they be available to the public as  
1120 part of the record of investigation for and prosecution in  
1121 disciplinary proceedings made available to the public by the  
1122 agency or the appropriate regulatory board. However, the agency  
1123 or the appropriate regulatory board shall make available, upon  
1124 written request by a health care professional against whom  
1125 probable cause has been found, any such records which form the  
1126 basis of the determination of probable cause. The agency may  
1127 investigate, as it deems appropriate, any such incident and  
1128 prescribe measures that must or may be taken in response to the  
1129 incident. The agency shall review each incident and determine  
1130 whether it potentially involved conduct by the health care  
1131 professional who is subject to disciplinary action, in which  
1132 case the provisions of s. 456.073 shall apply. Copies of all  
1133 reports of adverse incidents submitted to the agency by  
1134 hospitals and ambulatory surgical centers shall be forwarded to  
1135 the Florida Center for Excellence in Health Care, as defined in  
1136 s. 381.0409, for analysis by experts who may make  
1137 recommendations regarding the prevention of such incidents. Such  
1138 information shall remain confidential as otherwise provided by  
1139 law.

1140 (12) If appropriate, a licensed facility in which sexual



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1141 abuse occurs must offer the victim of sexual abuse testing for  
1142 sexually transmissible diseases and shall provide all such  
1143 testing at no cost to the victim.

1144 Section 11. Section 395.1012, Florida Statutes, is created  
1145 to read:

1146 395.1012 Patient safety.--

1147 (1) Each licensed facility shall adopt a patient safety  
1148 plan. A plan adopted to implement the requirements of 42 C.F.R.  
1149 s. 482.21 shall be deemed to comply with this requirement.

1150 (2) Each licensed facility shall appoint a patient safety  
1151 officer and a patient safety committee, which shall include at  
1152 least one person who is neither employed by nor practicing in  
1153 the facility, for the purpose of promoting the health and safety  
1154 of patients, reviewing and evaluating the quality of patient  
1155 safety measures used by the facility, and assisting in the  
1156 implementation of the facility patient safety plan.

1157 Section 12. Section 395.1051, Florida Statutes, is created  
1158 to read:

1159 395.1051 Duty to notify patients.-- Every licensed  
1160 facility shall inform each patient, or an individual identified  
1161 pursuant to s. 765.401(1), in person about unanticipated  
1162 outcomes of care that result in serious harm to the patient.  
1163 Notification of outcomes of care that result in harm to the  
1164 patient under this section shall not constitute an  
1165 acknowledgement or admission of liability, nor can it be  
1166 introduced as evidence in any civil lawsuit.

1167 Section 13. Section 456.026, Florida Statutes, is amended  
1168 to read:

1169 456.026 Annual report concerning finances, administrative  
1170 complaints, disciplinary actions, and recommendations.-- The



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1171 department is directed to prepare and submit a report to the  
1172 President of the Senate and the Speaker of the House of  
1173 Representatives by November 1 of each year. The department shall  
1174 publish the report on its website simultaneously with delivery  
1175 to the President of the Senate and the Speaker of the House of  
1176 Representatives. The report must be directly accessible on the  
1177 department's Internet homepage highlighted by easily  
1178 identifiable links and buttons. In addition to finances and any  
1179 other information the Legislature may require, the report shall  
1180 include statistics and relevant information, profession by  
1181 profession, detailing:

1182 (1) The number of health care practitioners licensed by  
1183 the Division of Medical Quality Assurance or otherwise  
1184 authorized to provide services in the state, if known to the  
1185 department.

1186 (2)~~(1)~~ The revenues, expenditures, and cash balances for  
1187 the prior year, and a review of the adequacy of existing fees.

1188 (3)~~(2)~~ The number of complaints received and investigated.

1189 (4)~~(3)~~ The number of findings of probable cause made.

1190 (5)~~(4)~~ The number of findings of no probable cause made.

1191 (6)~~(5)~~ The number of administrative complaints filed.

1192 (7)~~(6)~~ The disposition of all administrative complaints.

1193 (8)~~(7)~~ A description of disciplinary actions taken.

1194 (9) For licensees under chapter 458, chapter 459, chapter  
1195 461, or chapter 466, the professional liability claims and  
1196 actions reported by insurers, as provided in s. 627.912. This  
1197 information must be provided in a separate section of the report  
1198 restricted to providing professional liability claims and  
1199 actions data.





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1200        ~~(10)(8)~~ A description of any effort by the department to  
 1201 reduce or otherwise close any investigation or disciplinary  
 1202 proceeding not before the Division of Administrative Hearings  
 1203 under chapter 120 or otherwise not completed within 1 year after  
 1204 the initial filing of a complaint under this chapter.

1205        ~~(11)(9)~~ The status of the development and implementation  
 1206 of rules providing for disciplinary guidelines pursuant to s.  
 1207 456.079.

1208        ~~(12)(10)~~ Such recommendations for administrative and  
 1209 statutory changes necessary to facilitate efficient and cost-  
 1210 effective operation of the department and the various boards.

1211        Section 14. Paragraph (a) of subsection (1) of section  
 1212 456.039, Florida Statutes, is amended to read:

1213        456.039 Designated health care professionals; information  
 1214 required for licensure.--

1215        (1) Each person who applies for initial licensure as a  
 1216 physician under chapter 458, chapter 459, chapter 460, or  
 1217 chapter 461, except a person applying for registration pursuant  
 1218 to ss. 458.345 and 459.021, must, at the time of application,  
 1219 and each physician who applies for license renewal under chapter  
 1220 458, chapter 459, chapter 460, or chapter 461, except a person  
 1221 registered pursuant to ss. 458.345 and 459.021, must, in  
 1222 conjunction with the renewal of such license and under  
 1223 procedures adopted by the Department of Health, and in addition  
 1224 to any other information that may be required from the  
 1225 applicant, furnish the following information to the Department  
 1226 of Health:

1227        (a)1. The name of each medical school that the applicant  
 1228 has attended, with the dates of attendance and the date of  
 1229 graduation, and a description of all graduate medical education



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1230 completed by the applicant, excluding any coursework taken to  
1231 satisfy medical licensure continuing education requirements.

1232 2. The name of each hospital at which the applicant has  
1233 privileges.

1234 3. The address at which the applicant will primarily  
1235 conduct his or her practice.

1236 4. Any certification that the applicant has received from  
1237 a specialty board that is recognized by the board to which the  
1238 applicant is applying.

1239 5. The year that the applicant began practicing medicine.

1240 6. Any appointment to the faculty of a medical school  
1241 which the applicant currently holds and an indication as to  
1242 whether the applicant has had the responsibility for graduate  
1243 medical education within the most recent 10 years.

1244 7. A description of any criminal offense of which the  
1245 applicant has been found guilty, regardless of whether  
1246 adjudication of guilt was withheld, or to which the applicant  
1247 has pled guilty or nolo contendere. A criminal offense committed  
1248 in another jurisdiction which would have been a felony or  
1249 misdemeanor if committed in this state must be reported. If the  
1250 applicant indicates that a criminal offense is under appeal and  
1251 submits a copy of the notice for appeal of that criminal  
1252 offense, the department must state that the criminal offense is  
1253 under appeal if the criminal offense is reported in the  
1254 applicant's profile. If the applicant indicates to the  
1255 department that a criminal offense is under appeal, the  
1256 applicant must, upon disposition of the appeal, submit to the  
1257 department a copy of the final written order of disposition.

1258 8. A description of any final disciplinary action taken  
1259 within the previous 10 years against the applicant by the agency



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1260 regulating the profession that the applicant is or has been  
1261 licensed to practice, whether in this state or in any other  
1262 jurisdiction, by a specialty board that is recognized by the  
1263 American Board of Medical Specialties, the American Osteopathic  
1264 Association, or a similar national organization, or by a  
1265 licensed hospital, health maintenance organization, prepaid  
1266 health clinic, ambulatory surgical center, or nursing home.  
1267 Disciplinary action includes resignation from or nonrenewal of  
1268 medical staff membership or the restriction of privileges at a  
1269 licensed hospital, health maintenance organization, prepaid  
1270 health clinic, ambulatory surgical center, or nursing home taken  
1271 in lieu of or in settlement of a pending disciplinary case  
1272 related to competence or character. If the applicant indicates  
1273 that the disciplinary action is under appeal and submits a copy  
1274 of the document initiating an appeal of the disciplinary action,  
1275 the department must state that the disciplinary action is under  
1276 appeal if the disciplinary action is reported in the applicant's  
1277 profile.

1278 9. Relevant professional qualifications as defined by the  
1279 applicable board.

1280 Section 15 Section 456.041, Florida Statutes, is amended  
1281 to read:

1282 456.041 Practitioner profile; creation.--

1283 (1)(a) Beginning July 1, 1999, the Department of Health  
1284 shall compile the information submitted pursuant to s. 456.039  
1285 into a practitioner profile of the applicant submitting the  
1286 information, except that the Department of Health may develop a  
1287 format to compile uniformly any information submitted under s.  
1288 456.039(4)(b). Beginning July 1, 2001, the Department of Health  
1289 may, and beginning July 1, 2004, shall, compile the information



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1290 submitted pursuant to s. 456.0391 into a practitioner profile of  
 1291 the applicant submitting the information.

1292 (b) Each practitioner licensed under chapter 458 or  
 1293 chapter 459 must report to the Department of Health and the  
 1294 Board of Medicine or the Board of Osteopathic Medicine,  
 1295 respectively, all final disciplinary actions, sanctions by a  
 1296 governmental agency or a facility or entity licensed under state  
 1297 law, and claims or actions, as provided under s. 456.051, to  
 1298 which he or she is subject no later than 15 calendar days after  
 1299 such action or sanction is imposed. Failure to submit the  
 1300 requisite information within 15 calendar days in accordance with  
 1301 this paragraph shall subject the practitioner to discipline by  
 1302 the Board of Medicine or the Board of Osteopathic Medicine and a  
 1303 fine of \$100 for each day that the information is not submitted  
 1304 after the expiration of the 15-day reporting period.

1305 (c) Within 15 days after receiving a report under  
 1306 paragraph (b), the department shall update the practitioner's  
 1307 profile in accordance with the requirements of subsection (7).

1308 (2) On the profile published under subsection (1), the  
 1309 department shall indicate whether ~~if~~ the information provided  
 1310 under s. 456.039(1)(a)7. or s. 456.0391(1)(a)7. is or is not  
 1311 corroborated by a criminal history check conducted according to  
 1312 this subsection. ~~If the information provided under s.~~  
 1313 ~~456.039(1)(a)7. or s. 456.0391(1)(a)7. is corroborated by the~~  
 1314 ~~criminal history check, the fact that the criminal history check~~  
 1315 ~~was performed need not be indicated on the profile.~~ The  
 1316 department, or the board having regulatory authority over the  
 1317 practitioner acting on behalf of the department, shall  
 1318 investigate any information received by the department or the  
 1319 board when it has reasonable grounds to believe that the



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1320 practitioner has violated any law that relates to the  
1321 practitioner's practice.

1322 (3) The Department of Health shall ~~may~~ include in each  
1323 practitioner's practitioner profile that criminal information  
1324 that directly relates to the practitioner's ability to  
1325 competently practice his or her profession. The department must  
1326 include in each practitioner's practitioner profile the  
1327 following statement: "The criminal history information, if any  
1328 exists, may be incomplete; federal criminal history information  
1329 is not available to the public." The department shall provide in  
1330 each practitioner profile, for every final disciplinary action  
1331 taken against the practitioner, a narrative description, written  
1332 in plain English, that explains the administrative complaint  
1333 filed against the practitioner and the final disciplinary action  
1334 imposed on the practitioner. The department shall include a  
1335 hyperlink to each final order listed on its Internet website  
1336 report of dispositions of recent disciplinary actions taken  
1337 against practitioners.

1338 (4) The Department of Health shall include, with respect  
1339 to a practitioner licensed under chapter 458 or chapter 459, a  
1340 statement of how the practitioner has elected to comply with the  
1341 financial responsibility requirements of s. 458.320 or s.  
1342 459.0085. The department shall include, with respect to  
1343 practitioners subject to s. 456.048, a statement of how the  
1344 practitioner has elected to comply with the financial  
1345 responsibility requirements of that section. The department  
1346 shall include, with respect to practitioners licensed under  
1347 chapter 458, chapter 459, or chapter 461, information relating  
1348 to liability actions which has been reported under s. 456.049 or  
1349 s. 627.912 within the previous 10 years for any paid claim of



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1350 \$50,000 or more ~~that exceeds \$5,000~~. Such claims information  
1351 shall be reported in the context of comparing an individual  
1352 practitioner's claims to the experience of other practitioners  
1353 within the same specialty, or profession if the practitioner is  
1354 not a specialist, ~~to the extent such information is available to~~  
1355 ~~the Department of Health~~. The department shall include a  
1356 hyperlink to all such comparison reports in such practitioner's  
1357 profile on its Internet website. If information relating to a  
1358 liability action is included in a practitioner's practitioner  
1359 profile, the profile must also include the following statement:  
1360 "Settlement of a claim may occur for a variety of reasons that  
1361 do not necessarily reflect negatively on the professional  
1362 competence or conduct of the practitioner. A payment in  
1363 settlement of a medical malpractice action or claim should not  
1364 be construed as creating a presumption that medical malpractice  
1365 has occurred."

1366 (5) The Department of Health shall ~~may not~~ include the  
1367 date of a disciplinary action taken by a licensed hospital or an  
1368 ambulatory surgical center, in accordance with the requirements  
1369 of s. 395.0193, in the practitioner profile. Any practitioner  
1370 disciplined under paragraph (1)(b) must report to the department  
1371 the date the disciplinary action was imposed. The department  
1372 shall state whether the action is related to professional  
1373 competence and whether it is related to the delivery of services  
1374 to a patient.

1375 (6) The Department of Health may include in the  
1376 practitioner's practitioner profile any other information that  
1377 is a public record of any governmental entity and that relates  
1378 to a practitioner's ability to competently practice his or her  
1379 profession. However, the department must consult with the board



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1380 having regulatory authority over the practitioner before such  
1381 information is included in his or her profile.

1382 (7) Upon the completion of a practitioner profile under  
1383 this section, the Department of Health shall furnish the  
1384 practitioner who is the subject of the profile a copy of it. The  
1385 practitioner has a period of 30 days in which to review the  
1386 profile and to correct any factual inaccuracies in it. The  
1387 Department of Health shall make the profile available to the  
1388 public at the end of the 30-day period. The department shall  
1389 make the profiles available to the public through the World Wide  
1390 Web and other commonly used means of distribution.

1391 (8) The Department of Health shall provide in each profile  
1392 an easy-to-read explanation of any disciplinary action taken and  
1393 the reason the sanction or sanctions were imposed.

1394 (9)~~(8)~~ Making a practitioner profile available to the  
1395 public under this section does not constitute agency action for  
1396 which a hearing under s. 120.57 may be sought.

1397 Section 15. Section 456.042, Florida Statutes, is amended  
1398 to read:

1399 456.042 Practitioner profiles; update.-- A practitioner  
1400 must submit updates of required information within 15 days after  
1401 the final activity that renders such information a fact. The  
1402 Department of Health shall update each practitioner's  
1403 practitioner profile periodically. An updated profile is subject  
1404 to the same requirements as an original profile with respect to  
1405 the period within which the practitioner may review the profile  
1406 for the purpose of correcting factual inaccuracies.

1407 Section 16. Subsection (1) of section 456.049, Florida  
1408 Statutes, is amended, and subsection (3) is added to said  
1409 section, to read:



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1410 456.049 Health care practitioners; reports on professional  
1411 liability claims and actions.--

1412 (1) Any practitioner of medicine licensed pursuant to the  
1413 provisions of chapter 458, practitioner of osteopathic medicine  
1414 licensed pursuant to the provisions of chapter 459, podiatric  
1415 physician licensed pursuant to the provisions of chapter 461, or  
1416 dentist licensed pursuant to the provisions of chapter 466 shall  
1417 report to the department any claim or action for damages for  
1418 personal injury alleged to have been caused by error, omission,  
1419 or negligence in the performance of such licensee's professional  
1420 services or based on a claimed performance of professional  
1421 services without consent if ~~the claim was not covered by an~~  
1422 ~~insurer required to report under s. 627.912 and~~ the claim  
1423 resulted in:

1424 (a) A final judgment of \$50,000 or more or, with respect  
1425 to a dentist licensed pursuant to chapter 466, a final judgment  
1426 of \$25,000 or more in any amount.

1427 (b) A settlement of \$50,000 or more or, with respect to a  
1428 dentist licensed pursuant to chapter 466, a settlement of  
1429 \$25,000 or more in any amount.

1430 (c) A final disposition not resulting in payment on behalf  
1431 of the licensee.

1432

1433 Reports shall be filed with the department no later than 60 days  
1434 following the occurrence of any event listed in paragraph (a),  
1435 paragraph (b), or paragraph (c).

1436 (3) The department shall forward the information collected  
1437 under this section to the Office of Insurance Regulation.

1438 Section 17. Section 456.051, Florida Statutes, is amended  
1439 to read:





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1440 456.051 Reports of professional liability actions;  
1441 bankruptcies; Department of Health's responsibility to  
1442 provide.--

1443 (1) The report of a claim or action for damages for  
1444 personal injury which is required to be provided to the  
1445 Department of Health under s. 456.049 or s. 627.912 is public  
1446 information except for the name of the claimant or injured  
1447 person, which remains confidential as provided in ss.  
1448 456.049(2)(d) and 627.912(2)(e). The Department of Health shall,  
1449 upon request, make such report available to any person. The  
1450 department shall make such report available as a part of the  
1451 practitioner's profile within 45 calendar days after receipt.

1452 (2) Any information in the possession of the Department of  
1453 Health which relates to a bankruptcy proceeding by a  
1454 practitioner of medicine licensed under chapter 458, a  
1455 practitioner of osteopathic medicine licensed under chapter 459,  
1456 a podiatric physician licensed under chapter 461, or a dentist  
1457 licensed under chapter 466 is public information. The Department  
1458 of Health shall, upon request, make such information available  
1459 to any person. The department shall make such report available  
1460 as a part of the practitioner's profile within 45 calendar days  
1461 after receipt.

1462 Section 18. Paragraph (a) of subsection (7) of section  
1463 456.057, Florida Statutes, is amended to read:

1464 456.057 Ownership and control of patient records; report  
1465 or copies of records to be furnished.--

1466 (7)(a)1. The department may obtain patient records  
1467 pursuant to a subpoena without written authorization from the  
1468 patient if the department and the probable cause panel of the  
1469 appropriate board, if any, find reasonable cause to believe that



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1470 a health care practitioner has excessively or inappropriately  
1471 prescribed any controlled substance specified in chapter 893 in  
1472 violation of this chapter or any professional practice act or  
1473 that a health care practitioner has practiced his or her  
1474 profession below that level of care, skill, and treatment  
1475 required as defined by this chapter or any professional practice  
1476 act and also find that appropriate, reasonable attempts were  
1477 made to obtain a patient release.

1478 2. The department may obtain patient records and insurance  
1479 information pursuant to a subpoena without written authorization  
1480 from the patient if the department and the probable cause panel  
1481 of the appropriate board, if any, find reasonable cause to  
1482 believe that a health care practitioner has provided inadequate  
1483 medical care based on termination of insurance and also find  
1484 that appropriate, reasonable attempts were made to obtain a  
1485 patient release.

1486 3. The department may obtain patient records, billing  
1487 records, insurance information, provider contracts, and all  
1488 attachments thereto pursuant to a subpoena without written  
1489 authorization from the patient if the department and probable  
1490 cause panel of the appropriate board, if any, find reasonable  
1491 cause to believe that a health care practitioner has submitted a  
1492 claim, statement, or bill using a billing code that would result  
1493 in payment greater in amount than would be paid using a billing  
1494 code that accurately describes the services performed, requested  
1495 payment for services that were not performed by that health care  
1496 practitioner, used information derived from a written report of  
1497 an automobile accident generated pursuant to chapter 316 to  
1498 solicit or obtain patients personally or through an agent  
1499 regardless of whether the information is derived directly from



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1500 the report or a summary of that report or from another person,  
 1501 solicited patients fraudulently, received a kickback as defined  
 1502 in s. 456.054, violated the patient brokering provisions of s.  
 1503 817.505, or presented or caused to be presented a false or  
 1504 fraudulent insurance claim within the meaning of s.  
 1505 817.234(1)(a), and also find that, within the meaning of s.  
 1506 817.234(1)(a), patient authorization cannot be obtained because  
 1507 the patient cannot be located or is deceased, incapacitated, or  
 1508 suspected of being a participant in the fraud or scheme, and if  
 1509 the subpoena is issued for specific and relevant records.

1510 4. Notwithstanding subparagraphs 1.-3., when the  
 1511 department investigates a professional liability claim or  
 1512 undertakes action pursuant to s. 456.049 or s. 627.912, the  
 1513 department may obtain patient records pursuant to a subpoena  
 1514 without written authorization from the patient if the patient  
 1515 refuses to cooperate or attempts to obtain a patient release and  
 1516 failure to obtain the patient records would be detrimental to  
 1517 the investigation.

1518 Section 19. Section 456.0575, Florida Statutes, is created  
 1519 to read:

1520 456.0575 Duty to notify patients.-- Every licensed health  
 1521 care practitioner shall inform each patient, or an individual  
 1522 identified pursuant to s. 765.401(1), in person about adverse  
 1523 incidents that result in serious harm to the patient.  
 1524 Notification of outcomes of care that result in harm to the  
 1525 patient under this section shall not constitute an  
 1526 acknowledgement of admission of liability, nor can such  
 1527 notifications be introduced as evidence in any civil lawsuit.

1528 Section 20. Patient safety discount.-- A health care  
 1529 facility licensed pursuant to chapter 395, Florida Statutes, may



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1530 apply to the Department of Financial Services for certification  
 1531 of any program that is recommended by the Florida Center for  
 1532 Excellence in Health Care to reduce adverse incidents, as  
 1533 defined in s. 395.0197, Florida Statutes, which result in the  
 1534 reduction of serious events at that facility. The department  
 1535 shall develop criteria for such certification. Insurers shall  
 1536 file with the department a discount in the rate or rates  
 1537 applicable for insurance coverage to reflect the effect of a  
 1538 certified program. A health care facility shall receive a  
 1539 discount in the rate or rates applicable for mandated basic  
 1540 insurance coverage required by law. In reviewing filings under  
 1541 this section, the department shall consider whether, and the  
 1542 extent to which, the program certified under this section is  
 1543 otherwise covered under a program of risk management offered by  
 1544 an insurance company or exchange or self-insurance plan  
 1545 providing medical professional liability coverage.

1546 Section 21. Subsection (4) is added to section 456.063,  
 1547 Florida Statutes, to read:

1548 456.063 Sexual misconduct; disqualification for license,  
 1549 certificate, or registration.--

1550 (4) Each board, or the department if there is no board,  
 1551 may adopt rules to implement the requirements for reporting  
 1552 allegations of sexual misconduct, including rules to determine  
 1553 the sufficiency of the allegations.

1554 Section 22. Subsection (4) of section 456.072, Florida  
 1555 Statutes, is amended, and subsection (7) is added to said  
 1556 section, to read:

1557 456.072 Grounds for discipline; penalties; enforcement.--

1558 (4) In any addition to any other discipline imposed  
 1559 ~~through~~ final order, or citation, entered on or after July 1,



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1560 2001, that imposes a penalty or other form of discipline  
1561 pursuant to this section or ~~discipline imposed through final~~  
1562 ~~order, or citation, entered on or after July 1, 2001,~~ for a  
1563 violation of any practice act, the board, or the department when  
1564 there is no board, shall assess costs related to the  
1565 investigation and prosecution of the case, including costs  
1566 associated with an attorney's time. The amount of costs to be  
1567 assessed shall be determined by the board, or the department  
1568 when there is no board, following its consideration of an  
1569 affidavit of itemized costs and any written objections thereto.  
1570 In any case in which ~~where the board or the department imposes~~ a  
1571 fine or assessment of costs imposed by the board or department  
1572 ~~and the fine or assessment~~ is not paid within a reasonable time,  
1573 such reasonable time to be prescribed in the rules of the board,  
1574 or the department when there is no board, or in the order  
1575 assessing such fines or costs, the department or the Department  
1576 of Legal Affairs may contract for the collection of, or bring a  
1577 civil action to recover, the fine or assessment.

1578 (7) In any formal administrative hearing conducted under  
1579 s. 120.57(1), the board or department shall establish grounds  
1580 for the discipline of a licensee by the greater weight of the  
1581 evidence.

1582 Section 23. Subsections (1) and (5) of section 456.073,  
1583 Florida Statutes, are amended to read:

1584 456.073 Disciplinary proceedings.-- Disciplinary  
1585 proceedings for each board shall be within the jurisdiction of  
1586 the department.

1587 (1) The department, for the boards under its jurisdiction,  
1588 shall cause to be investigated any complaint that is filed  
1589 before it if the complaint is in writing, signed by the



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1590 complainant, and legally sufficient. A complaint is legally  
1591 sufficient if it contains ultimate facts that show that a  
1592 violation of this chapter, of any of the practice acts relating  
1593 to the professions regulated by the department, or of any rule  
1594 adopted by the department or a regulatory board in the  
1595 department has occurred. In order to determine legal  
1596 sufficiency, the department may require supporting information  
1597 or documentation. The department may investigate, and the  
1598 department or the appropriate board may take appropriate final  
1599 action on, a complaint even though the original complainant  
1600 withdraws it or otherwise indicates a desire not to cause the  
1601 complaint to be investigated or prosecuted to completion. The  
1602 department may investigate an anonymous complaint if the  
1603 complaint is in writing and is legally sufficient, if the  
1604 alleged violation of law or rules is substantial, and if the  
1605 department has reason to believe, after preliminary inquiry,  
1606 that the violations alleged in the complaint are true. The  
1607 department may investigate a complaint made by a confidential  
1608 informant if the complaint is legally sufficient, if the alleged  
1609 violation of law or rule is substantial, and if the department  
1610 has reason to believe, after preliminary inquiry, that the  
1611 allegations of the complainant are true. The department may  
1612 initiate an investigation if it has reasonable cause to believe  
1613 that a licensee or a group of licensees has violated a Florida  
1614 statute, a rule of the department, or a rule of a board. The  
1615 department may investigate information filed pursuant to s.  
1616 456.041(4) relating to liability actions with respect to health  
1617 care practitioners licensed under chapter 458 and chapter 459  
1618 which have been reported under s. 456.049 or s. 627.912 within  
1619 the previous 5 years for any paid claim that exceeds \$50,000.



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1620 Except as provided in ss. 458.331(9), 459.015(9), 460.413(5),  
1621 and 461.013(6), when an investigation of any subject is  
1622 undertaken, the department shall promptly furnish to the subject  
1623 or the subject's attorney a copy of the complaint or document  
1624 that resulted in the initiation of the investigation. The  
1625 subject may submit a written response to the information  
1626 contained in such complaint or document within 20 days after  
1627 service to the subject of the complaint or document. The  
1628 subject's written response shall be considered by the probable  
1629 cause panel. The right to respond does not prohibit the issuance  
1630 of a summary emergency order if necessary to protect the public.  
1631 However, if the secretary, or the secretary's designee, and the  
1632 chair of the respective board or the chair of its probable cause  
1633 panel agree in writing that such notification would be  
1634 detrimental to the investigation, the department may withhold  
1635 notification. The department may conduct an investigation  
1636 without notification to any subject if the act under  
1637 investigation is a criminal offense.

1638 (5)(a) A formal hearing before an administrative law judge  
1639 from the Division of Administrative Hearings shall be held  
1640 pursuant to chapter 120 if there are any disputed issues of  
1641 material fact. The administrative law judge shall issue a  
1642 recommended order pursuant to chapter 120. If any party raises  
1643 an issue of disputed fact during an informal hearing, the  
1644 hearing shall be terminated and a formal hearing pursuant to  
1645 chapter 120 shall be held.

1646 (b) Notwithstanding s. 120.569(2), the department shall  
1647 notify the Division of Administrative Hearings within 45 days  
1648 after receipt of a petition or request for a hearing that the



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1649 department has determined requires a formal hearing before an  
 1650 administrative law judge.

1651 Section 24. Subsections (1) and (2) of section 456.077,  
 1652 Florida Statutes, are amended to read:

1653 456.077 Authority to issue citations.--

1654 (1) Notwithstanding s. 456.073, the board, or the  
 1655 department if there is no board, shall adopt rules to permit the  
 1656 issuance of citations. The citation shall be issued to the  
 1657 subject and shall contain the subject's name and address, the  
 1658 subject's license number if applicable, a brief factual  
 1659 statement, the sections of the law allegedly violated, and the  
 1660 penalty imposed. The citation must clearly state that the  
 1661 subject may choose, in lieu of accepting the citation, to follow  
 1662 the procedure under s. 456.073. If the subject disputes the  
 1663 matter in the citation, the procedures set forth in s. 456.073  
 1664 must be followed. However, if the subject does not dispute the  
 1665 matter in the citation with the department within 30 days after  
 1666 the citation is served, the citation becomes a public final  
 1667 order and does not constitute ~~constitutes~~ discipline for a first  
 1668 offense, but does constitute discipline for a second or  
 1669 subsequent offense. The penalty shall be a fine or other  
 1670 conditions as established by rule.

1671 (2) The board, or the department if there is no board,  
 1672 shall adopt rules designating violations for which a citation  
 1673 may be issued. Such rules shall designate as citation violations  
 1674 those violations for which there is no substantial threat to the  
 1675 public health, safety, and welfare or no violation of standard  
 1676 of care involving injury to a patient. Violations for which a  
 1677 citation may be issued shall include violations of continuing  
 1678 education requirements; failure to timely pay required fees and





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1679 fines; failure to comply with the requirements of ss. 381.026  
 1680 and 381.0261 regarding the dissemination of information  
 1681 regarding patient rights; failure to comply with advertising  
 1682 requirements; failure to timely update practitioner profile and  
 1683 credentialing files; failure to display signs, licenses, and  
 1684 permits; failure to have required reference books available; and  
 1685 all other violations that do not pose a direct and serious  
 1686 threat to the health and safety of the patient or involve a  
 1687 violation of standard of care that has resulted in injury to a  
 1688 patient.

1689 Section 25. Subsections (1) and (2) of section 456.078,  
 1690 Florida Statutes, are amended to read:

1691 456.078 Mediation.--

1692 (1) Notwithstanding the provisions of s. 456.073, the  
 1693 board, or the department when there is no board, shall adopt  
 1694 rules to designate which violations of the applicable  
 1695 professional practice act are appropriate for mediation. The  
 1696 board, or the department when there is no board, shall ~~may~~  
 1697 designate as mediation offenses those complaints where harm  
 1698 caused by the licensee is economic in nature, except any act or  
 1699 omission involving intentional misconduct, ~~or~~ can be remedied by  
 1700 the licensee, is not a standard of care violation involving any  
 1701 type of injury to a patient, or does not result in an adverse  
 1702 incident. For the purposes of this section, an "adverse  
 1703 incident" means an event that results in:

- 1704 (a) The death of a patient;
- 1705 (b) Brain or spinal damage to a patient;
- 1706 (c) The performance of a surgical procedure on the wrong  
 1707 patient;
- 1708 (d) The performance of a wrong-site surgical procedure;



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1709       (e) The performance of a surgical procedure that is  
1710 medically unnecessary or otherwise unrelated to the patient's  
1711 diagnosis or medical condition;

1712       (f) The surgical repair of damage to a patient resulting  
1713 from a planned surgical procedure, which damage is not a  
1714 recognized specific risk as disclosed to the patient and  
1715 documented through the informed-consent process;

1716       (g) The performance of a procedure to remove unplanned  
1717 foreign objects remaining from a surgical procedure; or

1718       (h) The performance of any other surgical procedure that  
1719 breached the standard of care.

1720       (2) After the department determines a complaint is legally  
1721 sufficient and the alleged violations are defined as mediation  
1722 offenses, the department or any agent of the department may  
1723 conduct informal mediation to resolve the complaint. If the  
1724 complainant and the subject of the complaint agree to a  
1725 resolution of a complaint within 14 days after contact by the  
1726 mediator, the mediator shall notify the department of the terms  
1727 of the resolution. The department or board shall take no further  
1728 action unless the complainant and the subject each fail to  
1729 record with the department an acknowledgment of satisfaction of  
1730 the terms of mediation within 60 days of the mediator's  
1731 notification to the department. A successful mediation which  
1732 results in an award of \$50,000 or less shall not constitute  
1733 discipline. In the event the complainant and subject fail to  
1734 reach settlement terms or to record the required acknowledgment,  
1735 the department shall process the complaint according to the  
1736 provisions of s. 456.073.

1737       Section 26. Civil immunity for members of or consultants  
1738 to certain boards, committees, or other entities.--



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1739       (1) Each member of, or health care professional consultant  
1740 to, any committee, board, group, commission, or other entity  
1741 shall be immune from civil liability for any act, decision,  
1742 omission, or utterance done or made in performance of his or her  
1743 duties while serving as a member of or consultant to such  
1744 committee, board, group, commission, or other entity established  
1745 and operated for purposes of quality improvement review,  
1746 evaluation, and planning in a state-licensed health care  
1747 facility. Such entities must function primarily to review,  
1748 evaluate, or make recommendations relating to:

1749       (a) The duration of patient stays in health care  
1750 facilities;

1751       (b) The professional services furnished with respect to  
1752 the medical, dental, psychological, podiatric, chiropractic, or  
1753 optometric necessity for such services;

1754       (c) The purpose of promoting the most efficient use of  
1755 available health care facilities and services;

1756       (d) The adequacy or quality of professional services;

1757       (e) The competency and qualifications for professional  
1758 staff privileges;

1759       (f) The reasonableness or appropriateness of charges made  
1760 by or on behalf of health care facilities; or

1761       (g) Patient safety, including entering into contracts with  
1762 patient safety organizations.

1763       (2) Such committee, board, group, commission, or other  
1764 entity must be established in accordance with state law or in  
1765 accordance with requirements of the Joint Commission on  
1766 Accreditation of Healthcare Organizations, established and duly  
1767 constituted by one or more public or licensed private hospitals  
1768 or behavioral health agencies, or established by a governmental



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1769 agency. To be protected by this section, the act, decision,  
1770 omission, or utterance may not be made or done in bad faith or  
1771 with malicious intent.

1772 Section 27. Patient safety data privilege.--

1773 (1) As used in this section, the term:

1774 (a) "Patient safety data" means reports made to patient  
1775 safety organizations, including all health care data,  
1776 interviews, memoranda, analyses, root cause analyses, products  
1777 of quality assurance or quality improvement processes,  
1778 corrective action plans, or information collected or created by  
1779 a health care facility licensed under chapter 395, Florida  
1780 Statutes, or a health care practitioner as defined in s.  
1781 456.001(4), Florida Statutes, as a result of an occurrence  
1782 related to the provision of health care services which  
1783 exacerbates an existing medical condition or could result in  
1784 injury, illness, or death.

1785 (b) "Patient safety organization" means any organization,  
1786 group, or other entity that collects and analyzes patient safety  
1787 data for the purpose of improving patient safety and health care  
1788 outcomes and that is independent and not under the control of  
1789 the entity that reports patient safety data.

1790 (2) Patient safety data shall not be subject to discovery  
1791 or introduction into evidence in any civil or administrative  
1792 action.

1793 (3) Unless otherwise provided by law, a patient safety  
1794 organization shall promptly remove all patient-identifying  
1795 information after receipt of a complete patient safety data  
1796 report unless such organization is otherwise permitted by state  
1797 or federal law to maintain such information. Patient safety  
1798 organizations shall maintain the confidentiality of all patient-



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1799 identifying information and may not disseminate such  
1800 information, except as permitted by state or federal law.

1801 (4) The exchange of patient safety data among health care  
1802 facilities licensed under chapter 395, Florida Statutes, or  
1803 health care practitioners as defined in s. 456.001 (4), Florida  
1804 Statutes, or patient safety organizations which does not  
1805 identify any patient shall not constitute a waiver of any  
1806 privilege established in this section.

1807 (5) Reporting of patient safety data to patient safety  
1808 organizations does not abrogate obligations to make reports to  
1809 the Department of Health, the Agency for Health Care  
1810 Administration, or other state or federal regulatory agencies.

1811 (6) An employer may not take retaliatory action against an  
1812 employee who in good faith makes a report of patient safety data  
1813 to a patient safety organization.

1814 Section 28. Each board within the Department of Health  
1815 which has jurisdiction over health care practitioners who are  
1816 authorized to prescribe drugs may adopt by rule standards of  
1817 practice for health care practitioners who are under that  
1818 board's jurisdiction for the safe and ethical prescription of  
1819 drugs to patients via the Internet or other electronic means.

1820 Section 29. The Office of Program Policy Analysis and  
1821 Government Accountability and the Office of the Auditor General  
1822 must jointly conduct an audit of the Department of Health's  
1823 health care practitioner disciplinary process and closed claims  
1824 that are filed with the department under s. 627.912, Florida  
1825 Statutes. The Office of Program Policy Analysis and Government  
1826 Accountability and the Office of the Auditor General shall  
1827 submit a report to the Legislature by January 1, 2004.

1828 Section 30. Subsection (10) is added to section 458.320,



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1829 Florida Statutes, subsection (8) of said section is renumbered  
1830 as subsection (9), and a new subsection (8) is added to said  
1831 section, to read:

1832 458.320 Financial responsibility.--

1833 (8) Notwithstanding any other provision of this section,  
1834 the department shall suspend the license of any physician who  
1835 does not have insurance as required by this section against whom  
1836 has been entered a final judgment, arbitration award, or other  
1837 order or who has entered into a settlement agreement to pay  
1838 damages arising out of a claim for medical malpractice, if all  
1839 appellate remedies have been exhausted and payment up to the  
1840 amounts required by this section has not been made within 30  
1841 days after the entering of such judgment, award, order, or  
1842 agreement, until proof of payment is received by the department  
1843 or a payment schedule has been agreed upon by the physician and  
1844 the claimant and presented to the department. This subsection  
1845 does not apply to a physician who has met the financial  
1846 responsibility requirements in paragraphs (1)(b) and (2)(b).

1847 (10) Nothing in this section shall be construed as  
1848 creating a civil cause of action against any hospital as a  
1849 result of the failure of any physician with staff privileges to  
1850 comply with the requirements of this section.

1851 Section 31. Paragraph (t) of subsection (1) and  
1852 subsections (3) and (6) of section 458.331, Florida Statutes,  
1853 are amended to read:

1854 458.331 Grounds for disciplinary action; action by the  
1855 board and department.--

1856 (1) The following acts constitute grounds for denial of a  
1857 license or disciplinary action, as specified in s. 456.072(2):



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1858 (t) Gross or repeated malpractice or the failure to  
1859 practice medicine with that level of care, skill, and treatment  
1860 which is recognized by a reasonably prudent similar physician as  
1861 being acceptable under similar conditions and circumstances. The  
1862 board shall give great weight to the provisions of s. 766.102  
1863 when enforcing this paragraph. As used in this paragraph,  
1864 "repeated malpractice" includes, but is not limited to, three or  
1865 more claims for medical malpractice within the previous 5-year  
1866 period resulting in indemnities being paid in excess of \$50,000  
1867 ~~\$25,000~~ each to the claimant in a judgment or settlement and  
1868 which incidents involved negligent conduct by the physician. As  
1869 used in this paragraph, "gross malpractice" or "the failure to  
1870 practice medicine with that level of care, skill, and treatment  
1871 which is recognized by a reasonably prudent similar physician as  
1872 being acceptable under similar conditions and circumstances,"  
1873 shall not be construed so as to require more than one instance,  
1874 event, or act. Nothing in this paragraph shall be construed to  
1875 require that a physician be incompetent to practice medicine in  
1876 order to be disciplined pursuant to this paragraph.

1877 (3) In any administrative action against a physician ~~which~~  
1878 ~~does not involve revocation or suspension of license~~, the  
1879 division shall have the burden, by the greater weight of the  
1880 evidence, to establish the existence of grounds for disciplinary  
1881 action. ~~The division shall establish grounds for revocation or~~  
1882 ~~suspension of license by clear and convincing evidence.~~

1883 (6) Upon the department's receipt from an insurer or self-  
1884 insurer of a report of a closed claim against a physician  
1885 pursuant to s. 627.912 or from a health care practitioner of a  
1886 report pursuant to s. 456.049, or upon the receipt from a  
1887 claimant of a presuit notice against a physician pursuant to s.



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1888 766.106, the department shall review each report and determine  
 1889 whether it potentially involved conduct by a licensee that is  
 1890 subject to disciplinary action, in which case the provisions of  
 1891 s. 456.073 shall apply. However, if it is reported that a  
 1892 physician has had three or more claims with indemnities  
 1893 exceeding \$50,000 ~~\$25,000~~ each within the previous 5-year  
 1894 period, the department shall investigate the occurrences upon  
 1895 which the claims were based and determine if action by the  
 1896 department against the physician is warranted.

1897 Section 32. Section 458.3311, Florida Statutes, is created  
 1898 to read:

1899 458.3311 Emergency procedures for disciplinary action.--  
 1900 Notwithstanding any other provision of law to the contrary:

1901 (1) Each physician must report to the Department of Health  
 1902 any judgment for medical negligence levied against the  
 1903 physician. The physician must make the report no later than 15  
 1904 days after the exhaustion of the last opportunity for any party  
 1905 to appeal the judgment or request a rehearing.

1906 (2) No later than 30 days after a physician has, within a  
 1907 60-month period, made three reports as required by subsection  
 1908 (1), the Department of Health shall initiate an emergency  
 1909 investigation and the Board of Medicine shall conduct an  
 1910 emergency probable cause hearing to determine whether the  
 1911 physician should be disciplined for a violation of s.  
 1912 458.331(1)(t) or any other relevant provision of law.

1913 Section 33. Subsection (11) is added to section 459.0085,  
 1914 Florida Statutes, subsection (9) of said section is renumbered  
 1915 as subsection (10), and a new subsection (9) is added to said  
 1916 section, to read:

1917 459.0085 Financial responsibility.--





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1918       (9) Notwithstanding any other provision of this section,  
 1919 the department shall suspend the license of any osteopathic  
 1920 physician who does not have insurance as required by this  
 1921 section against whom has been entered a final judgment,  
 1922 arbitration award, or other order or who has entered into a  
 1923 settlement agreement to pay damages arising out of a claim for  
 1924 medical malpractice, if all appellate remedies have been  
 1925 exhausted and payment up to the amounts required by this section  
 1926 has not been made within 30 days after the entering of such  
 1927 judgment, award, order, or agreement, until proof of payment is  
 1928 received by the department or a payment schedule has been agreed  
 1929 upon by the osteopathic physician and the claimant and presented  
 1930 to the department. This subsection does not apply to an  
 1931 osteopathic physician who has met the financial responsibility  
 1932 requirements in paragraphs (1)(b) and (2)(b).

1933       (11) Nothing in this section shall be construed as  
 1934 creating a civil cause of action against any hospital as a  
 1935 result of the failure of any physician with staff privileges to  
 1936 comply with the requirements of this section.

1937       Section 34. Paragraph (x) of subsection (1) and  
 1938 subsections (3) and (6) of section 459.015, Florida Statutes,  
 1939 are amended to read:

1940       459.015 Grounds for disciplinary action; action by the  
 1941 board and department.--

1942       (1) The following acts constitute grounds for denial of a  
 1943 license or disciplinary action, as specified in s. 456.072(2):

1944       (x) Gross or repeated malpractice or the failure to  
 1945 practice osteopathic medicine with that level of care, skill,  
 1946 and treatment which is recognized by a reasonably prudent  
 1947 similar osteopathic physician as being acceptable under similar



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1948 conditions and circumstances. The board shall give great weight  
 1949 to the provisions of s. 766.102 when enforcing this paragraph.  
 1950 As used in this paragraph, "repeated malpractice" includes, but  
 1951 is not limited to, three or more claims for medical malpractice  
 1952 within the previous 5-year period resulting in indemnities being  
 1953 paid in excess of \$50,000 ~~\$25,000~~ each to the claimant in a  
 1954 judgment or settlement and which incidents involved negligent  
 1955 conduct by the osteopathic physician. As used in this paragraph,  
 1956 "gross malpractice" or "the failure to practice osteopathic  
 1957 medicine with that level of care, skill, and treatment which is  
 1958 recognized by a reasonably prudent similar osteopathic physician  
 1959 as being acceptable under similar conditions and circumstances"  
 1960 shall not be construed so as to require more than one instance,  
 1961 event, or act. Nothing in this paragraph shall be construed to  
 1962 require that an osteopathic physician be incompetent to practice  
 1963 osteopathic medicine in order to be disciplined pursuant to this  
 1964 paragraph. A recommended order by an administrative law judge or  
 1965 a final order of the board finding a violation under this  
 1966 paragraph shall specify whether the licensee was found to have  
 1967 committed "gross malpractice," "repeated malpractice," or  
 1968 "failure to practice osteopathic medicine with that level of  
 1969 care, skill, and treatment which is recognized as being  
 1970 acceptable under similar conditions and circumstances," or any  
 1971 combination thereof, and any publication by the board shall so  
 1972 specify.

1973 (3) In any administrative action against a physician ~~which~~  
 1974 ~~does not involve revocation or suspension of license~~, the  
 1975 division shall have the burden, by the greater weight of the  
 1976 evidence, to establish the existence of grounds for disciplinary



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1977 action. ~~The division shall establish grounds for revocation or~~  
 1978 ~~suspension of license by clear and convincing evidence.~~

1979 (6) Upon the department's receipt from an insurer or self-  
 1980 insurer of a report of a closed claim against an osteopathic  
 1981 physician pursuant to s. 627.912 or from a health care  
 1982 practitioner of a report pursuant to s. 456.049, or upon the  
 1983 receipt from a claimant of a presuit notice against an  
 1984 osteopathic physician pursuant to s. 766.106, the department  
 1985 shall review each report and determine whether it potentially  
 1986 involved conduct by a licensee that is subject to disciplinary  
 1987 action, in which case the provisions of s. 456.073 shall apply.  
 1988 However, if it is reported that an osteopathic physician has had  
 1989 three or more claims with indemnities exceeding \$50,000 ~~\$25,000~~  
 1990 each within the previous 5-year period, the department shall  
 1991 investigate the occurrences upon which the claims were based and  
 1992 determine if action by the department against the osteopathic  
 1993 physician is warranted.

1994 Section 35. Section 459.0151, Florida Statutes, is created  
 1995 to read:

1996 459.0151 Emergency procedures for disciplinary action.--  
 1997 Notwithstanding any other provision of law to the contrary:

1998 (1) Each osteopathic physician must report to the  
 1999 Department of Health any judgment for medical negligence levied  
 2000 against the physician. The osteopathic physician must make the  
 2001 report no later than 15 days after the exhaustion of the last  
 2002 opportunity for any party to appeal the judgment or request a  
 2003 rehearing.

2004 (2) No later than 30 days after an osteopathic physician  
 2005 has, within a 60-month period, made three reports as required by  
 2006 subsection (1), the Department of Health shall initiate an



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2007 emergency investigation and the Board of Osteopathic Medicine  
 2008 shall conduct an emergency probable cause hearing to determine  
 2009 whether the physician should be disciplined for a violation of  
 2010 s. 459.015(1)(x) or any other relevant provision of law.

2011 Section 36. Paragraph (s) of subsection (1) and paragraph  
 2012 (a) of subsection (5) of section 461.013, Florida Statutes, are  
 2013 amended to read:

2014 461.013 Grounds for disciplinary action; action by the  
 2015 board; investigations by department.--

2016 (1) The following acts constitute grounds for denial of a  
 2017 license or disciplinary action, as specified in s. 456.072(2):

2018 (s) Gross or repeated malpractice or the failure to  
 2019 practice podiatric medicine at a level of care, skill, and  
 2020 treatment which is recognized by a reasonably prudent podiatric  
 2021 physician as being acceptable under similar conditions and  
 2022 circumstances. The board shall give great weight to the  
 2023 standards for malpractice in s. 766.102 in interpreting this  
 2024 section. As used in this paragraph, "repeated malpractice"  
 2025 includes, but is not limited to, three or more claims for  
 2026 medical malpractice within the previous 5-year period resulting  
 2027 in indemnities being paid in excess of \$50,000 ~~\$10,000~~ each to  
 2028 the claimant in a judgment or settlement and which incidents  
 2029 involved negligent conduct by the podiatric physicians. As used  
 2030 in this paragraph, "gross malpractice" or "the failure to  
 2031 practice podiatric medicine with the level of care, skill, and  
 2032 treatment which is recognized by a reasonably prudent similar  
 2033 podiatric physician as being acceptable under similar conditions  
 2034 and circumstances" shall not be construed so as to require more  
 2035 than one instance, event, or act.



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2036 (5)(a) Upon the department's receipt from an insurer or  
 2037 self-insurer of a report of a closed claim against a podiatric  
 2038 physician pursuant to s. 627.912, or upon the receipt from a  
 2039 claimant of a presuit notice against a podiatric physician  
 2040 pursuant to s. 766.106, the department shall review each report  
 2041 and determine whether it potentially involved conduct by a  
 2042 licensee that is subject to disciplinary action, in which case  
 2043 the provisions of s. 456.073 shall apply. However, if it is  
 2044 reported that a podiatric physician has had three or more claims  
 2045 with indemnities exceeding \$50,000 ~~\$25,000~~ each within the  
 2046 previous 5-year period, the department shall investigate the  
 2047 occurrences upon which the claims were based and determine if  
 2048 action by the department against the podiatric physician is  
 2049 warranted.

2050 Section 37. Paragraph (x) of subsection (1) of section  
 2051 466.028, Florida Statutes, is amended to read:

2052 466.028 Grounds for disciplinary action; action by the  
 2053 board.--

2054 (1) The following acts constitute grounds for denial of a  
 2055 license or disciplinary action, as specified in s. 456.072(2):

2056 (x) Being guilty of incompetence or negligence by failing  
 2057 to meet the minimum standards of performance in diagnosis and  
 2058 treatment when measured against generally prevailing peer  
 2059 performance, including, but not limited to, the undertaking of  
 2060 diagnosis and treatment for which the dentist is not qualified  
 2061 by training or experience or being guilty of dental malpractice.  
 2062 For purposes of this paragraph, it shall be legally presumed  
 2063 that a dentist is not guilty of incompetence or negligence by  
 2064 declining to treat an individual if, in the dentist's  
 2065 professional judgment, the dentist or a member of her or his



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2066 clinical staff is not qualified by training and experience, or  
 2067 the dentist's treatment facility is not clinically satisfactory  
 2068 or properly equipped to treat the unique characteristics and  
 2069 health status of the dental patient, provided the dentist refers  
 2070 the patient to a qualified dentist or facility for appropriate  
 2071 treatment. As used in this paragraph, "dental malpractice"  
 2072 includes, but is not limited to, three or more claims within the  
 2073 previous 5-year period which resulted in indemnity being paid,  
 2074 or any single indemnity paid in excess of \$25,000 ~~\$5,000~~ in a  
 2075 judgment or settlement, as a result of negligent conduct on the  
 2076 part of the dentist.

2077 Section 38. Subsection (2) of section 624.462, Florida  
 2078 Statutes, is amended to read:

2079 624.462 Commercial self-insurance funds.--

2080 (2) As used in ss. 624.460-624.488, "commercial self-  
 2081 insurance fund" or "fund" means a group of members, operating  
 2082 individually and collectively through a trust or corporation,  
 2083 that must be:

2084 (a) Established by:

2085 1. A not-for-profit trade association, industry  
 2086 association, or professional association of employers or  
 2087 professionals which has a constitution or bylaws, which is  
 2088 incorporated under the laws of this state, and which has been  
 2089 organized for purposes other than that of obtaining or providing  
 2090 insurance and operated in good faith for a continuous period of  
 2091 1 year;

2092 2. A self-insurance trust fund organized pursuant to s.  
 2093 627.357 and maintained in good faith for a continuous period of  
 2094 1 year for purposes other than that of obtaining or providing  
 2095 insurance pursuant to this section. Each member of a commercial



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2096 self-insurance trust fund established pursuant to this  
 2097 subsection must maintain membership in the self-insurance trust  
 2098 fund organized pursuant to s. 627.357; ~~or~~

2099 3. A group of 10 or more health care providers, as defined  
 2100 in s. 627.351(4)(h); or

2101 4.3. A not-for-profit group comprised of no less than 10  
 2102 condominium associations as defined in s. 718.103(2), which is  
 2103 incorporated under the laws of this state, which restricts its  
 2104 membership to condominium associations only, and which has been  
 2105 organized and maintained in good faith for a continuous period  
 2106 of 1 year for purposes other than that of obtaining or providing  
 2107 insurance.

2108 (b)1. In the case of funds established pursuant to  
 2109 subparagraph (a)2. or subparagraph (a)~~4.3.~~, operated pursuant to  
 2110 a trust agreement by a board of trustees which shall have  
 2111 complete fiscal control over the fund and which shall be  
 2112 responsible for all operations of the fund. The majority of the  
 2113 trustees shall be owners, partners, officers, directors, or  
 2114 employees of one or more members of the fund. The trustees shall  
 2115 have the authority to approve applications of members for  
 2116 participation in the fund and to contract with an authorized  
 2117 administrator or servicing company to administer the day-to-day  
 2118 affairs of the fund.

2119 2. In the case of funds established pursuant to  
 2120 subparagraph (a)1. or subparagraph (a)3., operated pursuant to a  
 2121 trust agreement by a board of trustees or as a corporation by a  
 2122 board of directors which board shall:

2123 a. Be responsible to members of the fund or beneficiaries  
 2124 of the trust or policyholders of the corporation;



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- 2125           b. Appoint independent certified public accountants, legal
- 2126           counsel, actuaries, and investment advisers as needed;
- 2127           c. Approve payment of dividends to members;
- 2128           d. Approve changes in corporate structure; and
- 2129           e. Have the authority to contract with an administrator
- 2130           authorized under s. 626.88 to administer the day-to-day affairs
- 2131           of the fund including, but not limited to, marketing,
- 2132           underwriting, billing, collection, claims administration, safety
- 2133           and loss prevention, reinsurance, policy issuance, accounting,
- 2134           regulatory reporting, and general administration. The fees or
- 2135           compensation for services under such contract shall be
- 2136           comparable to the costs for similar services incurred by
- 2137           insurers writing the same lines of insurance, or where available
- 2138           such expenses as filed by boards, bureaus, and associations
- 2139           designated by insurers to file such data. A majority of the
- 2140           trustees or directors shall be owners, partners, officers,
- 2141           directors, or employees of one or more members of the fund.

2142           Section 39. Paragraph (a) of subsection (6) of section

2143           627.062, Florida Statutes, is amended and subsections (7), (8),

2144           (9), and (10) are added to said section, to read:

2145           627.062 Rate standards.--

2146           (6)(a) After any action with respect to a rate filing that

2147           constitutes agency action for purposes of the Administrative

2148           Procedure Act, except for a rate filing for medical malpractice

2149           insurance, an insurer may, in lieu of demanding a hearing under

2150           s. 120.57, require arbitration of the rate filing. Arbitration

2151           shall be conducted by a board of arbitrators consisting of an

2152           arbitrator selected by the department, an arbitrator selected by

2153           the insurer, and an arbitrator selected jointly by the other two

2154           arbitrators. Each arbitrator must be certified by the American





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2155 Arbitration Association. A decision is valid only upon the  
2156 affirmative vote of at least two of the arbitrators. No  
2157 arbitrator may be an employee of any insurance regulator or  
2158 regulatory body or of any insurer, regardless of whether or not  
2159 the employing insurer does business in this state. The  
2160 department and the insurer must treat the decision of the  
2161 arbitrators as the final approval of a rate filing. Costs of  
2162 arbitration shall be paid by the insurer.

2163 (7) Notwithstanding any other provision of this section,  
2164 in matters relating to professional liability insurance coverage  
2165 for medical negligence, any portion of a judgment entered as a  
2166 result of a statutory or common-law bad faith action and any  
2167 portion of a judgment entered that awards punitive damages  
2168 against an insurer may not be included in the insurer's rate  
2169 base and may not be used to justify a rate or rate change. In  
2170 matters relating to professional liability insurance coverage  
2171 for medical negligence, any portion of a settlement entered as a  
2172 result of a statutory or common-law bad faith action identified  
2173 as such and any portion of a settlement wherein an insurer  
2174 agrees to pay specific punitive damages may not be used to  
2175 justify a rate or rate change. The portion of the taxable costs  
2176 and attorney's fees that is identified as being related to the  
2177 bad faith and punitive damages in these judgments and  
2178 settlements may not be included in the insurer's rate base and  
2179 may not be utilized to justify a rate or rate change.

2180 (8) Each insurer writing professional liability insurance  
2181 coverage for medical negligence must make a rate filing under  
2182 this section with the Office of Insurance Regulation at least  
2183 once each calendar year.

2184 (9) Medical malpractice insurance companies shall submit a



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2185 rate filing to the Office of Insurance Regulation no earlier  
2186 than 30 days, but no later than 120 days, after the date upon  
2187 which this act becomes law.

2188 (10)(a) The provisions of this subsection apply only with  
2189 respect to rates for medical malpractice insurance and shall  
2190 control to the extent of any conflict with other provisions of  
2191 this section.

2192 (b) Any portion of a judgment entered or settlement paid  
2193 as a result of a statutory or common-law bad faith action and  
2194 any portion of a judgment entered which awards punitive damages  
2195 against an insurer may not be included in the insurer's rate  
2196 base and shall not be used to justify a rate or rate change. Any  
2197 common-law bad faith action identified as such and any portion  
2198 of a settlement entered as a result of a statutory or portion of  
2199 a settlement wherein an insurer agrees to pay specific punitive  
2200 damages may not be used to justify a rate or rate change. The  
2201 portion of the taxable costs and attorney's fees which is  
2202 identified as being related to the bad faith and punitive  
2203 damages in these judgments and settlements may not be included  
2204 in the insurer's rate base and may not be utilized to justify a  
2205 rate or rate change.

2206 (c) Upon reviewing a rate filing and determining whether  
2207 the rate is excessive, inadequate, or unfairly discriminatory,  
2208 the Office of Insurance Regulation shall consider, in accordance  
2209 with generally accepted and reasonable actuarial techniques,  
2210 past and present prospective loss experience, either using loss  
2211 experience solely for this state or giving greater credibility  
2212 to this state's loss data.

2213 (d) Rates shall be deemed excessive if, among other  
2214 standards established by this section, the rate structure



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2215 provides for replenishment of reserves or surpluses from  
 2216 premiums when the replenishment is attributable to investment  
 2217 losses.

2218 (e) The insurer must apply a discount or surcharge based  
 2219 on the health care provider's loss experience or shall establish  
 2220 an alternative method giving due consideration to the provider's  
 2221 loss experience. The insurer must include in the filing a copy  
 2222 of the surcharge or discount schedule or a description of the  
 2223 alternative method used and must provide a copy of such schedule  
 2224 or description, as approved by the office, to policyholders at  
 2225 the time of renewal and to prospective policyholders at the time  
 2226 of application for coverage.

2227 Section 40. Section 627.0662, Florida Statutes, is created  
 2228 to read:

2229 627.0662 Excessive profits for medical liability insurance  
 2230 prohibited.--

2231 (1) As used in this section:

2232 (a) "Medical liability insurance" means insurance that is  
 2233 written on a professional liability insurance policy issued to a  
 2234 health care practitioner or on a liability insurance policy  
 2235 covering medical malpractice claims issued to a health care  
 2236 facility.

2237 (b) "Medical liability insurer" means any insurance  
 2238 company or group of insurance companies writing medical  
 2239 liability insurance in this state and does not include any self-  
 2240 insurance fund or other nonprofit entity writing such insurance.

2241 (2) Each medical liability insurer shall file with the  
 2242 Office of Insurance Regulation, prior to July 1 of each year on  
 2243 forms prescribed by the office, the following data for medical  
 2244 liability insurance business in this state. The data shall



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2245 include both voluntary and joint underwriting association  
2246 business, as follows:

2247 (a) Calendar-year earned premium.

2248 (b) Accident-year incurred losses and loss adjustment  
2249 expenses.

2250 (c) The administrative and selling expenses incurred in  
2251 this state or allocated to this state for the calendar year.

2252 (d) Policyholder dividends incurred during the applicable  
2253 calendar year.

2254 (3)(a) Excessive profit has been realized if there has  
2255 been an underwriting gain for the 3 most recent calendar-  
2256 accident years combined which is greater than the anticipated  
2257 underwriting profit plus 5 percent of earned premiums for those  
2258 calendar-accident years.

2259 (b) As used in this subsection with respect to any 3-year  
2260 period, "anticipated underwriting profit" means the sum of the  
2261 dollar amounts obtained by multiplying, for each rate filing of  
2262 the insurer group in effect during such period, the earned  
2263 premiums applicable to such rate filing during such period by  
2264 the percentage factor included in such rate filing for profit  
2265 and contingencies, such percentage factor having been determined  
2266 with due recognition to investment income from funds generated  
2267 by business in this state. Separate calculations need not be  
2268 made for consecutive rate filings containing the same percentage  
2269 factor for profits and contingencies.

2270 (4) Each medical liability insurer shall also file a  
2271 schedule of medical liability insurance loss in this state and  
2272 loss adjustment experience for each of the 3 most recent  
2273 accident years. The incurred losses and loss adjustment expenses  
2274 shall be valued as of March 31 of the year following the close



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2275 of the accident year, developed to an ultimate basis, and at two  
2276 12-month intervals thereafter, each developed to an ultimate  
2277 basis, to the extent that a total of three evaluations is  
2278 provided for each accident year. The first year to be so  
2279 reported shall be accident year 2004, such that the reporting of  
2280 3 accident years will not take place until accident years 2005  
2281 and 2006 have become available.

2282 (5) Each insurer group's underwriting gain or loss for  
2283 each calendar-accident year shall be computed as follows: the  
2284 sum of the accident-year incurred losses and loss adjustment  
2285 expenses as of March 31 of the following year, developed to an  
2286 ultimate basis, plus the administrative and selling expenses  
2287 incurred in the calendar year, plus policyholder dividends  
2288 applicable to the calendar year, shall be subtracted from the  
2289 calendar-year earned premium to determine the underwriting gain  
2290 or loss.

2291 (6) For the 3 most recent calendar-accident years, the  
2292 underwriting gain or loss shall be compared to the anticipated  
2293 underwriting profit.

2294 (7) If the medical liability insurer has realized an  
2295 excessive profit, the office shall order a return of the  
2296 excessive amounts to policyholders after affording the insurer  
2297 an opportunity for hearing and otherwise complying with the  
2298 requirements of chapter 120. Such excessive amounts shall be  
2299 refunded to policyholders in all instances unless the insurer  
2300 affirmatively demonstrates to the office that the refund of the  
2301 excessive amounts will render the insurer or a member of the  
2302 insurer group financially impaired or will render it insolvent.

2303 (8) The excessive amount shall be refunded to  
2304 policyholders on a pro rata basis in relation to the final



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2305 compilation year earned premiums to the voluntary medical  
 2306 liability insurance policyholders of record of the insurer group  
 2307 on December 31 of the final compilation year.

2308 (9) Any return of excessive profits to policyholders under  
 2309 this section shall be provided in the form of a cash refund or a  
 2310 credit towards the future purchase of insurance.

2311 (10)(a) Cash refunds to policyholders may be rounded to  
 2312 the nearest dollar.

2313 (b) Data in required reports to the office may be rounded  
 2314 to the nearest dollar.

2315 (c) Rounding, if elected by the insurer group, shall be  
 2316 applied consistently.

2317 (11)(a) Refunds to policyholders shall be completed as  
 2318 follows:

2319 1. If the insurer elects to make a cash refund, the refund  
 2320 shall be completed within 60 days after entry of a final order  
 2321 determining that excessive profits have been realized; or

2322 2. If the insurer elects to make refunds in the form of a  
 2323 credit to renewal policies, such credits shall be applied to  
 2324 policy renewal premium notices which are forwarded to insureds  
 2325 more than 60 calendar days after entry of a final order  
 2326 determining that excessive profits have been realized. If an  
 2327 insurer has made this election but an insured thereafter cancels  
 2328 his or her policy or otherwise allows the policy to terminate,  
 2329 the insurer group shall make a cash refund not later than 60  
 2330 days after termination of such coverage.

2331 (b) Upon completion of the renewal credits or refund  
 2332 payments, the insurer shall immediately certify to the office  
 2333 that the refunds have been made.



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2334       (12) Any refund or renewal credit made pursuant to this  
 2335 section shall be treated as a policyholder dividend applicable  
 2336 to the year in which it is incurred, for purposes of reporting  
 2337 under this section for subsequent years.

2338           Section 41. Subsection (10) of section 627.357, Florida  
 2339 Statutes, is amended to read:

2340           627.357 Medical malpractice self-insurance.--

2341           (10)(a) An application to form a self-insurance fund under  
 2342 this section must be filed with the Office of Insurance  
 2343 Regulation.

2344           (b) The Office of Insurance Regulation must ensure that  
 2345 self-insurance funds remain solvent and provide insurance  
 2346 coverage purchased by participants. The Financial Services  
 2347 Commission may adopt rules pursuant to ss. 120.536(1) and 120.54  
 2348 to implement this subsection ~~A self-insurance fund may not be~~  
 2349 ~~formed under this section after October 1, 1992.~~

2350           Section 42. Section 627.3575, Florida Statutes, is created  
 2351 to read:

2352           627.3575 Health Care Professional Liability Insurance  
 2353 Facility.--

2354           (1) FACILITY CREATED; PURPOSE; STATUS.-- There is created  
 2355 the Health Care Professional Liability Insurance Facility. The  
 2356 facility is intended to meet ongoing availability and  
 2357 affordability problems relating to liability insurance for  
 2358 health care professionals by providing an affordable, self-  
 2359 supporting source of excess insurance coverage for those  
 2360 professionals who are willing and able to self-insure for  
 2361 smaller losses. The facility shall operate on a not-for-profit  
 2362 basis. The facility is self-funding and is intended to serve a



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2363 public purpose but is not a state agency or program, and no  
2364 activity of the facility shall create any state liability.

2365 (2) GOVERNANCE; POWERS.--

2366 (a) The facility shall operate under a seven-member board  
2367 of governors consisting of the Secretary of Health, three  
2368 members appointed by the Governor, and three members appointed  
2369 by the Chief Financial Officer. The board shall be chaired by  
2370 the Secretary of Health. The secretary shall serve by virtue of  
2371 his or her office, and the other members of the board shall  
2372 serve terms concurrent with the term of office of the official  
2373 who appointed them. Any vacancy on the board shall be filled in  
2374 the same manner as the original appointment. Members serve at  
2375 the pleasure of the official who appointed them. Members are not  
2376 eligible for compensation for their service on the board, but  
2377 the facility may reimburse them for per diem and travel expenses  
2378 at the same levels as are provided in s. 112.061 for state  
2379 employees.

2380 (b) The facility shall have such powers as are necessary  
2381 to operate as an insurer, including the power to:

2382 1. Sue and be sued.

2383 2. Hire such employees and retain such consultants,  
2384 attorneys, actuaries, and other professionals as it deems  
2385 appropriate.

2386 3. Contract with such service providers as it deems  
2387 appropriate.

2388 4. Maintain offices appropriate to the conduct of its  
2389 business.

2390 5. Take such other actions as are necessary or appropriate  
2391 in fulfillment of its responsibilities under this section.

2392 (3) COVERAGE PROVIDED.-- The facility shall provide





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2393 liability insurance coverage for health care professionals. The  
2394 facility shall allow policyholders to select from policies with  
2395 deductibles of \$25,000 per claim, \$50,000 per claim, and  
2396 \$100,000 per claim and with coverage limits of \$250,000 per  
2397 claim and \$750,000 annual aggregate and \$1 million per claim and  
2398 \$3 million annual aggregate. To the greatest extent possible,  
2399 the terms and conditions of the policies shall be consistent  
2400 with terms and conditions commonly used by professional  
2401 liability insurers. The facility shall offer policies to cover  
2402 health care professionals who have retired from practice or  
2403 maintain a part-time practice as set forth herein. For health  
2404 care professionals who meet the following requirements, the  
2405 premiums for such policies shall be no more than 50% of the cost  
2406 of premiums for similar specialties for health care  
2407 professionals who meet each of the following requirements:

2408 (a) The health care professional has held an active  
2409 license to practice in this state or another state or some  
2410 combination thereof for more than 15 years.

2411 (b) The health care professional has either retired from  
2412 the practice of medicine or maintains a part-time practice of no  
2413 more than 1,000 patient contact hours per year.

2414 (c) The health care professional has had no more than two  
2415 claims for medical malpractice resulting in an indemnity  
2416 exceeding \$50,000 each within the previous 5-year period.

2417 (d) The health care professional has not been convicted  
2418 of, or pled guilty or nolo contendere to, any criminal violation  
2419 specified in this chapter or the medical practice act of any  
2420 other state.

2421 (e) The health care professional has not been subject  
2422 within the last 10 years of practice to license revocation or



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2423 suspension for any period of time; probation for a period of 3  
2424 years or longer; or a fine of \$500 or more for a violation of  
2425 this chapter or the medical practice act of another  
2426 jurisdiction. The regulatory agency's acceptance of a health  
2427 care professional's relinquishment of a license, stipulation,  
2428 consent order, or other settlement, offered in response to or in  
2429 anticipation of the filing of administrative charges against the  
2430 health care professional's license, shall be construed as action  
2431 against the health care professional's license for the purposes  
2432 of this paragraph.

2433 (f) The health care professional has submitted a form  
2434 supplying necessary information as required by the department  
2435 and an affidavit affirming compliance with the provisions of  
2436 this subsection.

2437 (g) The health care professional submits biennially to the  
2438 facility certification stating compliance with the provisions of  
2439 this subsection. The health care professional shall, upon  
2440 request, demonstrate to the facility information verifying  
2441 compliance with this subsection.

2442 (4) ELIGIBILITY; TERMINATION.--

2443 (a) Any health care professional is eligible for coverage  
2444 provided by the facility if the professional at all times  
2445 maintains either:

2446 1. An escrow account consisting of cash or assets eligible  
2447 for deposit under s. 625.52 in an amount equal to the deductible  
2448 amount of the policy; or

2449 2. An unexpired, irrevocable letter of credit, established  
2450 pursuant to chapter 675, in an amount not less than the  
2451 deductible amount of the policy. The letter of credit shall be  
2452 payable to the health care professional as beneficiary upon



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2453 presentment of a final judgment indicating liability and  
2454 awarding damages to be paid by the health care professional or  
2455 upon presentment of a settlement agreement signed by all parties  
2456 to such agreement when such final judgment or settlement is a  
2457 result of a claim arising out of the rendering of, or the  
2458 failure to render, medical care and services. Such letter of  
2459 credit shall be nonassignable and nontransferable. Such letter  
2460 of credit shall be issued by any bank or savings association  
2461 organized and existing under the laws of this state or any bank  
2462 or savings association organized under the laws of the United  
2463 States that has its principal place of business in this state or  
2464 has a branch office which is authorized under the laws of this  
2465 state or of the United States to receive deposits in this state.

2466 (b) The eligibility of a health care professional for  
2467 coverage terminates upon:

2468 1. The failure of the professional to comply with  
2469 paragraph (a);

2470 2. The failure of the professional to timely pay premiums  
2471 or assessments; or

2472 3. The commission of any act of fraud in connection with  
2473 the policy, as determined by the board of governors.

2474 (c) The board of governors, in its discretion, may  
2475 reinstate the eligibility of a health care professional whose  
2476 eligibility has terminated pursuant to paragraph (b) upon  
2477 determining that the professional has subsequently complied with  
2478 paragraph (a) or has paid the overdue premiums or assessments.  
2479 Eligibility may be reinstated in the case of fraud only if the  
2480 board determines that its initial determination of fraud was in  
2481 error.

2482 (5) PREMIUMS; ASSESSMENTS.--



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2483       (a) The facility shall charge the actuarially indicated  
2484 premium for the coverage provided and shall retain the services  
2485 of consulting actuaries to prepare its rate filings. The  
2486 facility shall not provide dividends to policyholders, and, to  
2487 the extent that premiums are more than the amount required to  
2488 cover claims and expenses, such excess shall be retained by the  
2489 facility for payment of future claims. In the event of  
2490 dissolution of the facility, any amounts not required as a  
2491 reserve for outstanding claims shall be transferred to the  
2492 policyholders of record as of the last day of operation.

2493       (b) To ensure that the facility has the funds to pay  
2494 claims, the facility shall receive:

2495           1. From each judgment awarded and settlement agreed to  
2496 from which a claim will be paid in whole or in part by the  
2497 facility, the facility shall retain one percent of its portion  
2498 of the award or settlement for deposit into a separate account  
2499 for guaranteeing payment of claims.

2500           2. A surcharge of \$100 on each medical malpractice policy  
2501 issued or renewed after July 1, 2003.

2502       (6) REGULATION; APPLICABILITY OF OTHER STATUTES.--

2503       (a) The facility shall operate pursuant to a plan of  
2504 operation approved by order of the Office of Insurance  
2505 Regulation of the Financial Services Commission. The board of  
2506 governors may at any time adopt amendments to the plan of  
2507 operation and submit the amendments to the Office of Insurance  
2508 Regulation for approval.

2509       (b) The facility is subject to regulation by the Office of  
2510 Insurance Regulation of the Financial Services Commission in the  
2511 same manner as other insurers, except that, in recognition of  
2512 the fact that its ability to levy assessments against its own



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2513 policyholders is a substitute for the protections ordinarily  
2514 afforded by such statutory requirements, the facility is exempt  
2515 from statutory requirements relating to surplus as to  
2516 policyholders.

2517 (c) The facility is not subject to part II of chapter 631,  
2518 relating to the Florida Insurance Guaranty Association.

2519 (7) STARTUP PROVISIONS.--

2520 (a) It is the intent of the Legislature that the facility  
2521 begin providing coverage no later than January 1, 2004.

2522 (b) The Governor and the Chief Financial Officer shall  
2523 make their appointments to the board of governors of the  
2524 facility no later than August 1, 2003. Until the board is  
2525 appointed, the Secretary of Health may perform ministerial acts  
2526 on behalf of the facility as chair of the board of governors.

2527 (c) Until the facility is able to hire permanent staff and  
2528 enter into contracts for professional services, the office of  
2529 the Secretary of Health shall provide support services to the  
2530 facility.

2531 (d) In order to provide startup funds for the facility,  
2532 the board of governors may incur debt or enter into agreements  
2533 for lines of credit, provided that the sole source of funds for  
2534 repayment of any debt is future premium revenues of the  
2535 facility. The amount of such debt or lines of credit may not  
2536 exceed \$10 million.

2537 Section 43. Section 627.358, Florida Statutes, is created  
2538 to read:

2539 627.358 Medical malpractice insurance; part-time  
2540 coverage.-- Insurance carriers shall be permitted to offer  
2541 policies to cover health care professionals who have retired  
2542 from practice or maintain a part-time practice as set forth



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2543 herein. For health care professionals who meet each of the  
2544 following requirements, the premiums for such policies shall be  
2545 no more than 50 percent of the cost of premiums for similar  
2546 specialties for health care professionals who do meet each of  
2547 the following requirements:

2548 (1) The health care professional has held an active  
2549 license to practice in this state or another state or some  
2550 combination thereof for more than 15 years.

2551 (2) The health care professional has either retired from  
2552 the practice of medicine or maintains a part-time practice of no  
2553 more than 1,000 patient contact hours per year.

2554 (3) The health care professional has had no more than two  
2555 claims for medical malpractice resulting in an indemnity  
2556 exceeding \$50,000 each within the previous 5-year period.

2557 (4) The health care professional has not been convicted  
2558 of, or pled guilty or nolo contendere to, any criminal violation  
2559 specified in this chapter or the medical practice act of any  
2560 other state.

2561 (5) The health care professional has not been subject  
2562 within the last 10 years of practice to license revocation or  
2563 suspension for any period of time; probation for a period of 3  
2564 years or longer; or a fine of \$500 or more for a violation of  
2565 this chapter or the medical practice act of another  
2566 jurisdiction. The regulatory agency's acceptance of a health  
2567 care professional's relinquishment of a license, stipulation,  
2568 consent order, or other settlement, offered in response to or in  
2569 anticipation of the filing of administrative charges against the  
2570 health care professional's license, shall be construed as action  
2571 against the health care professional's license for the purposes  
2572 of this subsection.



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2573 (6) The health care professional has submitted a form  
2574 supplying necessary information as required by the department  
2575 and an affidavit affirming compliance with the provisions of  
2576 this section.

2577 (7) The health care professional submits biennially to his  
2578 or her insurance provider certification stating compliance with  
2579 the provisions of this section. The health care professional  
2580 shall, upon request, demonstrate to the Office of Insurance  
2581 Regulation information verifying compliance with this section.

2582 Section 44. Section 627.359, Florida Statutes, is created  
2583 to read:

2584 627.359 Discounts on medical malpractice liability  
2585 insurance.--

2586 (1)(a) Medical malpractice insurance providers, including  
2587 the Health Care Professional Liability Insurance Facility, shall  
2588 provide a 20 percent discount on premiums for health care  
2589 professionals who implement a system wherein the professional  
2590 enters medication orders using a computer linked to prescribing  
2591 error prevention software.

2592 (b) The Office of Insurance Regulation shall designate  
2593 software vendors who meet the requirements of paragraph (a).

2594 (2)(a) Medical malpractice insurance providers, including  
2595 the Health Care Professional Liability Insurance Facility, shall  
2596 provide a 10 percent discount on premiums for health care  
2597 professionals who implement a system wherein patients are only  
2598 referred to a hospital based on scientifically valid criteria.

2599 (b) The Agency for Health Care Administration shall  
2600 develop criteria that meet the requirements of paragraph (a).

2601 Section 45. Paragraph (c) of subsection (1) and subsection  
2602 (3) of section 627.4147, Florida Statutes, are amended, and



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2603 paragraph (d) is added to subsection (1) of said section, to  
 2604 read:

2605 627.4147 Medical malpractice insurance contracts.--

2606 (1) In addition to any other requirements imposed by law,  
 2607 each self-insurance policy as authorized under s. 627.357 or  
 2608 insurance policy providing coverage for claims arising out of  
 2609 the rendering of, or the failure to render, medical care or  
 2610 services, including those of the Florida Medical Malpractice  
 2611 Joint Underwriting Association, shall include:

2612 (c) A clause requiring the insurer or self-insurer to  
 2613 notify the insured no less than 90 ~~60~~ days prior to the  
 2614 effective date of cancellation of the policy or contract and, in  
 2615 the event of a determination by the insurer or self-insurer not  
 2616 to renew the policy or contract, to notify the insured no less  
 2617 than 90 ~~60~~ days prior to the end of the policy or contract  
 2618 period. If cancellation or nonrenewal is due to nonpayment or  
 2619 loss of license, 10 days' notice is required.

2620 (d) A clause requiring the insurer or self-insurer to  
 2621 notify the insured no less than 60 days prior to the effective  
 2622 date of a rate increase. The provisions of s. 627.4133 shall  
 2623 apply to such notice and to the failure of the insurer to  
 2624 provide such notice to the extent not in conflict with this  
 2625 section.

2626 (3) This section shall apply to all policies issued or  
 2627 renewed after October 1, 2003 ~~1985~~.

2628 Section 46. Section 627.41491, Florida Statutes, is  
 2629 created to read:

2630 627.41491 Medical malpractice rate comparison.-- The  
 2631 Office of Insurance Regulation shall annually publish a  
 2632 comparison of the rate in effect for each medical malpractice





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2633 insurer and self-insurer and the Florida Medical Malpractice  
2634 Joint Underwriting Association. Such rate comparison shall be  
2635 made available to the public through the Internet and other  
2636 commonly used means of distribution no later than July 1 of each  
2637 year.

2638 Section 47. Section 627.41492, Florida Statutes, is  
2639 created to read:

2640 627.41492 Annual medical malpractice report.-- The Office  
2641 of Insurance Regulation shall prepare an annual report by  
2642 October 1 of each year, which shall be available to the public  
2643 and posted on the Internet, which includes the following  
2644 information:

2645 (1) A summary and analysis of the closed claim information  
2646 required to be reported pursuant to s. 627.912.

2647 (2) A summary and analysis of the annual and quarterly  
2648 financial reports filed by each insurer writing medical  
2649 malpractice insurance in the state.

2650 Section 48. Section 627.41493, Florida Statutes, is  
2651 created to read:

2652 627.41493 Insurance rate rollback.--

2653 (1) For medical malpractice insurance policies issued or  
2654 renewed on or after July 1, 2003, and before July 1, 2004, every  
2655 insurer, including the Florida Medical Malpractice Joint  
2656 Underwriting Association, shall reduce its rates and premiums by  
2657 25 percent. The lower rates must be in effect for at least 12  
2658 months and may not be raised by more than 15 percent after the  
2659 expiration of those 12 months. Thereafter, there will be  
2660 consideration for a physician, hospital, other health care  
2661 professional, or other health care facility to receive a credit  
2662 against the rate or rates applicable to their medical



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2663 malpractice insurance, consistent with the level of such  
2664 discount set in rule by the Financial Services Commission. In  
2665 developing such rules, the commission may consider whether, and  
2666 the extent to which, the types of programs approved under this  
2667 act are otherwise covered under a program of risk management  
2668 offered by the insurer.

2669 (2) The Financial Services Commission may adopt rules to  
2670 implement the provisions of this section.

2671 Section 49. The Office of Program Policy Analysis and  
2672 Government Accountability shall complete a study of the  
2673 eligibility requirements for a birth to be covered under the  
2674 Florida Birth-Related Neurological Injury Compensation  
2675 Association and submit a report to the Legislature by January 1,  
2676 2004, recommending whether the statutory criteria for a claim to  
2677 qualify for referral to the Florida Birth-Related Neurological  
2678 Injury Compensation Association under s. 766.302, Florida  
2679 Statutes, should be modified.

2680 Section 50. Subsections (1) and (4) and paragraph (n) of  
2681 subsection (2) of section 627.912, Florida Statutes, are amended  
2682 to read:

2683 627.912 Professional liability claims and actions; reports  
2684 by insurers.--

2685 (1)(a) Each self-insurer authorized under s. 627.357 and  
2686 each insurer or joint underwriting association providing  
2687 professional liability insurance to a practitioner of medicine  
2688 licensed under chapter 458, to a practitioner of osteopathic  
2689 medicine licensed under chapter 459, to a podiatric physician  
2690 licensed under chapter 461, to a dentist licensed under chapter  
2691 466, to a hospital licensed under chapter 395, to a crisis  
2692 stabilization unit licensed under part IV of chapter 394, to a



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2693 health maintenance organization certificated under part I of  
 2694 chapter 641, to clinics included in chapter 390, to an  
 2695 ambulatory surgical center as defined in s. 395.002, or to a  
 2696 member of The Florida Bar shall report in duplicate to the  
 2697 Department of Insurance any claim or action for damages for  
 2698 personal injuries claimed to have been caused by error,  
 2699 omission, or negligence in the performance of such insured's  
 2700 professional services or based on a claimed performance of  
 2701 professional services without consent, if the claim resulted in:

- 2702 1.(a) A final judgment in any amount.
- 2703 2.(b) A settlement in any amount.

2704  
 2705 Reports shall be filed with the department.

2706 (b) In addition to the requirements of paragraph (a), if  
 2707 the insured party is licensed under chapter 395, chapter 458,  
 2708 chapter 459, chapter 461, or chapter 466, the insurer shall  
 2709 report in duplicate to the Office of Insurance Regulation any  
 2710 other disposition of the claim, including, but not limited to, a  
 2711 dismissal. If the insured is licensed under chapter 458, chapter  
 2712 459, or chapter 461, any claim that resulted in a final judgment  
 2713 or settlement in the amount of \$50,000 or more shall be reported  
 2714 to the Department of Health no later than 30 days following the  
 2715 occurrence of that event. If the insured is licensed under  
 2716 chapter 466, any claim that resulted in a final judgment or  
 2717 settlement in the amount of \$25,000 or more shall be reported to  
 2718 the Department of Health no later than 30 days following the  
 2719 occurrence of that event and, if the insured party is licensed  
 2720 under chapter 458, chapter 459, chapter 461, or chapter 466,  
 2721 with the Department of Health, no later than 30 days following  
 2722 the occurrence of any event listed in paragraph (a) or paragraph



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2723 ~~(b)~~. The Department of Health shall review each report and  
 2724 determine whether any of the incidents that resulted in the  
 2725 claim potentially involved conduct by the licensee that is  
 2726 subject to disciplinary action, in which case the provisions of  
 2727 s. 456.073 shall apply. The Department of Health, as part of the  
 2728 annual report required by s. 456.026, shall publish annual  
 2729 statistics, without identifying licensees, on the reports it  
 2730 receives, including final action taken on such reports by the  
 2731 Department of Health or the appropriate regulatory board.

2732 (2) The reports required by subsection (1) shall contain:

2733 (n) Any other information required by the department to  
 2734 analyze and evaluate the nature, causes, location, cost, and  
 2735 damages involved in professional liability cases. The Financial  
 2736 Services Commission shall adopt by rule requirements for  
 2737 additional information to assist the Office of Insurance  
 2738 Regulation in its analysis and evaluation of the nature, causes,  
 2739 location, cost, and damages involved in professional liability  
 2740 cases reported by insurers under this section.

2741 (4) There shall be no liability on the part of, and no  
 2742 cause of action of any nature shall arise against, any insurer  
 2743 reporting hereunder or its agents or employees or the department  
 2744 or its employees for any action taken by them under this  
 2745 section. The department shall ~~may~~ impose a fine of \$250 per day  
 2746 per case, but not to exceed a total of \$10,000 ~~\$1,000~~ per case,  
 2747 against an insurer that violates the requirements of this  
 2748 section. This subsection applies to claims accruing on or after  
 2749 October 1, 1997.

2750 Section 51. Section 627.9121, Florida Statutes, is created  
 2751 to read:

2752 627.9121 Required reporting of claims; penalties.-- Each



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2753 entity that makes payment under a policy of insurance, self-  
 2754 insurance, or otherwise in settlement, partial settlement, or  
 2755 satisfaction of a judgment in a medical malpractice action or  
 2756 claim that is required to report information to the National  
 2757 Practitioner Data Bank under 42 U.S.C. s. 11131 must also report  
 2758 the same information to the Office of Insurance Regulation. The  
 2759 office shall include such information in the data that it  
 2760 compiles under s. 627.912. The office must compile and review  
 2761 the data collected pursuant to this section and must assess an  
 2762 administrative fine on any entity that fails to fully comply  
 2763 with such reporting requirements.

2764 Section 52. Section 766.102, Florida Statutes, is amended  
 2765 to read:

2766 766.102 Medical negligence; standards of recovery.--

2767 (1) In any action for recovery of damages based on the  
 2768 death or personal injury of any person in which it is alleged  
 2769 that such death or injury resulted from the negligence of a  
 2770 health care provider as defined in s. 766.101(1)(b) ~~s.~~  
 2771 ~~768.50(2)(b)~~, the claimant shall have the burden of proving by  
 2772 the greater weight of evidence that the alleged actions of the  
 2773 health care provider represented a breach of the prevailing  
 2774 professional standard of care for that health care provider. The  
 2775 prevailing professional standard of care for a given health care  
 2776 provider shall be that level of care, skill, and treatment  
 2777 which, in light of all relevant surrounding circumstances, is  
 2778 recognized as acceptable and appropriate by reasonably prudent  
 2779 similar health care providers.

2780 ~~(2)(a) If the health care provider whose negligence is~~  
 2781 ~~claimed to have created the cause of action is not certified by~~  
 2782 ~~the appropriate American board as being a specialist, is not~~



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2783 ~~trained and experienced in a medical specialty, or does not hold~~  
 2784 ~~himself or herself out as a specialist, a "similar health care~~  
 2785 ~~provider" is one who:~~

2786 ~~1. Is licensed by the appropriate regulatory agency of~~  
 2787 ~~this state;~~

2788 ~~2. Is trained and experienced in the same discipline or~~  
 2789 ~~school of practice; and~~

2790 ~~3. Practices in the same or similar medical community.~~

2791 ~~(b) If the health care provider whose negligence is~~  
 2792 ~~claimed to have created the cause of action is certified by the~~  
 2793 ~~appropriate American board as a specialist, is trained and~~  
 2794 ~~experienced in a medical specialty, or holds himself or herself~~  
 2795 ~~out as a specialist, a "similar health care provider" is one~~  
 2796 ~~who:~~

2797 ~~1. Is trained and experienced in the same specialty; and~~

2798 ~~2. Is certified by the appropriate American board in the~~  
 2799 ~~same specialty.~~

2800  
 2801 ~~However, if any health care provider described in this paragraph~~  
 2802 ~~is providing treatment or diagnosis for a condition which is not~~  
 2803 ~~within his or her specialty, a specialist trained in the~~  
 2804 ~~treatment or diagnosis for that condition shall be considered a~~  
 2805 ~~"similar health care provider."~~

2806 ~~(c) The purpose of this subsection is to establish a~~  
 2807 ~~relative standard of care for various categories and~~  
 2808 ~~classifications of health care providers. Any health care~~  
 2809 ~~provider may testify as an expert in any action if he or she:~~

2810 ~~1. Is a similar health care provider pursuant to paragraph~~  
 2811 ~~(a) or paragraph (b); or~~



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2812       ~~2. Is not a similar health care provider pursuant to~~  
2813 ~~paragraph (a) or paragraph (b) but, to the satisfaction of the~~  
2814 ~~court, possesses sufficient training, experience, and knowledge~~  
2815 ~~as a result of practice or teaching in the specialty of the~~  
2816 ~~defendant or practice or teaching in a related field of~~  
2817 ~~medicine, so as to be able to provide such expert testimony as~~  
2818 ~~to the prevailing professional standard of care in a given field~~  
2819 ~~of medicine. Such training, experience, or knowledge must be as~~  
2820 ~~a result of the active involvement in the practice or teaching~~  
2821 ~~of medicine within the 5-year period before the incident giving~~  
2822 ~~rise to the claim.~~

2823       (2)~~(3)~~(a) If the injury is claimed to have resulted from  
2824 the negligent affirmative medical intervention of the health  
2825 care provider, the claimant must, in order to prove a breach of  
2826 the prevailing professional standard of care, show that the  
2827 injury was not within the necessary or reasonably foreseeable  
2828 results of the surgical, medicinal, or diagnostic procedure  
2829 constituting the medical intervention, if the intervention from  
2830 which the injury is alleged to have resulted was carried out in  
2831 accordance with the prevailing professional standard of care by  
2832 a reasonably prudent similar health care provider.

2833       (b) The provisions of this subsection shall apply only  
2834 when the medical intervention was undertaken with the informed  
2835 consent of the patient in compliance with the provisions of s.  
2836 766.103.

2837       (3)~~(4)~~ The existence of a medical injury shall not create  
2838 any inference or presumption of negligence against a health care  
2839 provider, and the claimant must maintain the burden of proving  
2840 that an injury was proximately caused by a breach of the  
2841 prevailing professional standard of care by the health care



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2842 provider. However, the discovery of the presence of a foreign  
2843 body, such as a sponge, clamp, forceps, surgical needle, or  
2844 other paraphernalia commonly used in surgical, examination, or  
2845 diagnostic procedures, shall be prima facie evidence of  
2846 negligence on the part of the health care provider.

2847 ~~(4)~~(5) The Legislature is cognizant of the changing trends  
2848 and techniques for the delivery of health care in this state and  
2849 the discretion that is inherent in the diagnosis, care, and  
2850 treatment of patients by different health care providers. The  
2851 failure of a health care provider to order, perform, or  
2852 administer supplemental diagnostic tests shall not be actionable  
2853 if the health care provider acted in good faith and with due  
2854 regard for the prevailing professional standard of care.

2855 (5) A person may not give expert testimony concerning the  
2856 prevailing professional standard of care unless that person is a  
2857 licensed health care provider and meets the following criteria:

2858 (a) If the party against whom or on whose behalf the  
2859 testimony is offered is a specialist, the expert witness must:

2860 1. Specialize in the same specialty as the party against  
2861 whom or on whose behalf the testimony is offered; or

2862 2. Specialize in a similar specialty that includes the  
2863 evaluation, diagnosis, or treatment of the medical condition  
2864 that is the subject of the claim and have prior experience  
2865 treating similar patients.

2866 (b) Have devoted professional time during the 3 years  
2867 immediately preceding the date of the occurrence that is the  
2868 basis for the action to:

2869 1. The active clinical practice of, or consulting with  
2870 respect to, the same or similar health profession as the health  
2871 care provider against whom or on whose behalf the testimony is





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2872 offered and, if that health care provider is a specialist, the  
2873 active clinical practice of, or consulting with respect to, the  
2874 same or similar specialty that includes the evaluation,  
2875 diagnosis, or treatment of the medical condition that is the  
2876 subject of the claim and have prior experience treating similar  
2877 patients;

2878 2. The instruction of students in an accredited health  
2879 professional school or accredited residency program in the same  
2880 or similar health profession in which the health care provider  
2881 against whom or on whose behalf the testimony is offered and, if  
2882 that health care provider is a specialist, an accredited health  
2883 professional school or accredited residency or clinical research  
2884 program in the same or similar specialty; or

2885 3. A clinical research program that is affiliated with an  
2886 accredited medical school or teaching hospital and that is in  
2887 the same or similar health profession as the health care  
2888 provider against whom or on whose behalf the testimony is  
2889 offered and, if that health care provider is a specialist, a  
2890 clinical research program that is affiliated with an accredited  
2891 health professional school or accredited residency or clinical  
2892 research program in the same or similar specialty.

2893 (c) If the party against whom or on whose behalf the  
2894 testimony is offered is a general practitioner, the expert  
2895 witness must have devoted professional time during the 5 years  
2896 immediately preceding the date of the occurrence that is the  
2897 basis for the action to:

2898 1. Active clinical practice or consultation as a general  
2899 practitioner;

2900 2. Instruction of students in an accredited health  
2901 professional school or accredited residency program in the



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2902 general practice of medicine; or

2903 3. A clinical research program that is affiliated with an  
2904 accredited medical school or teaching hospital and that is in  
2905 the general practice of medicine.

2906 (6) A physician licensed under chapter 458 or chapter 459  
2907 who qualifies as an expert witness under subsection (5) and who,  
2908 by reason of active clinical practice or instruction of  
2909 students, has knowledge of the applicable standard of care for  
2910 nurses, nurse practitioners, certified registered nurse  
2911 anesthetists, certified registered nurse midwives, physician  
2912 assistants, or other medical support staff may give expert  
2913 testimony in a medical malpractice action with respect to the  
2914 standard of care of such medical support staff.

2915 (7) Notwithstanding subsection (5), in a medical  
2916 malpractice action against a hospital, a health care facility,  
2917 or medical facility, a person may give expert testimony on the  
2918 appropriate standard of care as to administrative and other  
2919 nonclinical issues if the person has substantial knowledge, by  
2920 virtue of his or her training and experience, concerning the  
2921 standard of care among hospitals, health care facilities, or  
2922 medical facilities of the same type as the hospital, health care  
2923 facility, or medical facility whose acts or omissions are the  
2924 subject of the testimony and which are located in the same or  
2925 similar communities at the time of the alleged act giving rise  
2926 to the cause of action.

2927 (8) If a health care provider described in subsection (5),  
2928 subsection (6), or subsection (7) is providing evaluation,  
2929 treatment, or diagnosis for a condition that is not within his  
2930 or her specialty, a specialist trained in the evaluation,  
2931 treatment, or diagnosis for that condition shall be considered a



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2932 similar health care provider.

2933 (9)~~(6)~~(a) In any action for damages involving a claim of  
 2934 negligence against a physician licensed under chapter 458,  
 2935 osteopathic physician licensed under chapter 459, podiatric  
 2936 physician licensed under chapter 461, or chiropractic physician  
 2937 licensed under chapter 460 providing emergency medical services  
 2938 in a hospital emergency department, the court shall admit expert  
 2939 medical testimony only from physicians, osteopathic physicians,  
 2940 podiatric physicians, and chiropractic physicians who have had  
 2941 substantial professional experience within the preceding 5 years  
 2942 while assigned to provide emergency medical services in a  
 2943 hospital emergency department.

2944 (b) For the purposes of this subsection:

2945 1. The term "emergency medical services" means those  
 2946 medical services required for the immediate diagnosis and  
 2947 treatment of medical conditions which, if not immediately  
 2948 diagnosed and treated, could lead to serious physical or mental  
 2949 disability or death.

2950 2. "Substantial professional experience" shall be  
 2951 determined by the custom and practice of the manner in which  
 2952 emergency medical coverage is provided in hospital emergency  
 2953 departments in the same or similar localities where the alleged  
 2954 negligence occurred.

2955 (10) In any action alleging medical malpractice, an expert  
 2956 witness may not testify on a contingency fee basis.

2957 (11) Any attorney who proffers a person as an expert  
 2958 witness pursuant to this section must certify that such person  
 2959 has not been found guilty of fraud or perjury in any  
 2960 jurisdiction.

2961 (12) Any person who serves as an expert witness under



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2962 subsection (5) may not receive remuneration in excess of \$300  
2963 per hour.

2964 (13) This section does not limit the power of the trial  
2965 court to disqualify or qualify an expert witness on grounds  
2966 other than the qualifications in this section.

2967 Section 53. Subsections (2), (3), and (4) and paragraph  
2968 (a) of subsection (10) of section 766.106, Florida Statutes, are  
2969 amended, and subsections (13), (14), and (15) are added to said  
2970 section, to read:

2971 766.106 Notice before filing action for medical  
2972 malpractice; presuit screening period; offers for admission of  
2973 liability and for arbitration; informal discovery; review.--

2974 (2)(a) After completion of presuit investigation pursuant  
2975 to s. 766.203 and prior to filing a claim for medical  
2976 malpractice, a claimant shall notify each prospective defendant  
2977 by certified mail, return receipt requested, of intent to  
2978 initiate litigation for medical malpractice. Notice to each  
2979 prospective defendant must include, if available, a list of all  
2980 known health care providers seen by the claimant for the  
2981 injuries complained of subsequent to the alleged act of  
2982 malpractice, a list of all known health care providers during  
2983 the 2-year period prior to the alleged act of malpractice who  
2984 treated or evaluated the claimant, and copies of all of the  
2985 medical records relied upon by the expert in signing the  
2986 affidavit. The requirement of providing the list of known health  
2987 care providers may not serve as grounds for imposing sanctions  
2988 for failure to provide presuit discovery.

2989 (b) Following the initiation of a suit alleging medical  
2990 malpractice with a court of competent jurisdiction, and service  
2991 of the complaint upon a defendant, the claimant shall provide a



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2992 copy of the complaint to the Department of Health and, if the  
 2993 complaint involves a facility licensed under chapter 395, the  
 2994 Agency for Health Care Administration. The requirement of  
 2995 providing the complaint to the Department of Health or the  
 2996 Agency for Health Care Administration does not impair the  
 2997 claimant's legal rights or ability to seek relief for his or her  
 2998 claim. The Department of Health or the Agency for Health Care  
 2999 Administration shall review each incident that is the subject of  
 3000 the complaint and determine whether it involved conduct by a  
 3001 licensee which is potentially subject to disciplinary action, in  
 3002 which case the provisions of s. 456.073 or s. 395.1046 apply.

3003 (3)(a) No suit may be filed for a period of 150 ~~90~~ days  
 3004 after notice is mailed to any prospective defendant. During the  
 3005 150-day ~~90-day~~ period, the prospective defendant's insurer or  
 3006 self-insurer shall conduct a review to determine the liability  
 3007 of the defendant. Each insurer or self-insurer shall have a  
 3008 procedure for the prompt investigation, review, and evaluation  
 3009 of claims during the 150-day ~~90-day~~ period. This procedure shall  
 3010 include one or more of the following:

- 3011 1. Internal review by a duly qualified claims adjuster;
- 3012 2. Creation of a panel comprised of an attorney  
 3013 knowledgeable in the prosecution or defense of medical  
 3014 malpractice actions, a health care provider trained in the same  
 3015 or similar medical specialty as the prospective defendant, and a  
 3016 duly qualified claims adjuster;
- 3017 3. A contractual agreement with a state or local  
 3018 professional society of health care providers, which maintains a  
 3019 medical review committee;
- 3020 4. Any other similar procedure which fairly and promptly  
 3021 evaluates the pending claim.



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3022  
3023 Each insurer or self-insurer shall investigate the claim in good  
3024 faith, and both the claimant and prospective defendant shall  
3025 cooperate with the insurer in good faith. If the insurer  
3026 requires, a claimant shall appear before a pretrial screening  
3027 panel or before a medical review committee and shall submit to a  
3028 physical examination, if required. Unreasonable failure of any  
3029 party to comply with this section justifies dismissal of claims  
3030 or defenses. There shall be no civil liability for participation  
3031 in a pretrial screening procedure if done without intentional  
3032 fraud.

3033 (b) At or before the end of the 150 ~~90~~ days, the insurer  
3034 or self-insurer shall provide the claimant with a response:

- 3035 1. Rejecting the claim;  
3036 2. Making a settlement offer; or  
3037 3. Making an offer to arbitrate, in which case liability  
3038 is deemed admitted and arbitration will be held only of  
3039 ~~admission of liability and for arbitration~~ on the issue of  
3040 damages. This offer may be made contingent upon a limit of  
3041 general damages.

3042 (c) The response shall be delivered to the claimant if not  
3043 represented by counsel or to the claimant's attorney, by  
3044 certified mail, return receipt requested. Failure of the  
3045 prospective defendant or insurer or self-insurer to reply to the  
3046 notice within 150 ~~90~~ days after receipt shall be deemed a final  
3047 rejection of the claim for purposes of this section.

3048 (d) Within 30 days after ~~of~~ receipt of a response by a  
3049 prospective defendant, insurer, or self-insurer to a claimant  
3050 represented by an attorney, the attorney shall advise the  
3051 claimant in writing of the response, including:



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3052 1. The exact nature of the response under paragraph (b).

3053 2. The exact terms of any settlement offer, or admission  
3054 of liability and offer of arbitration on damages.

3055 3. The legal and financial consequences of acceptance or  
3056 rejection of any settlement offer, or admission of liability,  
3057 including the provisions of this section.

3058 4. An evaluation of the time and likelihood of ultimate  
3059 success at trial on the merits of the claimant's action.

3060 5. An estimation of the costs and attorney's fees of  
3061 proceeding through trial.

3062 (4) The notice of intent to initiate litigation shall be  
3063 served within the time limits set forth in s. 95.11. However,  
3064 during the 150-day ~~90-day~~ period, the statute of limitations is  
3065 tolled as to all potential defendants. Upon stipulation by the  
3066 parties, the 150-day ~~90-day~~ period may be extended and the  
3067 statute of limitations is tolled during any such extension. Upon  
3068 receiving notice of termination of negotiations in an extended  
3069 period, the claimant shall have 60 days or the remainder of the  
3070 period of the statute of limitations, whichever is greater,  
3071 within which to file suit.

3072 (10) If a prospective defendant makes an offer to admit  
3073 liability and for arbitration on the issue of damages, the  
3074 claimant has 50 days from the date of receipt of the offer to  
3075 accept or reject it. The claimant shall respond in writing to  
3076 the insurer or self-insurer by certified mail, return receipt  
3077 requested. If the claimant rejects the offer, he or she may then  
3078 file suit. Acceptance of the offer of admission of liability and  
3079 for arbitration waives recourse to any other remedy by the  
3080 parties, and the claimant's written acceptance of the offer  
3081 shall so state.



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3082 (a) If rejected, the offer to admit liability and for  
3083 arbitration on damages is not admissible in any subsequent  
3084 litigation. Upon rejection of the offer to admit liability and  
3085 for arbitration, the claimant has 60 days from receipt of the  
3086 rejection of the offer to admit liability and for arbitration,  
3087 60 days from the date of the declaration of impasse during  
3088 presuit mediation conducted pursuant to s. 766.1065, or the  
3089 remainder of the period of the statute of limitations, whichever  
3090 period is greater, in which to file suit.

3091 (13) In matters relating to professional liability  
3092 insurance coverage for medical negligence, an insurer shall not  
3093 be held in bad faith for failure to timely pay its policy limits  
3094 if it tenders its policy limits and meets all other conditions  
3095 of settlement prior to the conclusion of the presuit screening  
3096 period.

3097 (14) Failure to cooperate on the part of any party during  
3098 the presuit investigation may be grounds to strike any claim  
3099 made, or defense raised, by such party in suit.

3100 (15) In all matters relating to professional liability  
3101 insurance coverage for medical negligence, and in determining  
3102 whether the insurer has acted in good faith, the following  
3103 factors may be considered, along with all of the other  
3104 circumstances of the case:

3105 (a) Whether the damages recoverable against the insured  
3106 are large or small.

3107 (b) Whether the liability against the insured is  
3108 relatively clear.

3109 (c) Whether the insurance companies or its agents were  
3110 negligent in handling the claim.

3111 (d) Whether the carrier acted as a reasonable person would





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3112 who was facing the prospect of paying the entire loss.

3113 (e) Whether the insurance company made a fair offer as  
 3114 soon as a reasonable investigation would reveal that liability  
 3115 was reasonably clear and that the damages were greater than the  
 3116 policy limits.

3117 (f) Whether the insurer violated the unfair claims  
 3118 practice standards.

3119 (g) Whether the insurer's communications with its insureds  
 3120 were actually honest, candid, and complete.

3121 (h) Whether the insurer violated the adjuster's code of  
 3122 ethics in handling the claim.

3123 (i) Whether the insurer fully documented its claims  
 3124 handling activities and the reasons for its decisions.

3125 (j) Whether the insurer or its agents properly trained its  
 3126 adjusters and provided adequate written standards for the  
 3127 adjustment of claims.

3128 (k) Whether the insurer used the policy benefits available  
 3129 to the insurer to extinguish as much of the insured's liability  
 3130 as possible.

3131 (l) Whether the attorney appointed by the insurer to  
 3132 defend the insured was competent, independent, and faithfully  
 3133 representing the interests of the insured.

3134 Section 54. Section 766.1065, Florida Statutes, is created  
 3135 to read:

3136 766.1065 Mandatory staging of presuit investigation;  
 3137 mandatory mediation.--

3138 (1) Within 30 days after service of the presuit notice of  
 3139 intent to initiate medical malpractice litigation, each party  
 3140 shall voluntarily produce to all other parties, without being  
 3141 requested, any and all medical, hospital, health care, and



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3142 employment records concerning the claimant in the disclosing  
3143 party's possession, custody, or control, and the disclosing  
3144 party shall affirmatively certify in writing that the records  
3145 produced include all records in that party's possession,  
3146 custody, or control or that the disclosing party has no medical,  
3147 hospital, health care, or employment records concerning the  
3148 claimant.

3149 (a) Subpoenas may be issued according to the Florida Rules  
3150 of Civil Procedure as though suit had been filed for the limited  
3151 purpose of obtaining copies of medical, hospital, health care,  
3152 and employment records of the claimant. The party shall indicate  
3153 on the subpoena that it is being issued in accordance with the  
3154 presuit procedures of this section and shall not be required to  
3155 include a case number.

3156 (b) Nothing in this section shall limit the ability of any  
3157 party to use any other available form of presuit discovery  
3158 available under this chapter or the Florida Rules of Civil  
3159 Procedure.

3160 (2) Within 60 days after service of the presuit notice of  
3161 intent to initiate medical malpractice litigation, all parties  
3162 must be made available for a sworn deposition. Such deposition  
3163 may not be used in a civil suit for medical negligence.

3164 (3) Within 120 days after service of the presuit notice of  
3165 intent to initiate medical malpractice litigation, each party's  
3166 corroborating expert, who will otherwise be tendered as the  
3167 expert complying with the affidavit provisions set forth in s.  
3168 766.203, must be made available for a sworn deposition.

3169 (a) The expenses associated with the expert's time and  
3170 travel in preparing for and attending such deposition shall be  
3171 the responsibility of the party retaining such expert.



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3172 (b) An expert shall be deemed available for deposition if  
3173 suitable accommodations can be made for appearance of said  
3174 expert via real-time video technology.

3175 (4) Within 150 days after service of the presuit notice of  
3176 intent to initiate medical malpractice litigation, all parties  
3177 shall attend in-person mandatory mediation in accordance with s.  
3178 44.102 if binding arbitration under s. 766.106 or s. 766.207 has  
3179 not been agreed to by the parties. The Florida Rules of Civil  
3180 Procedure shall apply to mediation held pursuant to this  
3181 section.

3182 (5) If the parties declare an impasse during the mandatory  
3183 mediation required in subsection (4), the plaintiff shall  
3184 request, via certified mail, a hearing of a presuit screening  
3185 panel which shall be convened pursuant to s. 766.1066.

3186 Section 55. Section 766.1066, Florida Statutes, is created  
3187 to read:

3188 766.1066 Office of Presuit Screening Administration;  
3189 presuit screening panels.—

3190 (1)(a) There is created within the Department of Health  
3191 the Office of Presuit Screening Administration, which shall be  
3192 responsible for administering the presuit screening program.

3193 (b) The Office of Presuit Screening Administration shall  
3194 develop and maintain a database of physicians, attorneys, and  
3195 consumers to serve as members of presuit screening panels as  
3196 described in this section.

3197 (c) The Office of Presuit Screening Administration shall  
3198 develop an application by September 1, 2003, that can be  
3199 submitted in writing and via the Internet for physicians,  
3200 attorneys, and consumers to volunteer for the panels.

3201 (d) Funding for the Office of Presuit Screening



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3202 Administration shall come from:

3203 1. A fee equal to 0.5 percent of, and assessed against,  
3204 all judgments and settlements in medical malpractice liability  
3205 cases. The defendant shall remit such fee to the Office of  
3206 Presuit Administration.

3207 2. An annual fee of \$1 on all medical malpractice  
3208 liability insurance policies issued to physicians licensed by  
3209 the Department of Health, which shall be collected by the  
3210 insurer and submitted by the insurer to the Office of Presuit  
3211 Administration.

3212 (e)1. Physicians, attorneys, and consumers who volunteer  
3213 for the panels shall be obligated to serve on a panel for no  
3214 longer than 2 calendar days per selection.

3215 2. Every person applying to serve on a panel shall  
3216 designate in advance any time period during which he or she will  
3217 not be available to serve on a panel.

3218 3. When a plaintiff requests a hearing of a presuit  
3219 screening panel, the Office of Presuit Screening Administration  
3220 shall randomly select members for a panel as provided in  
3221 subsection (2) from among the available persons in the  
3222 appropriate categories who have not served on a panel in the  
3223 past 12 months. If there are no other potential panelists  
3224 available, a panelist may be asked to serve on another panel  
3225 within 12 months.

3226 (f) If a physician, attorney, or consumer is selected to  
3227 serve on a panel, he or she shall not be obligated to serve for  
3228 a period exceeding 2 days.

3229 (g) All persons serving on a panel shall receive  
3230 reimbursement for their travel expenses.

3231 (h) Physicians who are selected to serve on a panel:



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3232 1. Shall receive credit for 20 hours of continuing medical  
 3233 education for his or her service.

3234 2. Must reside and practice at least 50 miles from the  
 3235 location of the injury alleged by the plaintiff.

3236 3. Must have had no more than three judgments for medical  
 3237 malpractice liability against him or her within the preceding 5  
 3238 years and no more than 10 claims of medical malpractice filed  
 3239 against him or her within the preceding 3 years.

3240 4. Must have an active license with the Department of  
 3241 Health and be in good standing.

3242 (i) Attorneys who are selected to serve on a panel:

3243 1. Shall receive credit for 20 hours of continuing legal  
 3244 education and credit towards pro bono requirements for his or  
 3245 her service.

3246 2. Must reside and practice at least 50 miles from the  
 3247 location of the injury alleged by the plaintiff.

3248 3. Must have had no judgments of filing a frivolous  
 3249 lawsuit within the preceding 5 years.

3250 4. Must have an active license with The Florida Bar and be  
 3251 in good standing.

3252 (2)(a) A presuit screening panel shall be composed of five  
 3253 persons, consisting of:

3254 1. One physician board certified in the same specialty as  
 3255 the defendant physician.

3256 2. One physician who is a general practitioner, family  
 3257 practitioner, or an internist or one physician who serves as a  
 3258 full-time member in the faculty of an accredited public or  
 3259 private medical school in the state.

3260 3. One attorney who has served as a plaintiff's attorney,  
 3261 with 5 years' experience in medical malpractice liability cases



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3262 including at least one jury trial.

3263 4. One attorney who has served as a defendant's attorney,  
3264 with 5 years' experience in medical malpractice liability cases  
3265 including at least one jury trial.

3266 5. One consumer who shall not have a professional or  
3267 financial relationship with either a health care provider or an  
3268 attorney.

3269 (b) In cases with more than one physician defendant, the  
3270 plaintiff shall designate the subject areas in which both  
3271 physician members of the panel shall be board certified.

3272 (c) Any panelist who knowingly has a conflict of interest  
3273 or potential conflict of interest must disclose such conflict of  
3274 interest prior to the hearing.

3275 (d) A plaintiff or a defendant may challenge any panel  
3276 member for a conflict of interest and ask that the panelist be  
3277 replaced by the Office of Presuit Screening Administration.

3278 (3) The Office of Presuit Screening Administration shall  
3279 provide an administrator for the panel.

3280 (4) The plaintiff shall be allowed 8 hours to present his  
3281 or her case. The defendants shall be allowed a total of 8 hours  
3282 to present their case. No hearing shall exceed a total of 16  
3283 hours; however, the panel may hear the case over the course of 2  
3284 calendar days.

3285 (5) A presuit screening panel shall, by a majority vote  
3286 for each defendant, make its findings in regards to reasonable  
3287 grounds for liability of the defendant based on the  
3288 preponderance of the evidence.

3289 (a) If a panel finds that there are no reasonable grounds  
3290 for liability on the part of a defendant for the injury alleged,  
3291 the defendant may, within 10 days, request voluntary binding



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3292 arbitration pursuant to s. 766.207.

3293 (b) If a panel finds that there are reasonable grounds for  
 3294 liability on the part of a defendant for the injury alleged, the  
 3295 parties may elect to have damages determined by voluntary  
 3296 binding arbitration pursuant to s. 766.207.

3297 (c) If a panel finds that there are no reasonable grounds  
 3298 for liability on the part of a defendant for the injury alleged  
 3299 and the defendant does not request arbitration, or if a panel  
 3300 finds that there are reasonable grounds for liability on the  
 3301 part of a defendant for the injury alleged and either a  
 3302 defendant or the plaintiff do not agree to voluntary binding  
 3303 arbitration pursuant to s. 766.207, the claim shall proceed to  
 3304 trial or to any available legal alternative such as offer of  
 3305 judgment and demand for judgment under s. 768.79 or offer of  
 3306 settlement under s. 45.061. The damages that may be awarded  
 3307 during such trial are subject to the limitations included in s.  
 3308 766.118.

3309 Section 56. Section 766.1067, Florida Statutes, is created  
 3310 to read:

3311 766.1067 Structured judgments.-- For cases that are  
 3312 decided in a trial, the judgment may be structured as follows:

3313 (1) If the noneconomic damages awarded to the plaintiff  
 3314 are equal to or greater than \$500,000 and the jury finds the  
 3315 life expectancy of the plaintiff to be 20 years or greater, the  
 3316 defendant may compel a structured judgment for 50 percent of the  
 3317 noneconomic damages to be paid over the remaining life of the  
 3318 plaintiff. Such payments shall terminate upon the plaintiff's  
 3319 death.

3320 (2) If the economic damages awarded to the plaintiff are  
 3321 equal to or greater than \$250,000 and the jury finds the



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3322 plaintiff would otherwise have been able to work for 20 years or  
 3323 more, the defendant may compel a structured judgment for 75  
 3324 percent of the future economic damages to be paid over the years  
 3325 in which the jury finds the plaintiff would otherwise have been  
 3326 able to work. Any unpaid portion of a structured judgment made  
 3327 under this subsection which is attributable to medical expenses  
 3328 that have not yet been incurred shall terminate upon the death  
 3329 of the plaintiff. Any outstanding medical expenses incurred  
 3330 prior to the death of the plaintiff shall be paid from that  
 3331 portion of the structured judgment attributable to medical  
 3332 expenses.

3333 Section 57. Section 766.1068, Florida Statutes, is created  
 3334 to read:

3335 766.1068 Proposal for settlement; timing.--  
 3336 Notwithstanding any other provision of law, any party may serve  
 3337 another party in a medical malpractice suit with a proposal for  
 3338 settlement at any time after the filing of the complaint. If a  
 3339 claimant rejects the proposal for settlement, then either loses  
 3340 at trial or prevails at trial while receiving an award for  
 3341 damages less than the most recent proposal for settlement, the  
 3342 court may require the claimant to pay the attorney's fees and  
 3343 costs of the defendant from whom the claimant will receive the  
 3344 award. If a defendant rejects the proposal for settlement, then  
 3345 loses at trial while receiving a judgment greater than the most  
 3346 resent proposal for settlement, the court may require the  
 3347 defendant to pay the attorney's fees and costs of the claimant  
 3348 to whom the judgment is awarded.

3349 Section 58. Subsections (3), (4), (5), and (6) are added  
 3350 to section 766.110, Florida Statutes, to read:

3351 766.110 Liability of health care facilities.--





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3352       (3)(a) Members of the medical staff of a hospital licensed  
3353 under chapter 395 and any professional group comprised of such  
3354 persons shall be immune from liability for noneconomic damages  
3355 in excess of \$250,000 per emergency room admission arising from  
3356 medical injuries to a patient resulting from negligent acts or  
3357 omissions of such medical staff members in the performance of  
3358 emergency medical services as defined in s. 768.13(2) prior to  
3359 the patient's condition being sufficiently stable, and no member  
3360 of the medical staff of a hospital and no professional group  
3361 comprised of such persons shall be liable to pay noneconomic  
3362 damages in excess of \$250,000 to any person or persons for any  
3363 single incident of medical negligence that causes injuries to a  
3364 patient or patients in the performance of emergency medical  
3365 services.

3366       (b) For the purposes of paragraph (a), a patient's  
3367 condition shall be deemed to be sufficiently stable when that  
3368 patient could reasonably be transferred to another health care  
3369 facility without causing further injury, whether or not the  
3370 patient is in fact transferred.

3371       (4)(a) No person or persons may recover damages from a  
3372 public family practice teaching hospital licensed under chapter  
3373 395 and designated under s. 398.806, or its insurer, or any  
3374 health care professional who is a full-time member of the  
3375 faculty of an accredited public medical school, or his or her  
3376 insurer, in excess of \$250,000 per emergency room admission  
3377 arising from medical injuries to a patient or patients caused by  
3378 negligent acts or omissions on the part of the hospital or  
3379 members of the hospital's medical staff in the performance of  
3380 emergency medical services as defined in s. 768.13(2) prior to  
3381 the patient's condition being sufficiently stable.



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3382 (b) For the purposes of paragraph (a), a patient's  
3383 condition shall be deemed to be sufficiently stable when that  
3384 patient could reasonably be transferred to another health care  
3385 facility without causing further injury, whether or not the  
3386 patient is in fact transferred.

3387 (5)(a) Other than as provided in paragraph (c), when a  
3388 subsequent injury occurs after a patient's condition is  
3389 sufficiently stable, no person or persons may recover  
3390 noneconomic damages from any health care professional who is a  
3391 member of the medical staff of such facility, or his or her  
3392 insurer, in excess of \$250,000 per injury arising from medical  
3393 injury to a patient caused by negligent acts or omissions on the  
3394 part of the hospital or members of the hospital's medical staff  
3395 in the performance of emergency medical services as defined in  
3396 s. 768.13(2) until the patient's condition returns to  
3397 sufficiently stable.

3398 (b) For the purposes of paragraph (a), a patient's  
3399 condition shall be deemed to be sufficiently stable when that  
3400 patient could reasonably be transferred to another health care  
3401 facility without causing further injury, whether or not the  
3402 patient is in fact transferred.

3403 (c) A person or persons may recover damages from the  
3404 health care professional who caused the subsequent injury in  
3405 paragraph (a) and the hospital licensed under chapter 395, or  
3406 its insurer, where the injury occurred.

3407 (6) The limits established in this section shall be  
3408 adjusted annually in accordance with the changes in the Consumer  
3409 Price Index as issued by the United States Department of Labor  
3410 Bureau of Labor Statistics. The Agency for Health Care  
3411 Administration shall establish by rule the new limits on July 1



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3412 of each year.

3413 Section 59. Section 766.118, Florida Statutes, is created  
3414 to read:

3415 766.118 Determination of noneconomic damages.-- With  
3416 respect to a cause of action for personal injury or wrongful  
3417 death resulting from an occurrence of medical negligence,  
3418 including actions pursuant to s. 766.209, damages recoverable  
3419 for noneconomic losses to compensate for pain and suffering,  
3420 inconvenience, physical impairment, mental anguish,  
3421 disfigurement, loss of capacity for enjoyment of life, and all  
3422 other noneconomic damages shall be determined as follows:

3423 (1) The award for noneconomic damages from the jury shall  
3424 be reviewed by the judge to determine the appropriateness of the  
3425 award.

3426 (2) In reviewing the award, the judge shall utilize the  
3427 Florida Jury Verdict Database as provided in s. 766.26.

3428 (3)(a) The judge shall examine all cases where the  
3429 injuries alleged and the economic damages awarded are  
3430 substantially similar.

3431 (b) The judge shall adopt a presumptively reasonable range  
3432 of similar awards that shall be one standard deviation above and  
3433 below the mean award for similar cases. The judge shall then  
3434 subtract the economic damages awarded by the jury from the valid  
3435 range to find the valid range for noneconomic damages.

3436 (c) If the award for noneconomic damages is outside of the  
3437 presumptively reasonable range for noneconomic damages based on  
3438 similar cases, the judge may elect to change the award so that  
3439 it falls within said range, which is subject to appeal based on  
3440 abuse of discretion standards, or the judge may elect to leave  
3441 the amount as awarded by providing findings of fact on the



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3442 record, which shall be subject to appeal based on clear and  
3443 convincing evidence standards.

3444 (4) If a health care professional does not meet his or her  
3445 financial responsibility requirements as provided in s. 458.320  
3446 or 459.0085, as applicable, by July 1, 2004, the limits  
3447 established in this section shall not apply and awards for  
3448 economic and noneconomic damages shall not be limited.

3449 Section 60. Section 766.185, Florida Statutes, is created  
3450 to read:

3451 766.185 Apportionment of fault in medical negligence  
3452 actions.--

3453 (1) In an action for damages for personal injury or  
3454 wrongful death arising out of medical negligence, whether in  
3455 contract or tort, when a defendant asserts an affirmative  
3456 defense that one or more nonparties is liable, in whole or in  
3457 part, for damages arising out of medical negligence, such  
3458 defendant must join the nonparties into the action by means of a  
3459 third-party complaint asserting a cause of action for  
3460 comparative fault in medical negligence against the nonparties,  
3461 except with respect to a nonparty who meets one of the following  
3462 criteria:

3463 (a) The nonparty has entered into a settlement with each  
3464 of the plaintiffs;

3465 (b) The nonparty has complete immunity from suit;

3466 (c) The statute of limitations involving the nonparty  
3467 expired prior to filing of the presuit notice of intent to  
3468 initiate medical malpractice litigation; or

3469 (d) The nonparty cannot be otherwise legally joined to the  
3470 suit.

3471 (2) If the defendant has reasonable grounds to believe



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3472 during the presuit investigation that one or more nonparties are  
3473 liable, in whole or in part, for damages arising out of medical  
3474 negligence and that such nonparties would be joinable into the  
3475 action under this section, the defendant must notify the  
3476 claimant in writing of the identity and reasonable grounds for  
3477 inclusions of such nonparty in the action within 10 days after  
3478 obtaining such information.

3479 (3) If the defendant fails to comply with the provisions  
3480 set forth in this section, then the defendant shall be estopped  
3481 from asserting the negligence of the nonparty who should have  
3482 otherwise been joined into the action.

3483 (4) Any third party joined into the action under the  
3484 provisions of this section shall be liable to the plaintiff for  
3485 any damages adjudicated by the trier of fact subject to the  
3486 provisions of this chapter.

3487 Section 61. Subsection (5) of section 766.202, Florida  
3488 Statutes, is amended to read:

3489 766.202 Definitions; ss. 766.201-766.212.-- As used in ss.  
3490 766.201-766.212, the term:

3491 (5) "Medical expert" means a person duly and regularly  
3492 engaged in the practice of his or her profession who holds a  
3493 health care professional degree from a university or college and  
3494 who meets the requirements of an expert witness as set forth in  
3495 ~~s. 766.102 has had special professional training and experience~~  
3496 ~~or one possessed of special health care knowledge or skill about~~  
3497 ~~the subject upon which he or she is called to testify or provide~~  
3498 ~~an opinion.~~

3499 Section 62. Subsections (2) and (3) of section 766.203,  
3500 Florida Statutes, are amended to read:

3501 766.203 Presuit investigation of medical negligence claims



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3502 and defenses by prospective parties.--

3503 (2) Prior to issuing notification of intent to initiate  
3504 medical malpractice litigation pursuant to s. 766.106, the  
3505 claimant shall conduct an investigation to ascertain that there  
3506 are reasonable grounds to believe that:

3507 (a) Any named defendant in the litigation was negligent in  
3508 the care or treatment of the claimant; and

3509 (b) Such negligence resulted in injury to the claimant.

3510

3511 Corroboration of reasonable grounds to initiate medical  
3512 negligence litigation shall be provided by the claimant's  
3513 submission of a verified written medical expert opinion from a  
3514 medical expert as defined in s. 766.202(5), at the time the  
3515 notice of intent to initiate litigation is mailed, which  
3516 statement shall corroborate reasonable grounds to support the  
3517 claim of medical negligence. This opinion and statement are  
3518 subject to discovery.

3519 (3) Prior to issuing its response to the claimant's notice  
3520 of intent to initiate litigation, during the time period for  
3521 response authorized pursuant to s. 766.106, the defendant or the  
3522 defendant's insurer or self-insurer shall conduct an  
3523 investigation to ascertain whether there are reasonable grounds  
3524 to believe that:

3525 (a) The defendant was negligent in the care or treatment  
3526 of the claimant; and

3527 (b) Such negligence resulted in injury to the claimant.

3528

3529 Corroboration of lack of reasonable grounds for medical  
3530 negligence litigation shall be provided with any response  
3531 rejecting the claim by the defendant's submission of a verified



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3532 written medical expert opinion from a medical expert as defined  
3533 in s. 766.202(5), at the time the response rejecting the claim  
3534 is mailed, which statement shall corroborate reasonable grounds  
3535 for lack of negligent injury sufficient to support the response  
3536 denying negligent injury. This opinion and statement are subject  
3537 to discovery.

3538 Section 63. Subsections (2), (3), and (5) of section  
3539 766.206, Florida Statutes, are amended to read:

3540 766.206 Presuit investigation of medical negligence claims  
3541 and defenses by court.--

3542 (2) If the court finds that the notice of intent to  
3543 initiate litigation mailed by the claimant is not in compliance  
3544 with the reasonable investigation requirements of ss. 766.201-  
3545 766.212, including a review of the claim and a verified written  
3546 medical expert opinion by an expert witness as defined in s.  
3547 766.202, the court shall dismiss the claim, and the person who  
3548 mailed such notice of intent, whether the claimant or the  
3549 claimant's attorney, shall be personally liable for all  
3550 attorney's fees and costs incurred during the investigation and  
3551 evaluation of the claim, including the reasonable attorney's  
3552 fees and costs of the defendant or the defendant's insurer.

3553 (3) If the court finds that the response mailed by a  
3554 defendant rejecting the claim is not in compliance with the  
3555 reasonable investigation requirements of ss. 766.201-766.212,  
3556 including a review of the claim and a verified written medical  
3557 expert opinion by an expert witness as defined in s. 766.202,  
3558 the court shall strike the defendant's pleading. ~~response,~~ and  
3559 The person who mailed such response, whether the defendant, the  
3560 defendant's insurer, or the defendant's attorney, shall be  
3561 personally liable for all attorney's fees and costs incurred



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3562 during the investigation and evaluation of the claim, including  
 3563 the reasonable attorney's fees and costs of the claimant.

3564 (5)(a) If the court finds that the corroborating written  
 3565 medical expert opinion attached to any notice of claim or intent  
 3566 or to any response rejecting a claim lacked reasonable  
 3567 investigation, or that the medical expert submitting the opinion  
 3568 did not meet the expert witness qualifications as set forth in  
 3569 s. 766.202(5), the court shall report the medical expert issuing  
 3570 such corroborating opinion to the Division of Medical Quality  
 3571 Assurance or its designee. If such medical expert is not a  
 3572 resident of the state, the division shall forward such report to  
 3573 the disciplining authority of that medical expert.

3574 (b) The court shall ~~may~~ refuse to consider the testimony  
 3575 or opinion attached to any notice of intent or to any response  
 3576 rejecting a claim of ~~such~~ an expert who has been disqualified  
 3577 three times pursuant to this section.

3578 Section 64. Section 766.207, Florida Statutes, is amended  
 3579 to read:

3580 766.207 Voluntary binding arbitration of medical  
 3581 negligence claims.--

3582 (1) Voluntary binding arbitration pursuant to this section  
 3583 and ss. 766.208-766.212 shall not apply to rights of action  
 3584 involving the state or its agencies or subdivisions, or the  
 3585 officers, employees, or agents thereof, pursuant to s. 768.28.

3586 (2)(a) Upon the completion of the hearing of a presuit  
 3587 screening panel pursuant to s. 706.1066 ~~investigation with~~  
 3588 ~~preliminary reasonable grounds for a medical negligence claim~~  
 3589 ~~intact~~, the parties may elect to have damages determined by an  
 3590 arbitration panel. Such election may be initiated by either  
 3591 party by serving a request for voluntary binding arbitration of





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3592 damages within 10 ~~90~~ days after the hearing of a presuit  
3593 screening panel ~~service of the claimant's notice of intent to~~  
3594 ~~initiate litigation upon the defendant.~~ The evidentiary  
3595 standards for voluntary binding arbitration of medical  
3596 negligence claims shall be as provided in ss. 120.569(2)(g) and  
3597 120.57(1)(c).

3598 (b) If the presuit screening panel pursuant to s. 766.1066  
3599 found that the defendant was not liable by unanimous vote and  
3600 the plaintiff refuses arbitration, damages that can be awarded  
3601 during a trial shall not exceed a total of \$350,000, as adjusted  
3602 herein, per defendant for both future economic and all  
3603 noneconomic damages. If the presuit screening panel pursuant to  
3604 s. 766.1066 found that the defendant was not liable by majority  
3605 vote and the plaintiff refuses arbitration, damages that can be  
3606 awarded during a trial for all noneconomic damages shall not  
3607 exceed a total of \$350,000, as adjusted herein, per defendant.

3608 (3) Upon receipt of a party's request for such  
3609 arbitration, the opposing party may accept the offer of  
3610 voluntary binding arbitration within 30 days, and such  
3611 arbitration shall be held within 120 days of acceptance of the  
3612 offer of voluntary binding arbitration. ~~However, in no event~~  
3613 ~~shall the defendant be required to respond to the request for~~  
3614 ~~arbitration sooner than 90 days after service of the notice of~~  
3615 ~~intent to initiate litigation under s. 766.106.~~ Such acceptance  
3616 within the time period provided by this subsection shall be a  
3617 binding commitment to comply with the decision of the  
3618 arbitration panel. The liability of any insurer shall be subject  
3619 to any applicable insurance policy limits.

3620 (4) The arbitration panel shall be a presuit screening  
3621 panel selected by the Office of Presuit Screening as provided in



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3622 s. 766.1066. The Florida Rules of Civil Procedure shall apply to  
3623 discovery, except as follows:

3624 (a) Any 30-day deadline provided in such rules shall be  
3625 shortened to 10 business days.

3626 (b) Depositions of expert witnesses shall be permitted for  
3627 no more than five experts per side.

3628  
3629 Discovery disputes shall be resolved by an administrative law  
3630 judge assigned by the Division of Administrative Hearings until  
3631 arbitration is completed ~~composed of three arbitrators, one~~  
3632 ~~selected by the claimant, one selected by the defendant, and one~~  
3633 ~~an administrative law judge furnished by the Division of~~  
3634 ~~Administrative Hearings who shall serve as the chief arbitrator.~~  
3635 ~~In the event of multiple plaintiffs or multiple defendants, the~~  
3636 ~~arbitrator selected by the side with multiple parties shall be~~  
3637 ~~the choice of those parties. If the multiple parties cannot~~  
3638 ~~reach agreement as to their arbitrator, each of the multiple~~  
3639 ~~parties shall submit a nominee, and the director of the Division~~  
3640 ~~of Administrative Hearings shall appoint the arbitrator from~~  
3641 ~~among such nominees.~~

3642 (5) The panel ~~arbitrators~~ shall be independent of all  
3643 parties, witnesses, and legal counsel, and no officer, director,  
3644 affiliate, subsidiary, or employee of a party, witness, or legal  
3645 counsel may serve as a panelist ~~an arbitrator~~ in the proceeding.

3646 (6) The rate of compensation for arbitration panelists  
3647 shall be the same as for members of a presuit screening panel as  
3648 outlined in s. 766.1066 ~~medical negligence claims arbitrators~~  
3649 ~~other than the administrative law judge shall be set by the~~  
3650 ~~chief judge of the appropriate circuit court by schedule~~  
3651 ~~providing for compensation of not less than \$250 per day nor~~



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3652 ~~more than \$750 per day or as agreed by the parties. In setting~~  
3653 ~~the schedule, the chief judge shall consider the prevailing~~  
3654 ~~rates charged for the delivery of professional services in the~~  
3655 ~~community.~~

3656 (7) Arbitration pursuant to this section shall preclude  
3657 recourse to any other remedy by the claimant against any  
3658 participating defendant, and shall be undertaken with the  
3659 understanding that:

3660 (a) If the presuit screening panel pursuant to s. 766.1066  
3661 found that the defendant was not liable by unanimous vote, the  
3662 damages that can be awarded during arbitration shall not exceed  
3663 a total of \$250,000, as adjusted herein, per defendant for both  
3664 future economic and all noneconomic damages. If the presuit  
3665 screening panel established pursuant to s. 766.1066 found that  
3666 the defendant was not liable by majority vote, the damages that  
3667 can be awarded during arbitration for all noneconomic damages  
3668 shall not exceed a total of \$250,000, as adjusted herein, per  
3669 defendant.

3670 (b) If the presuit screening panel established pursuant to  
3671 s. 766.1066 found that the defendant was liable, the following  
3672 conditions shall apply:

3673 1.(a) Net economic damages shall be awardable, including,  
3674 but not limited to, past and future medical expenses and 80  
3675 percent of wage loss and loss of earning capacity, offset by any  
3676 collateral source payments, beginning at the time the injury  
3677 occurred and extended to a work-life expectancy as determined by  
3678 the jury. Net economic damages shall also include interest on  
3679 all economic damages occurring prior to trial.

3680 2.(b) Noneconomic damages shall be limited to a maximum of  
3681 \$250,000, as adjusted herein, per incident, and shall be



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3682 calculated on a percentage basis with respect to capacity to  
3683 enjoy life, so that a finding that the claimant's injuries  
3684 resulted in a 50-percent reduction in his or her capacity to  
3685 enjoy life would warrant an award of not more than \$125,000  
3686 noneconomic damages. The limits on damages established in this  
3687 paragraph shall be adjusted annually in accordance with the  
3688 changes in the Consumer Price Index as issued by the United  
3689 States Department of Labor Bureau of Labor Statistics. The  
3690 Agency for Health Care Administration shall establish by rule  
3691 the new limits on July 1 of each year.

3692 3.(e) Damages for future economic losses shall be awarded  
3693 to be paid by periodic payments pursuant to s. 766.1067(2) ~~s.~~  
3694 ~~766.202(8)~~ and shall be offset by future collateral source  
3695 payments.

3696 4.(d) Punitive damages shall not be awarded.

3697 5.(e) The defendant shall be responsible for the payment  
3698 of interest on all accrued damages with respect to which  
3699 interest would be awarded at trial.

3700 6.(f) The defendant shall pay the claimant's reasonable  
3701 attorney's fees and costs, as determined by the arbitration  
3702 panel, but in no event more than 15 percent of the award,  
3703 reduced to present value.

3704 ~~(g) The defendant shall pay all the costs of the~~  
3705 ~~arbitration proceeding and the fees of all the arbitrators other~~  
3706 ~~than the administrative law judge.~~

3707 ~~(h) Each defendant who submits to arbitration under this~~  
3708 ~~section shall be jointly and severally liable for all damages~~  
3709 ~~assessed pursuant to this section.~~

3710 7.(i) The defendant's obligation to pay the claimant's  
3711 damages shall be for the purpose of arbitration under this



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3712 section only. A defendant's or claimant's offer to arbitrate  
3713 shall not be used in evidence or in argument during any  
3714 subsequent litigation of the claim following the rejection  
3715 thereof.

3716 8.~~(j)~~ The fact of making or accepting an offer to  
3717 arbitrate shall not be admissible as evidence of liability in  
3718 any collateral or subsequent proceeding on the claim.

3719 9.~~(k)~~ Any offer by a claimant to arbitrate must be made to  
3720 each defendant against whom the claimant has made a claim. Any  
3721 offer by a defendant to arbitrate must be made to each claimant  
3722 who has joined in the notice of intent to initiate litigation,  
3723 as provided in s. 766.106. A defendant who rejects a claimant's  
3724 offer to arbitrate shall be subject to the provisions of  
3725 subsection (11) ~~s. 766.209(3)~~. A claimant who rejects a  
3726 defendant's offer to arbitrate shall be subject to the  
3727 provisions of subsection (12) ~~s. 766.209(4)~~.

3728 10.~~(l)~~ The hearing shall be conducted by the panel ~~all of~~  
3729 ~~the arbitrators~~, but a majority may determine any question of  
3730 fact and render a final decision. ~~The chief arbitrator shall~~  
3731 ~~decide all evidentiary matters.~~

3732  
3733 The provisions of this subsection shall not preclude settlement  
3734 at any time by mutual agreement of the parties.

3735 (8) Any issue between the defendant and the defendant's  
3736 insurer or self-insurer as to who shall control the defense of  
3737 the claim and any responsibility for payment of an arbitration  
3738 award, shall be determined under existing principles of law;  
3739 provided that the insurer or self-insurer shall not offer to  
3740 arbitrate or accept a claimant's offer to arbitrate without the  
3741 written consent of the defendant.



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3742 (9) The Division of Administrative Hearings is authorized  
3743 to promulgate rules to effect the orderly and efficient  
3744 processing of the arbitration procedures of ss. 766.201-766.212.

3745 (10) Rules promulgated by the Division of Administrative  
3746 Hearings pursuant to this section, s. 120.54, or s. 120.65 may  
3747 authorize any reasonable sanctions except contempt for violation  
3748 of the rules of the division or failure to comply with a  
3749 reasonable order issued by an administrative law judge, which is  
3750 not under judicial review.

3751 (11) If the defendant refuses a claimant's offer of  
3752 voluntary binding arbitration:

3753 (a) The claim shall proceed to trial without limitation on  
3754 damages and the claimant, upon proving medical negligence, shall  
3755 be entitled to recover prejudgment interest and reasonable  
3756 attorney's fees up to 25 percent of the award reduced to present  
3757 value.

3758 (b) The claimant's award at trial shall be reduced by any  
3759 damages recovered by the claimant from arbitrating codefendants  
3760 following arbitration.

3761 (c) The claimant shall be entitled to recover prejudgment  
3762 interest on economic damages incurred prior to trial.

3763 (12) If the claimant rejects a defendant's offer to enter  
3764 voluntary binding arbitration:

3765 (a) The damages awardable at trial shall be limited to net  
3766 economic damages, plus noneconomic damages not to exceed  
3767 \$350,000, as adjusted herein, per incident. The Legislature  
3768 expressly finds that such conditional limit on noneconomic  
3769 damages is warranted by the claimant's refusal to accept  
3770 arbitration, and represents an appropriate balance between the  
3771 interests of all patients who ultimately pay for medical



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3772 negligence losses and the interests of those patients who are  
3773 injured as a result of medical negligence. The limits on damages  
3774 established in this paragraph shall be adjusted annually in  
3775 accordance with the changes in the Consumer Price Index as  
3776 issued by the United States Department of Labor Bureau of Labor  
3777 Statistics. The Agency for Health Care Administration shall  
3778 establish by rule the new limits on July 1 of each year. Net  
3779 economic damages shall also include interest on all economic  
3780 damages occurring prior to trial.

3781 (b) Net economic damages reduced to present value shall be  
3782 awardable, including, but not limited to, past and future  
3783 medical expenses and 80 percent of wage loss and loss of earning  
3784 capacity, offset by any collateral source payments.

3785 (c) Damages for future economic losses shall be awarded to  
3786 be paid by periodic payments pursuant to s. 766.202(8), and  
3787 shall be offset by future collateral source payments.

3788 (13) The arbitration panel shall allocate financial  
3789 responsibility among all defendants named in the notice of  
3790 intent to initiate litigation, regardless of whether the  
3791 defendant has submitted to arbitration. The defendants in the  
3792 arbitration proceeding shall pay their proportionate share of  
3793 the economic and noneconomic damages awarded by the arbitration  
3794 panel. All defendants in the arbitration proceeding shall be  
3795 jointly and severally liable for any damages assessed in  
3796 arbitration. The determination of the percentage of fault of any  
3797 defendant not in the arbitration case shall neither be binding  
3798 against that defendant, nor shall it be admissible in any  
3799 subsequent legal proceeding.

3800 (14) Payment by the defendants of the damages awarded by  
3801 the arbitration panel shall extinguish those defendants'



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3802 liability to the claimant and shall also extinguish those  
3803 defendants' liability for contribution to any defendants who did  
3804 not participate in arbitration.

3805 (15) Any defendant paying damages assessed pursuant to  
3806 this section shall have an action for contribution against any  
3807 nonarbitrating person whose negligence contributed to the  
3808 injury.

3809 (16)(a) If a health care professional does not meet his or  
3810 her financial responsibility requirements as provided in s.  
3811 458.320(1)(b) or s. 459.0085(1)(b), as applicable, by July 1,  
3812 2004, the limits on damages established in this section shall  
3813 not apply and awards for economic and noneconomic damages shall  
3814 not be limited during arbitration or jury trial.

3815 (b) It is the intent of the Legislature to provide relief  
3816 from rising medical malpractice insurance premiums to those  
3817 physicians who pay premiums on medical malpractice liability  
3818 insurance. Physicians who do not carry medical malpractice  
3819 liability insurance and hence do not pay premiums require no  
3820 relief from the crisis referred to in the findings provided in  
3821 this act.

3822 (17) Jury trials shall proceed in accordance with existing  
3823 principles of law.

3824 Section 65. Sections 766.208 and 766.209, Florida  
3825 Statutes, are repealed.

3826 Section 66. Subsection (1) of section 766.112, Florida  
3827 Statutes, is amended to read:

3828 766.112 Comparative fault.--

3829 (1) Notwithstanding any provision of ~~anything in~~ law to  
3830 the contrary, in an action for damages for personal injury or  
3831 wrongful death arising out of medical malpractice, whether in





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3832 contract or tort, ~~when an apportionment of damages pursuant to~~  
 3833 ~~this section is attributed to a teaching hospital as defined in~~  
 3834 ~~s. 408.07, the court shall enter judgment against the teaching~~  
 3835 ~~hospital~~ on the basis of ~~such~~ party's percentage of fault and  
 3836 not on the basis of the doctrine of joint and several liability.  
 3837 In the trial of any action for medical malpractice which follows  
 3838 a settlement between the plaintiff and one or more defendants or  
 3839 potential defendants for the same injury, the plaintiff shall be  
 3840 estopped from denying that the fault on the part of any such  
 3841 settled defendant or prospective defendant contributed to  
 3842 causing the plaintiff's injuries with respect to any such  
 3843 settled defendant or prospective defendant who has been  
 3844 identified by way of affirmative defense or joined by a  
 3845 nonsettling defendant as a party who is liable, in whole or in  
 3846 part, for the plaintiff's damages.

3847 Section 67. Section 766.25, Florida Statutes, is created  
 3848 to read:

3849 766.25 Itemized verdict.--

3850 (1) In any action for damages based on personal injury or  
 3851 wrongful death arising out of medical malpractice, whether in  
 3852 tort or contract, to which this part applies in which the trier  
 3853 of fact determines that liability exists on the part of the  
 3854 defendant, the trier of fact shall, as a part of the verdict,  
 3855 itemize the amounts to be awarded to the claimant into the  
 3856 following categories of damages:

3857 (a) Amounts intended to compensate the claimant for:

3858 1. Past economic losses; and

3859 2. Future economic losses, not reduced to present value,  
 3860 and the number of years or part thereof which the award is  
 3861 intended to cover;



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3862 (b) Amounts intended to compensate the claimant for:

3863 1. Past noneconomic losses;

3864 2. Future noneconomic losses and the number of years or  
3865 part thereof which the award is intended to cover; and

3866 (c) Amounts awarded to the claimant for punitive damages,  
3867 if applicable.

3868 Section 68. Section 766.26, Florida Statutes, is created  
3869 to read:

3870 766.26 Florida Jury Verdict Database.--

3871 (1) The Agency for Health Care Administration shall  
3872 maintain the Florida Jury Verdict Database. For the initial  
3873 database, the department shall utilize information and  
3874 categories provided by a nationwide jury verdict research  
3875 database of plaintiff and defense verdicts and settlements  
3876 resulting from medical malpractice claims. The data to be used  
3877 must be reported, tabulated, and analyzed to determine values,  
3878 trends, and deviations for injuries and liabilities including  
3879 medical malpractice.

3880 (2) Beginning September 1, 2003, all awards under  
3881 subsection (1) shall be reported by the Clerk of the Court in  
3882 the circuit in which the judgment was entered to the agency  
3883 within 3 business days for compilation into the Florida Jury  
3884 Verdict Data Base. The agency, in conjunction with the Clerks of  
3885 the Court, shall develop a format for the clerks to use in  
3886 reporting the information required for the categories utilized  
3887 by the database in subsection (1).

3888 (3) Beginning July 1, 2007, the department shall only  
3889 utilize reports concerning cases within the state in the Florida  
3890 Jury Verdict Database.

3891 (4) The awards reported by the Clerks of the Court shall



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3892 be adjusted annually in accordance with the changes in the  
3893 Consumer Price Index as issued by the United States Department  
3894 of Labor Bureau of Labor Statistics. The Agency for Health Care  
3895 Administration shall adjust all previously reported awards in  
3896 the Florida Jury Verdict Database as provided herein prior to  
3897 July 1 of each year. Only those awards reported from courts in  
3898 this state after September 1, 2003, shall be adjusted.

3899 Section 69. Section 766.27, Florida Statutes, is created  
3900 to read:

3901 766.27 Sanctions for frivolous medical malpractice  
3902 lawsuits.-- Any attorney who receives three judgments of filing  
3903 a frivolous medical malpractice lawsuit in any 5-year period  
3904 shall be precluded from filing a medical malpractice lawsuit for  
3905 3 years. Such preclusion shall prohibit him or her from serving  
3906 as co-counsel on any medical malpractice lawsuit.

3907 Section 70. Office of Insurance Regulation; closed claim  
3908 forms; report required.-- The Office of Insurance Regulation  
3909 shall revise its closed claim form for readability at the ninth-  
3910 grade level. The office shall compile annual statistical reports  
3911 that provide data summaries of all closed claims, including, but  
3912 not limited to, the number of closed claims on file pertaining  
3913 to the referent health care professional or health care entity,  
3914 the nature of the errant conduct, the size of payments, and the  
3915 frequency and size of noneconomic damage awards. The office  
3916 shall develop annualized historical statistical summaries  
3917 beginning with the 1976 state fiscal year and publish these  
3918 reports on its website no later than the 2005 state fiscal year.  
3919 The form must accommodate the following minimum requirements:

3920 (1) A practitioner of medicine licensed pursuant to  
3921 chapter 458, Florida Statutes, or a practitioner of osteopathic



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3922 medicine licensed pursuant to chapter 459, Florida Statutes,  
3923 shall report to the Office of Insurance Regulation and the  
3924 Department of Health any claim or action for damages for  
3925 personal injury alleged to have been caused by error, omission,  
3926 or negligence in the performance of such licensee's professional  
3927 services or based on a claimed performance of professional  
3928 services without consent if the claim was not covered by an  
3929 insurer required to report under s. 627.912, Florida Statutes,  
3930 is not a claim for medical malpractice that is subject to the  
3931 provisions of s. 766.106, Florida Statutes, and the claim  
3932 resulted in:

- 3933 (a) A final judgment in any amount.  
3934 (b) A settlement in any amount.  
3935 (c) A final disposition not resulting in payment on behalf  
3936 of the licensee. Reports shall be filed with the Office of  
3937 Insurance Regulation no later than 60 days following the  
3938 occurrence of any event listed in this subsection.  
3939 (2) Health professional reports must contain:  
3940 (a) The name and address of the licensee.  
3941 (b) The alleged occurrence.  
3942 (c) The date of the alleged occurrence.  
3943 (d) The date the claim or action was reported to the  
3944 licensee.  
3945 (e) The name and address of the opposing party.  
3946 (f) The date of suit, if filed.  
3947 (g) The injured person's age and sex.  
3948 (h) The total number and names of all defendants involved  
3949 in the claim.  
3950 (i) The date and amount of judgment or settlement, if any,  
3951 including the itemization of the verdict, together with a copy



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3952 of the settlement or judgment.

3953 (j) In the case of a settlement, any information required  
3954 by the Office of Insurance Regulation concerning the injured  
3955 person's incurred and anticipated medical expense, wage loss,  
3956 and other expenses.

3957 (k) The loss adjustment expense paid to defense counsel,  
3958 and all other allocated loss adjustment expenses paid.

3959 (l) The date and reason for final disposition, if there  
3960 was no judgment or settlement.

3961 (m) A summary of the occurrence that created the claim,  
3962 which must include:

3963 1. The name of the institution, if any, and the location  
3964 within such institution at which the injury occurred.

3965 2. The final diagnosis for which treatment was sought or  
3966 rendered, including the patient's actual condition.

3967 3. A description of the misdiagnosis made, if any, of the  
3968 patient's actual condition.

3969 4. The operation or the diagnostic or treatment procedure  
3970 causing the injury.

3971 5. A description of the principal injury giving rise to  
3972 the claim.

3973 6. The safety management steps that have been taken by the  
3974 licensee to make similar occurrences or injuries less likely in  
3975 the future.

3976 (n) Any other information required by the Office of  
3977 Insurance Regulation to analyze and evaluate the nature, causes,  
3978 location, cost, and damages involved in professional liability  
3979 cases.

3980 Section 71. Subsection (8) of section 768.21, Florida  
3981 Statutes, is amended to read:



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3982           768.21 Damages.-- All potential beneficiaries of a  
 3983 recovery for wrongful death, including the decedent's estate,  
 3984 shall be identified in the complaint, and their relationships to  
 3985 the decedent shall be alleged. Damages may be awarded as  
 3986 follows:

3987           (8) Notwithstanding any other provision of law to the  
 3988 contrary, for purposes of a wrongful death action arising out of  
 3989 medical negligence, adult individuals named as beneficiaries  
 3990 under a testamentary estate may recover noneconomic damages as  
 3991 though they were within that class of survivors identified in  
 3992 this section when a health care practitioner commits an  
 3993 intentional tort or is convicted of a crime which resulted in  
 3994 the death of the benefactor. The personal representative of the  
 3995 estate shall be entitled to assert a cause of action on behalf  
 3996 of the class of beneficiaries for the noneconomic damages of  
 3997 such beneficiaries which shall be in addition to any other  
 3998 damages that the estate would otherwise be entitled to assert.  
 3999 However, in no event shall the total amount of noneconomic  
 4000 damages for the entire class of beneficiaries exceed any  
 4001 limitation on noneconomic damages imposed under s. 766.118 ~~The~~  
 4002 ~~damages specified in subsection (3) shall not be recoverable by~~  
 4003 ~~adult children and the damages specified in subsection (4) shall~~  
 4004 ~~not be recoverable by parents of an adult child with respect to~~  
 4005 ~~claims for medical malpractice as defined by s. 766.106(1).~~

4006           Section 72. Subsection (5) of section 768.81, Florida  
 4007 Statutes, is amended to read:

4008           768.81 Comparative fault.--

4009           (5) Notwithstanding any provision of ~~anything in~~ law to  
 4010 the contrary, in an action for damages for personal injury or  
 4011 wrongful death arising out of medical malpractice, whether in



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4012 contract or tort, ~~when an apportionment of damages pursuant to~~  
 4013 ~~this section is attributed to a teaching hospital as defined in~~  
 4014 ~~s. 408.07, the court shall enter judgment against the teaching~~  
 4015 ~~hospital~~ on the basis of each such party's percentage of fault  
 4016 and not on the basis of the doctrine of joint and several  
 4017 liability. In the trial of any action for medical malpractice  
 4018 which follows a settlement between the plaintiff and one or more  
 4019 defendants or potential defendants for the same injury, the  
 4020 plaintiff shall be estopped from denying that the fault on the  
 4021 part of any such settled defendant or prospective defendant  
 4022 contributed to causing the plaintiff's injuries with respect to  
 4023 any such settled defendant or prospective defendant who has been  
 4024 identified by way of affirmative defense or joined by a  
 4025 nonsettling defendant as a party who is liable, in whole or in  
 4026 part, for the plaintiff's damages.

4027 Section 73. Section 1004.08, Florida Statutes, is created  
 4028 to read:

4029 1004.08 Patient safety instructional requirements.-- Every  
 4030 public school, college, and university that offers degrees in  
 4031 medicine, nursing, and allied health shall include in the  
 4032 curricula applicable to such degrees material on patient safety,  
 4033 including patient safety improvement. Materials shall include,  
 4034 but need not be limited to, effective communication and  
 4035 teamwork; epidemiology of patient injuries and medical errors;  
 4036 vigilance, attention, and fatigue; checklists and inspections;  
 4037 automation and technological and computer support; psychological  
 4038 factors in human error; and reporting systems.

4039 Section 74. Section 1004.085, Florida Statutes, is created  
 4040 to read:

4041 1004.085 Informed consent standardization project.-- Every



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4042 public school, college, and university that offers degrees in  
4043 medicine, nursing, and allied health shall work with the Agency  
4044 for Health Care Administration to develop bilingual, multimedia  
4045 methods for communicating the risks of treatment options for  
4046 medical procedures. Such materials shall be provided to patients  
4047 and their families in an effort to educate them and to obtain  
4048 the informed consent to prescribe a treatment procedure. The  
4049 agency shall develop a list of treatment procedures based on  
4050 significance of risk and frequency of performance.

4051 Section 75. Section 1005.07, Florida Statutes, is created  
4052 to read:

4053 1005.07 Patient safety instructional requirements.-- Every  
4054 nonpublic school, college, and university that offers degrees in  
4055 medicine, nursing, and allied health shall include in the  
4056 curricula applicable to such degrees material on patient safety,  
4057 including patient safety improvement. Materials shall include,  
4058 but need not be limited to, effective communication and  
4059 teamwork; epidemiology of patient injuries and medical errors;  
4060 vigilance, attention, and fatigue; checklists and inspections;  
4061 automation and technological and computer support; psychological  
4062 factors in human error; and reporting systems.

4063 Section 76. Section 1005.075, Florida Statutes, is created  
4064 to read:

4065 1005.075 Informed consent standardization project.-- Every  
4066 nonpublic school, college, and university that offers degrees in  
4067 medicine, nursing, and allied health shall work with the Agency  
4068 for Health Care Administration to develop bilingual, multimedia  
4069 methods for communicating the risks of treatment options for  
4070 medical procedures. Such materials shall be provided to patients  
4071 and their families in an effort to educate them and to obtain





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4072 the informed consent to prescribe a treatment procedure. The  
4073 agency shall develop a list of treatment procedures based on  
4074 significance of risk and frequency of performance.

4075 Section 77. (1) The Agency for Health Care Administration  
4076 shall conduct or contract for a study to determine what  
4077 information is most feasible to provide to the public comparing  
4078 state-licensed hospitals on certain inpatient quality indicators  
4079 developed by the federal Agency for Healthcare Research and  
4080 Quality. Such indicators shall be designed to identify  
4081 information about specific procedures performed in hospitals for  
4082 which there is strong evidence of a link to quality of care. The  
4083 Agency for Health Care Administration or the study contractor  
4084 shall refer to the hospital quality reports published in New  
4085 York and Texas as guides during the evaluation.

4086 (2) The following concepts shall be specifically addressed  
4087 in the study report:

4088 (a) Whether hospital discharge data about services can be  
4089 translated into understandable and meaningful information for  
4090 the public.

4091 (b) Whether the following measures are useful consumer  
4092 guides relating to care provided in state-licensed hospitals:

4093 1. Inpatient mortality for medical conditions.

4094 2. Inpatient mortality for procedures.

4095 3. Utilization of procedures for which there are questions  
4096 of overuse, underuse, or misuse.

4097 4. Volume of procedures for which there is evidence that a  
4098 higher volume of procedures is associated with lower mortality.

4099 (c) Whether there are quality indicators that are  
4100 particularly useful relative to the state's unique demographics.

4101 (d) Whether all hospitals should be included in the



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4102 comparison.

4103 (e) The criteria for comparison.

4104 (f) Whether comparisons are best within metropolitan  
4105 statistical areas or some other geographic configuration.

4106 (g) Identification of several Internet websites on which  
4107 such a report should be published to achieve the broadest  
4108 dissemination of the information.

4109 (3) The Agency for Health Care Administration shall  
4110 consider the input of all interested parties, including  
4111 hospitals, physicians, consumer organizations, and patients, and  
4112 submit the final report to the Governor and the presiding  
4113 officers of the Legislature by January 1, 2004.

4114 Section 78. No later than September 1, 2003, the  
4115 Department of Health shall convene a workgroup to study the  
4116 current healthcare practitioner disciplinary process. The  
4117 workgroup shall include a representative of the Administrative  
4118 Law section of The Florida Bar, a representative of the Health  
4119 Law section of The Florida Bar, a representative of the Florida  
4120 Medical Association, a representative of the Florida Osteopathic  
4121 Medical Association, a representative of the Florida Dental  
4122 Association, a member of the Florida Board of Medicine who has  
4123 served on the probable cause panel, a member of the Board of  
4124 Osteopathic Medicine who has served on the probable cause panel,  
4125 and a member of the Board of Dentistry who has served on the  
4126 probable cause panel. The workgroup shall also include one  
4127 consumer member of the Board of Medicine. The Department of  
4128 Health shall present the findings and recommendations to the  
4129 Governor, the President of the Senate, and the Speaker of the  
4130 House of Representatives no later than January 1, 2004. The  
4131 sponsoring organizations shall assume the costs of their



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4132 representative.

4133       Section 79. The sum of \$687,786 is appropriated from the  
4134 Medical Quality Assurance Trust Fund to the Department of  
4135 Health, and seven positions are authorized for the purpose of  
4136 implementing this act during the 2003-2004 fiscal year. The sum  
4137 of \$452,122 is appropriated from the General Revenue Fund to the  
4138 Agency for Health Care Administration, and five positions are  
4139 authorized for the purpose of implementing this act during the  
4140 2003-2004 fiscal year.

4141       Section 80. If any provision of this act or the  
4142 application thereof to any person or circumstance is held  
4143 invalid, the invalidity does not affect other provisions or  
4144 applications of the act which can be given effect without the  
4145 invalid provision or application, and to this end the provisions  
4146 of this act are declared severable.

4147       Section 81. All provisions of this act shall be repealed  
4148 on July 1, 2007, unless the Legislature otherwise directs.

4149       Section 82. If any law amended by this act was also  
4150 amended by a law enacted at the 2003 Regular Session of the  
4151 Legislature or at the 2003 Special Session A of the Legislature,  
4152 such laws shall be construed as if they had been enacted at the  
4153 same session of the Legislature, and full effect shall be given  
4154 to each if possible.

4155       Section 83. This act shall take effect upon becoming a law  
4156 and shall apply to all actions filed after the effective date of  
4157 the act.