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1 A bill to be entitled

2 An act relating to medical incidents; providing  
3 legislative findings; amending s. 46.015, F.S.; revising  
4 requirements for setoffs against damages in medical  
5 malpractice actions if there is a written release or  
6 covenant not to sue; amending s. 395.0191, F.S.; deleting  
7 requirement that persons act in good faith to avoid  
8 liability or discipline for their actions regarding the  
9 awarding of staff membership or clinical privileges;  
10 creating s. 395.1012, F.S.; requiring hospitals,  
11 ambulatory surgical centers, and mobile surgical  
12 facilities to establish patient safety plans and  
13 committees; creating s. 395.1051, F.S.; providing for  
14 notification of injuries in a hospital, ambulatory  
15 surgical center, or mobile surgical facility; amending s.  
16 415.1111, F.S.; providing that such section shall not  
17 apply to actions involving allegations of medical  
18 malpractice by a hospital; amending s. 456.039, F.S.;  
19 providing additional information required to be furnished  
20 to the Department of Health for licensure purposes;  
21 amending s. 456.041, F.S.; requiring additional  
22 information to be included in health care practitioner  
23 profiles; providing for fines; revising requirements for  
24 the reporting of paid liability claims; amending s.  
25 456.042, F.S.; requiring health care practitioner profiles  
26 to be updated within a specific time period; amending s.  
27 456.049, F.S.; revising requirements for the reporting of  
28 paid liability claims; amending s. 456.051, F.S.;  
29 establishing the responsibility of the Department of  
30 Health to provide reports of professional liability



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31 actions and bankruptcies; requiring the department to  
32 include such reports in a practitioner's profile within a  
33 specified period; amending s. 456.057, F.S.; authorizing  
34 the Department of Health to utilize subpoenas to obtain  
35 patient records without patients' consent under certain  
36 circumstances; amending s. 456.063, F.S.; providing for  
37 adopting rules to implement requirements for reporting  
38 allegations of sexual misconduct; amending s. 456.072,  
39 F.S.; authorizing the Department of Health to determine  
40 administrative costs in disciplinary actions; amending s.  
41 456.073, F.S.; extending the time for the Department of  
42 Health to refer a request for an administrative hearing;  
43 amending s. 456.077, F.S.; revising provisions relating to  
44 designation of certain citation violations; amending s.  
45 456.078, F.S.; revising provisions relating to designation  
46 of certain mediation offenses; creating s. 456.085, F.S.;  
47 providing for notification of an injury by a physician;  
48 amending s. 458.320, F.S., relating to financial  
49 responsibility requirements for medical physicians;  
50 requiring the department to suspend the license of a  
51 medical physician who has not paid, up to the amounts  
52 required by any applicable financial responsibility  
53 provision, any outstanding judgment, arbitration award,  
54 other order, or settlement; amending s. 458.331, F.S.;  
55 increasing the amount of paid liability claims requiring  
56 investigation by the Department of Health; revising the  
57 definition of "repeated malpractice" to conform; creating  
58 s. 458.3311, F.S.; establishing emergency procedures for  
59 disciplinary actions; amending s. 459.0085, F.S., relating  
60 to financial responsibility requirements for osteopathic



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61 physicians; requiring that the department suspend the  
62 license of an osteopathic physician who has not paid, up  
63 to the amounts required by any applicable financial  
64 responsibility provision, any outstanding judgment,  
65 arbitration award, other order, or settlement; amending s.  
66 459.015, F.S.; increasing the amount of paid liability  
67 claims requiring investigation by the Department of  
68 Health; revising the definition of "repeated malpractice"  
69 to conform; creating s. 459.0151, F.S.; establishing  
70 emergency procedures for disciplinary actions; amending s.  
71 461.013, F.S.; increasing the amount of paid liability  
72 claims requiring investigation by the Department of  
73 Health; revising the definition of "repeated malpractice"  
74 to conform; amending s. 624.462, F.S.; authorizing health  
75 care providers to form a commercial self-insurance fund;  
76 amending s. 627.062, F.S.; providing additional  
77 requirements for medical malpractice insurance rate  
78 filings; providing that portions of judgments and  
79 settlements entered against a medical malpractice insurer  
80 for badfaith actions or for punitive damages against the  
81 insurer, as well as related taxable costs and attorney's  
82 fees, may not be included in an insurer's base rate;  
83 providing for review of rate filings by the Office of  
84 Insurance Regulation for excessive, inadequate, or  
85 unfairly discriminatory rates; requiring insurers to apply  
86 a discount based on the health care provider's loss  
87 experience; requiring annual rate filings; requiring  
88 medical malpractice insurers to make rate filings  
89 effective January 1, 2004, which reflect the impact of  
90 this act; providing requirements for rate deviation by



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91 insurers; authorizing adjustments to filed rates in the  
92 event a provision of this act is declared invalid by a  
93 court of competent jurisdiction; creating s. 627.0662,  
94 F.S.; providing definitions; requiring each medical  
95 liability insurer to report certain information to the  
96 Office of Insurance Regulation; providing for  
97 determination of whether excessive profit has been  
98 realized; requiring return of excessive amounts; amending  
99 s. 627.357, F.S.; deleting the prohibition against  
100 formation of medical malpractice self-insurance funds;  
101 providing requirements to form a self-insurance fund;  
102 providing rulemaking authority to the Financial Services  
103 Commission; creating s. 627.3575, F.S.; creating the  
104 Health Care Professional Liability Insurance Facility;  
105 providing purpose; providing for governance and powers;  
106 providing eligibility requirements; providing for premiums  
107 and assessments; providing for regulation; providing rule  
108 adoption authority to the Financial Services Commission;  
109 providing applicability; specifying duties of the  
110 Department of Health; providing for debt and regulation  
111 thereof; amending s. 627.4147, F.S.; requiring earlier  
112 notice of decisions to not renew certain insurance  
113 policies to insureds under certain circumstances;  
114 requiring prior notification of a rate increase; amending  
115 s. 627.912, F.S.; requiring certain claims information to  
116 be filed with the Office of Insurance Regulation and the  
117 Department of Health; providing for rulemaking by the  
118 Financial Services Commission; increasing the limit on a  
119 fine; creating s. 627.9121, F.S.; requiring certain  
120 information relating to medical malpractice to be reported



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121 to the Office of Insurance Regulation; providing for  
122 enforcement; amending s. 766.106, F.S.; requiring the  
123 inclusion of additional information in presuit notices  
124 provided to defendants; extending the time period for the  
125 presuit screening period; providing that liability is  
126 deemed admitted when an offer is made by a defendant to  
127 arbitrate providing conditions for causes of action for  
128 bad faith against insurers providing coverage for medical  
129 negligence; revising provisions relating to a claimant's  
130 period to file suit after rejection of a prospective  
131 defendant's offer to admit liability and for arbitration  
132 on the issue of damages; specifying consequences of  
133 failure to cooperate on the part of any party during the  
134 presuit investigation; providing factors to be considered  
135 with respect to certain claims against bad faith against  
136 an insurer; revising requirements for presuit notice and  
137 insurer or self-insurer response to a claim; permitting  
138 written questions during informal discovery; requiring a  
139 claimant to execute a medical release to authorize  
140 defendants in medical negligence actions to take unsworn  
141 statements from a claimant's treating physicians;  
142 providing for informal discovery without notice; imposing  
143 limits on such statements; creating s. 766.1065, F.S.;  
144 requiring parties to provide certain information to  
145 parties without request; authorizing the issuance of  
146 subpoenas without case numbers; requiring that parties and  
147 certain experts be made available for deposition; creating  
148 s. 766.1067, F.S.; providing for mandatory mediation in  
149 medical negligence causes of action; creating s. 766.118,  
150 F.S.; providing a limitation on noneconomic damages which



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151 can be awarded in causes of action involving medical  
152 negligence; amending s. 766.202, F.S.; redefining the  
153 terms "economic damages," "medical expert," "noneconomic  
154 damages," and "periodic payment"; extending the  
155 definitions of economic and noneconomic damages to include  
156 any such damages recoverable under the Wrongful Death Act  
157 or general law; providing requirements for medical  
158 experts; providing for periodic payments for future  
159 noneconomic damages; revising regulations of periodic  
160 payments; amending s. 766.203, F.S.; providing for  
161 discovery of opinions and statements tendered during  
162 presuit investigation; amending s. 766.207, F.S.;  
163 conforming provisions to the extension in the time period  
164 for presuit investigation; providing for the applicability  
165 of the Wrongful Death Act and general law to arbitration  
166 awards; creating s. 766.213, F.S.; providing for the  
167 termination of periodic payments for unincurred medical  
168 expenses upon the death of the claimant; providing for the  
169 payment of medical expenses incurred prior to the death of  
170 the claimant; amending s. 768.041, F.S.; revising  
171 requirements for setoffs against damages in medical  
172 malpractice actions if there is a written release or  
173 covenant not to sue; amending s. 768.77, F.S.; prescribing  
174 a method for itemization of specific categories of damages  
175 awarded in medical malpractice actions; amending s.  
176 768.78, F.S.; correcting a cross reference; providing that  
177 a defendant may elect to make lump sum payments rather  
178 than periodic payments for either or both future economic  
179 and noneconomic damages; authorizing the payment of  
180 certain losses for a shorter period of time under certain



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181 circumstances; providing for modification of periodic  
182 payments or for requiring additional security by order of  
183 the court under certain circumstances; amending s. 768.81,  
184 F.S.; providing that a defendant's liability for damages  
185 in medical negligence cases is several only; creating s.  
186 1004.08, F.S.; requiring patient safety instruction for  
187 certain students in public schools, colleges, and  
188 universities; creating s. 1005.07, F.S.; requiring patient  
189 safety instruction for certain students in nonpublic  
190 schools, colleges, and universities; requiring the  
191 Department of Health to study the efficacy and  
192 constitutionality of medical review panels; requiring a  
193 report; directing the Agency for Health Care  
194 Administration to conduct or contract for a study to  
195 determine what information to provide to the public  
196 comparing hospitals, based on inpatient quality indicators  
197 developed by the federal Agency for Healthcare Research  
198 and Quality; requiring a report by the Agency for Health  
199 Care Administration regarding the establishment of a  
200 Patient Safety Authority; specifying elements of the  
201 report; requiring the Office of Program Policy Analysis  
202 and Government Accountability to study and report to the  
203 Legislature on requirements for coverage by the Florida  
204 Birth-Related Neurological Injury Compensation  
205 Association; providing civil immunity for certain  
206 participants in quality improvement processes; requiring  
207 the Office of Program Policy Analysis and Government  
208 Accountability and the Office of the Auditor General to  
209 conduct an audit of the Department of Health's health care  
210 practitioner disciplinary process and certain closed



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211 claims and to report to the Legislature; creating a  
212 workgroup to study the health care practitioner  
213 disciplinary process; providing for workgroup membership;  
214 providing that the workgroup deliver its report by January  
215 1, 2004; providing severability; providing for  
216 construction of the act in pari materia with laws enacted  
217 during the 2003 Regular Session or the 2003 Special  
218 Session A of the Legislature; providing an effective date.  
219

220 Be It Enacted by the Legislature of the State of Florida:  
221

222 Section 1. Findings.--

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

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

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

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

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





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

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

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

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

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

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

265       (12) The Legislature finds that ensuring that physicians  
266 continue to practice in Florida is an overwhelming public  
267 necessity.

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



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271       (14) The Legislature finds, based upon the findings and  
272 recommendations of the Governor's Select Task Force on  
273 Healthcare Professional Liability Insurance, the findings and  
274 recommendations of various study groups throughout the nation,  
275 and the experience of other states, that the overwhelming public  
276 necessities of making quality health care available to the  
277 citizens of this state, of ensuring that physicians continue to  
278 practice in Florida, and of ensuring that those physicians have  
279 the opportunity to purchase affordable professional liability  
280 insurance cannot be met unless a cap on noneconomic damages in  
281 an amount no higher than \$250,000 is imposed.

282       (15) The Legislature finds that the high cost of medical  
283 malpractice claims can be substantially alleviated by imposing a  
284 limitation on noneconomic damages in medical malpractice  
285 actions.

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

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

294       (18) The Legislature finds that each of the provisions of  
295 this act is necessary to alleviate the crisis relating to  
296 medical malpractice insurance.

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

299       46.015 Release of parties.--

300       (4)(a) At trial pursuant to a suit filed under chapter 766



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301 or pursuant to s. 766.209, if any defendant shows the court that  
 302 the plaintiff, or his or her legal representative, has delivered  
 303 a written release or covenant not to sue to any person in  
 304 partial satisfaction of the damages sued for, the court shall  
 305 setoff this amount from the total amount of the damages set  
 306 forth in the verdict and before entry of the final judgment.

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

310 Section 3. Subsection (7) of section 395.0191, Florida  
 311 Statutes, is amended to read:

312 395.0191 Staff membership and clinical privileges.--

313 (7) There shall be no monetary liability on the part of,  
 314 and no cause of action for injunctive relief or damages shall  
 315 arise against, any licensed facility, its governing board or  
 316 governing board members, medical staff, or disciplinary board or  
 317 against its agents, investigators, witnesses, or employees, or  
 318 against any other person, for any action arising out of or  
 319 related to carrying out the provisions of this section, absent  
 320 ~~taken in good faith and without intentional fraud in carrying~~  
 321 ~~out the provisions of this section.~~

322 Section 4. Section 395.1012, Florida Statutes, is created  
 323 to read:

324 395.1012 Patient safety.--

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

328 (2) Each licensed facility shall appoint a patient safety  
 329 officer and a patient safety committee, which shall include at  
 330 least one person who is neither employed by nor practicing in



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331 the facility, for the purpose of promoting the health and safety  
332 of patients, reviewing and evaluating the quality of patient  
333 safety measures used by the facility, and assisting in the  
334 implementation of the facility patient safety plan.

335 Section 5. Section 395.1051, Florida Statutes, is created  
336 to read:

337 395.1051 Duty to notify patients.--Every licensed facility  
338 shall inform each patient, or an individual identified pursuant  
339 to s. 765.401(1), in person about unanticipated outcomes of care  
340 that result in serious harm to the patient. Notification of  
341 outcomes of care that result in harm to the patient under this  
342 section shall not constitute an acknowledgement or admission of  
343 liability, nor can it be introduced as evidence in any civil  
344 lawsuit.

345 Section 6. Section 415.1111, Florida Statutes, is amended  
346 to read:

347 415.1111 Civil actions.--A vulnerable adult who has been  
348 abused, neglected, or exploited as specified in this chapter has  
349 a cause of action against any perpetrator and may recover actual  
350 and punitive damages for such abuse, neglect, or exploitation.  
351 The action may be brought by the vulnerable adult, or that  
352 person's guardian, by a person or organization acting on behalf  
353 of the vulnerable adult with the consent of that person or that  
354 person's guardian, or by the personal representative of the  
355 estate of a deceased victim without regard to whether the cause  
356 of death resulted from the abuse, neglect, or exploitation. The  
357 action may be brought in any court of competent jurisdiction to  
358 enforce such action and to recover actual and punitive damages  
359 for any deprivation of or infringement on the rights of a  
360 vulnerable adult. A party who prevails in any such action may be



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361 entitled to recover reasonable attorney's fees, costs of the  
362 action, and damages. The remedies provided in this section are  
363 in addition to and cumulative with other legal and  
364 administrative remedies available to a vulnerable adult.  
365 Notwithstanding the foregoing, any civil action for damages  
366 against any licensee or entity who establishes, controls,  
367 conducts, manages, or operates a facility licensed under part II  
368 of chapter 400 relating to its operation of the licensed  
369 facility shall be brought pursuant to s. 400.023, or against any  
370 licensee or entity who establishes, controls, conducts, manages,  
371 or operates a facility licensed under part III of chapter 400  
372 relating to its operation of the licensed facility shall be  
373 brought pursuant to s. 400.429. Such licensee or entity shall  
374 not be vicariously liable for the acts or omissions of its  
375 employees or agents or any other third party in an action  
376 brought under this section. Notwithstanding the provisions of  
377 this section, any claim that qualifies as a claim for medical  
378 malpractice, as defined in s. 766.106(1)(a), against any  
379 licensee or entity who establishes, controls, conducts, manages,  
380 or operates a facility licensed under chapter 395 shall be  
381 brought pursuant to chapter 766.

382 Section 7. Paragraph (a) of subsection (1) of section  
383 456.039, Florida Statutes, is amended to read:

384 456.039 Designated health care professionals; information  
385 required for licensure.--

386 (1) Each person who applies for initial licensure as a  
387 physician under chapter 458, chapter 459, chapter 460, or  
388 chapter 461, except a person applying for registration pursuant  
389 to ss. 458.345 and 459.021, must, at the time of application,  
390 and each physician who applies for license renewal under chapter



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391 458, chapter 459, chapter 460, or chapter 461, except a person  
 392 registered pursuant to ss. 458.345 and 459.021, must, in  
 393 conjunction with the renewal of such license and under  
 394 procedures adopted by the Department of Health, and in addition  
 395 to any other information that may be required from the  
 396 applicant, furnish the following information to the Department  
 397 of Health:

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

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

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

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

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

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

415 7. A description of any criminal offense of which the  
 416 applicant has been found guilty, regardless of whether  
 417 adjudication of guilt was withheld, or to which the applicant  
 418 has pled guilty or nolo contendere. A criminal offense committed  
 419 in another jurisdiction which would have been a felony or  
 420 misdemeanor if committed in this state must be reported. If the



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421 applicant indicates that a criminal offense is under appeal and  
422 submits a copy of the notice for appeal of that criminal  
423 offense, the department must state that the criminal offense is  
424 under appeal if the criminal offense is reported in the  
425 applicant's profile. If the applicant indicates to the  
426 department that a criminal offense is under appeal, the  
427 applicant must, upon disposition of the appeal, submit to the  
428 department a copy of the final written order of disposition.

429 8. A description of any final disciplinary action taken  
430 within the previous 10 years against the applicant by the agency  
431 regulating the profession that the applicant is or has been  
432 licensed to practice, whether in this state or in any other  
433 jurisdiction, by a specialty board that is recognized by the  
434 American Board of Medical Specialties, the American Osteopathic  
435 Association, or a similar national organization, or by a  
436 licensed hospital, health maintenance organization, prepaid  
437 health clinic, ambulatory surgical center, or nursing home.  
438 Disciplinary action includes resignation from or nonrenewal of  
439 medical staff membership or the restriction of privileges at a  
440 licensed hospital, health maintenance organization, prepaid  
441 health clinic, ambulatory surgical center, or nursing home taken  
442 in lieu of or in settlement of a pending disciplinary case  
443 related to competence or character. If the applicant indicates  
444 that the disciplinary action is under appeal and submits a copy  
445 of the document initiating an appeal of the disciplinary action,  
446 the department must state that the disciplinary action is under  
447 appeal if the disciplinary action is reported in the applicant's  
448 profile.

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



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451 Section 8. Section 456.041, Florida Statutes, is amended  
452 to read:

453 456.041 Practitioner profile; creation.--

454 (1)(a) Beginning July 1, 1999, the Department of Health  
455 shall compile the information submitted pursuant to s. 456.039  
456 into a practitioner profile of the applicant submitting the  
457 information, except that the Department of Health may develop a  
458 format to compile uniformly any information submitted under s.  
459 456.039(4)(b). Beginning July 1, 2001, the Department of Health  
460 may, and beginning July 1, 2004, shall, compile the information  
461 submitted pursuant to s. 456.0391 into a practitioner profile of  
462 the applicant submitting the information.

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

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

479 (2) On the profile published under subsection (1), the  
480 department shall indicate whether ~~if~~ the information provided





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481 under s. 456.039(1)(a)7. or s. 456.0391(1)(a)7. is or is not  
482 corroborated by a criminal history check conducted according to  
483 this subsection. ~~If the information provided under s.~~  
484 ~~456.039(1)(a)7. or s. 456.0391(1)(a)7. is corroborated by the~~  
485 ~~criminal history check, the fact that the criminal history check~~  
486 ~~was performed need not be indicated on the profile.~~ The  
487 department, or the board having regulatory authority over the  
488 practitioner acting on behalf of the department, shall  
489 investigate any information received by the department or the  
490 board when it has reasonable grounds to believe that the  
491 practitioner has violated any law that relates to the  
492 practitioner's practice.

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

509 (4) The Department of Health shall include, with respect  
510 to a practitioner licensed under chapter 458 or chapter 459, a



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511 statement of how the practitioner has elected to comply with the  
 512 financial responsibility requirements of s. 458.320 or s.  
 513 459.0085. The department shall include, with respect to  
 514 practitioners subject to s. 456.048, a statement of how the  
 515 practitioner has elected to comply with the financial  
 516 responsibility requirements of that section. The department  
 517 shall include, with respect to practitioners licensed under  
 518 chapter 458, chapter 459, or chapter 461, information relating  
 519 to liability actions which has been reported under s. 456.049 or  
 520 s. 627.912 within the previous 10 years for any paid claim of  
 521 \$50,000 or more ~~that exceeds \$5,000~~. Such claims information  
 522 shall be reported in the context of comparing an individual  
 523 practitioner's claims to the experience of other practitioners  
 524 within the same specialty, or profession if the practitioner is  
 525 not a specialist, ~~to the extent such information is available to~~  
 526 ~~the Department of Health~~. The department shall include a  
 527 hyperlink to all such comparison reports in such practitioner's  
 528 profile on its Internet website. If information relating to a  
 529 liability action is included in a practitioner's practitioner  
 530 profile, the profile must also include the following statement:  
 531 "Settlement of a claim may occur for a variety of reasons that  
 532 do not necessarily reflect negatively on the professional  
 533 competence or conduct of the practitioner. A payment in  
 534 settlement of a medical malpractice action or claim should not  
 535 be construed as creating a presumption that medical malpractice  
 536 has occurred."

537 (5) The Department of Health shall ~~may not~~ include the  
 538 date of a disciplinary action taken by a licensed hospital or an  
 539 ambulatory surgical center, in accordance with the requirements  
 540 of s. 395.0193, in the practitioner profile. Any practitioner



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541 disciplined under paragraph (1)(b) must report to the department  
542 the date the disciplinary action was imposed. The department  
543 shall state whether the action is related to professional  
544 competence and whether it is related to the delivery of services  
545 to a patient.

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

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

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

565 (9)~~(8)~~ Making a practitioner profile available to the  
566 public under this section does not constitute agency action for  
567 which a hearing under s. 120.57 may be sought.

568 Section 9. Section 456.042, Florida Statutes, is amended  
569 to read:

570 456.042 Practitioner profiles; update.--A practitioner



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571 must submit updates of required information within 15 days after  
 572 the final activity that renders such information a fact. The  
 573 Department of Health shall update each practitioner's  
 574 practitioner profile periodically. An updated profile is subject  
 575 to the same requirements as an original profile with respect to  
 576 the period within which the practitioner may review the profile  
 577 for the purpose of correcting factual inaccuracies.

578 Section 10. Subsection (1) of section 456.049, Florida  
 579 Statutes, is amended, and subsection (3) is added to said  
 580 section, to read:

581 456.049 Health care practitioners; reports on professional  
 582 liability claims and actions.--

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

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

598 (b) A settlement of \$50,000 or more or, with respect to a  
 599 dentist licensed pursuant to chapter 466, a settlement of  
 600 \$25,000 or more in any amount.



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

603  
 604 Reports shall be filed with the department no later than 60 days  
 605 following the occurrence of any event listed in paragraph (a),  
 606 paragraph (b), or paragraph (c).

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

609 Section 11. Section 456.051, Florida Statutes, is amended  
 610 to read:

611 456.051 Reports of professional liability actions;  
 612 bankruptcies; Department of Health's responsibility to  
 613 provide.--

614 (1) The report of a claim or action for damages for  
 615 personal injury which is required to be provided to the  
 616 Department of Health under s. 456.049 or s. 627.912 is public  
 617 information except for the name of the claimant or injured  
 618 person, which remains confidential as provided in ss.  
 619 456.049(2)(d) and 627.912(2)(e). The Department of Health  
 620 shall, upon request, make such report available to any person.  
 621 The department shall make such report available as a part of the  
 622 practitioner's profile within 45 calendar days after receipt.

623 (2) Any information in the possession of the Department of  
 624 Health which relates to a bankruptcy proceeding by a  
 625 practitioner of medicine licensed under chapter 458, a  
 626 practitioner of osteopathic medicine licensed under chapter 459,  
 627 a podiatric physician licensed under chapter 461, or a dentist  
 628 licensed under chapter 466 is public information. The Department  
 629 of Health shall, upon request, make such information available  
 630 to any person. The department shall make such report available



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631 as a part of the practitioner's profile within 45 calendar days  
632 after receipt.

633 Section 12. Paragraph (a) of subsection (7) of section  
634 456.057, Florida Statutes, is amended to read:

635 456.057 Ownership and control of patient records; report  
636 or copies of records to be furnished.--

637 (7)(a)1. The department may obtain patient records  
638 pursuant to a subpoena without written authorization from the  
639 patient if the department and the probable cause panel of the  
640 appropriate board, if any, find reasonable cause to believe that  
641 a health care practitioner has excessively or inappropriately  
642 prescribed any controlled substance specified in chapter 893 in  
643 violation of this chapter or any professional practice act or  
644 that a health care practitioner has practiced his or her  
645 profession below that level of care, skill, and treatment  
646 required as defined by this chapter or any professional practice  
647 act and also find that appropriate, reasonable attempts were  
648 made to obtain a patient release.

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

657 3. The department may obtain patient records, billing  
658 records, insurance information, provider contracts, and all  
659 attachments thereto pursuant to a subpoena without written  
660 authorization from the patient if the department and probable



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661 cause panel of the appropriate board, if any, find reasonable  
662 cause to believe that a health care practitioner has submitted a  
663 claim, statement, or bill using a billing code that would result  
664 in payment greater in amount than would be paid using a billing  
665 code that accurately describes the services performed, requested  
666 payment for services that were not performed by that health care  
667 practitioner, used information derived from a written report of  
668 an automobile accident generated pursuant to chapter 316 to  
669 solicit or obtain patients personally or through an agent  
670 regardless of whether the information is derived directly from  
671 the report or a summary of that report or from another person,  
672 solicited patients fraudulently, received a kickback as defined  
673 in s. 456.054, violated the patient brokering provisions of s.  
674 817.505, or presented or caused to be presented a false or  
675 fraudulent insurance claim within the meaning of s.  
676 817.234(1)(a), and also find that, within the meaning of s.  
677 817.234(1)(a), patient authorization cannot be obtained because  
678 the patient cannot be located or is deceased, incapacitated, or  
679 suspected of being a participant in the fraud or scheme, and if  
680 the subpoena is issued for specific and relevant records.

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

689 Section 13. Subsection (4) is added to section 456.063,  
690 Florida Statutes, to read:



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691 456.063 Sexual misconduct; disqualification for license,  
 692 certificate, or registration.--

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

697 Section 14. Subsection (4) of section 456.072, Florida  
 698 Statutes, is amended to read:

699 456.072 Grounds for discipline; penalties; enforcement.--

700 (4) In any ~~any addition to any other discipline imposed~~  
 701 ~~through~~ final order, or citation, entered on or after July 1,  
 702 2001, that imposes a penalty or other form of discipline  
 703 ~~pursuant to this section or discipline imposed through final~~  
 704 ~~order, or citation, entered on or after July 1, 2001,~~ for a  
 705 violation of any practice act, the board, or the department when  
 706 there is no board, shall assess costs related to the  
 707 investigation and prosecution of the case, including costs  
 708 associated with an attorney's time. The amount of costs to be  
 709 assessed shall be determined by the board, or the department  
 710 when there is no board, following its consideration of an  
 711 affidavit of itemized costs and any written objections thereto.  
 712 In any case in which ~~where the board or the department imposes a~~  
 713 ~~fine or assessment~~ of costs imposed by the board or department  
 714 ~~and the fine or assessment~~ is not paid within a reasonable time,  
 715 such reasonable time to be prescribed in the rules of the board,  
 716 or the department when there is no board, or in the order  
 717 assessing such fines or costs, the department or the Department  
 718 of Legal Affairs may contract for the collection of, or bring a  
 719 civil action to recover, the fine or assessment.

720 Section 15. Subsection (5) of section 456.073, Florida





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721 Statutes, is amended to read:

722 456.073 Disciplinary proceedings.--Disciplinary  
723 proceedings for each board shall be within the jurisdiction of  
724 the department.

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

733 (b) Notwithstanding s. 120.569(2), the department shall  
734 notify the Division of Administrative Hearings within 45 days  
735 after receipt of a petition or request for a hearing that the  
736 department has determined requires a formal hearing before an  
737 administrative law judge.

738 Section 16. Subsections (1) and (2) of section 456.077,  
739 Florida Statutes, are amended to read:

740 456.077 Authority to issue citations.--

741 (1) Notwithstanding s. 456.073, the board, or the  
742 department if there is no board, shall adopt rules to permit the  
743 issuance of citations. The citation shall be issued to the  
744 subject and shall contain the subject's name and address, the  
745 subject's license number if applicable, a brief factual  
746 statement, the sections of the law allegedly violated, and the  
747 penalty imposed. The citation must clearly state that the  
748 subject may choose, in lieu of accepting the citation, to follow  
749 the procedure under s. 456.073. If the subject disputes the  
750 matter in the citation, the procedures set forth in s. 456.073



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751 must be followed. However, if the subject does not dispute the  
752 matter in the citation with the department within 30 days after  
753 the citation is served, the citation becomes a public final  
754 order and does not constitute ~~constitutes~~ discipline for a first  
755 offense, but does constitute discipline for a second or  
756 subsequent offense. The penalty shall be a fine or other  
757 conditions as established by rule.

758 (2) The board, or the department if there is no board,  
759 shall adopt rules designating violations for which a citation  
760 may be issued. Such rules shall designate as citation violations  
761 those violations for which there is no substantial threat to the  
762 public health, safety, and welfare or no violation of standard  
763 of care involving injury to a patient. Violations for which a  
764 citation may be issued shall include violations of continuing  
765 education requirements; failure to timely pay required fees and  
766 fines; failure to comply with the requirements of ss. 381.026  
767 and 381.0261 regarding the dissemination of information  
768 regarding patient rights; failure to comply with advertising  
769 requirements; failure to timely update practitioner profile and  
770 credentialing files; failure to display signs, licenses, and  
771 permits; failure to have required reference books available; and  
772 all other violations that do not pose a direct and serious  
773 threat to the health and safety of the patient or involve a  
774 violation of standard of care that has resulted in injury to a  
775 patient.

776 Section 17. Subsections (1) and (2) of section 456.078,  
777 Florida Statutes, are amended to read:

778 456.078 Mediation.--

779 (1) Notwithstanding the provisions of s. 456.073, the  
780 board, or the department when there is no board, shall adopt



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

- 791 (a) The death of a patient;  
792 (b) Brain or spinal damage to a patient;  
793 (c) The performance of a surgical procedure on the wrong  
794 patient;  
795 (d) The performance of a wrong-site surgical procedure;  
796 (e) The performance of a surgical procedure that is  
797 medically unnecessary or otherwise unrelated to the patient's  
798 diagnosis or medical condition;  
799 (f) The surgical repair of damage to a patient resulting  
800 from a planned surgical procedure, which damage is not a  
801 recognized specific risk as disclosed to the patient and  
802 documented through the informed-consent process;  
803 (g) The performance of a procedure to remove unplanned  
804 foreign objects remaining from a surgical procedure; or  
805 (h) The performance of any other surgical procedure that  
806 breached the standard of care.

807 (2) After the department determines a complaint is legally  
808 sufficient and the alleged violations are defined as mediation  
809 offenses, the department or any agent of the department may  
810 conduct informal mediation to resolve the complaint. If the



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811 complainant and the subject of the complaint agree to a  
812 resolution of a complaint within 14 days after contact by the  
813 mediator, the mediator shall notify the department of the terms  
814 of the resolution. The department or board shall take no further  
815 action unless the complainant and the subject each fail to  
816 record with the department an acknowledgment of satisfaction of  
817 the terms of mediation within 60 days of the mediator's  
818 notification to the department. A successful mediation shall not  
819 constitute discipline. In the event the complainant and subject  
820 fail to reach settlement terms or to record the required  
821 acknowledgment, the department shall process the complaint  
822 according to the provisions of s. 456.073.

823 Section 18. Section 456.085, Florida Statutes, is created  
824 to read:

825 456.085 Duty to notify patients.--Every physician licensed  
826 under chapter 458 or chapter 459 shall inform each patient, or  
827 an individual identified pursuant to s. 765.401(1), in person  
828 about unanticipated outcomes of care that result in serious harm  
829 to the patient. Notification of outcomes of care that result in  
830 harm to the patient under this section shall not constitute an  
831 acknowledgement or admission of liability, nor can it be  
832 introduced as evidence in any civil lawsuit.

833 Section 19. Present subsection (8) of section 458.320,  
834 Florida Statutes, is renumbered as subsection (9), and a new  
835 subsection (8) is added to said section, to read:

836 458.320 Financial responsibility.--

837 (8) Notwithstanding any other provision of this section,  
838 the department shall suspend the license of any physician  
839 against whom has been entered a final judgment, arbitration  
840 award, or other order or who has entered into a settlement



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841 agreement to pay damages arising out of a claim for medical  
842 malpractice, if all appellate remedies have been exhausted and  
843 payment up to the amounts required by this section has not been  
844 made within 30 days after the entering of such judgment, award,  
845 or order or agreement, until proof of payment is received by the  
846 department or a payment schedule has been agreed upon by the  
847 physician and the claimant and presented to the department. This  
848 subsection does not apply to a physician who has met the  
849 financial responsibility requirements in paragraphs (1)(b) and  
850 (2)(b).

851 Section 20. Paragraph (t) of subsection (1) and subsection  
852 (6) of section 458.331, Florida Statutes, are amended to read:

853 458.331 Grounds for disciplinary action; action by the  
854 board and department.--

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

857 (t) Gross or repeated malpractice or the failure to  
858 practice medicine with that level of care, skill, and treatment  
859 which is recognized by a reasonably prudent similar physician as  
860 being acceptable under similar conditions and circumstances. The  
861 board shall give great weight to the provisions of s. 766.102  
862 when enforcing this paragraph. As used in this paragraph,  
863 "repeated malpractice" includes, but is not limited to, three or  
864 more claims for medical malpractice within the previous 5-year  
865 period resulting in indemnities being paid in excess of \$50,000  
866 ~~\$25,000~~ each to the claimant in a judgment or settlement and  
867 which incidents involved negligent conduct by the physician. As  
868 used in this paragraph, "gross malpractice" or "the failure to  
869 practice medicine with that level of care, skill, and treatment  
870 which is recognized by a reasonably prudent similar physician as



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871 being acceptable under similar conditions and circumstances,"  
 872 shall not be construed so as to require more than one instance,  
 873 event, or act. Nothing in this paragraph shall be construed to  
 874 require that a physician be incompetent to practice medicine in  
 875 order to be disciplined pursuant to this paragraph.

876 (6) Upon the department's receipt from an insurer or self-  
 877 insurer of a report of a closed claim against a physician  
 878 pursuant to s. 627.912 or from a health care practitioner of a  
 879 report pursuant to s. 456.049, or upon the receipt from a  
 880 claimant of a presuit notice against a physician pursuant to s.  
 881 766.106, the department shall review each report and determine  
 882 whether it potentially involved conduct by a licensee that is  
 883 subject to disciplinary action, in which case the provisions of  
 884 s. 456.073 shall apply. However, if it is reported that a  
 885 physician has had three or more claims with indemnities  
 886 exceeding \$50,000 ~~\$25,000~~ each within the previous 5-year  
 887 period, the department shall investigate the occurrences upon  
 888 which the claims were based and determine if action by the  
 889 department against the physician is warranted.

890 Section 21. Section 458.3311, Florida Statutes, is created  
 891 to read:

892 458.3311 Emergency procedures for disciplinary  
 893 action.--Notwithstanding any other provision of law to the  
 894 contrary:

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

900 (2) No later than 30 days after a physician has, within a



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901 60-month period, made three reports as required by subsection  
902 (1), the Department of Health shall initiate an emergency  
903 investigation and the Board of Medicine shall conduct an  
904 emergency probable cause hearing to determine whether the  
905 physician should be disciplined for a violation of s.  
906 458.331(1)(t) or any other relevant provision of law.

907 Section 22. Present subsection (9) of section 459.0085,  
908 Florida Statutes, is renumbered as subsection (10), and a new  
909 subsection (9) is added to said section, to read:

910 459.0085 Financial responsibility.--

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

925 Section 23. Paragraph (x) of subsection (1) and subsection  
926 (6) of section 459.015, Florida Statutes, are amended to read:

927 459.015 Grounds for disciplinary action; action by the  
928 board and department.--

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



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931 (x) Gross or repeated malpractice or the failure to  
932 practice osteopathic medicine with that level of care, skill,  
933 and treatment which is recognized by a reasonably prudent  
934 similar osteopathic physician as being acceptable under similar  
935 conditions and circumstances. The board shall give great weight  
936 to the provisions of s. 766.102 when enforcing this paragraph.  
937 As used in this paragraph, "repeated malpractice" includes, but  
938 is not limited to, three or more claims for medical malpractice  
939 within the previous 5-year period resulting in indemnities being  
940 paid in excess of \$50,000 ~~\$25,000~~ each to the claimant in a  
941 judgment or settlement and which incidents involved negligent  
942 conduct by the osteopathic physician. As used in this paragraph,  
943 "gross malpractice" or "the failure to practice osteopathic  
944 medicine with that level of care, skill, and treatment which is  
945 recognized by a reasonably prudent similar osteopathic physician  
946 as being acceptable under similar conditions and circumstances"  
947 shall not be construed so as to require more than one instance,  
948 event, or act. Nothing in this paragraph shall be construed to  
949 require that an osteopathic physician be incompetent to practice  
950 osteopathic medicine in order to be disciplined pursuant to this  
951 paragraph. A recommended order by an administrative law judge or  
952 a final order of the board finding a violation under this  
953 paragraph shall specify whether the licensee was found to have  
954 committed "gross malpractice," "repeated malpractice," or  
955 "failure to practice osteopathic medicine with that level of  
956 care, skill, and treatment which is recognized as being  
957 acceptable under similar conditions and circumstances," or any  
958 combination thereof, and any publication by the board shall so  
959 specify.

960 (6) Upon the department's receipt from an insurer or self-





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961 insurer of a report of a closed claim against an osteopathic  
 962 physician pursuant to s. 627.912 or from a health care  
 963 practitioner of a report pursuant to s. 456.049, or upon the  
 964 receipt from a claimant of a presuit notice against an  
 965 osteopathic physician pursuant to s. 766.106, the department  
 966 shall review each report and determine whether it potentially  
 967 involved conduct by a licensee that is subject to disciplinary  
 968 action, in which case the provisions of s. 456.073 shall apply.  
 969 However, if it is reported that an osteopathic physician has had  
 970 three or more claims with indemnities exceeding \$50,000 ~~\$25,000~~  
 971 each within the previous 5-year period, the department shall  
 972 investigate the occurrences upon which the claims were based and  
 973 determine if action by the department against the osteopathic  
 974 physician is warranted.

975 Section 24. Section 459.0151, Florida Statutes, is created  
 976 to read:

977 459.0151 Emergency procedures for disciplinary  
 978 action.--Notwithstanding any other provision of law to the  
 979 contrary:

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

986 (2) No later than 30 days after an osteopathic physician  
 987 has, within a 60-month period, made three reports as required by  
 988 subsection (1), the Department of Health shall initiate an  
 989 emergency investigation and the Board of Osteopathic Medicine  
 990 shall conduct an emergency probable cause hearing to determine



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991 whether the physician should be disciplined for a violation of  
 992 s. 459.015(1)(x) or any other relevant provision of law.

993 Section 25. Paragraph (s) of subsection (1) and paragraph  
 994 (a) of subsection (5) of section 461.013, Florida Statutes, are  
 995 amended to read:

996 461.013 Grounds for disciplinary action; action by the  
 997 board; investigations by department.--

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

1000 (s) Gross or repeated malpractice or the failure to  
 1001 practice podiatric medicine at a level of care, skill, and  
 1002 treatment which is recognized by a reasonably prudent podiatric  
 1003 physician as being acceptable under similar conditions and  
 1004 circumstances. The board shall give great weight to the  
 1005 standards for malpractice in s. 766.102 in interpreting this  
 1006 section. As used in this paragraph, "repeated malpractice"  
 1007 includes, but is not limited to, three or more claims for  
 1008 medical malpractice within the previous 5-year period resulting  
 1009 in indemnities being paid in excess of \$50,000 ~~\$10,000~~ each to  
 1010 the claimant in a judgment or settlement and which incidents  
 1011 involved negligent conduct by the podiatric physicians. As used  
 1012 in this paragraph, "gross malpractice" or "the failure to  
 1013 practice podiatric medicine with the level of care, skill, and  
 1014 treatment which is recognized by a reasonably prudent similar  
 1015 podiatric physician as being acceptable under similar conditions  
 1016 and circumstances" shall not be construed so as to require more  
 1017 than one instance, event, or act.

1018 (5)(a) Upon the department's receipt from an insurer or  
 1019 self-insurer of a report of a closed claim against a podiatric  
 1020 physician pursuant to s. 627.912, or upon the receipt from a



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1021 claimant of a presuit notice against a podiatric physician  
1022 pursuant to s. 766.106, the department shall review each report  
1023 and determine whether it potentially involved conduct by a  
1024 licensee that is subject to disciplinary action, in which case  
1025 the provisions of s. 456.073 shall apply. However, if it is  
1026 reported that a podiatric physician has had three or more claims  
1027 with indemnities exceeding \$50,000 ~~\$25,000~~ each within the  
1028 previous 5-year period, the department shall investigate the  
1029 occurrences upon which the claims were based and determine if  
1030 action by the department against the podiatric physician is  
1031 warranted.

1032 Section 26. Subsection (2) of section 624.462, Florida  
1033 Statutes, is amended to read:

1034 624.462 Commercial self-insurance funds.--

1035 (2) As used in ss. 624.460-624.488, "commercial self-  
1036 insurance fund" or "fund" means a group of members, operating  
1037 individually and collectively through a trust or corporation,  
1038 that must be:

1039 (a) Established by:

1040 1. A not-for-profit trade association, industry  
1041 association, or professional association of employers or  
1042 professionals which has a constitution or bylaws, which is  
1043 incorporated under the laws of this state, and which has been  
1044 organized for purposes other than that of obtaining or providing  
1045 insurance and operated in good faith for a continuous period of  
1046 1 year;

1047 2. A self-insurance trust fund organized pursuant to s.  
1048 627.357 and maintained in good faith for a continuous period of  
1049 1 year for purposes other than that of obtaining or providing  
1050 insurance pursuant to this section. Each member of a commercial



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1051 self-insurance trust fund established pursuant to this  
 1052 subsection must maintain membership in the self-insurance trust  
 1053 fund organized pursuant to s. 627.357; ~~or~~

1054 3. A group of 10 or more health care providers, as defined  
 1055 in s. 627.351(4)(h); or

1056 ~~4.3-~~ A not-for-profit group comprised of no less than 10  
 1057 condominium associations as defined in s. 718.103(2), which is  
 1058 incorporated under the laws of this state, which restricts its  
 1059 membership to condominium associations only, and which has been  
 1060 organized and maintained in good faith for a continuous period  
 1061 of 1 year for purposes other than that of obtaining or providing  
 1062 insurance.

1063 (b)1. In the case of funds established pursuant to  
 1064 subparagraph (a)2. or subparagraph (a)~~4.3-~~, operated pursuant to  
 1065 a trust agreement by a board of trustees which shall have  
 1066 complete fiscal control over the fund and which shall be  
 1067 responsible for all operations of the fund. The majority of the  
 1068 trustees shall be owners, partners, officers, directors, or  
 1069 employees of one or more members of the fund. The trustees  
 1070 shall have the authority to approve applications of members for  
 1071 participation in the fund and to contract with an authorized  
 1072 administrator or servicing company to administer the day-to-day  
 1073 affairs of the fund.

1074 2. In the case of funds established pursuant to  
 1075 subparagraph (a)1. or subparagraph (a)3., operated pursuant to a  
 1076 trust agreement by a board of trustees or as a corporation by a  
 1077 board of directors which board shall:

1078 a. Be responsible to members of the fund or beneficiaries  
 1079 of the trust or policyholders of the corporation;

1080 b. Appoint independent certified public accountants, legal



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1081 counsel, actuaries, and investment advisers as needed;  
 1082 c. Approve payment of dividends to members;  
 1083 d. Approve changes in corporate structure; and  
 1084 e. Have the authority to contract with an administrator  
 1085 authorized under s. 626.88 to administer the day-to-day affairs  
 1086 of the fund including, but not limited to, marketing,  
 1087 underwriting, billing, collection, claims administration, safety  
 1088 and loss prevention, reinsurance, policy issuance, accounting,  
 1089 regulatory reporting, and general administration. The fees or  
 1090 compensation for services under such contract shall be  
 1091 comparable to the costs for similar services incurred by  
 1092 insurers writing the same lines of insurance, or where available  
 1093 such expenses as filed by boards, bureaus, and associations  
 1094 designated by insurers to file such data. A majority of the  
 1095 trustees or directors shall be owners, partners, officers,  
 1096 directors, or employees of one or more members of the fund.

1097 Section 27. Subsections (7), (8), and (9) are added to  
 1098 section 627.062, Florida Statutes, to read:

1099 627.062 Rate standards.--

1100 (7)(a) The provisions of this subsection apply only with  
 1101 respect to rates for medical malpractice insurance and shall  
 1102 control to the extent of any conflict with other provisions of  
 1103 this section.

1104 (b) Any portion of a judgment entered or settlement paid  
 1105 as a result of a statutory or common-law badfaith action and any  
 1106 portion of a judgment entered which awards punitive damages  
 1107 against an insurer may not be included in the insurer's rate  
 1108 base and shall not be used to justify a rate or rate change. Any  
 1109 common-law badfaith action identified as such and any portion of  
 1110 a settlement entered as a result of a statutory or portion of a



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1111 settlement wherein an insurer agrees to pay specific punitive  
1112 damages may not be used to justify a rate or rate change. The  
1113 portion of the taxable costs and attorney's fees which is  
1114 identified as being related to the bad faith and punitive  
1115 damages in these judgments and settlements may not be included  
1116 in the insurer's rate base and may not be utilized to justify a  
1117 rate or rate change.

1118 (c) Upon reviewing a rate filing and determining whether  
1119 the rate is excessive, inadequate, or unfairly discriminatory,  
1120 the Office of Insurance Regulation shall consider, in accordance  
1121 with generally accepted and reasonable actuarial techniques,  
1122 past and present prospective loss experience, either using loss  
1123 experience solely for this state or giving greater credibility  
1124 to this state's loss data.

1125 (d) Rates shall be deemed excessive if, among other  
1126 standards established by this section, the rate structure  
1127 provides for replenishment of reserves or surpluses from  
1128 premiums when the replenishment is attributable to investment  
1129 losses.

1130 (e) The insurer must apply a discount or surcharge based  
1131 on the health care provider's loss experience or shall establish  
1132 an alternative method giving due consideration to the provider's  
1133 loss experience. The insurer must include in the filing a copy  
1134 of the surcharge or discount schedule or a description of the  
1135 alternative method used and must provide a copy of such schedule  
1136 or description, as approved by the office, to policyholders at  
1137 the time of renewal and to prospective policyholders at the time  
1138 of application for coverage.

1139 (8) Each insurer writing professional liability insurance  
1140 coverage for medical negligence must make a rate filing under



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1141 this section with the Office of Insurance Regulation at least  
1142 once each calendar year.

1143 (9)(a) Medical malpractice insurance companies shall  
1144 submit a rate filing effective January 1, 2004, to the Office of  
1145 Insurance Regulation no earlier than 30 days, but no later than  
1146 120 days, after the date upon which this act becomes law which  
1147 reduces rates by a presumed factor that reflects the impact the  
1148 changes contained in all medical malpractice legislation enacted  
1149 by the Florida Legislature in 2003 will have on such rates, as  
1150 determined by the Office of Insurance Regulation. In determining  
1151 the presumed factor, the office shall use generally accepted  
1152 actuarial techniques and standards provided in this section in  
1153 determining the expected impact on losses, expenses, and  
1154 investment income of the insurer. Inclusion in the presumed  
1155 factor of the expected impact of such legislation shall be held  
1156 in abeyance during the review of such measure's validity in any  
1157 proceeding by a court of competent jurisdiction.

1158 (b) Any insurer or rating organization that contends that  
1159 the rate provided for in subsection (1) is excessive,  
1160 inadequate, or unfairly discriminatory shall separately state in  
1161 its filing the rate it contends is appropriate and shall state  
1162 with specificity the factors or data that it contends should be  
1163 considered in order to produce such appropriate rate. The  
1164 insurer or rating organization shall be permitted to use all of  
1165 the generally accepted actuarial techniques provided in this  
1166 section in making any filing pursuant to this subsection. The  
1167 Office of Insurance Regulation shall review each such exception  
1168 and approve or disapprove it prior to use. It shall be the  
1169 insurer's burden to actuarially justify any deviations from the  
1170 rates filed under subsection (1). Each insurer or rating



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1171 organization shall include in the filing the expected impact of  
1172 all malpractice legislation enacted by the Florida Legislature  
1173 in 2003 on losses, expenses, and rates. If any provision of this  
1174 act is held invalid by a court of competent jurisdiction, the  
1175 department shall permit an adjustment of all rates filed under  
1176 this section to reflect the impact of such holding on such rates  
1177 so as to ensure that the rates are not excessive, inadequate, or  
1178 unfairly discriminatory.

1179 Section 28. Section 627.0662, Florida Statutes, is created  
1180 to read:

1181 627.0662 Excessive profits for medical liability insurance  
1182 prohibited.--

1183 (1) As used in this section:

1184 (a) "Medical liability insurance" means insurance that is  
1185 written on a professional liability insurance policy issued to a  
1186 health care practitioner or on a liability insurance policy  
1187 covering medical malpractice claims issued to a health care  
1188 facility.

1189 (b) "Medical liability insurer" means any insurance  
1190 company or group of insurance companies writing medical  
1191 liability insurance in this state and does not include any self-  
1192 insurance fund or other nonprofit entity writing such insurance.

1193 (2) Each medical liability insurer shall file with the  
1194 Office of Insurance Regulation, prior to July 1 of each year on  
1195 forms prescribed by the office, the following data for medical  
1196 liability insurance business in this state. The data shall  
1197 include both voluntary and joint underwriting association  
1198 business, as follows:

1199 (a) Calendar-year earned premium.

1200 (b) Accident-year incurred losses and loss adjustment





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1201 expenses.

1202 (c) The administrative and selling expenses incurred in  
 1203 this state or allocated to this state for the calendar year.

1204 (d) Policyholder dividends incurred during the applicable  
 1205 calendar year.

1206 (3)(a) Excessive profit has been realized if there has  
 1207 been an underwriting gain for the 3 most recent calendar-  
 1208 accident years combined which is greater than the anticipated  
 1209 underwriting profit plus 5 percent of earned premiums for those  
 1210 calendar-accident years.

1211 (b) As used in this subsection with respect to any 3-year  
 1212 period, "anticipated underwriting profit" means the sum of the  
 1213 dollar amounts obtained by multiplying, for each rate filing of  
 1214 the insurer group in effect during such period, the earned  
 1215 premiums applicable to such rate filing during such period by  
 1216 the percentage factor included in such rate filing for profit  
 1217 and contingencies, such percentage factor having been determined  
 1218 with due recognition to investment income from funds generated  
 1219 by business in this state. Separate calculations need not be  
 1220 made for consecutive rate filings containing the same percentage  
 1221 factor for profits and contingencies.

1222 (4) Each medical liability insurer shall also file a  
 1223 schedule of medical liability insurance loss in this state and  
 1224 loss adjustment experience for each of the 3 most recent  
 1225 accident years. The incurred losses and loss adjustment expenses  
 1226 shall be valued as of March 31 of the year following the close  
 1227 of the accident year, developed to an ultimate basis, and at two  
 1228 12-month intervals thereafter, each developed to an ultimate  
 1229 basis, to the extent that a total of three evaluations is  
 1230 provided for each accident year. The first year to be so



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1231 reported shall be accident year 2004, such that the reporting of  
1232 3 accident years will not take place until accident years 2005  
1233 and 2006 have become available.

1234 (5) Each insurer group's underwriting gain or loss for  
1235 each calendar-accident year shall be computed as follows: the  
1236 sum of the accident-year incurred losses and loss adjustment  
1237 expenses as of March 31 of the following year, developed to an  
1238 ultimate basis, plus the administrative and selling expenses  
1239 incurred in the calendar year, plus policyholder dividends  
1240 applicable to the calendar year, shall be subtracted from the  
1241 calendar-year earned premium to determine the underwriting gain  
1242 or loss.

1243 (6) For the 3 most recent calendar-accident years, the  
1244 underwriting gain or loss shall be compared to the anticipated  
1245 underwriting profit.

1246 (7) If the medical liability insurer has realized an  
1247 excessive profit, the office shall order a return of the  
1248 excessive amounts to policyholders after affording the insurer  
1249 an opportunity for hearing and otherwise complying with the  
1250 requirements of chapter 120. Such excessive amounts shall be  
1251 refunded to policyholders in all instances unless the insurer  
1252 affirmatively demonstrates to the office that the refund of the  
1253 excessive amounts will render the insurer or a member of the  
1254 insurer group financially impaired or will render it insolvent.

1255 (8) The excessive amount shall be refunded to  
1256 policyholders on a pro rata basis in relation to the final  
1257 compilation year earned premiums to the voluntary medical  
1258 liability insurance policyholders of record of the insurer group  
1259 on December 31 of the final compilation year.

1260 (9) Any return of excessive profits to policyholders under



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1261 this section shall be provided in the form of a cash refund or a  
1262 credit towards the future purchase of insurance.

1263 (10)(a) Cash refunds to policyholders may be rounded to  
1264 the nearest dollar.

1265 (b) Data in required reports to the office may be rounded  
1266 to the nearest dollar.

1267 (c) Rounding, if elected by the insurer group, shall be  
1268 applied consistently.

1269 (11)(a) Refunds to policyholders shall be completed as  
1270 follows:

1271 1. If the insurer elects to make a cash refund, the refund  
1272 shall be completed within 60 days after entry of a final order  
1273 determining that excessive profits have been realized; or

1274 2. If the insurer elects to make refunds in the form of a  
1275 credit to renewal policies, such credits shall be applied to  
1276 policy renewal premium notices which are forwarded to insureds  
1277 more than 60 calendar days after entry of a final order  
1278 determining that excessive profits have been realized. If an  
1279 insurer has made this election but an insured thereafter cancels  
1280 his or her policy or otherwise allows the policy to terminate,  
1281 the insurer group shall make a cash refund not later than 60  
1282 days after termination of such coverage.

1283 (b) Upon completion of the renewal credits or refund  
1284 payments, the insurer shall immediately certify to the office  
1285 that the refunds have been made.

1286 (12) Any refund or renewal credit made pursuant to this  
1287 section shall be treated as a policyholder dividend applicable  
1288 to the year in which it is incurred, for purposes of reporting  
1289 under this section for subsequent years.

1290 Section 29. Subsection (10) of section 627.357, Florida



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1291 Statutes, is amended to read:

1292           627.357 Medical malpractice self-insurance.--

1293           (10)(a) An application to form a self-insurance fund under  
 1294 this section must be filed with the Office of Insurance  
 1295 Regulation.

1296           (b) The Office of Insurance Regulation must ensure that  
 1297 self-insurance funds remain solvent and provide insurance  
 1298 coverage purchased by participants. The Financial Services  
 1299 Commission may adopt rules pursuant to ss. 120.536(1) and 120.54  
 1300 to implement this subsection ~~A self-insurance fund may not be~~  
 1301 ~~formed under this section after October 1, 1992.~~

1302           Section 30. Section 627.3575, Florida Statutes, is created  
 1303 to read:

1304           627.3575 Health Care Professional Liability Insurance  
 1305 Facility.--

1306           (1) FACILITY CREATED; PURPOSE; STATUS.--There is created  
 1307 the Health Care Professional Liability Insurance Facility. The  
 1308 facility is intended to meet ongoing availability and  
 1309 affordability problems relating to liability insurance for  
 1310 health care professionals by providing an affordable, self-  
 1311 supporting source of professional liability insurance coverage  
 1312 with a high deductible for those professionals who are willing  
 1313 and able to self-insure for smaller losses. The facility shall  
 1314 operate on a not-for-profit basis. The facility is self-funding  
 1315 and is intended to serve a public purpose but is not a state  
 1316 agency or program, and no activity of the facility shall create  
 1317 any state liability.

1318           (2) GOVERNANCE; POWERS.--

1319           (a) The facility shall operate under a seven-member board  
 1320 of governors consisting of the Secretary of Health, three



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1321 members appointed by the Governor, and three members appointed  
1322 by the Chief Financial Officer. The board shall be chaired by  
1323 the Secretary of Health. The secretary shall serve by virtue of  
1324 his or her office, and the other members of the board shall  
1325 serve terms concurrent with the term of office of the official  
1326 who appointed them. Any vacancy on the board shall be filled in  
1327 the same manner as the original appointment. Members serve at  
1328 the pleasure of the official who appointed them. Members are not  
1329 eligible for compensation for their service on the board, but  
1330 the facility may reimburse them for per diem and travel expenses  
1331 at the same levels as are provided in s. 112.061 for state  
1332 employees.

1333 (b) The facility shall have such powers as are necessary  
1334 to operate as an insurer, including the power to:

1335 1. Sue and be sued.

1336 2. Hire such employees and retain such consultants,  
1337 attorneys, actuaries, and other professionals as it deems  
1338 appropriate.

1339 3. Contract with such service providers as it deems  
1340 appropriate.

1341 4. Maintain offices appropriate to the conduct of its  
1342 business.

1343 5. Take such other actions as are necessary or appropriate  
1344 in fulfillment of its responsibilities under this section.

1345 (3) COVERAGE PROVIDED.--The facility shall provide  
1346 liability insurance coverage for health care professionals. The  
1347 facility shall allow policyholders to select only from policies  
1348 with deductibles of \$25,000 per claim, \$50,000 per claim, and  
1349 \$100,000 per claim and with coverage limits of \$250,000 per  
1350 claim and \$750,000 annual aggregate and \$1 million per claim and



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1351 \$3 million annual aggregate. To the greatest extent possible,  
1352 the terms and conditions of the policies shall be consistent  
1353 with terms and conditions commonly used by professional  
1354 liability insurers.

1355 (4) ELIGIBILITY; TERMINATION.--

1356 (a) Any health care professional is eligible for coverage  
1357 provided by the facility if the professional at all times  
1358 maintains either:

1359 1. An escrow account consisting of cash or assets eligible  
1360 for deposit under s. 625.52 in an amount equal to the deductible  
1361 amount of the policy; or

1362 2. An unexpired, irrevocable letter of credit, established  
1363 pursuant to chapter 675, in an amount not less than the  
1364 deductible amount of the policy. The letter of credit shall be  
1365 payable to the health care professional as beneficiary upon  
1366 presentment of a final judgment indicating liability and  
1367 awarding damages to be paid by the physician or upon presentment  
1368 of a settlement agreement signed by all parties to such  
1369 agreement when such final judgment or settlement is a result of  
1370 a claim arising out of the rendering of, or the failure to  
1371 render, medical care and services. Such letter of credit shall  
1372 be nonassignable and nontransferable. Such letter of credit  
1373 shall be issued by any bank or savings association organized and  
1374 existing under the laws of this state or any bank or savings  
1375 association organized under the laws of the United States that  
1376 has its principal place of business in this state or has a  
1377 branch office which is authorized under the laws of this state  
1378 or of the United States to receive deposits in this state.

1379 (b) The eligibility of a health care professional for  
1380 coverage terminates upon:



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- 1381       1. The failure of the professional to comply with  
1382 paragraph (a);
- 1383       2. The failure of the professional to timely pay premiums  
1384 or assessments; or
- 1385       3. The commission of any act of fraud in connection with  
1386 the policy, as determined by the board of governors.
- 1387       (c) The board of governors, in its discretion, may  
1388 reinstate the eligibility of a health care professional whose  
1389 eligibility has terminated pursuant to paragraph (b) upon  
1390 determining that the professional has come back into compliance  
1391 with paragraph (a) or has paid the overdue premiums or  
1392 assessments. Eligibility may be reinstated in the case of fraud  
1393 only if the board determines that its initial determination of  
1394 fraud was in error.
- 1395       (5) PREMIUMS; ASSESSMENTS.--
- 1396       (a) The facility shall charge the actuarially indicated  
1397 rate for the coverage provided plus a component for debt service  
1398 and shall retain the services of consulting actuaries to prepare  
1399 its rate filings. The facility shall not provide dividends to  
1400 policyholders, and, to the extent that premiums are more than  
1401 the amount required to cover claims and expenses, such excess  
1402 shall be retained by the facility for payment of future claims.  
1403 In the event of dissolution of the facility, any amounts not  
1404 required as a reserve for outstanding claims shall be  
1405 transferred to the policyholders of record as of the last day of  
1406 operation.
- 1407       (b) In the event that the premiums for a particular year,  
1408 together with any investment income or reinsurance recoveries  
1409 attributable to that year, are insufficient to pay losses  
1410 arising out of claims accruing in that year, the facility shall



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1411 levy assessments against all of the persons who were its  
1412 policyholders in that year in a uniform percentage of premium.  
1413 Each policyholder's assessment shall be such percentage of the  
1414 premium that policyholder paid for coverage for the year to  
1415 which the insufficiency is attributable.

1416 (c) The policyholder is personally liable for any  
1417 assessment. The failure to timely pay an assessment is grounds  
1418 for suspension or revocation of the policyholder's professional  
1419 license by the appropriate licensing entity.

1420 (6) REGULATION; APPLICABILITY OF OTHER STATUTES.--

1421 (a) The facility shall operate pursuant to a plan of  
1422 operation approved by order of the Office of Insurance  
1423 Regulation of the Financial Services Commission. The board of  
1424 governors may at any time adopt amendments to the plan of  
1425 operation and submit the amendments to the Office of Insurance  
1426 Regulation for approval.

1427 (b) The facility is subject to regulation by the Office of  
1428 Insurance Regulation of the Financial Services Commission in the  
1429 same manner as other insurers, except that, in recognition of  
1430 the fact that its ability to levy assessments against its own  
1431 policyholders is a substitute for the protections ordinarily  
1432 afforded by such statutory requirements, the facility is exempt  
1433 from statutory requirements relating to surplus as to  
1434 policyholders.

1435 (c) The facility is not subject to part II of chapter 631,  
1436 relating to the Florida Insurance Guaranty Association.

1437 (d) The Financial Service Commission may adopt rules to  
1438 provide for the regulation of the facility consistent with the  
1439 provisions of this section.

1440 (7) STARTUP PROVISIONS.--





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1441 (a) It is the intent of the Legislature that the facility  
1442 begin providing coverage no later than January 1, 2004.

1443 (b) The Governor and the Chief Financial Officer shall  
1444 make their appointments to the board of governors of the  
1445 facility no later than August 1, 2003. Until the board is  
1446 appointed, the Secretary of Health may perform ministerial acts  
1447 on behalf of the facility as chair of the board of governors.

1448 (c) Until the facility is able to hire permanent staff and  
1449 enter into contracts for professional services, the office of  
1450 the Secretary of Health shall provide support services to the  
1451 facility.

1452 (d) In order to provide startup funds for the facility,  
1453 the board of governors may incur debt or enter into agreements  
1454 for lines of credit, provided that the sole source of funds for  
1455 repayment of any debt is future premium revenues of the  
1456 facility. The amount of such debt or lines of credit may not  
1457 exceed \$10 million.

1458 Section 31. Paragraph (c) of subsection (1) of section  
1459 627.4147, Florida Statutes, is amended, and paragraph (d) is  
1460 added to said subsection, to read:

1461 627.4147 Medical malpractice insurance contracts.--

1462 (1) In addition to any other requirements imposed by law,  
1463 each self-insurance policy as authorized under s. 627.357 or  
1464 insurance policy providing coverage for claims arising out of  
1465 the rendering of, or the failure to render, medical care or  
1466 services, including those of the Florida Medical Malpractice  
1467 Joint Underwriting Association, shall include:

1468 (c)1. If the insurer is not leaving the state, a clause  
1469 requiring the insurer or self-insurer to notify the insured no  
1470 less than 60 days prior to the effective date of cancellation of



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1471 the policy or contract and, in the event of a determination by  
1472 the insurer or self-insurer not to renew the policy or contract,  
1473 to notify the insured no less than 60 days prior to the end of  
1474 the policy or contract period. If cancellation or nonrenewal is  
1475 due to nonpayment or loss of license, 10 days' notice is  
1476 required.

1477 2. If the insurer is leaving the state, a clause requiring  
1478 the insurer or self-insurer to notify the insured no less than  
1479 90 days prior to the effective date of cancellation of the  
1480 policy or contract and, in the event of a determination by the  
1481 insurer or self-insurer not to renew the policy or contract, to  
1482 notify the insured no less than 90 days prior to the end of the  
1483 policy or contract period. If cancellation or nonrenewal is due  
1484 to nonpayment or loss of license, 10 days' notice is required.

1485 (d) A clause requiring the insurer or self-insurer to  
1486 notify the insured no less than 60 days prior to the effective  
1487 date of a rate increase. The provisions of s. 627.4133 shall  
1488 apply to such notice and to the failure of the insurer to  
1489 provide such notice to the extent not in conflict with this  
1490 section.

1491 Section 32. Subsections (1) and (4) and paragraph (n) of  
1492 subsection (2) of section 627.912, Florida Statutes, are amended  
1493 to read:

1494 627.912 Professional liability claims and actions; reports  
1495 by insurers.--

1496 (1)(a) Each self-insurer authorized under s. 627.357 and  
1497 each insurer or joint underwriting association providing  
1498 professional liability insurance to a practitioner of medicine  
1499 licensed under chapter 458, to a practitioner of osteopathic  
1500 medicine licensed under chapter 459, to a podiatric physician



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1501 licensed under chapter 461, to a dentist licensed under chapter  
 1502 466, to a hospital licensed under chapter 395, to a crisis  
 1503 stabilization unit licensed under part IV of chapter 394, to a  
 1504 health maintenance organization certificated under part I of  
 1505 chapter 641, to clinics included in chapter 390, to an  
 1506 ambulatory surgical center as defined in s. 395.002, or to a  
 1507 member of The Florida Bar shall report in duplicate to the  
 1508 Department of Insurance any claim or action for damages for  
 1509 personal injuries claimed to have been caused by error,  
 1510 omission, or negligence in the performance of such insured's  
 1511 professional services or based on a claimed performance of  
 1512 professional services without consent, if the claim resulted in:

1513 1.(a) A final judgment in any amount.

1514 2.(b) A settlement in any amount.

1515  
 1516 Reports shall be filed with the department.

1517 (b) In addition to the requirements of paragraph (a), if  
 1518 the insured party is licensed under chapter 395, chapter 458,  
 1519 chapter 459, chapter 461, or chapter 466, the insurer shall  
 1520 report in duplicate to the Office of Insurance Regulation any  
 1521 other disposition of the claim, including, but not limited to, a  
 1522 dismissal. If the insured is licensed under chapter 458, chapter  
 1523 459, or chapter 461, any claim that resulted in a final judgment  
 1524 or settlement in the amount of \$50,000 or more shall be reported  
 1525 to the Department of Health no later than 30 days following the  
 1526 occurrence of that event. If the insured is licensed under  
 1527 chapter 466, any claim that resulted in a final judgment or  
 1528 settlement in the amount of \$25,000 or more shall be reported to  
 1529 the Department of Health no later than 30 days following the  
 1530 occurrence of that event and, if the insured party is licensed



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1531 ~~under chapter 458, chapter 459, chapter 461, or chapter 466,~~  
 1532 ~~with the Department of Health, no later than 30 days following~~  
 1533 ~~the occurrence of any event listed in paragraph (a) or paragraph~~  
 1534 ~~(b).~~ The Department of Health shall review each report and  
 1535 determine whether any of the incidents that resulted in the  
 1536 claim potentially involved conduct by the licensee that is  
 1537 subject to disciplinary action, in which case the provisions of  
 1538 s. 456.073 shall apply. The Department of Health, as part of the  
 1539 annual report required by s. 456.026, shall publish annual  
 1540 statistics, without identifying licensees, on the reports it  
 1541 receives, including final action taken on such reports by the  
 1542 Department of Health or the appropriate regulatory board.

1543 (2) The reports required by subsection (1) shall contain:

1544 (n) Any other information required by the department to  
 1545 analyze and evaluate the nature, causes, location, cost, and  
 1546 damages involved in professional liability cases. The Financial  
 1547 Services Commission shall adopt by rule requirements for  
 1548 additional information to assist the Office of Insurance  
 1549 Regulation in its analysis and evaluation of the nature, causes,  
 1550 location, cost, and damages involved in professional liability  
 1551 cases reported by insurers under this section.

1552 (4) There shall be no liability on the part of, and no  
 1553 cause of action of any nature shall arise against, any insurer  
 1554 reporting hereunder or its agents or employees or the department  
 1555 or its employees for any action taken by them under this  
 1556 section. The department may impose a fine of \$250 per day per  
 1557 case, but not to exceed a total of \$10,000 ~~\$1,000~~ per case,  
 1558 against an insurer that violates the requirements of this  
 1559 section. This subsection applies to claims accruing on or after  
 1560 October 1, 1997.



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1561 Section 33. Section 627.9121, Florida Statutes, is created  
1562 to read:

1563 627.9121 Required reporting of claims; penalties.--Each  
1564 entity that makes payment under a policy of insurance, self-  
1565 insurance, or otherwise in settlement, partial settlement, or  
1566 satisfaction of a judgment in a medical malpractice action or  
1567 claim that is required to report information to the National  
1568 Practitioner Data Bank under 42 U.S.C. s. 11131 must also report  
1569 the same information to the Office of Insurance Regulation. The  
1570 office shall include such information in the data that it  
1571 compiles under s. 627.912. The office must compile and review  
1572 the data collected pursuant to this section and must assess an  
1573 administrative fine on any entity that fails to fully comply  
1574 with such reporting requirements.

1575 Section 34. Subsections (2), (3), (4), and (7) and  
1576 paragraph (a) of subsection (10) of section 766.106, Florida  
1577 Statutes, are amended, and subsections (13), (14), (15), and  
1578 (16) are added to said section, to read:

1579 766.106 Notice before filing action for medical  
1580 malpractice; presuit screening period; offers for admission of  
1581 liability and for arbitration; informal discovery; review.--

1582 (2)(a) After completion of presuit investigation pursuant  
1583 to s. 766.203 and prior to filing a claim for medical  
1584 malpractice, a claimant shall notify each prospective defendant  
1585 by certified mail, return receipt requested, of intent to  
1586 initiate litigation for medical malpractice. Notice to each  
1587 prospective defendant must include, if available, a list of all  
1588 known health care providers seen by the claimant for the  
1589 injuries complained of subsequent to the alleged act of  
1590 malpractice, a list of all known health care providers during



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1591 the 2-year period prior to the alleged act of malpractice who  
 1592 treated or evaluated the claimant, and copies of all of the  
 1593 medical records relied upon by the expert in signing the  
 1594 affidavit. The requirement of providing the list of known health  
 1595 care providers may not serve as grounds for imposing sanctions  
 1596 for failure to provide presuit discovery.

1597 (b) Following the initiation of a suit alleging medical  
 1598 malpractice with a court of competent jurisdiction, and service  
 1599 of the complaint upon a defendant, the claimant shall provide a  
 1600 copy of the complaint to the Department of Health. The  
 1601 requirement of providing the complaint to the Department of  
 1602 Health does not impair the claimant's legal rights or ability to  
 1603 seek relief for his or her claim. The Department of Health shall  
 1604 review each incident and determine whether it involved conduct  
 1605 by a licensee which is potentially subject to disciplinary  
 1606 action, in which case the provisions of s. 456.073 apply.

1607 (3)(a) No suit may be filed for a period of 180 ~~90~~ days  
 1608 after notice is mailed to any prospective defendant. During the  
 1609 180-day ~~90-day~~ period, the prospective defendant's insurer or  
 1610 self-insurer shall conduct a review to determine the liability  
 1611 of the defendant. Each insurer or self-insurer shall have a  
 1612 procedure for the prompt investigation, review, and evaluation  
 1613 of claims during the 180-day ~~90-day~~ period. This procedure shall  
 1614 include one or more of the following:

- 1615 1. Internal review by a duly qualified claims adjuster;
- 1616 2. Creation of a panel comprised of an attorney  
 1617 knowledgeable in the prosecution or defense of medical  
 1618 malpractice actions, a health care provider trained in the same  
 1619 or similar medical specialty as the prospective defendant, and a  
 1620 duly qualified claims adjuster;



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1621 3. A contractual agreement with a state or local  
 1622 professional society of health care providers, which maintains a  
 1623 medical review committee;

1624 4. Any other similar procedure which fairly and promptly  
 1625 evaluates the pending claim.

1626

1627 Each insurer or self-insurer shall investigate the claim in good  
 1628 faith, and both the claimant and prospective defendant shall  
 1629 cooperate with the insurer in good faith. If the insurer  
 1630 requires, a claimant shall appear before a pretrial screening  
 1631 panel or before a medical review committee and shall submit to a  
 1632 physical examination, if required. Unreasonable failure of any  
 1633 party to comply with this section justifies dismissal of claims  
 1634 or defenses. There shall be no civil liability for participation  
 1635 in a pretrial screening procedure if done without intentional  
 1636 fraud.

1637 (b) At or before the end of the 180 ~~90~~ days, the insurer  
 1638 or self-insurer shall provide the claimant with a response:

- 1639 1. Rejecting the claim;
- 1640 2. Making a settlement offer; or
- 1641 3. Making an offer to arbitrate, in which case liability  
 1642 is deemed admitted and arbitration will be held only ~~of~~  
 1643 ~~admission of liability and for arbitration~~ on the issue of  
 1644 damages. This offer may be made contingent upon a limit of  
 1645 general damages.

1646 (c) The response shall be delivered to the claimant if not  
 1647 represented by counsel or to the claimant's attorney, by  
 1648 certified mail, return receipt requested. Failure of the  
 1649 prospective defendant or insurer or self-insurer to reply to the  
 1650 notice within 180 ~~90~~ days after receipt shall be deemed a final



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1651 rejection of the claim for purposes of this section.

1652 (d) Within 30 days after ~~of~~ receipt of a response by a  
 1653 prospective defendant, insurer, or self-insurer to a claimant  
 1654 represented by an attorney, the attorney shall advise the  
 1655 claimant in writing of the response, including:

1656 1. The exact nature of the response under paragraph (b).

1657 2. The exact terms of any settlement offer, or admission  
 1658 of liability and offer of arbitration on damages.

1659 3. The legal and financial consequences of acceptance or  
 1660 rejection of any settlement offer, or admission of liability,  
 1661 including the provisions of this section.

1662 4. An evaluation of the time and likelihood of ultimate  
 1663 success at trial on the merits of the claimant's action.

1664 5. An estimation of the costs and attorney's fees of  
 1665 proceeding through trial.

1666 (4) The notice of intent to initiate litigation shall be  
 1667 served within the time limits set forth in s. 95.11. However,  
 1668 during the 180-day ~~90-day~~ period, the statute of limitations is  
 1669 tolled as to all potential defendants. Upon stipulation by the  
 1670 parties, the 180-day ~~90-day~~ period may be extended and the  
 1671 statute of limitations is tolled during any such extension. Upon  
 1672 receiving notice of termination of negotiations in an extended  
 1673 period, the claimant shall have 60 days or the remainder of the  
 1674 period of the statute of limitations, whichever is greater,  
 1675 within which to file suit.

1676 (7) Informal discovery may be used by a party to obtain  
 1677 unsworn statements, the production of documents or things, and  
 1678 physical and mental examinations, as follows:

1679 (a) *Unsworn statements.*--Any party may require other  
 1680 parties to appear for the taking of an unsworn statement. Such





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1681 statements may be used only for the purpose of presuit screening  
1682 and are not discoverable or admissible in any civil action for  
1683 any purpose by any party. A party desiring to take the unsworn  
1684 statement of any party must give reasonable notice in writing to  
1685 all parties. The notice must state the time and place for taking  
1686 the statement and the name and address of the party to be  
1687 examined. Unless otherwise impractical, the examination of any  
1688 party must be done at the same time by all other parties. Any  
1689 party may be represented by counsel at the taking of an unsworn  
1690 statement. An unsworn statement may be recorded electronically,  
1691 stenographically, or on videotape. The taking of unsworn  
1692 statements is subject to the provisions of the Florida Rules of  
1693 Civil Procedure and may be terminated for abuses.

1694 (b) *Documents or things.*--Any party may request discovery  
1695 of documents or things. The documents or things must be  
1696 produced, at the expense of the requesting party, within 20 days  
1697 after the date of receipt of the request. A party is required to  
1698 produce discoverable documents or things within that party's  
1699 possession or control.

1700 (c) *Physical and mental examinations.*--A prospective  
1701 defendant may require an injured prospective claimant to appear  
1702 for examination by an appropriate health care provider. The  
1703 defendant shall give reasonable notice in writing to all parties  
1704 as to the time and place for examination. Unless otherwise  
1705 impractical, a prospective claimant is required to submit to  
1706 only one examination on behalf of all potential defendants. The  
1707 practicality of a single examination must be determined by the  
1708 nature of the potential claimant's condition, as it relates to  
1709 the liability of each potential defendant. Such examination  
1710 report is available to the parties and their attorneys upon



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1711 payment of the reasonable cost of reproduction and may be used  
1712 only for the purpose of presuit screening. Otherwise, such  
1713 examination report is confidential and exempt from the  
1714 provisions of s. 119.07(1) and s. 24(a), Art. I of the State  
1715 Constitution.

1716 (d) Written questions.--Any party may request answers to  
1717 written questions, the number of which may not exceed 30,  
1718 including subparts. A response must be made within 20 days after  
1719 receipt of the questions.

1720 (e) Informal discovery.--It is the intent of the  
1721 Legislature that informal discovery may be conducted pursuant to  
1722 this subsection by any party without notice to any other party.

1723 (10) If a prospective defendant makes an offer to admit  
1724 liability and for arbitration on the issue of damages, the  
1725 claimant has 50 days from the date of receipt of the offer to  
1726 accept or reject it. The claimant shall respond in writing to  
1727 the insurer or self-insurer by certified mail, return receipt  
1728 requested. If the claimant rejects the offer, he or she may then  
1729 file suit. Acceptance of the offer of admission of liability and  
1730 for arbitration waives recourse to any other remedy by the  
1731 parties, and the claimant's written acceptance of the offer  
1732 shall so state.

1733 (a) If rejected, the offer to admit liability and for  
1734 arbitration on damages is not admissible in any subsequent  
1735 litigation. Upon rejection of the offer to admit liability and  
1736 for arbitration, the claimant has 60 days from receipt of the  
1737 rejection of the offer for arbitration, 60 days from the date of  
1738 the declaration of impasse during presuit mediation conducted  
1739 pursuant to s. 766.1065, or the remainder of the period of the  
1740 statute of limitations, whichever period is greater, in which to



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1741 file suit.

1742 (13) In matters relating to professional liability  
1743 insurance coverage for medical negligence, an insurer shall not  
1744 be held in bad faith for failure to timely pay its policy limits  
1745 if it tenders its policy limits and meets all other conditions  
1746 of settlement prior to the conclusion of the presuit screening  
1747 period provided for in this section.

1748 (14) Failure to cooperate on the part of any party during  
1749 the presuit investigation may be grounds to strike any claim  
1750 made, or defense raised, by such party in suit.

1751 (15) In all matters relating to professional liability  
1752 insurance coverage for medical negligence, and in determining  
1753 whether the insurer acted fairly and honestly towards its  
1754 insured with due regard for her or his interest during the  
1755 presuit process or after a complaint has been filed, the  
1756 following factors shall be considered:

1757 (a) The insurer's willingness to negotiate with the  
1758 claimant;

1759 (b) The insurer's consideration of the advice of its  
1760 defense counsel;

1761 (c) The insurer's proper investigation of the claim;

1762 (d) Whether the insurer informed the insured of the offer  
1763 to settle within the limits of coverage, the right to retain  
1764 personal counsel, and risk of litigation;

1765 (e) Whether the insured denied liability or requested that  
1766 the case be defended; and

1767 (f) Whether the claimant imposed any condition, other than  
1768 the tender of the policy limits, on the settlement of the claim.

1769 (16) The claimant must execute a medical information  
1770 release that allows a defendant or his or her legal



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1771 representative to obtain unsworn statements of the claimant's  
1772 treating physicians, which statements must be limited to those  
1773 areas that are potentially relevant to the claim of personal  
1774 injury or wrongful death.

1775 Section 35. Section 766.1065, Florida Statutes, is created  
1776 to read:

1777 766.1065 Mandatory staging of presuit investigation and  
1778 mandatory mediation.--

1779 (1) Within 30 days after service of the presuit notice of  
1780 intent to initiate medical malpractice litigation, each party  
1781 shall voluntarily produce to all other parties, without being  
1782 requested, any and all medical, hospital, health care, and  
1783 employment records concerning the claimant in the disclosing  
1784 party's possession, custody, or control, and the disclosing  
1785 party shall affirmatively certify in writing that the records  
1786 produced include all records in that party's possession,  
1787 custody, or control or that the disclosing party has no medical,  
1788 hospital, health care, or employment records concerning the  
1789 claimant.

1790 (a) Subpoenas may be issued according to the Florida Rules  
1791 of Civil Procedure as though suit had been filed for the limited  
1792 purpose of obtaining copies of medical, hospital, health care,  
1793 and employment records of the claimant. The party shall indicate  
1794 on the subpoena that it is being issued in accordance with the  
1795 presuit procedures of this section and shall not be required to  
1796 include a case number.

1797 (b) Nothing in this section shall limit the ability of any  
1798 party to use any other available form of presuit discovery  
1799 available under this chapter or the Florida Rules of Civil  
1800 Procedure.



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1801 (2) Within 60 days after service of the presuit notice of  
1802 intent to initiate medical malpractice litigation, all parties  
1803 must be made available for a sworn deposition. Such deposition  
1804 may not be used in a civil suit for medical negligence.

1805 (3) Within 120 days after service of the presuit notice of  
1806 intent to initiate medical malpractice litigation, each party's  
1807 corroborating expert, who will otherwise be tendered as the  
1808 expert complying with the affidavit provisions set forth in s.  
1809 766.203, must be made available for a sworn deposition.

1810 (a) The expenses associated with the expert's time and  
1811 travel in preparing for and attending such deposition shall be  
1812 the responsibility of the party retaining such expert.

1813 (b) An expert shall be deemed available for deposition if  
1814 suitable accommodations can be made for appearance of said  
1815 expert via real-time video technology.

1816 Section 36. Section 766.1067, Florida Statutes, is created  
1817 to read:

1818 766.1067 Mandatory mediation after suit is filed.--Within  
1819 120 days after suit being filed, unless such period is extended  
1820 by mutual agreement of all parties, all parties shall attend in-  
1821 person mandatory mediation in accordance with s. 44.102 if  
1822 binding arbitration under s. 766.106 or s. 766.207 has not been  
1823 agreed to by the parties. The Florida Rules of Civil Procedure  
1824 shall apply to mediation held pursuant to this section.

1825 Section 37. Section 766.118, Florida Statutes, is created  
1826 to read:

1827 766.118 Determination of noneconomic damages.--With  
1828 respect to a cause of action for personal injury or wrongful  
1829 death resulting from an occurrence of medical negligence,  
1830 including actions pursuant to s. 766.209, damages recoverable



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1831 for noneconomic losses to compensate for pain and suffering,  
 1832 inconvenience, physical impairment, mental anguish,  
 1833 disfigurement, loss of capacity for enjoyment of life, and all  
 1834 other noneconomic damages shall not exceed \$250,000, regardless  
 1835 of the number of claimants or defendants involved in the action.

1836 Section 38. Subsections (3), (5), (7), and (8) of section  
 1837 766.202, Florida Statutes, are amended to read:

1838 766.202 Definitions; ss. 766.201-766.212.--As used in ss.  
 1839 766.201-766.212, the term:

1840 (3) "Economic damages" means financial losses that ~~which~~  
 1841 would not have occurred but for the injury giving rise to the  
 1842 cause of action, including, but not limited to, past and future  
 1843 medical expenses and 80 percent of wage loss and loss of earning  
 1844 capacity, to the extent the claimant is entitled to recover such  
 1845 damages under general law, including the Wrongful Death Act.

1846 (5) "Medical expert" means a person familiar with the  
 1847 evaluation, diagnosis, or treatment of the medical condition at  
 1848 issue who:

1849 (a) Is duly and regularly engaged in the practice of his  
 1850 or her profession, ~~who~~ holds a health care professional degree  
 1851 from a university or college, and has had special professional  
 1852 training and experience; or

1853 (b) Has ~~one possessed of~~ special health care knowledge or  
 1854 skill about the subject upon which he or she is called to  
 1855 testify or provide an opinion.

1856  
 1857 Such expert shall certify that he or she has similar credentials  
 1858 and expertise in the area of the defendant's particular practice  
 1859 or specialty, if the defendant is a specialist.

1860 (7) "Noneconomic damages" means nonfinancial losses which



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1861 would not have occurred but for the injury giving rise to the  
1862 cause of action, including pain and suffering, inconvenience,  
1863 physical impairment, mental anguish, disfigurement, loss of  
1864 capacity for enjoyment of life, and other nonfinancial losses,  
1865 to the extent the claimant is entitled to recover such damages  
1866 under general law, including the Wrongful Death Act.

1867 (8) "Periodic payment" means provision for the structuring  
1868 of future economic and future noneconomic damages payments, in  
1869 whole or in part, over a period of time, as follows:

1870 (a) A specific finding must be made of the dollar amount  
1871 of periodic payments which will compensate for these future  
1872 damages after offset for collateral sources and after having  
1873 been reduced to present value shall be made. A periodic payment  
1874 must be structured to last as long as the claimant lives or the  
1875 condition of the claimant for which the award was made persists,  
1876 whichever may be shorter, but without regard for the number of  
1877 years for which future damages are awarded ~~The total dollar~~  
1878 ~~amount of the periodic payments shall equal the dollar amount of~~  
1879 ~~all such future damages before any reduction to present value.~~

1880 (b) A defendant that elects to make periodic payments of  
1881 either or both future economic and future noneconomic losses may  
1882 contractually obligate a company that is authorized to do  
1883 business in this state and rated by A.M. Best Company as "A+" or  
1884 higher to make those periodic payments on its behalf. Upon a  
1885 joint petition by the defendant and the company that is  
1886 contractually obligated to make the periodic payments, the court  
1887 shall discharge the defendant from any further obligations to  
1888 the claimant for those future economic and future noneconomic  
1889 damages that are to be paid by that company by periodic  
1890 payments.



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1891       (c) A bond or security may not be required of any  
1892 defendant or company that is obligated to make periodic payments  
1893 pursuant to this section; however, if, upon petition by a  
1894 claimant who is receiving periodic payments pursuant to this  
1895 section, the court finds that there is substantial, competent  
1896 evidence that the defendant that is responsible for the periodic  
1897 payments cannot adequately ensure full and continuous payments  
1898 thereof or that the company that is obligated to make the  
1899 payments has been rated by A.M. Best Company as "B+" or lower,  
1900 and that doing so is in the best interest of the claimant, the  
1901 court may require the defendant or the company that is obligated  
1902 to make the periodic payments to provide such additional  
1903 financial security as the court determines to be reasonable  
1904 under the circumstances.

1905       (d) The provision for the periodic payments must specify  
1906 the recipient or recipients of the payments, the address to  
1907 which the payments are to be delivered, and the amount and  
1908 intervals of the payments; however, in any one year, any payment  
1909 or payments may not exceed the amount intended by the trier of  
1910 fact to be awarded each year, offset for collateral sources. A  
1911 periodic payment may not be accelerated, deferred, increased, or  
1912 decreased, except by court order based upon the mutual consent  
1913 and agreement of the claimant, the defendant, whether or not  
1914 discharged, and the company that is obligated to make the  
1915 periodic payments, if any; nor may the claimant sell, mortgage,  
1916 encumber, or anticipate the periodic payments or any part  
1917 thereof, by assignment or otherwise. ~~The defendant shall be~~  
1918 ~~required to post a bond or security or otherwise to assure full~~  
1919 ~~payment of these damages awarded. A bond is not adequate unless~~  
1920 ~~it is written by a company authorized to do business in this~~





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1921 ~~state and is rated A+ by Best's. If the defendant is unable to~~  
 1922 ~~adequately assure full payment of the damages, all damages,~~  
 1923 ~~reduced to present value, shall be paid to the claimant in a~~  
 1924 ~~lump sum. No bond may be canceled or be subject to cancellation~~  
 1925 ~~unless at least 60 days' advance written notice is filed with~~  
 1926 ~~the court and the claimant. Upon termination of periodic~~  
 1927 ~~payments, the security, or so much as remains, shall be returned~~  
 1928 ~~to the defendant.~~

1929 ~~(c) The provision for payment of future damages by~~  
 1930 ~~periodic payments shall specify the recipient or recipients of~~  
 1931 ~~the payments, the dollar amounts of the payments, the interval~~  
 1932 ~~between payments, and the number of payments or the period of~~  
 1933 ~~time over which payments shall be made.~~

1934 Section 39. Subsections (2) and (3) of section 766.203,  
 1935 Florida Statutes, are amended to read:

1936 766.203 Presuit investigation of medical negligence claims  
 1937 and defenses by prospective parties.--

1938 (2) Prior to issuing notification of intent to initiate  
 1939 medical malpractice litigation pursuant to s. 766.106, the  
 1940 claimant shall conduct an investigation to ascertain that there  
 1941 are reasonable grounds to believe that:

1942 (a) Any named defendant in the litigation was negligent in  
 1943 the care or treatment of the claimant; and

1944 (b) Such negligence resulted in injury to the claimant.

1945  
 1946 Corroboration of reasonable grounds to initiate medical  
 1947 negligence litigation shall be provided by the claimant's  
 1948 submission of a verified written medical expert opinion from a  
 1949 medical expert as defined in s. 766.202(5), at the time the  
 1950 notice of intent to initiate litigation is mailed, which



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1951 statement shall corroborate reasonable grounds to support the  
1952 claim of medical negligence. This opinion and statement are  
1953 subject to discovery.

1954 (3) Prior to issuing its response to the claimant's notice  
1955 of intent to initiate litigation, during the time period for  
1956 response authorized pursuant to s. 766.106, the defendant or the  
1957 defendant's insurer or self-insurer shall conduct an  
1958 investigation to ascertain whether there are reasonable grounds  
1959 to believe that:

1960 (a) The defendant was negligent in the care or treatment  
1961 of the claimant; and

1962 (b) Such negligence resulted in injury to the claimant.

1963

1964 Corroboration of lack of reasonable grounds for medical  
1965 negligence litigation shall be provided with any response  
1966 rejecting the claim by the defendant's submission of a verified  
1967 written medical expert opinion from a medical expert as defined  
1968 in s. 766.202(5), at the time the response rejecting the claim  
1969 is mailed, which statement shall corroborate reasonable grounds  
1970 for lack of negligent injury sufficient to support the response  
1971 denying negligent injury. This opinion and statement are subject  
1972 to discovery.

1973 Section 40. Subsections (2), (3), and (7) of section  
1974 766.207, Florida Statutes, are amended to read:

1975 766.207 Voluntary binding arbitration of medical  
1976 negligence claims.--

1977 (2) Upon the completion of presuit investigation with  
1978 preliminary reasonable grounds for a medical negligence claim  
1979 intact, the parties may elect to have damages determined by an  
1980 arbitration panel. Such election may be initiated by either



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1981 party by serving a request for voluntary binding arbitration of  
 1982 damages within 180 ~~90~~ days after service of the claimant's  
 1983 notice of intent to initiate litigation upon the defendant. The  
 1984 evidentiary standards for voluntary binding arbitration of  
 1985 medical negligence claims shall be as provided in ss.  
 1986 120.569(2)(g) and 120.57(1)(c).

1987 (3) Upon receipt of a party's request for such  
 1988 arbitration, the opposing party may accept the offer of  
 1989 voluntary binding arbitration within 30 days. However, in no  
 1990 event shall the defendant be required to respond to the request  
 1991 for arbitration sooner than 180 ~~90~~ days after service of the  
 1992 notice of intent to initiate litigation under s. 766.106. Such  
 1993 acceptance within the time period provided by this subsection  
 1994 shall be a binding commitment to comply with the decision of the  
 1995 arbitration panel. The liability of any insurer shall be subject  
 1996 to any applicable insurance policy limits.

1997 (7) Arbitration pursuant to this section shall preclude  
 1998 recourse to any other remedy by the claimant against any  
 1999 participating defendant, and shall be undertaken with the  
 2000 understanding that damages shall be awarded as provided by  
 2001 general law, including the Wrongful Death Act, subject to the  
 2002 following limitations:

2003 (a) Net economic damages shall be awardable, including,  
 2004 but not limited to, past and future medical expenses and 80  
 2005 percent of wage loss and loss of earning capacity, offset by any  
 2006 collateral source payments.

2007 (b) Noneconomic damages shall be limited to a maximum of  
 2008 \$250,000 per incident, and shall be calculated on a percentage  
 2009 basis with respect to capacity to enjoy life, so that a finding  
 2010 that the claimant's injuries resulted in a 50-percent reduction



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2011 in his or her capacity to enjoy life would warrant an award of  
 2012 not more than \$125,000 noneconomic damages.

2013 (c) Damages for future economic losses shall be awarded to  
 2014 be paid by periodic payments pursuant to s. 766.202(8) and shall  
 2015 be offset by future collateral source payments.

2016 (d) Punitive damages shall not be awarded.

2017 (e) The defendant shall be responsible for the payment of  
 2018 interest on all accrued damages with respect to which interest  
 2019 would be awarded at trial.

2020 (f) The defendant shall pay the claimant's reasonable  
 2021 attorney's fees and costs, as determined by the arbitration  
 2022 panel, but in no event more than 15 percent of the award,  
 2023 reduced to present value.

2024 (g) The defendant shall pay all the costs of the  
 2025 arbitration proceeding and the fees of all the arbitrators other  
 2026 than the administrative law judge.

2027 (h) Each defendant who submits to arbitration under this  
 2028 section shall be jointly and severally liable for all damages  
 2029 assessed pursuant to this section.

2030 (i) The defendant's obligation to pay the claimant's  
 2031 damages shall be for the purpose of arbitration under this  
 2032 section only. A defendant's or claimant's offer to arbitrate  
 2033 shall not be used in evidence or in argument during any  
 2034 subsequent litigation of the claim following the rejection  
 2035 thereof.

2036 (j) The fact of making or accepting an offer to arbitrate  
 2037 shall not be admissible as evidence of liability in any  
 2038 collateral or subsequent proceeding on the claim.

2039 (k) Any offer by a claimant to arbitrate must be made to  
 2040 each defendant against whom the claimant has made a claim. Any



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2041 offer by a defendant to arbitrate must be made to each claimant  
 2042 who has joined in the notice of intent to initiate litigation,  
 2043 as provided in s. 766.106. A defendant who rejects a claimant's  
 2044 offer to arbitrate shall be subject to the provisions of s.  
 2045 766.209(3). A claimant who rejects a defendant's offer to  
 2046 arbitrate shall be subject to the provisions of s. 766.209(4).

2047 (1) The hearing shall be conducted by all of the  
 2048 arbitrators, but a majority may determine any question of fact  
 2049 and render a final decision. The chief arbitrator shall decide  
 2050 all evidentiary matters.

2051  
 2052 The provisions of this subsection shall not preclude settlement  
 2053 at any time by mutual agreement of the parties.

2054 Section 41. Section 766.213, Florida Statutes, is created  
 2055 to read:

2056 766.213 Periodic payment of damages upon death of  
 2057 claimant.--Any portion of a periodic payment made pursuant to a  
 2058 settlement or jury award or pursuant to mediation or arbitration  
 2059 which is attributable to medical expenses that have not yet been  
 2060 incurred shall terminate upon the death of the claimant. Any  
 2061 outstanding medical expenses incurred prior to the death of the  
 2062 claimant shall be paid from that portion of the periodic payment  
 2063 attributable to medical expenses.

2064 Section 42. Subsection (4) is added to section 768.041,  
 2065 Florida Statutes, to read:

2066 768.041 Release or covenant not to sue.--

2067 (4)(a) At trial pursuant to a suit filed under chapter  
 2068 766, or at trial pursuant to s. 766.209, if any defendant shows  
 2069 the court that the plaintiff, or his or her legal  
 2070 representative, has delivered a written release or covenant not



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2071 to sue to any person in partial satisfaction of the damages sued  
2072 for, the court shall set off this amount from the total amount  
2073 of the damages set forth in the verdict and before entry of the  
2074 final judgment.

2075 (b) The amount of the setoff pursuant to this subsection  
2076 shall include all sums received by the plaintiff, including  
2077 economic and noneconomic damages, costs, and attorney's fees.

2078 Section 43. Section 768.77, Florida Statutes, is amended  
2079 to read:

2080 768.77 Itemized verdict.--

2081 (1) Except as provided in subsection (2), in any action to  
2082 which this part applies in which the trier of fact determines  
2083 that liability exists on the part of the defendant, the trier of  
2084 fact shall, as a part of the verdict, itemize the amounts to be  
2085 awarded to the claimant into the following categories of  
2086 damages:

2087 (a)~~(1)~~ Amounts intended to compensate the claimant for  
2088 economic losses;

2089 (b)~~(2)~~ Amounts intended to compensate the claimant for  
2090 noneconomic losses; and

2091 (c)~~(3)~~ Amounts awarded to the claimant for punitive  
2092 damages, if applicable.

2093 (2) In any action for damages based on personal injury or  
2094 wrongful death arising out of medical malpractice, whether in  
2095 tort or contract, to which this part applies in which the trier  
2096 of fact determines that liability exists on the part of the  
2097 defendant, the trier of fact shall, as a part of the verdict,  
2098 itemize the amounts to be awarded to the claimant into the  
2099 following categories of damages:

2100 (a) Amounts intended to compensate the claimant for:



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2101       1. Past economic losses; and  
 2102       2. Future economic losses, not reduced to present value,  
 2103 and the number of years or part thereof which the award is  
 2104 intended to cover;

2105       (b) Amounts intended to compensate the claimant for:

2106       1. Past noneconomic losses; and  
 2107       2. Future noneconomic losses and the number of years or  
 2108 part thereof which the award is intended to cover; and

2109       (c) Amounts awarded to the claimant for punitive damages,  
 2110 if applicable.

2111       Section 44. Subsection (2) and paragraph (a) of subsection  
 2112 (1) of section 768.78, Florida Statutes, is amended to read:

2113       768.78 Alternative methods of payment of damage awards.--

2114       (1)(a) In any action to which this part applies in which  
 2115 the court determines that an award to compensate the claimant  
 2116 includes future economic losses which exceed \$250,000, payment  
 2117 of amounts intended to compensate the claimant for these losses  
 2118 shall be made by one of the following means, unless an  
 2119 alternative method of payment of damages is provided in this  
 2120 section:

2121       1. The defendant may make a lump-sum payment for all  
 2122 damages so assessed, with future economic losses and expenses  
 2123 reduced to present value; or

2124       2. Subject to the provisions of this subsection, the court  
 2125 shall, at the request of either party, unless the court  
 2126 determines that manifest injustice would result to any party,  
 2127 enter a judgment ordering future economic damages, as itemized  
 2128 pursuant to s. 768.77(1)(a), in excess of \$250,000 to be paid in  
 2129 whole or in part by periodic payments rather than by a lump-sum  
 2130 payment.



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2131 (2)(a) In any action for damages based on personal injury  
2132 or wrongful death arising out of medical malpractice, whether in  
2133 tort or contract, in which the trier of fact makes an award to  
2134 compensate the claimant for future economic or future  
2135 noneconomic losses, payment of amounts intended to compensate  
2136 the claimant for these future losses shall be made by one of the  
2137 following means:

2138 1. The defendant may elect to make a lump-sum payment for  
2139 either or both the all damages so assessed, with future economic  
2140 and future noneconomic losses after offset for collateral  
2141 sources and after having been and expenses reduced to present  
2142 value by the court based upon competent, substantial evidence  
2143 presented to it by the parties; or

2144 2. The defendant, if determined by the court to be  
2145 financially capable or adequately insured, may elect to use  
2146 periodic payments to satisfy in whole or in part the assessed  
2147 future economic and future noneconomic losses awarded by the  
2148 trier of fact after offset for collateral sources for so long as  
2149 the claimant lives or the condition for which the award was made  
2150 persists, whichever period may be shorter, but without regard  
2151 for the number of years awarded by the trier of fact. The court  
2152 shall review and, unless clearly unresponsive to the future  
2153 needs of the claimant, approve the amounts and schedule of the  
2154 periodic payments proposed by the defendant. Upon motion of the  
2155 defendant, whether or not discharged from any obligation to make  
2156 the payments pursuant to paragraph (b), and the establishment by  
2157 substantial, competent evidence of either the death of the  
2158 claimant or that the condition for which the award was made no  
2159 longer persists, the court shall enter an order terminating the  
2160 periodic payments effective as of the date of the death of the





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2161 claimant or the date the condition for which the award was made  
2162 no longer persisted.

2163 (b) A defendant that elects to make periodic payments of  
2164 either or both future economic and future noneconomic losses may  
2165 contractually obligate a company that is authorized to do  
2166 business in this state and rated by A.M. Best Company as "A+" or  
2167 higher to make those periodic payments on its behalf. Upon a  
2168 joint petition by the defendant and the company that is  
2169 contractually obligated to make the periodic payments, the court  
2170 shall discharge the defendant from any further obligations to  
2171 the claimant for those future economic and future noneconomic  
2172 damages that are to be paid by that company by periodic  
2173 payments.

2174 (c) Upon notice of a defendant's election to make periodic  
2175 payments pursuant hereto, the claimant may request that the  
2176 court modify the periodic payments to reasonably provide for  
2177 attorney's fees; however, a court may not make any such  
2178 modification that would increase the amount the defendant would  
2179 have been obligated to pay had no such adjustment been made.

2180 (d) A bond or security may not be required of any  
2181 defendant or company that is obligated to make periodic payments  
2182 pursuant to this section; however, if, upon petition by a  
2183 claimant who is receiving periodic payments pursuant to this  
2184 section, the court finds that there is substantial, competent  
2185 evidence that the defendant that is responsible for the periodic  
2186 payments cannot adequately ensure full and continuous payments  
2187 thereof or that the company that is obligated to make the  
2188 payments has been rated by A.M. Best Company as "B+" or lower,  
2189 and that doing so is in the best interest of the claimant, the  
2190 court may require the defendant or the company that is obligated



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2191 to make the periodic payments to provide such additional  
2192 financial security as the court determines to be reasonable  
2193 under the circumstances.

2194 (e) The provision for the periodic payments must specify  
2195 the recipient or recipients of the payments, the address to  
2196 which the payments are to be delivered, and the amount and  
2197 intervals of the payments; however, in any one year, any payment  
2198 or payments may not exceed the amount intended by the trier of  
2199 fact to be awarded each year, offset for collateral sources. A  
2200 periodic payment may not be accelerated, deferred, increased, or  
2201 decreased, except by court order based upon the mutual consent  
2202 and agreement of the claimant, the defendant, whether or not  
2203 discharged, and the company that is obligated to make the  
2204 periodic payments, if any; nor may the claimant sell, mortgage,  
2205 encumber, or anticipate the periodic payments or any part  
2206 thereof, by assignment or otherwise.

2207 (f) For purposes of this section, the term "periodic  
2208 payment" means the payment of money or delivery of other  
2209 property to the claimant at regular intervals.

2210 (g) It is the intent of the Legislature to authorize and  
2211 encourage the payment of awards for future economic and future  
2212 noneconomic losses by periodic payments to meet the continuing  
2213 needs of the patient while eliminating the misdirection of such  
2214 funds for purposes not intended by the trier of fact ~~court~~  
2215 ~~shall, at the request of either party, enter a judgment ordering~~  
2216 ~~future economic damages, as itemized pursuant to s. 768.77, to~~  
2217 ~~be paid by periodic payments rather than lump sum.~~

2218 ~~(b) For purposes of this subsection, "periodic payment"~~  
2219 ~~means provision for the spreading of future economic damage~~  
2220 ~~payments, in whole or in part, over a period of time, as~~



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2221 follows:

2222 ~~1. A specific finding of the dollar amount of periodic~~  
 2223 ~~payments which will compensate for these future damages after~~  
 2224 ~~offset for collateral sources shall be made. The total dollar~~  
 2225 ~~amount of the periodic payments shall equal the dollar amount of~~  
 2226 ~~all such future damages before any reduction to present value.~~

2227 ~~2. The defendant shall be required to post a bond or~~  
 2228 ~~security or otherwise to assure full payment of these damages~~  
 2229 ~~awarded. A bond is not adequate unless it is written by a~~  
 2230 ~~company authorized to do business in this state and is rated A+~~  
 2231 ~~by Best's. If the defendant is unable to adequately assure full~~  
 2232 ~~payment of the damages, all damages, reduced to present value,~~  
 2233 ~~shall be paid to the claimant in a lump sum. No bond may be~~  
 2234 ~~canceled or be subject to cancellation unless at least 60 days'~~  
 2235 ~~advance written notice is filed with the court and the claimant.~~  
 2236 ~~Upon termination of periodic payments, the security, or so much~~  
 2237 ~~as remains, shall be returned to the defendant.~~

2238 ~~3. The provision for payment of future damages by periodic~~  
 2239 ~~payments shall specify the recipient or recipients of the~~  
 2240 ~~payments, the dollar amounts of the payments, the interval~~  
 2241 ~~between payments, and the number of payments or the period of~~  
 2242 ~~time over which payments shall be made.~~

2243 Section 45. Subsection (5) of section 768.81, Florida  
 2244 Statutes, is amended to read:

2245 768.81 Comparative fault.--

2246 (5) Notwithstanding anything in law to the contrary, in an  
 2247 action for damages for personal injury or wrongful death arising  
 2248 out of medical malpractice, whether in contract or tort, ~~when an~~  
 2249 ~~apportionment of damages pursuant to this section is attributed~~  
 2250 ~~to a teaching hospital as defined in s. 408.07, the court shall~~



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2251 enter judgment ~~against the teaching hospital~~ on the basis of  
2252 each such party's percentage of fault and not on the basis of  
2253 the doctrine of joint and several liability.

2254 Section 46. Section 1004.08, Florida Statutes, is created  
2255 to read:

2256 1004.08 Patient safety instructional requirements.--Every  
2257 public school, college, and university that offers degrees in  
2258 medicine, nursing, and allied health shall include in the  
2259 curricula applicable to such degrees material on patient safety,  
2260 including patient safety improvement. Materials shall include,  
2261 but need not be limited to, effective communication and  
2262 teamwork; epidemiology of patient injuries and medical errors;  
2263 vigilance, attention, and fatigue; checklists and inspections;  
2264 automation and technological and computer support; psychological  
2265 factors in human error; and reporting systems.

2266 Section 47. Section 1005.07, Florida Statutes, is created  
2267 to read:

2268 1005.07 Patient safety instructional requirements.--Every  
2269 nonpublic school, college, and university that offers degrees in  
2270 medicine, nursing, and allied health shall include in the  
2271 curricula applicable to such degrees material on patient safety,  
2272 including patient safety improvement. Materials shall include,  
2273 but need not be limited to, effective communication and  
2274 teamwork; epidemiology of patient injuries and medical errors;  
2275 vigilance, attention, and fatigue; checklists and inspections;  
2276 automation and technological and computer support; psychological  
2277 factors in human error; and reporting systems.

2278 Section 48. (1) The Department of Health shall study and  
2279 report to the Legislature as to whether medical review panels  
2280 should be included as part of the presuit process in medical



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2281 malpractice litigation. Medical review panels review a medical  
2282 malpractice case during the presuit process and make judgments  
2283 on the merits of the case based on established standards of care  
2284 with the intent of reducing the number of frivolous claims. The  
2285 panel's report could be used as admissible evidence at trial or  
2286 for other purposes. The department's report should address:

2287 (a) Historical use of medical review panels and similar  
2288 pretrial programs in this state, including the mediation panels  
2289 created by chapter 75-9, Laws of Florida.

2290 (b) Constitutional issues relating to the use of medical  
2291 review panels.

2292 (c) The use of medical review panels or similar programs  
2293 in other states.

2294 (d) Whether medical review panels or similar panels should  
2295 be created for use during the presuit process.

2296 (e) Other recommendations and information that the  
2297 department deems appropriate.

2298 (f) In submitting its report with respect to (a)-(c), the  
2299 Department should identify at a minimum:

2300 1. The percentage of medical malpractice claims submitted  
2301 to the panels during the time period the panels were in  
2302 existence.

2303 2. The percentage of claims that were settled while the  
2304 panels were in existence and the percentage of claims that were  
2305 settled in the 3 years prior to the establishment of such panels  
2306 or, for each panel which no longer exists, 3 years after the  
2307 dissolution of such panels.

2308 3. In those state where panels have been discontinued,  
2309 whether additional safeguards have been implemented to avoid the  
2310 filing of frivolous lawsuits and what those additional



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2311 safeguards are.

2312 4. How the rates for medical malpractice insurance in  
2313 states utilizing such panels compares with the rates in states  
2314 not utilizing such panels.

2315 5. Whether, and to what extent, a finding by a panel is  
2316 subject to review and the burden of proof required to overcome a  
2317 finding by the panel.

2318 (2) If the department finds that medical review panels or  
2319 a similar structure should be created in this state, it shall  
2320 include draft legislation to implement its recommendations in  
2321 its report.

2322 (3) The department shall submit its report to the Speaker  
2323 of the House of Representatives and the President of the Senate  
2324 no later than December 31, 2003.

2325 Section 49. (1) The Agency for Health Care Administration  
2326 shall conduct or contract for a study to determine what  
2327 information is most feasible to provide to the public comparing  
2328 state-licensed hospitals on certain inpatient quality indicators  
2329 developed by the federal Agency for Healthcare Research and  
2330 Quality. Such indicators shall be designed to identify  
2331 information about specific procedures performed in hospitals for  
2332 which there is strong evidence of a link to quality of care. The  
2333 Agency for Health Care Administration or the study contractor  
2334 shall refer to the hospital quality reports published in New  
2335 York and Texas as guides during the evaluation.

2336 (2) The following concepts shall be specifically addressed  
2337 in the study report:

2338 (a) Whether hospital discharge data about services can be  
2339 translated into understandable and meaningful information for  
2340 the public.



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2341 (b) Whether the following measures are useful consumer  
2342 guides relating to care provided in state-licensed hospitals:  
2343 1. Inpatient mortality for medical conditions;  
2344 2. Inpatient mortality for procedures;  
2345 3. Utilization of procedures for which there are questions  
2346 of overuse, underuse, or misuse; and  
2347 4. Volume of procedures for which there is evidence that a  
2348 higher volume of procedures is associated with lower mortality.

2349 (c) Whether there are quality indicators that are  
2350 particularly useful relative to the state's unique demographics.

2351 (d) Whether all hospitals should be included in the  
2352 comparison.

2353 (e) The criteria for comparison.

2354 (f) Whether comparisons are best within metropolitan  
2355 statistical areas or some other geographic configuration.

2356 (g) Identification of several Internet websites on which  
2357 such a report should be published to achieve the broadest  
2358 dissemination of the information.

2359 (3) The Agency for Health Care Administration shall  
2360 consider the input of all interested parties, including  
2361 hospitals, physicians, consumer organizations, and patients, and  
2362 submit the final report to the Governor and the presiding  
2363 officers of the Legislature by January 1, 2004.

2364 Section 50. Comprehensive study and report on the creation  
2365 of a Patient Safety Authority.--

2366 (1) The Agency for Health Care Administration, in  
2367 consultation with the Department of Health, is directed to study  
2368 the need for, and the implementation requirements of,  
2369 establishing a Patient Safety Authority. The authority would be  
2370 responsible for performing activities and functions designed to



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2371 improve patient safety and the quality of care delivered by  
2372 health care facilities and health care practitioners.

2373 (2) In undertaking its study, the agency shall examine and  
2374 evaluate a Patient Safety Authority that would, either directly  
2375 or by contract:

2376 (a) Analyze information concerning adverse incidents  
2377 reported to the Agency for Health Care Administration pursuant  
2378 to s. 395.0197, Florida Statutes, for the purpose of  
2379 recommending changes in practices and procedures that may be  
2380 implemented by health care practitioners and health care  
2381 facilities to prevent future adverse incidents.

2382 (b) Collect, analyze, and evaluate patient safety data  
2383 submitted voluntarily by a health care practitioner or health  
2384 care facility. The authority would communicate to health care  
2385 practitioners and health care facilities changes in practices  
2386 and procedures that may be implemented for the purpose of  
2387 improving patient safety and preventing future patient safety  
2388 events from resulting in serious injury or death. At a minimum,  
2389 the authority would:

2390 1. Be designed and operated by an individual or entity  
2391 with demonstrated expertise in health care quality data and  
2392 systems analysis, health information management, systems  
2393 thinking and analysis, human factors analysis, and  
2394 identification of latent and active errors.

2395 2. Include procedures for ensuring its confidentiality,  
2396 timeliness, and independence.

2397 (c) Foster the development of a statewide electronic  
2398 infrastructure, which would be implemented in phases over a  
2399 multiyear period, that is designed to improve patient care and  
2400 the delivery and quality of health care services by health care





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2401 facilities and practitioners. The electronic infrastructure  
2402 would be a secure platform for communication and the sharing of  
2403 clinical and other data, such as business data, among providers  
2404 and between patients and providers. The electronic  
2405 infrastructure would include a core electronic medical record.  
2406 Health care providers would have access to individual electronic  
2407 medical records, subject to the consent of the individual. The  
2408 right, if any, of other entities, including health insurers and  
2409 researchers, to access the records would need further  
2410 examination and evaluation by the agency.

2411 (d) Foster the use of computerized physician medication  
2412 ordering systems by hospitals that do not have such systems and  
2413 develop protocols for these systems.

2414 (e) Implement paragraphs (c) and (d) as a demonstration  
2415 project for Medicaid recipients.

2416 (f) Identify best practices and share this information  
2417 with health care providers.

2418 (g) Engage in other activities that improve health care  
2419 quality, improve the diagnosis and treatment of diseases and  
2420 medical conditions, increase the efficiency of the delivery of  
2421 health care services, increase administrative efficiency, and  
2422 increase access to quality health care services.

2423 (3) The agency shall also consider ways in which a Patient  
2424 Safety Authority would be able to facilitate the development of  
2425 no-fault demonstration projects as means to reduce and prevent  
2426 medical errors and promote patient safety.

2427 (4) The agency shall seek information and advice from and  
2428 consult with hospitals, physicians, other health care providers,  
2429 attorneys, consumers, and individuals involved with and  
2430 knowledgeable about patient safety and quality-of-care



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2431 initiatives.

2432 (5) In evaluating the need for, and the operation of, a  
2433 Patient Safety Authority, the agency shall determine the costs  
2434 of implementing and administering an authority and suggest  
2435 funding sources and mechanisms.

2436 (6) The agency shall complete its study and issue a report  
2437 to the Legislature by February 1, 2004. In its report, the  
2438 agency shall include specific findings, recommendations, and  
2439 proposed legislation.

2440 Section 51. The Office of Program Policy Analysis and  
2441 Government Accountability shall complete a study of the  
2442 eligibility requirements for a birth to be covered under the  
2443 Florida Birth-Related Neurological Injury Compensation  
2444 Association and submit a report to the Legislature by January 1,  
2445 2004, recommending whether the statutory criteria for a claim to  
2446 qualify for referral to the Florida Birth-Related Neurological  
2447 Injury Compensation Association under s. 766.302, Florida  
2448 Statutes, should be modified.

2449 Section 52. Civil immunity for members of or consultants  
2450 to certain boards, committees, or other entities.--

2451 (1) Each member of, or health care professional consultant  
2452 to, any committee, board, group, commission, or other entity  
2453 shall be immune from civil liability for any act, decision,  
2454 omission, or utterance done or made in performance of his or her  
2455 duties while serving as a member of or consultant to such  
2456 committee, board, group, commission, or other entity established  
2457 and operated for purposes of quality improvement review,  
2458 evaluation, and planning in a state-licensed health care  
2459 facility. Such entities must function primarily to review,  
2460 evaluate, or make recommendations relating to:



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- 2461        (a) The duration of patient stays in health care
- 2462        facilities;
- 2463        (b) The professional services furnished with respect to
- 2464        the medical, dental, psychological, podiatric, chiropractic, or
- 2465        optometric necessity for such services;
- 2466        (c) The purpose of promoting the most efficient use of
- 2467        available health care facilities and services;
- 2468        (d) The adequacy or quality of professional services;
- 2469        (e) The competency and qualifications for professional
- 2470        staff privileges;
- 2471        (f) The reasonableness or appropriateness of charges made
- 2472        by or on behalf of health care facilities; or
- 2473        (g) Patient safety, including entering into contracts with
- 2474        patient safety organizations.

2475        (2) Such committee, board, group, commission, or other

2476        entity must be established in accordance with state law or in

2477        accordance with requirements of the Joint Commission on

2478        Accreditation of Healthcare Organizations, established and duly

2479        constituted by one or more public or licensed private hospitals

2480        or behavioral health agencies, or established by a governmental

2481        agency. To be protected by this section, the act, decision,

2482        omission, or utterance may not be made or done in bad faith or

2483        with malicious intent.

2484        Section 53. The Office of Program Policy Analysis and

2485        Government Accountability and the Office of the Auditor General

2486        must jointly conduct an audit of the Department of Health's

2487        health care practitioner disciplinary process and closed claims

2488        that are filed with the department under section 627.912,

2489        Florida Statutes. The Office of Program Policy Analysis and

2490        Government Accountability and the Office of the Auditor General



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2491 shall submit a report to the Legislature by January 1, 2005.

2492 Section 54. No later than September 1, 2003, the  
2493 Department of Health shall convene a workgroup to study the  
2494 current healthcare practitioner disciplinary process. The  
2495 workgroup shall include a representative of the Administrative  
2496 Law section of The Florida Bar, a representative of the Health  
2497 Law section of The Florida Bar, a representative of the Florida  
2498 Medical Association, a representative of the Florida Osteopathic  
2499 Medical Association, a representative of the Florida Dental  
2500 Association, a member of the Florida Board of Medicine who has  
2501 served on the probable cause panel, a member of the Board of  
2502 Osteopathic Medicine who has served on the probable cause panel,  
2503 and a member of the Board of Dentistry who has served on the  
2504 probable cause panel. The workgroup shall also include one  
2505 consumer member of the Board of Medicine. The Department of  
2506 Health shall present the findings and recommendations to the  
2507 Governor, the President of the Senate, and the Speaker of the  
2508 House of Representatives no later than January 1, 2004. The  
2509 sponsoring organizations shall assume the costs of their  
2510 representatives.

2511 Section 55. If any provision of this act or the  
2512 application thereof to any person or circumstance is held  
2513 invalid, the invalidity does not affect other provisions or  
2514 applications of the act which can be given effect without the  
2515 invalid provision or application, and to this end the provisions  
2516 of this act are declared severable.

2517 Section 56. If any law amended by this act was also  
2518 amended by a law enacted at the 2003 Regular Session of the  
2519 Legislature or at the 2003 Special Session A of the Legislature,  
2520 such laws shall be construed as if they had been enacted at the



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2521 same session of the Legislature, and full effect shall be given  
2522 to each if possible.

2523 Section 57. This act shall take effect upon becoming law  
2524 and shall apply to any action arising from a medical malpractice  
2525 claim initiated by a notice of intent to litigate received by a  
2526 potential defendant in a medical malpractice case on or after  
2527 that date.