



1 A bill to be entitled

2 An act relating to medical incidents; providing
3 legislative findings; amending s. 46.015, F.S.; providing
4 for a setoff of amounts received by a claimant in
5 settlements; authorizing settling defendants to assign
6 rights of contribution; amending s. 391.025, F.S.;
7 providing that the Children's Medical Services Act applies
8 to infants eligible for compensation under the Florida
9 Birth-Related Neurological Injury Compensation Plan;
10 amending s. 391.029, F.S.; providing that infants eligible
11 for compensation under the Florida Birth-Related
12 Neurological Injury Compensation Plan are eligible for the
13 Children's Medical Services program; requiring the plan to
14 reimburse the program for certain costs; creating s.
15 395.0056, F.S.; requiring the Agency for Health Care
16 Administration to review complaints submitted if the
17 defendant is a hospital; amending s. 395.0191, F.S.;
18 deleting requirement that persons act in good faith to
19 avoid liability or discipline for their actions regarding
20 the awarding of staff membership or clinical privileges;
21 amending s. 395.0197, F.S.; revising provisions relating
22 to internal risk management programs; requiring additional
23 reports to and by the Department of Health and the Agency
24 for Health Care Administration; repealing s. 395.0198,
25 F.S., relating to public records exemptions for
26 notification of adverse incidents; creating s. 395.1012,
27 F.S.; requiring hospitals, ambulatory surgical centers,
28 and mobile surgical facilities to establish patient safety
29 plans and committees; creating s. 395.1051, F.S.;
30 requiring certain facilities to notify patients about



31 adverse incidents under specified conditions; amending s.
32 415.1111, F.S.; providing that such section shall not
33 apply to actions involving allegations of medical
34 malpractice; amending s. 456.013, F.S.; requiring certain
35 information to be included in courses for health care
36 practitioners relating to prevention of medical errors;
37 amending s. 456.025, F.S.; eliminating certain
38 restrictions on the setting of licensure renewal fees for
39 health care practitioners; amending s. 456.039, F.S.;
40 providing additional information required to be furnished
41 to the Department of Health for licensure purposes;
42 amending s. 456.041, F.S.; requiring additional
43 information to be included in health care practitioner
44 profiles; providing for fines; revising requirements for
45 the reporting of paid liability claims; amending s.
46 456.042, F.S.; requiring health care practitioner profiles
47 to be updated within a specific time period; amending s.
48 456.049, F.S.; revising requirements for the reporting of
49 paid liability claims; amending s. 456.051, F.S.;
50 establishing the responsibility of the Department of
51 Health to provide reports of professional liability
52 actions and bankruptcies; requiring the department to
53 include such reports in a practitioner's profile within a
54 specified period; amending s. 456.057, F.S.; authorizing
55 the Department of Health to utilize subpoenas to obtain
56 patient records without patients' consent under certain
57 circumstances; creating s. 456.0575, F.S.; requiring
58 licensed health care practitioners to notify patients
59 about adverse incidents under certain conditions; amending
60 s. 456.072, F.S.; providing for determining the amount of



61 any costs to be assessed in a disciplinary proceeding;
62 prescribing the standard of proof in certain disciplinary
63 proceedings; amending s. 456.073, F.S.; authorizing the
64 Department of Health to investigate certain paid claims
65 made on behalf of practitioners licensed under ch. 458 or
66 ch. 459, F.S.; extending the time for the Department of
67 Health to refer a request for an administrative hearing;
68 providing that certain findings are findings of, not
69 findings of fact; amending s. 456.077, F.S.; revising
70 provisions relating to designation of certain citation
71 violations; amending s. 456.078, F.S.; revising provisions
72 relating to designation of certain mediation offenses;
73 amending s. 458.320, F.S., relating to financial
74 responsibility requirements for medical physicians;
75 requiring the department to suspend the license of a
76 medical physician who has not paid, up to the amounts
77 required by any applicable financial responsibility
78 provision, any outstanding judgment, arbitration award,
79 other order, or settlement; amending s. 458.331, F.S.;
80 increasing the amount of paid liability claims requiring
81 investigation by the Department of Health; revising the
82 definition of "repeated malpractice" to conform; requiring
83 the inclusion of certain findings in certain orders issued
84 by administrative law judges; revising the standards for
85 the burden of proof in an administrative action against a
86 physician; creating s. 458.3311, F.S.; establishing
87 emergency procedures for disciplinary actions; amending s.
88 459.0085, F.S., relating to financial responsibility
89 requirements for osteopathic physicians; requiring that
90 the department suspend the license of an osteopathic



91 physician who has not paid, up to the amounts required by
92 any applicable financial responsibility provision, any
93 outstanding judgment, arbitration award, other order, or
94 settlement; amending s. 459.015, F.S.; increasing the
95 amount of paid liability claims requiring investigation by
96 the Department of Health; revising the definition of
97 "repeated malpractice" to conform; revising the standards
98 for the burden of proof in an administrative action
99 against an osteopathic physician; creating s. 459.0151,
100 F.S.; establishing emergency procedures for disciplinary
101 actions; amending s. 460.413, F.S., relating to grounds
102 for disciplinary action against a chiropractic physician;
103 revising the standards for the burden of proof in an
104 administrative action against a chiropractic physician;
105 amending s. 461.013, F.S.; increasing the amount of paid
106 liability claims requiring investigation by the Department
107 of Health; revising the definition of "repeated
108 malpractice" to conform; amending s. 466.028, F.S.,
109 relating to grounds for disciplinary action against a
110 dentist or a dental hygienist; redefining the term "dental
111 malpractice"; revising the minimum amount of a claim
112 against a dentist which will trigger a departmental
113 investigation; amending s. 624.155, F.S.; providing that
114 an action for bad faith may not be brought against a
115 medical malpractice insurer if such insurer offers to pay
116 policy limits within a specified time period; providing
117 for factors to be considered in determining whether a
118 medical malpractice insurer has acted in bad faith;
119 providing a limitation on the amount of damages which may
120 be awarded to certain third parties in actions alleging



121 bad faith by a medical malpractice insurer; amending s.
122 624.462, F.S.; authorizing health care providers to form a
123 commercial self-insurance fund; amending s. 627.062, F.S.;
124 providing additional requirements for medical malpractice
125 insurance rate filings; providing that portions of
126 judgments and settlements entered against a medical
127 malpractice insurer for bad faith actions or for punitive
128 damages against the insurer, as well as related taxable
129 costs and attorney's fees, may not be included in an
130 insurer's rate base; providing for review of rate filings
131 by the Office of Insurance Regulation for excessive,
132 inadequate, or unfairly discriminatory rates; requiring
133 insurers to apply a discount based on the health care
134 provider's loss experience; requiring annual rate filings;
135 requiring medical malpractice insurers to make rate
136 filings effective January 1, 2004, which reflect the
137 impact of this act; providing requirements for rate
138 deviation by insurers; authorizing adjustments to filed
139 rates in the event a provision of this act is declared
140 invalid by a court of competent jurisdiction; amending s.
141 627.357, F.S.; deleting the prohibition against formation
142 of medical malpractice self-insurance funds; providing
143 requirements to form a self-insurance fund; providing
144 rulemaking authority to the Financial Services Commission;
145 creating s. 627.3575, F.S.; creating the Health Care
146 Professional Liability Insurance Facility; providing
147 purpose; providing for governance and powers; providing
148 eligibility requirements; providing for premiums and
149 assessments; providing for regulation; providing rule
150 adoption authority to the Financial Services Commission;



151 providing applicability; specifying duties of the
152 Department of Health; providing for debt and regulation
153 thereof; amending s. 627.4147, F.S.; deleting the
154 requirement that medical malpractice policies authorize the
155 insurer to admit liability without the consent of the
156 insured; requiring earlier notice of decisions to not
157 renew certain insurance policies to insureds under certain
158 circumstances; requiring prior notification of a rate
159 increase; amending s. 627.912, F.S.; requiring certain
160 claims information to be filed with the Office of
161 Insurance Regulation and the Department of Health;
162 providing for rulemaking by the Financial Services
163 Commission; increasing the limit on a fine; creating s.
164 627.9121, F.S.; requiring certain information relating to
165 medical malpractice to be reported to the Office of
166 Insurance Regulation; providing for enforcement; amending
167 s. 641.19, F.S.; providing that health care providers
168 providing services pursuant to coverage provided under a
169 health maintenance organization contract are not employees
170 or agents of the health maintenance organization;
171 providing exceptions; amending s. 641.51, F.S.;
172 proscribing a health maintenance organization's right to
173 control the professional judgment of a physician;
174 providing that a health maintenance organization shall not
175 be vicariously liable for the medical negligence of a
176 health care provider; providing exceptions; amending s.
177 766.102, F.S.; revising requirements for health care
178 providers providing expert testimony in medical negligence
179 actions; prohibiting contingency fees for an expert
180 witness; amending s. 766.106, F.S.; requiring the



181 inclusion of additional information in presuit notices
 182 provided to defendants; extending the time period for the
 183 presuit screening period; providing that liability is
 184 deemed admitted when an offer is made by a defendant to
 185 arbitrate; specifying consequences of failure to cooperate
 186 on the part of any party during the presuit investigation;
 187 revising requirements for presuit notice and insurer or
 188 self-insurer response to a claim; permitting written
 189 questions during informal discovery; requiring a claimant
 190 to execute a medical release to authorize defendants in
 191 medical negligence actions to take unsworn statements from
 192 a claimant's treating physicians; imposing limits on such
 193 statements; creating s. 766.1065, F.S.; requiring parties
 194 to provide certain information to parties without request;
 195 authorizing the issuance of subpoenas without case
 196 numbers; requiring that parties and certain experts be
 197 made available for deposition; creating s. 766.1067, F.S.;
 198 providing for mandatory mediation in medical negligence
 199 causes of action; creating s. 766.118, F.S.; providing
 200 limitations on noneconomic damages which can be awarded in
 201 causes of action involving medical negligence; amending s.
 202 766.202, F.S.; redefining the terms "economic damages,"
 203 "medical expert," "noneconomic damages," and "periodic
 204 payment"; extending the definitions of economic and
 205 noneconomic damages to include any such damages
 206 recoverable under the Wrongful Death Act or general law;
 207 providing for periodic payments for future noneconomic
 208 damages; revising regulations of periodic payments;
 209 amending s. 766.203, F.S.; providing for discovery of
 210 opinions and statements tendered during presuit



211 investigation; amending s. 766.206, F.S.; providing for
212 dismissal of a claim under certain circumstances;
213 requiring the court to make certain reports concerning a
214 medical expert who fails to meet qualifications; providing
215 for retroactive application; amending s. 766.207, F.S.;
216 conforming provisions to the extension in the time period
217 for presuit investigation; providing for the applicability
218 of the Wrongful Death Act and general law to arbitration
219 awards; amending s. 766.209, F.S.; revising applicable
220 damages available in voluntary binding arbitration
221 relating to claims of medical negligence; creating s.
222 766.213, F.S.; providing for the termination of periodic
223 payments for unincurred medical expenses upon the death of
224 the claimant; providing for the payment of medical
225 expenses incurred prior to the death of the claimant;
226 amending s. 766.304, F.S.; providing that a claimant may
227 not receive compensation from the Florida Birth-Related
228 Neurological Injury Compensation Plan if damages are
229 provided pursuant to a settlement or a final judgment in a
230 civil action is entered; prohibiting the filing of civil
231 actions under certain circumstances; amending s. 766.305,
232 F.S.; revising the information required to be included in
233 a petition seeking recovery from the Florida Birth-Related
234 Neurological Injury Compensation Plan; revising
235 requirements for the service of such petitions; requiring
236 claimants to provide additional information to the Florida
237 Birth-Related Neurological Injury Compensation
238 Association; amending s. 766.31, F.S.; providing a death
239 benefit under the Florida Birth-Related Neurological
240 Injury Compensation Plan in lieu of funeral expenses;



241 amending s. 766.314, F.S.; correcting terminology;
242 authorizing certain hospitals to pay assessments on behalf
243 of certain health care professionals; providing for the
244 dates of coverage of a participating physician; amending
245 s. 768.041, F.S.; providing for a setoff of amounts
246 received by a claimant in settlements; authorizing
247 settling defendants to assign rights of contribution;
248 amending s. 768.13, F.S.; revising guidelines for immunity
249 from liability under the Good Samaritan Act; amending s.
250 768.28, F.S., relating to waiver of sovereign immunity in
251 tort actions; revising the definition of the term
252 "officer, employee, or agent"; providing such immunity to
253 certain colleges and universities affiliated with public
254 hospitals while providing patient services; amending s.
255 768.77, F.S.; prescribing a method for itemization of
256 specific categories of damages awarded in medical
257 malpractice actions; amending s. 768.78, F.S.; correcting
258 a cross reference; providing that a defendant may elect to
259 make lump sum payments rather than periodic payments for
260 either or both future economic and noneconomic damages;
261 authorizing the payment of certain losses for a shorter
262 period of time under certain circumstances; providing for
263 modification of periodic payments or for requiring
264 additional security by order of the court under certain
265 circumstances; amending ss. 766.112 and 768.81, F.S.;
266 providing that a defendant's liability for damages in
267 medical negligence cases is several only; creating s.
268 1004.08, F.S.; requiring patient safety instruction for
269 certain students in public schools, colleges, and
270 universities; creating s. 1005.07, F.S.; requiring patient



271 safety instruction for certain students in nonpublic
272 schools, colleges, and universities; amending s. 1006.20,
273 F.S.; requiring completion of a uniform participation
274 physical evaluation and history form incorporating
275 recommendations of the American Heart Association;
276 deleting revisions to procedures for students' physical
277 examinations; deleting provisions requiring practitioners
278 to certify that students are physically capable of
279 participating in interscholastic athletic competition;
280 defining the terms "patient safety data" and "patient
281 safety organization"; providing for use of patient safety
282 data by a patient safety organization; providing
283 limitations on use of patient safety data; providing for
284 protection of patient-identifying information; providing
285 for determination of whether the privilege applies as
286 asserted; providing that an employer may not take
287 retaliatory action against an employee who makes a good
288 faith report concerning patient safety data; requiring the
289 Division of Administrative Hearings to designate
290 administrative law judges who have special qualifications
291 for hearings involving certain health care practitioners;
292 requiring the Department of Health to study the efficacy
293 and constitutionality of medical review panels; requiring
294 a report; directing the Agency for Health Care
295 Administration to conduct or contract for a study to
296 determine what information to provide to the public
297 comparing hospitals, based on inpatient quality indicators
298 developed by the federal Agency for Healthcare Research
299 and Quality; requiring a report by the Agency for Health
300 Care Administration regarding the establishment of a



301 Patient Safety Authority; specifying elements of the
302 report; requiring the Office of Program Policy Analysis
303 and Government Accountability to study and report to the
304 Legislature on requirements for coverage by the Florida
305 Birth-Related Neurological Injury Compensation
306 Association; providing civil immunity for certain
307 participants in quality improvement processes; requiring
308 the Office of Program Policy Analysis and Government
309 Accountability and the Office of the Auditor General to
310 conduct an audit of the Department of Health's health care
311 practitioner disciplinary process and certain closed
312 claims and to report to the Legislature; creating a
313 workgroup to study the health care practitioner
314 disciplinary process; providing for workgroup membership;
315 providing that the workgroup deliver its report by January
316 1, 2004; providing legislative findings and intent;
317 providing a statement of legislative intent regarding the
318 change in the standard of proof in disciplinary cases
319 involving the suspension or revocation of a license;
320 providing that the practice of health care is a privilege,
321 not a right; providing that protecting patients overrides
322 purported property interest in the license of a health
323 care practitioner; providing that certain disciplinary
324 actions are remedial and protective, not penal; providing
325 that the Legislature specifically reverses case law to the
326 contrary; reenacting ss. 624.488, F.S., 628.6016, F.S.;
327 and s. 631.717, F.S., to incorporate by reference
328 amendments to s. 624.155, F.S.; providing severability;
329 providing for construction of the act in pari materia with
330 laws enacted during the 2003 Regular Session, the 2003



HB 0015C, Engrossed 1

2003

331 Special Session A, or the 2003 Special Session B of the
 332 Legislature; providing an effective date.

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

335
 336 Section 1. Findings.--

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

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

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

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

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

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

360 (7) The Legislature finds that there are certain elements



361 of damage presently recoverable that have no monetary value,
 362 except on a purely arbitrary basis, while other elements of
 363 damage are either easily measured on a monetary basis or reflect
 364 ultimate monetary loss.

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

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

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

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

379 (12) The Legislature finds that ensuring that physicians
 380 continue to practice in Florida is an overwhelming public
 381 necessity.

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

385 (14) The Legislature finds, based upon the findings and
 386 recommendations of the Governor's Select Task Force on
 387 Healthcare Professional Liability Insurance, the findings and
 388 recommendations of various study groups throughout the nation,
 389 and the experience of other states, that the overwhelming public
 390 necessities of making quality health care available to the



391 citizens of this state, of ensuring that physicians continue to
 392 practice in Florida, and of ensuring that those physicians have
 393 the opportunity to purchase affordable professional liability
 394 insurance cannot be met unless a cap on noneconomic damages is
 395 imposed.

396 (15) The Legislature finds that the high cost of medical
 397 malpractice claims can be substantially alleviated by imposing a
 398 limitation on noneconomic damages in medical malpractice
 399 actions.

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

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

408 (18) The Legislature finds that each of the provisions of
 409 this act is necessary to alleviate the crisis relating to
 410 medical malpractice insurance.

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

413 46.015 Release of parties.--

414 (4)(a) At trial pursuant to a suit filed under chapter 766
 415 or pursuant to s. 766.209, or in arbitration pursuant to s.
 416 766.207, if any defendant shows the court that the plaintiff, or
 417 his or her legal representative, has delivered a written release
 418 or covenant not to sue to any person in partial satisfaction of
 419 the damages resulting from the same injury or injuries, the
 420 court shall set off this amount from the amount of any judgment



421 to which the plaintiff would otherwise be entitled at the time
 422 of rendering judgment, regardless of whether the jury has
 423 allocated fault to the settling defendant at trial.

424 (b) The amount of any setoff under this subsection shall
 425 include all sums received by the plaintiff, including economic
 426 and noneconomic damages, costs, and attorney's fees, and shall
 427 be applied against the total damages, after reduction for any
 428 comparative negligence of the plaintiff, rather than against the
 429 apportioned damages caused by a particular defendant.

430 (c) A defendant entering into a settlement agreement with
 431 a plaintiff may assign any right of contribution arising under
 432 s. 768.31 as a consequence of having paid more than his or her
 433 proportionate share of the entire liability.

434 Section 3. Subsection (1) of section 391.025, Florida
 435 Statutes, is amended to read:

436 391.025 Applicability and scope.--

437 (1) This act applies to health services provided to
 438 eligible individuals who are:

439 (a) Enrolled in the Medicaid program.‡

440 (b) Enrolled in the Florida Kidcare program.‡~~and~~

441 (c) Uninsured or underinsured, provided that they meet the
 442 financial eligibility requirements established in this act, and
 443 to the extent that resources are appropriated for their care.

444 (d) Infants who receive an award of compensation pursuant
 445 to s. 766.31(1).

446 Section 4. Paragraph (f) is added to subsection (2) of
 447 section 391.029, Florida Statutes, to read:

448 391.029 Program eligibility.--

449 (2) The following individuals are financially eligible for
 450 the program:



451 (f) An infant who receives an award of compensation
 452 pursuant to s. 766.31(1), provided the Florida Birth-Related
 453 Neurological Injury Compensation Association shall reimburse the
 454 Children's Medical Services Network the state's share of funding,
 455 which funding shall be used to obtain matching federal funds
 456 under Title XXI of the Social Security Act.

457
 458 The department may continue to serve certain children with
 459 special health care needs who are 21 years of age or older and
 460 who were receiving services from the program prior to April 1,
 461 1998. Such children may be served by the department until July
 462 1, 2000.

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

465 395.0056 Litigation notice requirement.--Upon receipt of a
 466 copy of a complaint filed against a hospital as a defendant in a
 467 medical malpractice action as required by s. 766.106(2), the
 468 agency shall:

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

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

476 Section 6. Subsection (7) of section 395.0191, Florida
 477 Statutes, is amended to read:

478 395.0191 Staff membership and clinical privileges.--

479 (7) There shall be no monetary liability on the part of,
 480 and no cause of action for injunctive relief or damages shall



481 arise against, any licensed facility, its governing board or
 482 governing board members, medical staff, or disciplinary board or
 483 against its agents, investigators, witnesses, or employees, or
 484 against any other person, for any action arising out of or
 485 related to carrying out the provisions of this section, absent
 486 ~~taken in good faith and without intentional fraud in carrying~~
 487 ~~out the provisions of this section.~~

488 Section 7. Section 395.0197, Florida Statutes, is amended
 489 to read:

490 395.0197 Internal risk management program.--

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

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

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

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

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

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



510 2. A prohibition, except when emergency circumstances
511 require otherwise, against a staff member of the licensed
512 facility attending a patient in the recovery room, unless the
513 staff member is authorized to attend the patient in the recovery
514 room and is in the company of at least one other person.

515 However, a licensed facility is exempt from the two-person
516 requirement if it has:

- 517 a. Live visual observation;
- 518 b. Electronic observation; or
- 519 c. Any other reasonable measure taken to ensure patient
520 protection and privacy.

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

528 4. Development, implementation, and ongoing evaluation of
529 procedures, protocols, and systems to accurately identify
530 patients, planned procedures, and the correct site of the
531 planned procedure so as to minimize the performance of a
532 surgical procedure on the wrong patient, a wrong surgical
533 procedure, a wrong-site surgical procedure, or a surgical
534 procedure otherwise unrelated to the patient's diagnosis or
535 medical condition.

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

538 (d) The development and implementation of an incident
539 reporting system based upon the affirmative duty of all health



540 care providers and all agents and employees of the licensed
 541 health care facility to report adverse incidents to the risk
 542 manager, or to his or her designee, within 3 business days after
 543 their occurrence.

544 (2) The internal risk management program is the
 545 responsibility of the governing board of the health care
 546 facility. Each licensed facility shall hire a risk manager,
 547 licensed under s. 395.10974, who is responsible for
 548 implementation and oversight of such facility's internal risk
 549 management program as required by this section. A risk manager
 550 must not be made responsible for more than four internal risk
 551 management programs in separate licensed facilities, unless the
 552 facilities are under one corporate ownership or the risk
 553 management programs are in rural hospitals.

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



570 (4) The agency shall adopt rules governing the
571 establishment of internal risk management programs to meet the
572 needs of individual licensed facilities. Each internal risk
573 management program shall include the use of incident reports to
574 be filed with an individual of responsibility who is competent
575 in risk management techniques in the employ of each licensed
576 facility, such as an insurance coordinator, or who is retained
577 by the licensed facility as a consultant. The individual
578 responsible for the risk management program shall have free
579 access to all medical records of the licensed facility. The
580 incident reports are part of the workpapers of the attorney
581 defending the licensed facility in litigation relating to the
582 licensed facility and are subject to discovery, but are not
583 admissible as evidence in court. A person filing an incident
584 report is not subject to civil suit by virtue of such incident
585 report. As a part of each internal risk management program, the
586 incident reports shall be used to develop categories of
587 incidents which identify problem areas. Once identified,
588 procedures shall be adjusted to correct the problem areas.

589 (5) For purposes of reporting to the agency pursuant to
590 this section, the term "adverse incident" means an event over
591 which health care personnel could exercise control and which is
592 associated in whole or in part with medical intervention, rather
593 than the condition for which such intervention occurred, and
594 which:

- 595 (a) Results in one of the following injuries:
596 1. Death;
597 2. Brain or spinal damage;
598 3. Permanent disfigurement;
599 4. Fracture or dislocation of bones or joints;



600 5. A resulting limitation of neurological, physical, or
 601 sensory function which continues after discharge from the
 602 facility;

603 6. Any condition that required specialized medical
 604 attention or surgical intervention resulting from nonemergency
 605 medical intervention, other than an emergency medical condition,
 606 to which the patient has not given his or her informed consent;
 607 or

608 7. Any condition that required the transfer of the
 609 patient, within or outside the facility, to a unit providing a
 610 more acute level of care due to the adverse incident, rather
 611 than the patient's condition prior to the adverse incident;

612 (b) Was the performance of a surgical procedure on the
 613 wrong patient, a wrong surgical procedure, a wrong-site surgical
 614 procedure, or a surgical procedure otherwise unrelated to the
 615 patient's diagnosis or medical condition;

616 (c) Required the surgical repair of damage resulting to a
 617 patient from a planned surgical procedure, where the damage was
 618 not a recognized specific risk, as disclosed to the patient and
 619 documented through the informed-consent process; or

620 (d) Was a procedure to remove unplanned foreign objects
 621 remaining from a surgical procedure.

622 (6)(a) Each licensed facility subject to this section
 623 shall submit an annual report to the agency summarizing the
 624 incident reports that have been filed in the facility for that
 625 year. The report shall include:

- 626 1. The total number of adverse incidents.
- 627 2. A listing, by category, of the types of operations,
 628 diagnostic or treatment procedures, or other actions causing the



629 injuries, and the number of incidents occurring within each
630 category.

631 3. A listing, by category, of the types of injuries caused
632 and the number of incidents occurring within each category.

633 4. A code number using the health care professional's
634 licensure number and a separate code number identifying all
635 other individuals directly involved in adverse incidents to
636 patients, the relationship of the individual to the licensed
637 facility, and the number of incidents in which each individual
638 has been directly involved. Each licensed facility shall
639 maintain names of the health care professionals and individuals
640 identified by code numbers for purposes of this section.

641 5. A description of all malpractice claims filed against
642 the licensed facility, including the total number of pending and
643 closed claims and the nature of the incident which led to, the
644 persons involved in, and the status and disposition of each
645 claim.

646 6. The name and judgments entered against each health care
647 practitioner for which the facility assumes liability pursuant
648 to subsection (3).

649
650 Each report shall update status and disposition for all prior
651 reports.

652 (b) The information reported to the agency pursuant to
653 paragraph (a) which relates to persons licensed under chapter
654 458, chapter 459, chapter 461, or chapter 466 shall be reviewed
655 by the agency. The agency shall determine whether any of the
656 incidents potentially involved conduct by a health care
657 professional who is subject to disciplinary action, in which
658 case the provisions of s. 456.073 shall apply.



659 (c) The report submitted to the agency shall also contain
 660 the name and license number of the risk manager of the licensed
 661 facility, a copy of its policy and procedures which govern the
 662 measures taken by the facility and its risk manager to reduce
 663 the risk of injuries and adverse incidents, and the results of
 664 such measures. The annual report is confidential and is not
 665 available to the public pursuant to s. 119.07(1) or any other
 666 law providing access to public records. The annual report is not
 667 discoverable or admissible in any civil or administrative
 668 action, except in disciplinary proceedings by the agency or the
 669 appropriate regulatory board. The annual report is not available
 670 to the public as part of the record of investigation for and
 671 prosecution in disciplinary proceedings made available to the
 672 public by the agency or the appropriate regulatory board.
 673 However, the agency or the appropriate regulatory board shall
 674 make available, upon written request by a health care
 675 professional against whom probable cause has been found, any
 676 such records which form the basis of the determination of
 677 probable cause.

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

- 685 ~~(a) The death of a patient;~~
- 686 ~~(b) Brain or spinal damage to a patient;~~
- 687 ~~(c) The performance of a surgical procedure on the wrong~~
 688 ~~patient;~~



689 ~~(d) The performance of a wrong-site surgical procedure; or~~
 690 ~~(e) The performance of a wrong surgical procedure.~~

691
 692 ~~The notification must be made in writing and be provided by~~
 693 ~~facsimile device or overnight mail delivery. The notification~~
 694 ~~must include information regarding the identity of the affected~~
 695 ~~patient, the type of adverse incident, the initiation of an~~
 696 ~~investigation by the facility, and whether the events causing or~~
 697 ~~resulting in the adverse incident represent a potential risk to~~
 698 ~~other patients.~~

699 (7)~~(8)~~ Any of the following adverse incidents, whether
 700 occurring in the licensed facility or arising from health care
 701 prior to admission in the licensed facility, shall be reported
 702 by the facility to the agency within 15 calendar days after its
 703 occurrence:

- 704 (a) The death of a patient;
- 705 (b) Brain or spinal damage to a patient;
- 706 (c) The performance of a surgical procedure on the wrong
 707 patient;
- 708 (d) The performance of a wrong-site surgical procedure;
- 709 (e) The performance of a wrong surgical procedure;
- 710 (f) The performance of a surgical procedure that is
 711 medically unnecessary or otherwise unrelated to the patient's
 712 diagnosis or medical condition;
- 713 (g) The surgical repair of damage resulting to a patient
 714 from a planned surgical procedure, where the damage is not a
 715 recognized specific risk, as disclosed to the patient and
 716 documented through the informed-consent process; or
- 717 (h) The performance of procedures to remove unplanned
 718 foreign objects remaining from a surgical procedure.



719
720 The agency may grant extensions to this reporting requirement
721 for more than 15 days upon justification submitted in writing by
722 the facility administrator to the agency. The agency may require
723 an additional, final report. These reports shall not be
724 available to the public pursuant to s. 119.07(1) or any other
725 law providing access to public records, nor be discoverable or
726 admissible in any civil or administrative action, except in
727 disciplinary proceedings by the agency or the appropriate
728 regulatory board, nor shall they be available to the public as
729 part of the record of investigation for and prosecution in
730 disciplinary proceedings made available to the public by the
731 agency or the appropriate regulatory board. However, the agency
732 or the appropriate regulatory board shall make available, upon
733 written request by a health care professional against whom
734 probable cause has been found, any such records which form the
735 basis of the determination of probable cause. The agency may
736 investigate, as it deems appropriate, any such incident and
737 prescribe measures that must or may be taken in response to the
738 incident. The agency shall review each incident and determine
739 whether it potentially involved conduct by the health care
740 professional who is subject to disciplinary action, in which
741 case the provisions of s. 456.073 shall apply.

742 (8)~~(9)~~ The agency shall publish on the agency's website,
743 no less than quarterly, a summary and trend analysis of adverse
744 incident reports received pursuant to this section, which shall
745 not include information that would identify the patient, the
746 reporting facility, or the health care practitioners involved.
747 The agency shall publish on the agency's website an annual
748 summary and trend analysis of all adverse incident reports and



749 malpractice claims information provided by facilities in their
 750 annual reports, which shall not include information that would
 751 identify the patient, the reporting facility, or the
 752 practitioners involved. The purpose of the publication of the
 753 summary and trend analysis is to promote the rapid dissemination
 754 of information relating to adverse incidents and malpractice
 755 claims to assist in avoidance of similar incidents and reduce
 756 morbidity and mortality.

757 (9)~~(10)~~ The internal risk manager of each licensed
 758 facility shall:

759 (a) Investigate every allegation of sexual misconduct
 760 which is made against a member of the facility's personnel who
 761 has direct patient contact, when the allegation is that the
 762 sexual misconduct occurred at the facility or on the grounds of
 763 the facility.

764 (b) Report every allegation of sexual misconduct to the
 765 administrator of the licensed facility.

766 (c) Notify the family or guardian of the victim, if a
 767 minor, that an allegation of sexual misconduct has been made and
 768 that an investigation is being conducted.

769 (d) Report to the Department of Health every allegation of
 770 sexual misconduct, as defined in chapter 456 and the respective
 771 practice act, by a licensed health care practitioner that
 772 involves a patient.

773 (10)~~(11)~~ Any witness who witnessed or who possesses actual
 774 knowledge of the act that is the basis of an allegation of
 775 sexual abuse shall:

776 (a) Notify the local police; and

777 (b) Notify the hospital risk manager and the
 778 administrator.



779
780 For purposes of this subsection, "sexual abuse" means acts of a
781 sexual nature committed for the sexual gratification of anyone
782 upon, or in the presence of, a vulnerable adult, without the
783 vulnerable adult's informed consent, or a minor. "Sexual abuse"
784 includes, but is not limited to, the acts defined in s.
785 794.011(1)(h), fondling, exposure of a vulnerable adult's or
786 minor's sexual organs, or the use of the vulnerable adult or
787 minor to solicit for or engage in prostitution or sexual
788 performance. "Sexual abuse" does not include any act intended
789 for a valid medical purpose or any act which may reasonably be
790 construed to be a normal caregiving action.

791 (11)~~(12)~~ A person who, with malice or with intent to
792 discredit or harm a licensed facility or any person, makes a
793 false allegation of sexual misconduct against a member of a
794 licensed facility's personnel is guilty of a misdemeanor of the
795 second degree, punishable as provided in s. 775.082 or s.
796 775.083.

797 (12)~~(13)~~ In addition to any penalty imposed pursuant to
798 this section, the agency shall require a written plan of
799 correction from the facility. For a single incident or series of
800 isolated incidents that are nonwillful violations of the
801 reporting requirements of this section, the agency shall first
802 seek to obtain corrective action by the facility. If the
803 correction is not demonstrated within the timeframe established
804 by the agency or if there is a pattern of nonwillful violations
805 of this section, the agency may impose an administrative fine,
806 not to exceed \$5,000 for any violation of the reporting
807 requirements of this section. The administrative fine for
808 repeated nonwillful violations shall not exceed \$10,000 for any



809 violation. The administrative fine for each intentional and
 810 willful violation may not exceed \$25,000 per violation, per day.
 811 The fine for an intentional and willful violation of this
 812 section may not exceed \$250,000. In determining the amount of
 813 fine to be levied, the agency shall be guided by s.
 814 395.1065(2)(b). ~~This subsection does not apply to the notice~~
 815 ~~requirements under subsection (7).~~

816 (13)~~(14)~~ The agency shall have access to all licensed
 817 facility records necessary to carry out the provisions of this
 818 section. The records obtained by the agency under subsection
 819 (6), subsection (7) ~~(8)~~, or subsection (9) ~~(10)~~ are not
 820 available to the public under s. 119.07(1), nor shall they be
 821 discoverable or admissible in any civil or administrative
 822 action, except in disciplinary proceedings by the agency or the
 823 appropriate regulatory board, nor shall records obtained
 824 pursuant to s. 456.071 be available to the public as part of the
 825 record of investigation for and prosecution in disciplinary
 826 proceedings made available to the public by the agency or the
 827 appropriate regulatory board. However, the agency or the
 828 appropriate regulatory board shall make available, upon written
 829 request by a health care professional against whom probable
 830 cause has been found, any such records which form the basis of
 831 the determination of probable cause, except that, with respect
 832 to medical review committee records, s. 766.101 controls.

833 (14)~~(15)~~ The meetings of the committees and governing
 834 board of a licensed facility held solely for the purpose of
 835 achieving the objectives of risk management as provided by this
 836 section shall not be open to the public under the provisions of
 837 chapter 286. The records of such meetings are confidential and



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838 exempt from s. 119.07(1), except as provided in subsection (13)
 839 ~~(14)~~.

840 (15)~~(16)~~ The agency shall review, as part of its licensure
 841 inspection process, the internal risk management program at each
 842 licensed facility regulated by this section to determine whether
 843 the program meets standards established in statutes and rules,
 844 whether the program is being conducted in a manner designed to
 845 reduce adverse incidents, and whether the program is
 846 appropriately reporting incidents under this section.

847 (16)~~(17)~~ There shall be no monetary liability on the part
 848 of, and no cause of action for damages shall arise against, any
 849 risk manager, licensed under s. 395.10974, for the
 850 implementation and oversight of the internal risk management
 851 program in a facility licensed under this chapter or chapter 390
 852 as required by this section, for any act or proceeding
 853 undertaken or performed within the scope of the functions of
 854 such internal risk management program if the risk manager acts
 855 without intentional fraud.

856 (17)~~(18)~~ A privilege against civil liability is hereby
 857 granted to any licensed risk manager or licensed facility with
 858 regard to information furnished pursuant to this chapter, unless
 859 the licensed risk manager or facility acted in bad faith or with
 860 malice in providing such information.

861 (18)~~(19)~~ If the agency, through its receipt of any reports
 862 required under this section or through any investigation, has a
 863 reasonable belief that conduct by a staff member or employee of
 864 a licensed facility is grounds for disciplinary action by the
 865 appropriate regulatory board, the agency shall report this fact
 866 to such regulatory board.



867 ~~(19)(20)~~ It shall be unlawful for any person to coerce,
 868 intimidate, or preclude a risk manager from lawfully executing
 869 his or her reporting obligations pursuant to this chapter. Such
 870 unlawful action shall be subject to civil monetary penalties not
 871 to exceed \$10,000 per violation.

872 Section 8. Section 395.0198, Florida Statutes, is
 873 repealed.

874 Section 9. Section 395.1012, Florida Statutes, is created
 875 to read:

876 395.1012 Patient safety.--

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

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

887 Section 10. Section 395.1051, Florida Statutes, is created
 888 to read:

889 395.1051 Duty to notify patients.--Every licensed facility
 890 shall inform each patient, or an individual identified pursuant
 891 to s. 765.401(1), in person about adverse incidents that result
 892 in serious harm to the patient. Notification of outcomes of care
 893 that result in harm to the patient under this section shall not
 894 constitute an acknowledgement or admission of liability, nor can
 895 such notifications be introduced as evidence.

896 Section 11. Section 415.1111, Florida Statutes, is amended



897 to read:

898 415.1111 Civil actions.--A vulnerable adult who has been
 899 abused, neglected, or exploited as specified in this chapter has
 900 a cause of action against any perpetrator and may recover actual
 901 and punitive damages for such abuse, neglect, or exploitation.
 902 The action may be brought by the vulnerable adult, or that
 903 person's guardian, by a person or organization acting on behalf
 904 of the vulnerable adult with the consent of that person or that
 905 person's guardian, or by the personal representative of the
 906 estate of a deceased victim without regard to whether the cause
 907 of death resulted from the abuse, neglect, or exploitation. The
 908 action may be brought in any court of competent jurisdiction to
 909 enforce such action and to recover actual and punitive damages
 910 for any deprivation of or infringement on the rights of a
 911 vulnerable adult. A party who prevails in any such action may be
 912 entitled to recover reasonable attorney's fees, costs of the
 913 action, and damages. The remedies provided in this section are
 914 in addition to and cumulative with other legal and
 915 administrative remedies available to a vulnerable adult.
 916 Notwithstanding the foregoing, any civil action for damages
 917 against any licensee or entity who establishes, controls,
 918 conducts, manages, or operates a facility licensed under part II
 919 of chapter 400 relating to its operation of the licensed
 920 facility shall be brought pursuant to s. 400.023, or against any
 921 licensee or entity who establishes, controls, conducts, manages,
 922 or operates a facility licensed under part III of chapter 400
 923 relating to its operation of the licensed facility shall be
 924 brought pursuant to s. 400.429. Such licensee or entity shall
 925 not be vicariously liable for the acts or omissions of its
 926 employees or agents or any other third party in an action



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927 brought under this section. Notwithstanding the provisions of
 928 this section, any claim that qualifies as a claim for medical
 929 malpractice, as defined in s. 766.106(1)(a), shall be brought
 930 pursuant to chapter 766.

931 Section 12. Subsection (7) of section 456.013, Florida
 932 Statutes, is amended to read:

933 456.013 Department; general licensing provisions.--

934 (7) The boards, or the department when there is no board,
 935 shall require the completion of a 2-hour course relating to
 936 prevention of medical errors as part of the licensure and
 937 renewal process. The 2-hour course shall count towards the total
 938 number of continuing education hours required for the
 939 profession. The course shall be approved by the board or
 940 department, as appropriate, ~~and~~ shall include a study of root-
 941 cause analysis, error reduction and prevention, and patient
 942 safety, and shall contain information relating to the five most
 943 misdiagnosed conditions during the previous biennium, as
 944 determined by the board or department. If the course is being
 945 offered by a facility licensed pursuant to chapter 395 for its
 946 employees, the board may approve up to 1 hour of the 2-hour
 947 course to be specifically related to error reduction and
 948 prevention methods used in that facility.

949 Section 13. Subsection (1) of section 456.025, Florida
 950 Statutes, is amended to read:

951 456.025 Fees; receipts; disposition.--

952 (1) It is the intent of the Legislature that all costs of
 953 regulating health care professions and practitioners shall be
 954 borne solely by licensees and licensure applicants. It is also
 955 the intent of the Legislature that fees should be reasonable and
 956 not serve as a barrier to licensure. Moreover, it is the intent



957 of the Legislature that the department operate as efficiently as
 958 possible and regularly report to the Legislature additional
 959 methods to streamline operational costs. Therefore, the boards
 960 in consultation with the department, or the department if there
 961 is no board, shall, by rule, set renewal fees which:

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

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

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

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

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

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

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

978 (g)~~(h)~~ Shall be subject to challenge pursuant to chapter
 979 120.

980 Section 14. Paragraph (a) of subsection (1) of section
 981 456.039, Florida Statutes, is amended to read:

982 456.039 Designated health care professionals; information
 983 required for licensure.--

984 (1) Each person who applies for initial licensure as a
 985 physician under chapter 458, chapter 459, chapter 460, or
 986 chapter 461, except a person applying for registration pursuant



987 to ss. 458.345 and 459.021, must, at the time of application,
 988 and each physician who applies for license renewal under chapter
 989 458, chapter 459, chapter 460, or chapter 461, except a person
 990 registered pursuant to ss. 458.345 and 459.021, must, in
 991 conjunction with the renewal of such license and under
 992 procedures adopted by the Department of Health, and in addition
 993 to any other information that may be required from the
 994 applicant, furnish the following information to the Department
 995 of Health:

996 (a)1. The name of each medical school that the applicant
 997 has attended, with the dates of attendance and the date of
 998 graduation, and a description of all graduate medical education
 999 completed by the applicant, excluding any coursework taken to
 1000 satisfy medical licensure continuing education requirements.

1001 2. The name of each hospital at which the applicant has
 1002 privileges.

1003 3. The address at which the applicant will primarily
 1004 conduct his or her practice.

1005 4. Any certification that the applicant has received from
 1006 a specialty board that is recognized by the board to which the
 1007 applicant is applying.

1008 5. The year that the applicant began practicing medicine.

1009 6. Any appointment to the faculty of a medical school
 1010 which the applicant currently holds and an indication as to
 1011 whether the applicant has had the responsibility for graduate
 1012 medical education within the most recent 10 years.

1013 7. A description of any criminal offense of which the
 1014 applicant has been found guilty, regardless of whether
 1015 adjudication of guilt was withheld, or to which the applicant
 1016 has pled guilty or nolo contendere. A criminal offense committed



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1017 in another jurisdiction which would have been a felony or
1018 misdemeanor if committed in this state must be reported. If the
1019 applicant indicates that a criminal offense is under appeal and
1020 submits a copy of the notice for appeal of that criminal
1021 offense, the department must state that the criminal offense is
1022 under appeal if the criminal offense is reported in the
1023 applicant's profile. If the applicant indicates to the
1024 department that a criminal offense is under appeal, the
1025 applicant must, upon disposition of the appeal, submit to the
1026 department a copy of the final written order of disposition.

1027 8. A description of any final disciplinary action taken
1028 within the previous 10 years against the applicant by the agency
1029 regulating the profession that the applicant is or has been
1030 licensed to practice, whether in this state or in any other
1031 jurisdiction, by a specialty board that is recognized by the
1032 American Board of Medical Specialties, the American Osteopathic
1033 Association, or a similar national organization, or by a
1034 licensed hospital, health maintenance organization, prepaid
1035 health clinic, ambulatory surgical center, or nursing home.
1036 Disciplinary action includes resignation from or nonrenewal of
1037 medical staff membership or the restriction of privileges at a
1038 licensed hospital, health maintenance organization, prepaid
1039 health clinic, ambulatory surgical center, or nursing home taken
1040 in lieu of or in settlement of a pending disciplinary case
1041 related to competence or character. If the applicant indicates
1042 that the disciplinary action is under appeal and submits a copy
1043 of the document initiating an appeal of the disciplinary action,
1044 the department must state that the disciplinary action is under
1045 appeal if the disciplinary action is reported in the applicant's
1046 profile.



1047 9. Relevant professional qualifications as defined by the
 1048 applicable board.

1049 Section 15. Section 456.041, Florida Statutes, is amended
 1050 to read:

1051 456.041 Practitioner profile; creation.--

1052 (1)(a) Beginning July 1, 1999, the Department of Health
 1053 shall compile the information submitted pursuant to s. 456.039
 1054 into a practitioner profile of the applicant submitting the
 1055 information, except that the Department of Health may develop a
 1056 format to compile uniformly any information submitted under s.
 1057 456.039(4)(b). Beginning July 1, 2001, the Department of Health
 1058 may, and beginning July 1, 2004, shall, compile the information
 1059 submitted pursuant to s. 456.0391 into a practitioner profile of
 1060 the applicant submitting the information.

1061 (b) Each practitioner licensed under chapter 458 or
 1062 chapter 459 must report to the Department of Health and the
 1063 Board of Medicine or the Board of Osteopathic Medicine,
 1064 respectively, all final disciplinary actions, sanctions by a
 1065 governmental agency or a facility or entity licensed under state
 1066 law, and claims or actions, as provided under s. 456.051, to
 1067 which he or she is subjected no later than 15 calendar days
 1068 after such action or sanction is imposed. Failure to submit the
 1069 requisite information within 15 calendar days in accordance with
 1070 this paragraph shall subject the practitioner to discipline by
 1071 the Board of Medicine or the Board of Osteopathic Medicine and a
 1072 fine of \$100 for each day that the information is not submitted
 1073 after the expiration of the 15-day reporting period.

1074 (c) Within 15 days after receiving a report under
 1075 paragraph (b), the department shall update the practitioner's
 1076 profile in accordance with the requirements of subsection (7).



1077 (2) On the profile published under subsection (1), the
 1078 department shall indicate whether ~~if~~ the information provided
 1079 under s. 456.039(1)(a)7. or s. 456.0391(1)(a)7. is or is not
 1080 corroborated by a criminal history check conducted according to
 1081 this subsection. ~~If the information provided under s.~~
 1082 ~~456.039(1)(a)7. or s. 456.0391(1)(a)7. is corroborated by the~~
 1083 ~~criminal history check, the fact that the criminal history check~~
 1084 ~~was performed need not be indicated on the profile.~~ The
 1085 department, or the board having regulatory authority over the
 1086 practitioner acting on behalf of the department, shall
 1087 investigate any information received by the department or the
 1088 board when it has reasonable grounds to believe that the
 1089 practitioner has violated any law that relates to the
 1090 practitioner's practice.

1091 (3) The Department of Health shall ~~may~~ include in each
 1092 practitioner's practitioner profile that criminal information
 1093 that directly relates to the practitioner's ability to
 1094 competently practice his or her profession. The department must
 1095 include in each practitioner's practitioner profile the
 1096 following statement: "The criminal history information, if any
 1097 exists, may be incomplete; federal criminal history information
 1098 is not available to the public." The department shall provide in
 1099 each practitioner profile, for every final disciplinary action
 1100 taken against the practitioner, a narrative description, written
 1101 in plain English, that explains the administrative complaint
 1102 filed against the practitioner and the final disciplinary action
 1103 imposed on the practitioner. The department shall include a
 1104 hyperlink to each final order listed on its Internet website
 1105 report of dispositions of recent disciplinary actions taken
 1106 against practitioners.



1107 (4) The Department of Health shall include, with respect
 1108 to a practitioner licensed under chapter 458 or chapter 459, a
 1109 statement of how the practitioner has elected to comply with the
 1110 financial responsibility requirements of s. 458.320 or s.
 1111 459.0085. The department shall include, with respect to
 1112 practitioners subject to s. 456.048, a statement of how the
 1113 practitioner has elected to comply with the financial
 1114 responsibility requirements of that section. The department
 1115 shall include, with respect to practitioners licensed under
 1116 chapter 458, chapter 459, or chapter 461, information relating
 1117 to liability actions which has been reported under s. 456.049 or
 1118 s. 627.912 within the previous 10 years for any paid claim of
 1119 \$50,000 or more ~~that exceeds \$5,000~~. Such claims information
 1120 shall be reported in the context of comparing an individual
 1121 practitioner's claims to the experience of other practitioners
 1122 within the same specialty, or profession if the practitioner is
 1123 not a specialist, ~~to the extent such information is available to~~
 1124 ~~the Department of Health.~~ The department shall include a
 1125 hyperlink to all such comparison reports in such practitioner's
 1126 profile on its Internet website. If information relating to a
 1127 liability action is included in a practitioner's practitioner
 1128 profile, the profile must also include the following statement:
 1129 "Settlement of a claim may occur for a variety of reasons that
 1130 do not necessarily reflect negatively on the professional
 1131 competence or conduct of the practitioner. A payment in
 1132 settlement of a medical malpractice action or claim should not
 1133 be construed as creating a presumption that medical malpractice
 1134 has occurred."

1135 (5) The Department of Health shall ~~may not~~ include the
 1136 date of a disciplinary action taken by a licensed hospital or an



1137 ambulatory surgical center, in accordance with the requirements
 1138 of s. 395.0193, in the practitioner profile. Any practitioner
 1139 disciplined under paragraph (1)(b) must report to the department
 1140 the date the disciplinary action was imposed. The department
 1141 shall state whether the action is related to professional
 1142 competence and whether it is related to the delivery of services
 1143 to a patient.

1144 (6) The Department of Health may include in the
 1145 practitioner's practitioner profile any other information that
 1146 is a public record of any governmental entity and that relates
 1147 to a practitioner's ability to competently practice his or her
 1148 profession. However, the department must consult with the board
 1149 having regulatory authority over the practitioner before such
 1150 information is included in his or her profile.

1151 (7) Upon the completion of a practitioner profile under
 1152 this section, the Department of Health shall furnish the
 1153 practitioner who is the subject of the profile a copy of it. The
 1154 practitioner has a period of 30 days in which to review the
 1155 profile and to correct any factual inaccuracies in it. The
 1156 Department of Health shall make the profile available to the
 1157 public at the end of the 30-day period. The department shall
 1158 make the profiles available to the public through the World Wide
 1159 Web and other commonly used means of distribution.

1160 (8) The Department of Health shall provide in each profile
 1161 an easy-to-read explanation of any disciplinary action taken and
 1162 the reason the sanction or sanctions were imposed.

1163 ~~(9)~~(8) Making a practitioner profile available to the
 1164 public under this section does not constitute agency action for
 1165 which a hearing under s. 120.57 may be sought.

1166 Section 16. Section 456.042, Florida Statutes, is amended



1167 to read:

1168 456.042 Practitioner profiles; update.--A practitioner
 1169 must submit updates of required information within 15 days after
 1170 the final activity that renders such information a fact. The
 1171 Department of Health shall update each practitioner's
 1172 practitioner profile periodically. An updated profile is subject
 1173 to the same requirements as an original profile with respect to
 1174 the period within which the practitioner may review the profile
 1175 for the purpose of correcting factual inaccuracies.

1176 Section 17. Subsection (1) of section 456.049, Florida
 1177 Statutes, is amended, and subsection (3) is added to said
 1178 section, to read:

1179 456.049 Health care practitioners; reports on professional
 1180 liability claims and actions.--

1181 (1) Any practitioner of medicine licensed pursuant to the
 1182 provisions of chapter 458, practitioner of osteopathic medicine
 1183 licensed pursuant to the provisions of chapter 459, podiatric
 1184 physician licensed pursuant to the provisions of chapter 461, or
 1185 dentist licensed pursuant to the provisions of chapter 466 shall
 1186 report to the department any claim or action for damages for
 1187 personal injury alleged to have been caused by error, omission,
 1188 or negligence in the performance of such licensee's professional
 1189 services or based on a claimed performance of professional
 1190 services without consent if ~~the claim was not covered by an~~
 1191 ~~insurer required to report under s. 627.912 and~~ the claim
 1192 resulted in:

1193 (a) A final judgment of \$50,000 or more or, with respect
 1194 to a dentist licensed pursuant to chapter 466, a final judgment
 1195 of \$25,000 or more in any amount.

1196 (b) A settlement of \$50,000 or more or, with respect to a



1197 dentist licensed pursuant to chapter 466, a settlement of
 1198 \$25,000 or more ~~in any amount.~~

1199 (c) A final disposition not resulting in payment on behalf
 1200 of the licensee.

1201
 1202 Reports shall be filed with the department no later than 60 days
 1203 following the occurrence of any event listed in paragraph (a),
 1204 paragraph (b), or paragraph (c).

1205 (3) The department shall forward the information collected
 1206 under this section to the Office of Insurance Regulation.

1207 Section 18. Section 456.051, Florida Statutes, is amended
 1208 to read:

1209 456.051 Reports of professional liability actions;
 1210 bankruptcies; Department of Health's responsibility to
 1211 provide.--

1212 (1) The report of a claim or action for damages for
 1213 personal injury which is required to be provided to the
 1214 Department of Health under s. 456.049 or s. 627.912 is public
 1215 information except for the name of the claimant or injured
 1216 person, which remains confidential as provided in ss.

1217 456.049(2)(d) and 627.912(2)(e). The Department of Health
 1218 shall, upon request, make such report available to any person.
 1219 The department shall make such report available as a part of the
 1220 practitioner's profile within 45 calendar days after receipt.

1221 (2) Any information in the possession of the Department of
 1222 Health which relates to a bankruptcy proceeding by a
 1223 practitioner of medicine licensed under chapter 458, a
 1224 practitioner of osteopathic medicine licensed under chapter 459,
 1225 a podiatric physician licensed under chapter 461, or a dentist
 1226 licensed under chapter 466 is public information. The Department



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1227 of Health shall, upon request, make such information available
 1228 to any person. The department shall make such report available
 1229 as a part of the practitioner's profile within 45 calendar days
 1230 after receipt.

1231 Section 19. Paragraph (a) of subsection (7) of section
 1232 456.057, Florida Statutes, is amended to read:

1233 456.057 Ownership and control of patient records; report
 1234 or copies of records to be furnished.--

1235 (7)(a)1. The department may obtain patient records
 1236 pursuant to a subpoena without written authorization from the
 1237 patient if the department and the probable cause panel of the
 1238 appropriate board, if any, find reasonable cause to believe that
 1239 a health care practitioner has excessively or inappropriately
 1240 prescribed any controlled substance specified in chapter 893 in
 1241 violation of this chapter or any professional practice act or
 1242 that a health care practitioner has practiced his or her
 1243 profession below that level of care, skill, and treatment
 1244 required as defined by this chapter or any professional practice
 1245 act and also find that appropriate, reasonable attempts were
 1246 made to obtain a patient release.

1247 2. The department may obtain patient records and insurance
 1248 information pursuant to a subpoena without written authorization
 1249 from the patient if the department and the probable cause panel
 1250 of the appropriate board, if any, find reasonable cause to
 1251 believe that a health care practitioner has provided inadequate
 1252 medical care based on termination of insurance and also find
 1253 that appropriate, reasonable attempts were made to obtain a
 1254 patient release.

1255 3. The department may obtain patient records, billing
 1256 records, insurance information, provider contracts, and all



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1257 attachments thereto pursuant to a subpoena without written
1258 authorization from the patient if the department and probable
1259 cause panel of the appropriate board, if any, find reasonable
1260 cause to believe that a health care practitioner has submitted a
1261 claim, statement, or bill using a billing code that would result
1262 in payment greater in amount than would be paid using a billing
1263 code that accurately describes the services performed, requested
1264 payment for services that were not performed by that health care
1265 practitioner, used information derived from a written report of
1266 an automobile accident generated pursuant to chapter 316 to
1267 solicit or obtain patients personally or through an agent
1268 regardless of whether the information is derived directly from
1269 the report or a summary of that report or from another person,
1270 solicited patients fraudulently, received a kickback as defined
1271 in s. 456.054, violated the patient brokering provisions of s.
1272 817.505, or presented or caused to be presented a false or
1273 fraudulent insurance claim within the meaning of s.
1274 817.234(1)(a), and also find that, within the meaning of s.
1275 817.234(1)(a), patient authorization cannot be obtained because
1276 the patient cannot be located or is deceased, incapacitated, or
1277 suspected of being a participant in the fraud or scheme, and if
1278 the subpoena is issued for specific and relevant records.

1279 4. Notwithstanding subparagraphs 1.-3., when the
1280 department investigates a professional liability claim or
1281 undertakes action pursuant to s. 456.049 or s. 627.912, the
1282 department may obtain patient records pursuant to a subpoena
1283 without written authorization from the patient if the patient
1284 refuses to cooperate or attempts to obtain a patient release and
1285 failure to obtain the patient records would be detrimental to
1286 the investigation.



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1287 Section 20. Section 456.0575, Florida Statutes, is created
 1288 to read:

1289 456.0575 Duty to notify patients.--Every licensed health
 1290 care practitioner shall inform each patient, or an individual
 1291 identified pursuant to s. 765.401(1), in person about adverse
 1292 incidents that result in serious harm to the patient.
 1293 Notification of outcomes of care that result in harm to the
 1294 patient under this section shall not constitute an
 1295 acknowledgement of admission of liability, nor can such
 1296 notifications be introduced as evidence.

1297 Section 21. Subsection (4) of section 456.072, Florida
 1298 Statutes, is amended, and subsection (7) is added to said
 1299 section, to read:

1300 456.072 Grounds for discipline; penalties; enforcement.--

1301 (4) In addition to any other discipline imposed through
 1302 final order, or citation, entered on or after July 1, 2001,
 1303 pursuant to this section or discipline imposed through final
 1304 order, or citation, entered on or after July 1, 2001, for a
 1305 violation of any practice act, the board, or the department when
 1306 there is no board, shall assess costs related to the
 1307 investigation and prosecution of the case. Such costs related to
 1308 the investigation and prosecution include, but are not limited
 1309 to, salaries and benefits of personnel, costs related to the
 1310 time spent by the attorney and other personnel working on the
 1311 case, and any other expenses incurred by the department for the
 1312 case. The board, or the department when there in no board, shall
 1313 determine the amount of costs to be assessed after its
 1314 consideration of an affidavit of itemized costs and any written
 1315 objections thereto. In any case where the board or the
 1316 department imposes a fine or assessment and the fine or



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1317 assessment is not paid within a reasonable time, such reasonable
 1318 time to be prescribed in the rules of the board, or the
 1319 department when there is no board, or in the order assessing
 1320 such fines or costs, the department or the Department of Legal
 1321 Affairs may contract for the collection of, or bring a civil
 1322 action to recover, the fine or assessment.

1323 (7) In any formal administrative hearing conducted under
 1324 s. 120.57(1), the department shall establish grounds for the
 1325 discipline of a licensee by the greater weight of the evidence.

1326 Section 22. Subsections (1) and (5) of section 456.073,
 1327 Florida Statutes, as amended by section 1 of chapter 2003-27,
 1328 Laws of Florida, are amended to read:

1329 456.073 Disciplinary proceedings.--Disciplinary
 1330 proceedings for each board shall be within the jurisdiction of
 1331 the department.

1332 (1) The department, for the boards under its jurisdiction,
 1333 shall cause to be investigated any complaint that is filed
 1334 before it if the complaint is in writing, signed by the
 1335 complainant, and legally sufficient. A complaint filed by a
 1336 state prisoner against a health care practitioner employed by or
 1337 otherwise providing health care services within a facility of
 1338 the Department of Corrections is not legally sufficient unless
 1339 there is a showing that the prisoner complainant has exhausted
 1340 all available administrative remedies within the state
 1341 correctional system before filing the complaint. However, if the
 1342 Department of Health determines after a preliminary inquiry of a
 1343 state prisoner's complaint that the practitioner may present a
 1344 serious threat to the health and safety of any individual who is
 1345 not a state prisoner, the Department of Health may determine
 1346 legal sufficiency and proceed with discipline. The Department of



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1347 Health shall be notified within 15 days after the Department of
 1348 Corrections disciplines or allows a health care practitioner to
 1349 resign for an offense related to the practice of his or her
 1350 profession. A complaint is legally sufficient if it contains
 1351 ultimate facts that show that a violation of this chapter, of
 1352 any of the practice acts relating to the professions regulated
 1353 by the department, or of any rule adopted by the department or a
 1354 regulatory board in the department has occurred. In order to
 1355 determine legal sufficiency, the department may require
 1356 supporting information or documentation. The department may
 1357 investigate, and the department or the appropriate board may
 1358 take appropriate final action on, a complaint even though the
 1359 original complainant withdraws it or otherwise indicates a
 1360 desire not to cause the complaint to be investigated or
 1361 prosecuted to completion. The department may investigate an
 1362 anonymous complaint if the complaint is in writing and is
 1363 legally sufficient, if the alleged violation of law or rules is
 1364 substantial, and if the department has reason to believe, after
 1365 preliminary inquiry, that the violations alleged in the
 1366 complaint are true. The department may investigate a complaint
 1367 made by a confidential informant if the complaint is legally
 1368 sufficient, if the alleged violation of law or rule is
 1369 substantial, and if the department has reason to believe, after
 1370 preliminary inquiry, that the allegations of the complainant are
 1371 true. The department may initiate an investigation if it has
 1372 reasonable cause to believe that a licensee or a group of
 1373 licensees has violated a Florida statute, a rule of the
 1374 department, or a rule of a board. The department may investigate
 1375 information filed pursuant to s. 456.041(4) relating to
 1376 liability actions with respect to practitioners licensed under



1377 chapter 458 or chapter 459 which have been reported under s.
 1378 456.049 or s. 627.912 within the previous 6 years for any paid
 1379 claim that exceeds \$50,000. Except as provided in ss.
 1380 458.331(9), 459.015(9), 460.413(5), and 461.013(6), when an
 1381 investigation of any subject is undertaken, the department shall
 1382 promptly furnish to the subject or the subject's attorney a copy
 1383 of the complaint or document that resulted in the initiation of
 1384 the investigation. The subject may submit a written response to
 1385 the information contained in such complaint or document within
 1386 20 days after service to the subject of the complaint or
 1387 document. The subject's written response shall be considered by
 1388 the probable cause panel. The right to respond does not prohibit
 1389 the issuance of a summary emergency order if necessary to
 1390 protect the public. However, if the secretary, or the
 1391 secretary's designee, and the chair of the respective board or
 1392 the chair of its probable cause panel agree in writing that such
 1393 notification would be detrimental to the investigation, the
 1394 department may withhold notification. The department may conduct
 1395 an investigation without notification to any subject if the act
 1396 under investigation is a criminal offense.

1397 (5)(a) A formal hearing before an administrative law judge
 1398 from the Division of Administrative Hearings shall be held
 1399 pursuant to chapter 120 if there are any disputed issues of
 1400 material fact. The determination of whether a licensee has
 1401 violated the laws and rules regulating the profession, including
 1402 a determination of the reasonable standard of care, is a
 1403 conclusion of law to be determined by the board, or department
 1404 when there is no board, and is not a finding of fact to be
 1405 determined by an administrative law judge. The administrative
 1406 law judge shall issue a recommended order pursuant to chapter



1407 120. If any party raises an issue of disputed fact during an
 1408 informal hearing, the hearing shall be terminated and a formal
 1409 hearing pursuant to chapter 120 shall be held.

1410 (b) Notwithstanding s. 120.569(2), the department shall
 1411 notify the Division of Administrative Hearings within 45 days
 1412 after receipt of a petition or request for a hearing that the
 1413 department has determined requires a formal hearing before an
 1414 administrative law judge.

1415 Section 23. Subsections (1) and (2) of section 456.077,
 1416 Florida Statutes, are amended to read:

1417 456.077 Authority to issue citations.--

1418 (1) Notwithstanding s. 456.073, the board, or the
 1419 department if there is no board, shall adopt rules to permit the
 1420 issuance of citations. The citation shall be issued to the
 1421 subject and shall contain the subject's name and address, the
 1422 subject's license number if applicable, a brief factual
 1423 statement, the sections of the law allegedly violated, and the
 1424 penalty imposed. The citation must clearly state that the
 1425 subject may choose, in lieu of accepting the citation, to follow
 1426 the procedure under s. 456.073. If the subject disputes the
 1427 matter in the citation, the procedures set forth in s. 456.073
 1428 must be followed. However, if the subject does not dispute the
 1429 matter in the citation with the department within 30 days after
 1430 the citation is served, the citation becomes a public final
 1431 order and does not constitute ~~constitutes~~ discipline for a first
 1432 offense, but does constitute discipline for a second or
 1433 subsequent offense. The penalty shall be a fine or other
 1434 conditions as established by rule.

1435 (2) The board, or the department if there is no board,
 1436 shall adopt rules designating violations for which a citation



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1437 may be issued. Such rules shall designate as citation violations
 1438 those violations for which there is no substantial threat to the
 1439 public health, safety, and welfare or no violation of standard
 1440 of care involving injury to a patient. Violations for which a
 1441 citation may be issued shall include violations of continuing
 1442 education requirements; failure to timely pay required fees and
 1443 fines; failure to comply with the requirements of ss. 381.026
 1444 and 381.0261 regarding the dissemination of information
 1445 regarding patient rights; failure to comply with advertising
 1446 requirements; failure to timely update practitioner profile and
 1447 credentialing files; failure to display signs, licenses, and
 1448 permits; failure to have required reference books available; and
 1449 all other violations that do not pose a direct and serious
 1450 threat to the health and safety of the patient or involve a
 1451 violation of standard of care that has resulted in injury to a
 1452 patient.

1453 Section 24. Subsections (1) and (2) of section 456.078,
 1454 Florida Statutes, are amended to read:

1455 456.078 Mediation.--

1456 (1) Notwithstanding the provisions of s. 456.073, the
 1457 board, or the department when there is no board, shall adopt
 1458 rules to designate which violations of the applicable
 1459 professional practice act are appropriate for mediation. The
 1460 board, or the department when there is no board, shall ~~may~~
 1461 designate as mediation offenses those complaints where harm
 1462 caused by the licensee is economic in nature, except any act or
 1463 omission involving intentional misconduct, ~~or~~ can be remedied by
 1464 the licensee, is not a standard of care violation involving any
 1465 type of injury to a patient, or does not result in an adverse
 1466 incident. For the purposes of this section, an "adverse



- 1467 incident" means an event that results in:
 1468 (a) The death of a patient;
 1469 (b) Brain or spinal damage to a patient;
 1470 (c) The performance of a surgical procedure on the wrong
 1471 patient;
 1472 (d) The performance of a wrong-site surgical procedure;
 1473 (e) The performance of a surgical procedure that is
 1474 medically unnecessary or otherwise unrelated to the patient's
 1475 diagnosis or medical condition;
 1476 (f) The surgical repair of damage to a patient resulting
 1477 from a planned surgical procedure, which damage is not a
 1478 recognized specific risk as disclosed to the patient and
 1479 documented through the informed-consent process;
 1480 (g) The performance of a procedure to remove unplanned
 1481 foreign objects remaining from a surgical procedure; or
 1482 (h) The performance of any other surgical procedure that
 1483 breached the standard of care.

1484 (2) After the department determines a complaint is legally
 1485 sufficient and the alleged violations are defined as mediation
 1486 offenses, the department or any agent of the department may
 1487 conduct informal mediation to resolve the complaint. If the
 1488 complainant and the subject of the complaint agree to a
 1489 resolution of a complaint within 14 days after contact by the
 1490 mediator, the mediator shall notify the department of the terms
 1491 of the resolution. The department or board shall take no further
 1492 action unless the complainant and the subject each fail to
 1493 record with the department an acknowledgment of satisfaction of
 1494 the terms of mediation within 60 days of the mediator's
 1495 notification to the department. A successful mediation shall not
 1496 constitute discipline. In the event the complainant and subject



1497 fail to reach settlement terms or to record the required
 1498 acknowledgment, the department shall process the complaint
 1499 according to the provisions of s. 456.073.

1500 Section 25. Present subsection (8) of section 458.320,
 1501 Florida Statutes, is renumbered as subsection (9), and a new
 1502 subsection (8) is added to said section, to read:

1503 458.320 Financial responsibility.--

1504 (8) Notwithstanding any other provision of this section,
 1505 the department shall suspend the license of any physician
 1506 against whom has been entered a final judgment, arbitration
 1507 award, or other order or who has entered into a settlement
 1508 agreement to pay damages arising out of a claim for medical
 1509 malpractice, if all appellate remedies have been exhausted and
 1510 payment up to the amounts required by this section has not been
 1511 made within 30 days after the entering of such judgment, award,
 1512 or order or agreement, until proof of payment is received by the
 1513 department or a payment schedule has been agreed upon by the
 1514 physician and the claimant and presented to the department. This
 1515 subsection does not apply to a physician who has met the
 1516 financial responsibility requirements in paragraphs (1)(b) and
 1517 (2)(b).

1518 Section 26. Paragraph (t) of subsection (1) and
 1519 subsections (3) and (6) of section 458.331, Florida Statutes,
 1520 are amended to read:

1521 458.331 Grounds for disciplinary action; action by the
 1522 board and department.--

1523 (1) The following acts constitute grounds for denial of a
 1524 license or disciplinary action, as specified in s. 456.072(2):

1525 (t) Gross or repeated malpractice or the failure to
 1526 practice medicine with that level of care, skill, and treatment



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1527 which is recognized by a reasonably prudent similar physician as
 1528 being acceptable under similar conditions and circumstances. The
 1529 board shall give great weight to the provisions of s. 766.102
 1530 when enforcing this paragraph. As used in this paragraph,
 1531 "repeated malpractice" includes, but is not limited to, three or
 1532 more claims for medical malpractice within the previous 5-year
 1533 period resulting in indemnities being paid in excess of \$50,000
 1534 ~~\$25,000~~ each to the claimant in a judgment or settlement and
 1535 which incidents involved negligent conduct by the physician. As
 1536 used in this paragraph, "gross malpractice" or "the failure to
 1537 practice medicine with that level of care, skill, and treatment
 1538 which is recognized by a reasonably prudent similar physician as
 1539 being acceptable under similar conditions and circumstances,"
 1540 shall not be construed so as to require more than one instance,
 1541 event, or act. Nothing in this paragraph shall be construed to
 1542 require that a physician be incompetent to practice medicine in
 1543 order to be disciplined pursuant to this paragraph. A
 1544 recommended order by an administrative law judge or a final
 1545 order of the board finding a violation under this paragraph
 1546 shall specify whether the licensee was found to have committed
 1547 "gross malpractice," "repeated malpractice," or "failure to
 1548 practice medicine with that level of care, skill, and treatment
 1549 which is recognized as being acceptable under similar conditions
 1550 and circumstances," or any combination thereof, and any
 1551 publication by the board must so specify.

1552 (3) In any administrative action against a physician ~~which~~
 1553 ~~does not involve revocation or suspension of license,~~ the
 1554 division shall have the burden, by the greater weight of the
 1555 evidence, to establish the existence of grounds for disciplinary
 1556 action. ~~The division shall establish grounds for revocation or~~



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1557 ~~suspension of license by clear and convincing evidence.~~

1558 (6) Upon the department's receipt from an insurer or self-
1559 insurer of a report of a closed claim against a physician
1560 pursuant to s. 627.912 or from a health care practitioner of a
1561 report pursuant to s. 456.049, or upon the receipt from a
1562 claimant of a presuit notice against a physician pursuant to s.
1563 766.106, the department shall review each report and determine
1564 whether it potentially involved conduct by a licensee that is
1565 subject to disciplinary action, in which case the provisions of
1566 s. 456.073 shall apply. However, if it is reported that a
1567 physician has had three or more claims with indemnities
1568 exceeding \$50,000 ~~\$25,000~~ each within the previous 5-year
1569 period, the department shall investigate the occurrences upon
1570 which the claims were based and determine if action by the
1571 department against the physician is warranted.

1572 Section 27. Section 458.3311, Florida Statutes, is created
1573 to read:

1574 458.3311 Emergency procedures for disciplinary
1575 action.--Notwithstanding any other provision of law to the
1576 contrary:

1577 (1) Each physician must report to the Department of Health
1578 any judgment for medical negligence levied against the
1579 physician. The physician must make the report no later than 15
1580 days after the exhaustion of the last opportunity for any party
1581 to appeal the judgment or request a rehearing.

1582 (2) No later than 30 days after a physician has, within a
1583 60-month period, made three reports as required by subsection
1584 (1), the Department of Health shall initiate an emergency
1585 investigation and the Board of Medicine shall conduct an
1586 emergency probable cause hearing to determine whether the



1587 physician should be disciplined for a violation of s.
 1588 458.331(1)(t) or any other relevant provision of law.

1589 Section 28. Present subsection (9) of section 459.0085,
 1590 Florida Statutes, is renumbered as subsection (10), and a new
 1591 subsection (9) is added to said section, to read:

1592 459.0085 Financial responsibility.--

1593 (9) Notwithstanding any other provision of this section,
 1594 the department shall suspend the license of any osteopathic
 1595 physician against whom has been entered a final judgment,
 1596 arbitration award, or other order or who has entered into a
 1597 settlement agreement to pay damages arising out of a claim for
 1598 medical malpractice, if all appellate remedies have been
 1599 exhausted and payment up to the amounts required by this section
 1600 has not been made within 30 days after the entering of such
 1601 judgment, award, or order or agreement, until proof of payment
 1602 is received by the department or a payment schedule has been
 1603 agreed upon by the osteopathic physician and the claimant and
 1604 presented to the department. This subsection does not apply to
 1605 an osteopathic physician who has met the financial
 1606 responsibility requirements in paragraphs (1)(b) and (2)(b).

1607 Section 29. Paragraph (x) of subsection (1) and
 1608 subsections (3) and (6) of section 459.015, Florida Statutes,
 1609 are amended to read:

1610 459.015 Grounds for disciplinary action; action by the
 1611 board and department.--

1612 (1) The following acts constitute grounds for denial of a
 1613 license or disciplinary action, as specified in s. 456.072(2):

1614 (x) Gross or repeated malpractice or the failure to
 1615 practice osteopathic medicine with that level of care, skill,
 1616 and treatment which is recognized by a reasonably prudent



1617 similar osteopathic physician as being acceptable under similar
 1618 conditions and circumstances. The board shall give great weight
 1619 to the provisions of s. 766.102 when enforcing this paragraph.
 1620 As used in this paragraph, "repeated malpractice" includes, but
 1621 is not limited to, three or more claims for medical malpractice
 1622 within the previous 5-year period resulting in indemnities being
 1623 paid in excess of \$50,000 ~~\$25,000~~ each to the claimant in a
 1624 judgment or settlement and which incidents involved negligent
 1625 conduct by the osteopathic physician. As used in this paragraph,
 1626 "gross malpractice" or "the failure to practice osteopathic
 1627 medicine with that level of care, skill, and treatment which is
 1628 recognized by a reasonably prudent similar osteopathic physician
 1629 as being acceptable under similar conditions and circumstances"
 1630 shall not be construed so as to require more than one instance,
 1631 event, or act. Nothing in this paragraph shall be construed to
 1632 require that an osteopathic physician be incompetent to practice
 1633 osteopathic medicine in order to be disciplined pursuant to this
 1634 paragraph. A recommended order by an administrative law judge or
 1635 a final order of the board finding a violation under this
 1636 paragraph shall specify whether the licensee was found to have
 1637 committed "gross malpractice," "repeated malpractice," or
 1638 "failure to practice osteopathic medicine with that level of
 1639 care, skill, and treatment which is recognized as being
 1640 acceptable under similar conditions and circumstances," or any
 1641 combination thereof, and any publication by the board shall so
 1642 specify.

1643 (3) In any administrative action against a physician ~~which~~
 1644 ~~does not involve revocation or suspension of license,~~ the
 1645 division shall have the burden, by the greater weight of the
 1646 evidence, to establish the existence of grounds for disciplinary



1647 action. ~~The division shall establish grounds for revocation or~~
 1648 ~~suspension of license by clear and convincing evidence.~~

1649 (6) Upon the department's receipt from an insurer or self-
 1650 insurer of a report of a closed claim against an osteopathic
 1651 physician pursuant to s. 627.912 or from a health care
 1652 practitioner of a report pursuant to s. 456.049, or upon the
 1653 receipt from a claimant of a presuit notice against an
 1654 osteopathic physician pursuant to s. 766.106, the department
 1655 shall review each report and determine whether it potentially
 1656 involved conduct by a licensee that is subject to disciplinary
 1657 action, in which case the provisions of s. 456.073 shall apply.
 1658 However, if it is reported that an osteopathic physician has had
 1659 three or more claims with indemnities exceeding \$50,000 ~~\$25,000~~
 1660 each within the previous 5-year period, the department shall
 1661 investigate the occurrences upon which the claims were based and
 1662 determine if action by the department against the osteopathic
 1663 physician is warranted.

1664 Section 30. Section 459.0151, Florida Statutes, is created
 1665 to read:

1666 459.0151 Emergency procedures for disciplinary
 1667 action.--Notwithstanding any other provision of law to the
 1668 contrary:

1669 (1) Each osteopathic physician must report to the
 1670 Department of Health any judgment for medical negligence levied
 1671 against the physician. The osteopathic physician must make the
 1672 report no later than 15 days after the exhaustion of the last
 1673 opportunity for any party to appeal the judgment or request a
 1674 rehearing.

1675 (2) No later than 30 days after an osteopathic physician
 1676 has, within a 60-month period, made three reports as required by



1677 subsection (1), the Department of Health shall initiate an
 1678 emergency investigation and the Board of Osteopathic Medicine
 1679 shall conduct an emergency probable cause hearing to determine
 1680 whether the physician should be disciplined for a violation of
 1681 s. 459.015(1)(x) or any other relevant provision of law.

1682 Section 31. Subsection (6) of section 460.413, Florida
 1683 Statutes, is amended to read:

1684 460.413 Grounds for disciplinary action; action by board
 1685 or department.--

1686 (6) In any administrative action against a chiropractic
 1687 physician ~~which does not involve revocation or suspension of~~
 1688 ~~license~~, the department shall have the burden, by the greater
 1689 weight of the evidence, to establish the existence of grounds
 1690 for disciplinary action. ~~The department shall establish grounds~~
 1691 ~~for revocation or suspension of license by clear and convincing~~
 1692 ~~evidence.~~

1693 Section 32. Paragraph (s) of subsection (1) and paragraph
 1694 (a) of subsection (5) of section 461.013, Florida Statutes, are
 1695 amended to read:

1696 461.013 Grounds for disciplinary action; action by the
 1697 board; investigations by department.--

1698 (1) The following acts constitute grounds for denial of a
 1699 license or disciplinary action, as specified in s. 456.072(2):

1700 (s) Gross or repeated malpractice or the failure to
 1701 practice podiatric medicine at a level of care, skill, and
 1702 treatment which is recognized by a reasonably prudent podiatric
 1703 physician as being acceptable under similar conditions and
 1704 circumstances. The board shall give great weight to the
 1705 standards for malpractice in s. 766.102 in interpreting this
 1706 section. As used in this paragraph, "repeated malpractice"



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1707 includes, but is not limited to, three or more claims for
1708 medical malpractice within the previous 5-year period resulting
1709 in indemnities being paid in excess of \$50,000 ~~\$10,000~~ each to
1710 the claimant in a judgment or settlement and which incidents
1711 involved negligent conduct by the podiatric physicians. As used
1712 in this paragraph, "gross malpractice" or "the failure to
1713 practice podiatric medicine with the level of care, skill, and
1714 treatment which is recognized by a reasonably prudent similar
1715 podiatric physician as being acceptable under similar conditions
1716 and circumstances" shall not be construed so as to require more
1717 than one instance, event, or act.

1718 (5)(a) Upon the department's receipt from an insurer or
1719 self-insurer of a report of a closed claim against a podiatric
1720 physician pursuant to s. 627.912, or upon the receipt from a
1721 claimant of a presuit notice against a podiatric physician
1722 pursuant to s. 766.106, the department shall review each report
1723 and determine whether it potentially involved conduct by a
1724 licensee that is subject to disciplinary action, in which case
1725 the provisions of s. 456.073 shall apply. However, if it is
1726 reported that a podiatric physician has had three or more claims
1727 with indemnities exceeding \$50,000 ~~\$25,000~~ each within the
1728 previous 5-year period, the department shall investigate the
1729 occurrences upon which the claims were based and determine if
1730 action by the department against the podiatric physician is
1731 warranted.

1732 Section 33. Paragraph (x) of subsection (1) of section
1733 466.028, Florida Statutes, is amended to read:

1734 466.028 Grounds for disciplinary action; action by the
1735 board.--

1736 (1) The following acts constitute grounds for denial of a



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1737 license or disciplinary action, as specified in s. 456.072(2):
1738 (x) Being guilty of incompetence or negligence by failing
1739 to meet the minimum standards of performance in diagnosis and
1740 treatment when measured against generally prevailing peer
1741 performance, including, but not limited to, the undertaking of
1742 diagnosis and treatment for which the dentist is not qualified
1743 by training or experience or being guilty of dental malpractice.
1744 For purposes of this paragraph, it shall be legally presumed
1745 that a dentist is not guilty of incompetence or negligence by
1746 declining to treat an individual if, in the dentist's
1747 professional judgment, the dentist or a member of her or his
1748 clinical staff is not qualified by training and experience, or
1749 the dentist's treatment facility is not clinically satisfactory
1750 or properly equipped to treat the unique characteristics and
1751 health status of the dental patient, provided the dentist refers
1752 the patient to a qualified dentist or facility for appropriate
1753 treatment. As used in this paragraph, "dental malpractice"
1754 includes, but is not limited to, three or more claims within the
1755 previous 5-year period which resulted in indemnity being paid,
1756 or any single indemnity paid in excess of \$25,000 ~~\$5,000~~ in a
1757 judgment or settlement, as a result of negligent conduct on the
1758 part of the dentist.

1759 Section 34. Subsections (2) through (7) of section
1760 624.155, Florida Statutes, are renumbered as subsections (3)
1761 through (8), respectively, and a new subsection (2) is added to
1762 said section to read:

1763 624.155 Civil remedy.--

1764 (2) In all matters under this section relating to
1765 professional liability insurance coverage for medical
1766 negligence, and in determining whether the insurer acted fairly



1767 and honestly towards its insured with due regard for her or his
 1768 interest:

1769 (a)1. An insurer shall not be held in bad faith for
 1770 failure to pay its policy limits if it offers to pay policy
 1771 limits by the earlier of either:

1772 a. The 365th day after service of the complaint in the
 1773 medical negligence action upon the insured. The time period
 1774 specified in this sub-subparagraph shall be extended by an
 1775 additional 60 days upon motion of the insurer if the court finds
 1776 that, at any time during such period and after the 305th day
 1777 after service of the complaint, the claimant provided new
 1778 information relating to the identity or testimony of any
 1779 witnesses or the identity of any additional claimants or
 1780 defendants. Such an extension may be ordered each time the
 1781 claimant provides such new information after the 305th day after
 1782 service of the complaint and before expiration of the time
 1783 period provided in this sub-subparagraph, including any
 1784 extensions thereof; or

1785 b. The 60th day after the conclusion of all of the
 1786 following:

1787 (I) Deposition of all claimants named in the complaint or
 1788 amended complaint.

1789 (II) Deposition of all defendants named in the complaint
 1790 or amended complaint, including, in the case of a corporate
 1791 defendant, deposition of a designated representative.

1792 (III) Deposition of all of the claimant's expert
 1793 witnesses.

1794 (IV) Deposition of treating physicians identified by the
 1795 claimant as witnesses for trial.

1796 (V) Disclosure of witnesses and production of documents.



1797 (VI) Mediation.

1798 2. Either party may request that the court enter an order
1799 finding that the other party has unnecessarily or
1800 inappropriately delayed any of the events specified in sub-
1801 subparagraph 1.b. If the court finds that the claimant was
1802 responsible for such unnecessary or inappropriate delays, sub-
1803 subparagraph 1.a. shall not apply to the insurer's offer to pay.
1804 If the court finds that the defendant or insurer was responsible
1805 for such unnecessary or inappropriate delays, sub-subparagraph
1806 1.b. shall not apply to the insurer's offer to pay.

1807 3. The fact that the insurer did not offer to pay policy
1808 limits during the time periods specified in this paragraph is
1809 not presumptive evidence that the insurer acted in bad faith.

1810 (b) When paragraph (a) does not apply, the court, in
1811 determining whether an insurer has acted in bad faith, shall
1812 consider:

1813 1. The insurer's willingness to negotiate with the
1814 claimant in anticipation of settlement.

1815 2. The insurer's consideration of the advice of the
1816 insured's defense counsel.

1817 3. The propriety of the insurer's methods of investigating
1818 and evaluating the claim.

1819 4. Whether the insurer informed the insured of the offer
1820 to settle within the limits of coverage, the right to retain
1821 personal counsel, and the risk of litigation.

1822 5. Whether the insured denied liability or requested that
1823 the case be defended after the insurer fully advised the insured
1824 as to the facts and risks.

1825 6. Whether the claimant imposed any condition, other than
1826 the tender of the policy limits, on the settlement of the claim.



1827 7. Whether the claimant provided relevant information to
 1828 the insurer on a timely basis.

1829 8. Whether and when other defendants in the case settled
 1830 or were dismissed from the case.

1831 9. Whether there were multiple claimants seeking, in the
 1832 aggregate, compensation in excess of policy limits from the
 1833 defendant or the defendant's insurer.

1834 10. Whether the insured misrepresented material facts to
 1835 the insurer or made material omissions of fact to the insurer.

1836
 1837 Upon motion of either party for good cause shown, the court may
 1838 allow consideration of such additional factors as it determines
 1839 to be relevant.

1840 (c) In an action under this section brought by any person
 1841 other than the insured or a third-party claimant to whom the
 1842 insured has assigned his or her cause of action under paragraph
 1843 (d), damages may not exceed the lesser of:

- 1844 1. An amount equal to the insured's policy limits; or
- 1845 2. An amount equal to the excess judgment in the action
 1846 for medical negligence.

1847 (d) Nothing in this subsection shall be construed to
 1848 prohibit an insured from assigning a cause of action to a third-
 1849 party claimant for the insurer's failure to act fairly and
 1850 honestly towards its insured with due regard for the insured's
 1851 interest.

1852 (e) The award of damages under this subsection to all
 1853 first-party claimants and third-party claimants combined shall
 1854 not be in an aggregate amount exceeding the excess judgment.

1855 Section 35. Subsection (2) of section 624.462, Florida
 1856 Statutes, is amended to read:



1857 624.462 Commercial self-insurance funds.--

1858 (2) As used in ss. 624.460-624.488, "commercial self-
 1859 insurance fund" or "fund" means a group of members, operating
 1860 individually and collectively through a trust or corporation,
 1861 that must be:

1862 (a) Established by:

1863 1. A not-for-profit trade association, industry
 1864 association, or professional association of employers or
 1865 professionals which has a constitution or bylaws, which is
 1866 incorporated under the laws of this state, and which has been
 1867 organized for purposes other than that of obtaining or providing
 1868 insurance and operated in good faith for a continuous period of
 1869 1 year;

1870 2. A self-insurance trust fund organized pursuant to s.
 1871 627.357 and maintained in good faith for a continuous period of
 1872 1 year for purposes other than that of obtaining or providing
 1873 insurance pursuant to this section. Each member of a commercial
 1874 self-insurance trust fund established pursuant to this
 1875 subsection must maintain membership in the self-insurance trust
 1876 fund organized pursuant to s. 627.357; ~~or~~

1877 3. A group of 10 or more health care providers, as defined
 1878 in s. 627.351(4)(h); or

1879 ~~4.3.~~ A not-for-profit group comprised of no less than 10
 1880 condominium associations as defined in s. 718.103(2), which is
 1881 incorporated under the laws of this state, which restricts its
 1882 membership to condominium associations only, and which has been
 1883 organized and maintained in good faith for a continuous period
 1884 of 1 year for purposes other than that of obtaining or providing
 1885 insurance.

1886 (b)1. In the case of funds established pursuant to



1887 subparagraph (a)2. or subparagraph (a)~~4.3~~, operated pursuant to
 1888 a trust agreement by a board of trustees which shall have
 1889 complete fiscal control over the fund and which shall be
 1890 responsible for all operations of the fund. The majority of the
 1891 trustees shall be owners, partners, officers, directors, or
 1892 employees of one or more members of the fund. The trustees
 1893 shall have the authority to approve applications of members for
 1894 participation in the fund and to contract with an authorized
 1895 administrator or servicing company to administer the day-to-day
 1896 affairs of the fund.

1897 2. In the case of funds established pursuant to
 1898 subparagraph (a)1. or subparagraph (a)3., operated pursuant to a
 1899 trust agreement by a board of trustees or as a corporation by a
 1900 board of directors which board shall:

- 1901 a. Be responsible to members of the fund or beneficiaries
- 1902 of the trust or policyholders of the corporation;
- 1903 b. Appoint independent certified public accountants, legal
- 1904 counsel, actuaries, and investment advisers as needed;
- 1905 c. Approve payment of dividends to members;
- 1906 d. Approve changes in corporate structure; and
- 1907 e. Have the authority to contract with an administrator
- 1908 authorized under s. 626.88 to administer the day-to-day affairs
- 1909 of the fund including, but not limited to, marketing,
- 1910 underwriting, billing, collection, claims administration, safety
- 1911 and loss prevention, reinsurance, policy issuance, accounting,
- 1912 regulatory reporting, and general administration. The fees or
- 1913 compensation for services under such contract shall be
- 1914 comparable to the costs for similar services incurred by
- 1915 insurers writing the same lines of insurance, or where available
- 1916 such expenses as filed by boards, bureaus, and associations



1917 designated by insurers to file such data. A majority of the
 1918 trustees or directors shall be owners, partners, officers,
 1919 directors, or employees of one or more members of the fund.

1920 Section 36. Subsections (7), (8), and (9) are added to
 1921 section 627.062, Florida Statutes, to read:

1922 627.062 Rate standards.--

1923 (7)(a) The provisions of this subsection apply only with
 1924 respect to rates for medical malpractice insurance and shall
 1925 control to the extent of any conflict with other provisions of
 1926 this section.

1927 (b) Any portion of a judgment entered or settlement paid
 1928 as a result of a statutory or common-law bad faith action and
 1929 any portion of a judgment entered which awards punitive damages
 1930 against an insurer may not be included in the insurer's rate
 1931 base and shall not be used to justify a rate or rate change. Any
 1932 common-law bad faith action identified as such and any portion
 1933 of a settlement entered as a result of a statutory or portion of
 1934 a settlement wherein an insurer agrees to pay specific punitive
 1935 damages may not be used to justify a rate or rate change. The
 1936 portion of the taxable costs and attorney's fees which is
 1937 identified as being related to the bad faith and punitive
 1938 damages in these judgments and settlements may not be included
 1939 in the insurer's rate base and may not be utilized to justify a
 1940 rate or rate change.

1941 (c) Upon reviewing a rate filing and determining whether
 1942 the rate is excessive, inadequate, or unfairly discriminatory,
 1943 the Office of Insurance Regulation shall consider, in accordance
 1944 with generally accepted and reasonable actuarial techniques,
 1945 past and present prospective loss experience, either using loss
 1946 experience solely for this state or giving greater credibility



1947 to this state's loss data.

1948 (d) Rates shall be deemed excessive if, among other
 1949 standards established by this section, the rate structure
 1950 provides for replenishment of reserves or surpluses from
 1951 premiums when the replenishment is attributable to investment
 1952 losses.

1953 (e) The insurer must apply a discount or surcharge based
 1954 on the health care provider's loss experience or shall establish
 1955 an alternative method giving due consideration to the provider's
 1956 loss experience. The insurer must include in the filing a copy
 1957 of the surcharge or discount schedule or a description of the
 1958 alternative method used and must provide a copy of such schedule
 1959 or description, as approved by the office, to policyholders at
 1960 the time of renewal and to prospective policyholders at the time
 1961 of application for coverage.

1962 (8) Each insurer writing professional liability insurance
 1963 coverage for medical negligence must make a rate filing under
 1964 this section with the Office of Insurance Regulation at least
 1965 once each calendar year.

1966 (9)(a) Medical malpractice insurance companies shall
 1967 submit a rate filing effective January 1, 2004, to the Office of
 1968 Insurance Regulation no earlier than 30 days, but no later than
 1969 120 days, after the date upon which this act becomes law which
 1970 reduces rates by a presumed factor that reflects the impact the
 1971 changes contained in all medical malpractice legislation enacted
 1972 by the Florida Legislature in 2003 will have on such rates, as
 1973 determined by the Office of Insurance Regulation. In determining
 1974 the presumed factor, the office shall use generally accepted
 1975 actuarial techniques and standards provided in this section in
 1976 determining the expected impact on losses, expenses, and



1977 investment income of the insurer. Inclusion in the presumed
 1978 factor of the expected impact of such legislation shall be held
 1979 in abeyance during the review of such measure's validity in any
 1980 proceeding by a court of competent jurisdiction.

1981 (b) Any insurer or rating organization that contends that
 1982 the rate provided for in paragraph (a) is excessive, inadequate,
 1983 or unfairly discriminatory shall separately state in its filing
 1984 the rate it contends is appropriate and shall state with
 1985 specificity the factors or data that it contends should be
 1986 considered in order to produce such appropriate rate. The
 1987 insurer or rating organization shall be permitted to use all of
 1988 the generally accepted actuarial techniques provided in this
 1989 section in making any filing pursuant to this subsection. The
 1990 Office of Insurance Regulation shall review each such exception
 1991 and approve or disapprove it prior to use. It shall be the
 1992 insurer's burden to actuarially justify any deviations from the
 1993 rates filed under paragraph (a). Each insurer or rating
 1994 organization shall include in the filing the expected impact of
 1995 all malpractice legislation enacted by the Florida Legislature
 1996 in 2003 on losses, expenses, and rates. If any provision of this
 1997 act is held invalid by a court of competent jurisdiction, the
 1998 department shall permit an adjustment of all rates filed under
 1999 this section to reflect the impact of such holding on such rates
 2000 so as to ensure that the rates are not excessive, inadequate, or
 2001 unfairly discriminatory.

2002 Section 37. Subsection (10) of section 627.357, Florida
 2003 Statutes, is amended to read:

2004 627.357 Medical malpractice self-insurance.--

2005 (10)(a) An application to form a self-insurance fund under
 2006 this section must be filed with the Office of Insurance



2007 Regulation.

2008 (b) The Office of Insurance Regulation must ensure that
 2009 self-insurance funds remain solvent and provide insurance
 2010 coverage purchased by participants. The Financial Services
 2011 Commission may adopt rules pursuant to ss. 120.536(1) and 120.54
 2012 to implement this subsection ~~A self-insurance fund may not be~~
 2013 ~~formed under this section after October 1, 1992.~~

2014 Section 38. Section 627.3575, Florida Statutes, is created
 2015 to read:

2016 627.3575 Health Care Professional Liability Insurance
 2017 Facility.--

2018 (1) FACILITY CREATED; PURPOSE; STATUS.--There is created
 2019 the Health Care Professional Liability Insurance Facility. The
 2020 facility is intended to meet ongoing availability and
 2021 affordability problems relating to liability insurance for
 2022 health care professionals by providing an affordable, self-
 2023 supporting source of professional liability insurance coverage
 2024 with a high deductible for those professionals who are willing
 2025 and able to self-insure for smaller losses. The facility shall
 2026 operate on a not-for-profit basis. The facility is self-funding
 2027 and is intended to serve a public purpose but is not a state
 2028 agency or program, and no activity of the facility shall create
 2029 any state liability.

2030 (2) GOVERNANCE; POWERS.--

2031 (a) The facility shall operate under a seven-member board
 2032 of governors consisting of the Secretary of Health, three
 2033 members appointed by the Governor, and three members appointed
 2034 by the Chief Financial Officer. The board shall be chaired by
 2035 the Secretary of Health. The secretary shall serve by virtue of
 2036 his or her office, and the other members of the board shall



2037 serve terms concurrent with the term of office of the official
 2038 who appointed them. Any vacancy on the board shall be filled in
 2039 the same manner as the original appointment. Members serve at
 2040 the pleasure of the official who appointed them. Members are not
 2041 eligible for compensation for their service on the board, but
 2042 the facility may reimburse them for per diem and travel expenses
 2043 at the same levels as are provided in s. 112.061 for state
 2044 employees.

2045 (b) The facility shall have such powers as are necessary
 2046 to operate as an insurer, including the power to:

2047 1. Sue and be sued.

2048 2. Hire such employees and retain such consultants,
 2049 attorneys, actuaries, and other professionals as it deems
 2050 appropriate.

2051 3. Contract with such service providers as it deems
 2052 appropriate.

2053 4. Maintain offices appropriate to the conduct of its
 2054 business.

2055 5. Take such other actions as are necessary or appropriate
 2056 in fulfillment of its responsibilities under this section.

2057 (3) COVERAGE PROVIDED.--The facility shall provide
 2058 liability insurance coverage for health care professionals. The
 2059 facility shall allow policyholders to select only from policies
 2060 with deductibles of \$25,000 per claim, \$50,000 per claim, and
 2061 \$100,000 per claim and with coverage limits of \$250,000 per
 2062 claim and \$750,000 annual aggregate and \$1 million per claim and
 2063 \$3 million annual aggregate. To the greatest extent possible,
 2064 the terms and conditions of the policies shall be consistent
 2065 with terms and conditions commonly used by professional
 2066 liability insurers.



2067 (4) ELIGIBILITY; TERMINATION.--

2068 (a) Any health care professional is eligible for coverage
 2069 provided by the facility if the professional at all times
 2070 maintains either:

2071 1. An escrow account consisting of cash or assets eligible
 2072 for deposit under s. 625.52 in an amount equal to the deductible
 2073 amount of the policy; or

2074 2. An unexpired, irrevocable letter of credit, established
 2075 pursuant to chapter 675, in an amount not less than the
 2076 deductible amount of the policy. The letter of credit shall be
 2077 payable to the health care professional as beneficiary upon
 2078 presentment of a final judgment indicating liability and
 2079 awarding damages to be paid by the physician or upon presentment
 2080 of a settlement agreement signed by all parties to such
 2081 agreement when such final judgment or settlement is a result of
 2082 a claim arising out of the rendering of, or the failure to
 2083 render, medical care and services. Such letter of credit shall
 2084 be nonassignable and nontransferable. Such letter of credit
 2085 shall be issued by any bank or savings association organized and
 2086 existing under the laws of this state or any bank or savings
 2087 association organized under the laws of the United States that
 2088 has its principal place of business in this state or has a
 2089 branch office which is authorized under the laws of this state
 2090 or of the United States to receive deposits in this state.

2091 (b) The eligibility of a health care professional for
 2092 coverage terminates upon:

2093 1. The failure of the professional to comply with
 2094 paragraph (a);

2095 2. The failure of the professional to timely pay premiums
 2096 or assessments; or



2097 3. The commission of any act of fraud in connection with
 2098 the policy, as determined by the board of governors.

2099 (c) The board of governors, in its discretion, may
 2100 reinstate the eligibility of a health care professional whose
 2101 eligibility has terminated pursuant to paragraph (b) upon
 2102 determining that the professional has come back into compliance
 2103 with paragraph (a) or has paid the overdue premiums or
 2104 assessments. Eligibility may be reinstated in the case of fraud
 2105 only if the board determines that its initial determination of
 2106 fraud was in error.

2107 (5) PREMIUMS; ASSESSMENTS.--

2108 (a) The facility shall charge the actuarially indicated
 2109 rate for the coverage provided plus a component for debt service
 2110 and shall retain the services of consulting actuaries to prepare
 2111 its rate filings. The facility shall not provide dividends to
 2112 policyholders, and, to the extent that premiums are more than
 2113 the amount required to cover claims and expenses, such excess
 2114 shall be retained by the facility for payment of future claims.
 2115 In the event of dissolution of the facility, any amounts not
 2116 required as a reserve for outstanding claims shall be
 2117 transferred to the policyholders of record as of the last day of
 2118 operation.

2119 (b) In the event that the premiums for a particular year,
 2120 together with any investment income or reinsurance recoveries
 2121 attributable to that year, are insufficient to pay losses
 2122 arising out of claims accruing in that year, the facility shall
 2123 levy assessments against all of the persons who were its
 2124 policyholders in that year in a uniform percentage of premium.
 2125 Each policyholder's assessment shall be such percentage of the
 2126 premium that policyholder paid for coverage for the year to



2127 which the insufficiency is attributable.

2128 (c) The policyholder is personally liable for any
2129 assessment. The failure to timely pay an assessment is grounds
2130 for suspension or revocation of the policyholder's professional
2131 license by the appropriate licensing entity.

2132 (6) REGULATION; APPLICABILITY OF OTHER STATUTES.--

2133 (a) The facility shall operate pursuant to a plan of
2134 operation approved by order of the Office of Insurance
2135 Regulation of the Financial Services Commission. The board of
2136 governors may at any time adopt amendments to the plan of
2137 operation and submit the amendments to the Office of Insurance
2138 Regulation for approval.

2139 (b) The facility is subject to regulation by the Office of
2140 Insurance Regulation of the Financial Services Commission in the
2141 same manner as other insurers, except that, in recognition of
2142 the fact that its ability to levy assessments against its own
2143 policyholders is a substitute for the protections ordinarily
2144 afforded by such statutory requirements, the facility is exempt
2145 from statutory requirements relating to surplus as to
2146 policyholders.

2147 (c) The facility is not subject to part II of chapter 631,
2148 relating to the Florida Insurance Guaranty Association.

2149 (d) The Financial Service Commission may adopt rules to
2150 provide for the regulation of the facility consistent with the
2151 provisions of this section.

2152 (7) STARTUP PROVISIONS.--

2153 (a) It is the intent of the Legislature that the facility
2154 begin providing coverage no later than January 1, 2004.

2155 (b) The Governor and the Chief Financial Officer shall
2156 make their appointments to the board of governors of the



2157 facility no later than August 1, 2003. Until the board is
 2158 appointed, the Secretary of Health may perform ministerial acts
 2159 on behalf of the facility as chair of the board of governors.

2160 (c) Until the facility is able to hire permanent staff and
 2161 enter into contracts for professional services, the office of
 2162 the Secretary of Health shall provide support services to the
 2163 facility.

2164 (d) In order to provide startup funds for the facility,
 2165 the board of governors may incur debt or enter into agreements
 2166 for lines of credit, provided that the sole source of funds for
 2167 repayment of any debt is future premium revenues of the
 2168 facility. The amount of such debt or lines of credit may not
 2169 exceed \$10 million.

2170 Section 39. Subsection (1) of section 627.4147, Florida
 2171 Statutes, is amended to read:

2172 627.4147 Medical malpractice insurance contracts.--

2173 (1) In addition to any other requirements imposed by law,
 2174 each self-insurance policy as authorized under s. 627.357 or
 2175 insurance policy providing coverage for claims arising out of
 2176 the rendering of, or the failure to render, medical care or
 2177 services, including those of the Florida Medical Malpractice
 2178 Joint Underwriting Association, shall include:

2179 (a) A clause requiring the insured to cooperate fully in
 2180 the review process prescribed under s. 766.106 if a notice of
 2181 intent to file a claim for medical malpractice is made against
 2182 the insured.

2183 ~~(b)1. Except as provided in subparagraph 2., a clause~~
 2184 ~~authorizing the insurer or self-insurer to determine, to make,~~
 2185 ~~and to conclude, without the permission of the insured, any~~
 2186 ~~offer of admission of liability and for arbitration pursuant to~~



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2187 ~~s. 766.106, settlement offer, or offer of judgment, if the offer~~
2188 ~~is within the policy limits. It is against public policy for any~~
2189 ~~insurance or self-insurance policy to contain a clause giving~~
2190 ~~the insured the exclusive right to veto any offer for admission~~
2191 ~~of liability and for arbitration made pursuant to s. 766.106,~~
2192 ~~settlement offer, or offer of judgment, when such offer is~~
2193 ~~within the policy limits. However, any offer of admission of~~
2194 ~~liability, settlement offer, or offer of judgment made by an~~
2195 ~~insurer or self-insurer shall be made in good faith and in the~~
2196 ~~best interests of the insured.~~

2197 ~~2.a. With respect to dentists licensed under chapter 466,~~
2198 ~~a clause clearly stating whether or not the insured has the~~
2199 ~~exclusive right to veto any offer of admission of liability and~~
2200 ~~for arbitration pursuant to s. 766.106, settlement offer, or~~
2201 ~~offer of judgment if the offer is within policy limits. An~~
2202 ~~insurer or self-insurer shall not make or conclude, without the~~
2203 ~~permission of the insured, any offer of admission of liability~~
2204 ~~and for arbitration pursuant to s. 766.106, settlement offer, or~~
2205 ~~offer of judgment, if such offer is outside the policy limits.~~
2206 ~~However, any offer for admission of liability and for~~
2207 ~~arbitration made under s. 766.106, settlement offer, or offer of~~
2208 ~~judgment made by an insurer or self-insurer shall be made in~~
2209 ~~good faith and in the best interest of the insured.~~

2210 ~~b. If the policy contains a clause stating the insured~~
2211 ~~does not have the exclusive right to veto any offer or admission~~
2212 ~~of liability and for arbitration made pursuant to s. 766.106,~~
2213 ~~settlement offer or offer of judgment, the insurer or self-~~
2214 ~~insurer shall provide to the insured or the insured's legal~~
2215 ~~representative by certified mail, return receipt requested, a~~
2216 ~~copy of the final offer of admission of liability and for~~



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2217 ~~arbitration made pursuant to s. 766.106, settlement offer or~~
 2218 ~~offer of judgment and at the same time such offer is provided to~~
 2219 ~~the claimant. A copy of any final agreement reached between the~~
 2220 ~~insurer and claimant shall also be provided to the insurer or~~
 2221 ~~his or her legal representative by certified mail, return~~
 2222 ~~receipt requested not more than 10 days after affecting such~~
 2223 ~~agreement.~~

2224 (b)(e) A clause requiring the insurer or self-insurer to
 2225 notify the insured no less than 90 ~~60~~ days prior to the
 2226 effective date of cancellation of the policy or contract and, in
 2227 the event of a determination by the insurer or self-insurer not
 2228 to renew the policy or contract, to notify the insured no less
 2229 than 90 ~~60~~ days prior to the end of the policy or contract
 2230 period. If cancellation or nonrenewal is due to nonpayment or
 2231 loss of license, 10 days' notice is required.

2232 (d) A clause requiring the insurer or self-insurer to
 2233 notify the insured no less than 60 days prior to the effective
 2234 date of a rate increase. The provisions of s. 627.4133 shall
 2235 apply to such notice and to the failure of the insurer to
 2236 provide such notice to the extent not in conflict with this
 2237 section.

2238 Section 40. Subsections (1) and (4) and paragraph (n) of
 2239 subsection (2) of section 627.912, Florida Statutes, are amended
 2240 to read:

2241 627.912 Professional liability claims and actions; reports
 2242 by insurers.--

2243 (1)(a) Each self-insurer authorized under s. 627.357 and
 2244 each insurer or joint underwriting association providing
 2245 professional liability insurance to a practitioner of medicine
 2246 licensed under chapter 458, to a practitioner of osteopathic



2247 medicine licensed under chapter 459, to a podiatric physician
 2248 licensed under chapter 461, to a dentist licensed under chapter
 2249 466, to a hospital licensed under chapter 395, to a crisis
 2250 stabilization unit licensed under part IV of chapter 394, to a
 2251 health maintenance organization certificated under part I of
 2252 chapter 641, to clinics included in chapter 390, to an
 2253 ambulatory surgical center as defined in s. 395.002, or to a
 2254 member of The Florida Bar shall report in duplicate to the
 2255 Department of Insurance any claim or action for damages for
 2256 personal injuries claimed to have been caused by error,
 2257 omission, or negligence in the performance of such insured's
 2258 professional services or based on a claimed performance of
 2259 professional services without consent, if the claim resulted in:

2260 1.(a) A final judgment in any amount.

2261 2.(b) A settlement in any amount.

2262
 2263 Reports shall be filed with the department.

2264 (b) In addition to the requirements of paragraph (a), if
 2265 the insured party is licensed under chapter 395, chapter 458,
 2266 chapter 459, chapter 461, or chapter 466, the insurer shall
 2267 report in duplicate to the Office of Insurance Regulation any
 2268 other disposition of the claim, including, but not limited to, a
 2269 dismissal. If the insured is licensed under chapter 458, chapter
 2270 459, or chapter 461, any claim that resulted in a final judgment
 2271 or settlement in the amount of \$50,000 or more shall be reported
 2272 to the Department of Health no later than 30 days following the
 2273 occurrence of that event. If the insured is licensed under
 2274 chapter 466, any claim that resulted in a final judgment or
 2275 settlement in the amount of \$25,000 or more shall be reported to
 2276 the Department of Health no later than 30 days following the



2277 occurrence of that event ~~and, if the insured party is licensed~~
 2278 ~~under chapter 458, chapter 459, chapter 461, or chapter 466,~~
 2279 ~~with the Department of Health, no later than 30 days following~~
 2280 ~~the occurrence of any event listed in paragraph (a) or paragraph~~
 2281 ~~(b).~~ The Department of Health shall review each report and
 2282 determine whether any of the incidents that resulted in the
 2283 claim potentially involved conduct by the licensee that is
 2284 subject to disciplinary action, in which case the provisions of
 2285 s. 456.073 shall apply. The Department of Health, as part of the
 2286 annual report required by s. 456.026, shall publish annual
 2287 statistics, without identifying licensees, on the reports it
 2288 receives, including final action taken on such reports by the
 2289 Department of Health or the appropriate regulatory board.

2290 (2) The reports required by subsection (1) shall contain:

2291 (n) Any other information required by the department to
 2292 analyze and evaluate the nature, causes, location, cost, and
 2293 damages involved in professional liability cases. The Financial
 2294 Services Commission shall adopt by rule requirements for
 2295 additional information to assist the Office of Insurance
 2296 Regulation in its analysis and evaluation of the nature, causes,
 2297 location, cost, and damages involved in professional liability
 2298 cases reported by insurers under this section.

2299 (4) There shall be no liability on the part of, and no
 2300 cause of action of any nature shall arise against, any insurer
 2301 reporting hereunder or its agents or employees or the department
 2302 or its employees for any action taken by them under this
 2303 section. The department shall ~~may~~ impose a fine of \$250 per day
 2304 per case, but not to exceed a total of \$10,000 ~~\$1,000~~ per case,
 2305 against an insurer that violates the requirements of this
 2306 section. This subsection applies to claims accruing on or after



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2307 October 1, 1997.

2308 Section 41. Section 627.9121, Florida Statutes, is created
2309 to read:

2310 627.9121 Required reporting of claims; penalties.--Each
2311 entity that makes payment under a policy of insurance, self-
2312 insurance, or otherwise in settlement, partial settlement, or
2313 satisfaction of a judgment in a medical malpractice action or
2314 claim that is required to report information to the National
2315 Practitioner Data Bank under 42 U.S.C. s. 11131 must also report
2316 the same information to the Office of Insurance Regulation. The
2317 office shall include such information in the data that it
2318 compiles under s. 627.912. The office must compile and review
2319 the data collected pursuant to this section and must assess an
2320 administrative fine on any entity that fails to fully comply
2321 with such reporting requirements.

2322 Section 42. Subsections (12), (13), and (18) of section
2323 641.19, Florida Statutes, are amended to read:

2324 641.19 Definitions.--As used in this part, the term:

2325 (12) "Health maintenance contract" means any contract
2326 entered into by a health maintenance organization with a
2327 subscriber or group of subscribers to provide coverage for
2328 comprehensive health care services in exchange for a prepaid per
2329 capita or prepaid aggregate fixed sum.

2330 (13) "Health maintenance organization" means any
2331 organization authorized under this part which:

2332 (a) Provides, through arrangements with other persons,
2333 emergency care, inpatient hospital services, physician care
2334 including care provided by physicians licensed under chapters
2335 458, 459, 460, and 461, ambulatory diagnostic treatment, and
2336 preventive health care services.†



2337 (b) Provides, either directly or through arrangements with
 2338 other persons, health care services to persons enrolled with
 2339 such organization, on a prepaid per capita or prepaid aggregate
 2340 fixed-sum basis.†

2341 (c) Provides, either directly or through arrangements with
 2342 other persons, comprehensive health care services which
 2343 subscribers are entitled to receive pursuant to a contract.†

2344 (d) Provides physician services, by physicians licensed
 2345 under chapters 458, 459, 460, and 461, directly through
 2346 physicians who are either employees or partners of such
 2347 organization or under arrangements with a physician or any group
 2348 of physicians.†~~and~~

2349 (e) If offering services through a managed care system,
 2350 then the managed care system must be a system in which a primary
 2351 physician licensed under chapter 458 or chapter 459 and chapters
 2352 460 and 461 is designated for each subscriber upon request of a
 2353 subscriber requesting service by a physician licensed under any
 2354 of those chapters, and is responsible for coordinating the
 2355 health care of the subscriber of the respectively requested
 2356 service and for referring the subscriber to other providers of
 2357 the same discipline when necessary. Each female subscriber may
 2358 select as her primary physician an obstetrician/gynecologist who
 2359 has agreed to serve as a primary physician and is in the health
 2360 maintenance organization's provider network.

2361 (f) Except in cases in which the health care provider is
 2362 an employee of the health maintenance organization, the fact
 2363 that the health maintenance organization arranges for the
 2364 provision of health care services under this chapter does not
 2365 create an actual agency, apparent agency, or employer-employee
 2366 relationship between the health care provider and the health



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2367 maintenance organization for purposes of vicarious liability for
 2368 the medical negligence of the health care provider.

2369 (18) "Subscriber" means an entity or individual who has
 2370 contracted, or on whose behalf a contract has been entered into,
 2371 with a health maintenance organization for health care coverage
 2372 ~~services~~ or other persons who also receive health care coverage
 2373 ~~services~~ as a result of the contract.

2374 Section 43. Subsection (3) of section 641.51, Florida
 2375 Statutes, is amended to read:

2376 641.51 Quality assurance program; second medical opinion
 2377 requirement.--

2378 (3) The health maintenance organization shall not have the
 2379 right to control the professional judgment of a physician
 2380 licensed under chapter 458, chapter 459, chapter 460, or chapter
 2381 461 concerning the proper course of treatment of a subscriber
 2382 ~~shall not be subject to modification by the organization or its~~
 2383 ~~board of directors, officers, or administrators, unless the~~
 2384 ~~course of treatment prescribed is inconsistent with the~~
 2385 ~~prevailing standards of medical practice in the community.~~
 2386 However, this subsection shall not be considered to restrict a
 2387 utilization management program established by an organization or
 2388 to affect an organization's decision as to payment for covered
 2389 services. Except in cases in which the health care provider is
 2390 an employee of the health maintenance organization, the health
 2391 maintenance organization shall not be vicariously liable for the
 2392 medical negligence of the health care provider, whether such
 2393 claim is alleged under a theory of actual agency, apparent
 2394 agency, or employer-employee relationship.

2395 Section 44. Section 766.102, Florida Statutes, is amended
 2396 to read:



2397 766.102 Medical negligence; standards of recovery; expert
 2398 witness.--

2399 (1) In any action for recovery of damages based on the
 2400 death or personal injury of any person in which it is alleged
 2401 that such death or injury resulted from the negligence of a
 2402 health care provider as defined in s. 768.50(2)(b), the claimant
 2403 shall have the burden of proving by the greater weight of
 2404 evidence that the alleged actions of the health care provider
 2405 represented a breach of the prevailing professional standard of
 2406 care for that health care provider. The prevailing professional
 2407 standard of care for a given health care provider shall be that
 2408 level of care, skill, and treatment which, in light of all
 2409 relevant surrounding circumstances, is recognized as acceptable
 2410 and appropriate by reasonably prudent similar health care
 2411 providers.

2412 ~~(2)(a) If the health care provider whose negligence is~~
 2413 ~~claimed to have created the cause of action is not certified by~~
 2414 ~~the appropriate American board as being a specialist, is not~~
 2415 ~~trained and experienced in a medical specialty, or does not hold~~
 2416 ~~himself or herself out as a specialist, a "similar health care~~
 2417 ~~provider" is one who:~~

2418 1. ~~Is licensed by the appropriate regulatory agency of~~
 2419 ~~this state;~~

2420 2. ~~Is trained and experienced in the same discipline or~~
 2421 ~~school of practice; and~~

2422 3. ~~Practices in the same or similar medical community.~~

2423 ~~(b) If the health care provider whose negligence is~~
 2424 ~~claimed to have created the cause of action is certified by the~~
 2425 ~~appropriate American board as a specialist, is trained and~~
 2426 ~~experienced in a medical specialty, or holds himself or herself~~



2427 ~~out as a specialist, a "similar health care provider" is one~~
 2428 ~~who:~~

- 2429 ~~1. Is trained and experienced in the same specialty; and~~
- 2430 ~~2. Is certified by the appropriate American board in the~~
- 2431 ~~same specialty.~~

2432
 2433 ~~However, if any health care provider described in this paragraph~~
 2434 ~~is providing treatment or diagnosis for a condition which is not~~
 2435 ~~within his or her specialty, a specialist trained in the~~
 2436 ~~treatment or diagnosis for that condition shall be considered a~~
 2437 ~~"similar health care provider."~~

2438 ~~(c) The purpose of this subsection is to establish a~~
 2439 ~~relative standard of care for various categories and~~
 2440 ~~classifications of health care providers. Any health care~~
 2441 ~~provider may testify as an expert in any action if he or she:~~

- 2442 ~~1. Is a similar health care provider pursuant to paragraph~~
- 2443 ~~(a) or paragraph (b); or~~
- 2444 ~~2. Is not a similar health care provider pursuant to~~
- 2445 ~~paragraph (a) or paragraph (b) but, to the satisfaction of the~~
- 2446 ~~court, possesses sufficient training, experience, and knowledge~~
- 2447 ~~as a result of practice or teaching in the specialty of the~~
- 2448 ~~defendant or practice or teaching in a related field of~~
- 2449 ~~medicine, so as to be able to provide such expert testimony as~~
- 2450 ~~to the prevailing professional standard of care in a given field~~
- 2451 ~~of medicine. Such training, experience, or knowledge must be as~~
- 2452 ~~a result of the active involvement in the practice or teaching~~
- 2453 ~~of medicine within the 5 year period before the incident giving~~
- 2454 ~~rise to the claim.~~

2455 ~~(2)(3)(a)~~ If the injury is claimed to have resulted from
 2456 the negligent affirmative medical intervention of the health



2457 care provider, the claimant must, in order to prove a breach of
 2458 the prevailing professional standard of care, show that the
 2459 injury was not within the necessary or reasonably foreseeable
 2460 results of the surgical, medicinal, or diagnostic procedure
 2461 constituting the medical intervention, if the intervention from
 2462 which the injury is alleged to have resulted was carried out in
 2463 accordance with the prevailing professional standard of care by
 2464 a reasonably prudent similar health care provider.

2465 (b) The provisions of this subsection shall apply only
 2466 when the medical intervention was undertaken with the informed
 2467 consent of the patient in compliance with the provisions of s.
 2468 766.103.

2469 ~~(3)~~(4) The existence of a medical injury shall not create
 2470 any inference or presumption of negligence against a health care
 2471 provider, and the claimant must maintain the burden of proving
 2472 that an injury was proximately caused by a breach of the
 2473 prevailing professional standard of care by the health care
 2474 provider. However, the discovery of the presence of a foreign
 2475 body, such as a sponge, clamp, forceps, surgical needle, or
 2476 other paraphernalia commonly used in surgical, examination, or
 2477 diagnostic procedures, shall be prima facie evidence of
 2478 negligence on the part of the health care provider.

2479 ~~(4)~~(5) The Legislature is cognizant of the changing trends
 2480 and techniques for the delivery of health care in this state and
 2481 the discretion that is inherent in the diagnosis, care, and
 2482 treatment of patients by different health care providers. The
 2483 failure of a health care provider to order, perform, or
 2484 administer supplemental diagnostic tests shall not be actionable
 2485 if the health care provider acted in good faith and with due
 2486 regard for the prevailing professional standard of care.



2487 (5) A person may not give expert testimony concerning the
 2488 prevailing professional standard of care unless that person is a
 2489 licensed health care provider and meets the following criteria:

2490 (a) If the party against whom or on whose behalf the
 2491 testimony is offered is a specialist, the expert witness must:

2492 1. Specialize in the same specialty as the party against
 2493 whom or on whose behalf the testimony is offered; or

2494 2. Specialize in a similar specialty that includes the
 2495 evaluation, diagnosis, or treatment of the medical condition
 2496 that is the subject of the claim and have prior experience
 2497 treating similar patients.

2498 (b) Has devoted professional time during the 3 years
 2499 immediately preceding the date of the occurrence that is the
 2500 basis for the action to:

2501 1. The active clinical practice of, or consulting with
 2502 respect to, the same or similar health profession as the health
 2503 care provider against whom or on whose behalf the testimony is
 2504 offered and, if that health care provider is a specialist, the
 2505 active clinical practice of, or consulting with respect to, the
 2506 same or similar specialty that includes the evaluation,
 2507 diagnosis, or treatment of the medical condition that is the
 2508 subject of the claim and have prior experience treating similar
 2509 patients;

2510 2. The instruction of students in an accredited health
 2511 professional school or accredited residency program in the same
 2512 or similar health profession in which the health care provider
 2513 against whom or on whose behalf the testimony is offered and, if
 2514 that health care provider is a specialist, an accredited health
 2515 professional school or accredited residency or clinical research
 2516 program in the same or similar specialty; or



2517 3. A clinical research program that is affiliated with an
 2518 accredited medical school or teaching hospital and that is in
 2519 the same or similar health profession as the health care
 2520 provider against whom or on whose behalf the testimony is
 2521 offered and, if that health care provider is a specialist, a
 2522 clinical research program that is affiliated with an accredited
 2523 health professional school or accredited residency or clinical
 2524 research program in the same or similar specialty.

2525 (c) If the party against whom or on whose behalf the
 2526 testimony is offered is a general practitioner, the expert
 2527 witness must have devoted professional time during the 5 years
 2528 immediately preceding the date of the occurrence that is the
 2529 basis for the action to:

2530 1. Active clinical practice or consultation as a general
 2531 practitioner;

2532 2. Instruction of students in an accredited health
 2533 professional school or accredited residency program in the
 2534 general practice of medicine; or

2535 3. A clinical research program that is affiliated with an
 2536 accredited medical school or teaching hospital and that is in
 2537 the general practice of medicine.

2538 (6) A physician licensed under chapter 458 or chapter 459
 2539 who qualifies as an expert witness under subsection (5) and who,
 2540 by reason of active clinical practice or instruction of
 2541 students, has knowledge of the applicable standard of care for
 2542 nurses, nurse practitioners, certified registered nurse
 2543 anesthetists, certified registered nurse midwives, physician
 2544 assistants, or other medical support staff may give expert
 2545 testimony in a medical malpractice action with respect to the
 2546 standard of care of such medical support staff.



2547 (7) Notwithstanding subsection (5), in a medical
 2548 malpractice action against a hospital, health care facility, or
 2549 medical facility, a person may give expert testimony on the
 2550 appropriate standard of care as to administrative and other
 2551 nonclinical issues if the person has substantial knowledge, by
 2552 virtue of his or her training and experience, concerning the
 2553 standard of care among hospitals, health care facilities, or
 2554 medical facilities of the same type as the hospital, health care
 2555 facility, or medical facility whose acts or omissions are the
 2556 subject of the testimony and which are located in the same or
 2557 similar communities at the time of the alleged act giving rise
 2558 to the cause of action.

2559 (8) If a health care provider described in subsection (5),
 2560 subsection (6), or subsection (7) is providing evaluation,
 2561 treatment, or diagnosis for a condition that is not within his
 2562 or her specialty, a specialist trained in the evaluation,
 2563 treatment, or diagnosis for that condition shall be considered a
 2564 similar health care provider.

2565 (9)~~(6)~~(a) In any action for damages involving a claim of
 2566 negligence against a physician licensed under chapter 458,
 2567 osteopathic physician licensed under chapter 459, podiatric
 2568 physician licensed under chapter 461, or chiropractic physician
 2569 licensed under chapter 460 providing emergency medical services
 2570 in a hospital emergency department, the court shall admit expert
 2571 medical testimony only from physicians, osteopathic physicians,
 2572 podiatric physicians, and chiropractic physicians who have had
 2573 substantial professional experience within the preceding 5 years
 2574 while assigned to provide emergency medical services in a
 2575 hospital emergency department.

2576 (b) For the purposes of this subsection:



2577 1. The term "emergency medical services" means those
 2578 medical services required for the immediate diagnosis and
 2579 treatment of medical conditions which, if not immediately
 2580 diagnosed and treated, could lead to serious physical or mental
 2581 disability or death.

2582 2. "Substantial professional experience" shall be
 2583 determined by the custom and practice of the manner in which
 2584 emergency medical coverage is provided in hospital emergency
 2585 departments in the same or similar localities where the alleged
 2586 negligence occurred.

2587 (10) In any action alleging medical malpractice, an expert
 2588 witness may not testify on a contingency fee basis.

2589 (11) Any attorney who proffers a person as an expert
 2590 witness pursuant to this section must certify that such person
 2591 has not been found guilty of fraud or perjury in any
 2592 jurisdiction.

2593 (12) This section does not limit the power of the trial
 2594 court to disqualify or qualify an expert witness on grounds
 2595 other than the qualifications in this section.

2596 Section 45. Subsections (2), (3), (4), and (7) of section
 2597 766.106, Florida Statutes, are amended, and subsections (13) and
 2598 (14) are added to said section, to read:

2599 766.106 Notice before filing action for medical
 2600 malpractice; presuit screening period; offers for admission of
 2601 liability and for arbitration; informal discovery; review.--

2602 (2)(a) After completion of presuit investigation pursuant
 2603 to s. 766.203 and prior to filing a claim for medical
 2604 malpractice, a claimant shall notify each prospective defendant
 2605 by certified mail, return receipt requested, of intent to
 2606 initiate litigation for medical malpractice. Notice to each



2607 prospective defendant must include, if available, a list of all
 2608 known health care providers seen by the claimant for the
 2609 injuries complained of subsequent to the alleged act of
 2610 malpractice, a list of all known health care providers during
 2611 the 2-year period prior to the alleged act of malpractice who
 2612 treated or evaluated the claimant, and copies of all of the
 2613 medical records relied upon by the expert in signing the
 2614 affidavit. The requirement of providing the list of known health
 2615 care providers may not serve as grounds for imposing sanctions
 2616 for failure to provide presuit discovery.

2617 (b) Following the initiation of a suit alleging medical
 2618 malpractice with a court of competent jurisdiction, and service
 2619 of the complaint upon a defendant, the claimant shall provide a
 2620 copy of the complaint to the Department of Health. The
 2621 requirement of providing the complaint to the Department of
 2622 Health does not impair the claimant's legal rights or ability to
 2623 seek relief for his or her claim. The Department of Health shall
 2624 review each incident and determine whether it involved conduct
 2625 by a licensee which is potentially subject to disciplinary
 2626 action, in which case the provisions of s. 456.073 apply.

2627 (3)(a) No suit may be filed for a period of 120 ~~90~~ days
 2628 after notice is mailed to any prospective defendant. During the
 2629 120-day ~~90-day~~ period, the prospective defendant's insurer or
 2630 self-insurer shall conduct a review to determine the liability
 2631 of the defendant. Each insurer or self-insurer shall have a
 2632 procedure for the prompt investigation, review, and evaluation
 2633 of claims during the 120-day ~~90-day~~ period. This procedure shall
 2634 include one or more of the following:

- 2635 1. Internal review by a duly qualified claims adjuster;
- 2636 2. Creation of a panel comprised of an attorney



2637 knowledgeable in the prosecution or defense of medical
 2638 malpractice actions, a health care provider trained in the same
 2639 or similar medical specialty as the prospective defendant, and a
 2640 duly qualified claims adjuster;

2641 3. A contractual agreement with a state or local
 2642 professional society of health care providers, which maintains a
 2643 medical review committee;

2644 4. Any other similar procedure which fairly and promptly
 2645 evaluates the pending claim.

2646
 2647 Each insurer or self-insurer shall investigate the claim in good
 2648 faith, and both the claimant and prospective defendant shall
 2649 cooperate with the insurer in good faith. If the insurer
 2650 requires, a claimant shall appear before a pretrial screening
 2651 panel or before a medical review committee and shall submit to a
 2652 physical examination, if required. Unreasonable failure of any
 2653 party to comply with this section justifies dismissal of claims
 2654 or defenses. There shall be no civil liability for participation
 2655 in a pretrial screening procedure if done without intentional
 2656 fraud.

2657 (b) At or before the end of the 120 ~~90~~ days, the insurer
 2658 or self-insurer shall provide the claimant with a response:

- 2659 1. Rejecting the claim;
- 2660 2. Making a settlement offer; or
- 2661 3. Making an offer to arbitrate, in which case liability
 2662 is deemed admitted and arbitration will be held only of
 2663 ~~admission of liability and for arbitration~~ on the issue of
 2664 damages. This offer may be made contingent upon a limit of
 2665 general damages.

2666 (c) The response shall be delivered to the claimant if not



2667 represented by counsel or to the claimant's attorney, by
 2668 certified mail, return receipt requested. Failure of the
 2669 prospective defendant or insurer or self-insurer to reply to the
 2670 notice within 120 ~~90~~ days after receipt shall be deemed a final
 2671 rejection of the claim for purposes of this section.

2672 (d) Within 30 days after ~~of~~ receipt of a response by a
 2673 prospective defendant, insurer, or self-insurer to a claimant
 2674 represented by an attorney, the attorney shall advise the
 2675 claimant in writing of the response, including:

- 2676 1. The exact nature of the response under paragraph (b).
- 2677 2. The exact terms of any settlement offer, or admission
 2678 of liability and offer of arbitration on damages.
- 2679 3. The legal and financial consequences of acceptance or
 2680 rejection of any settlement offer, or admission of liability,
 2681 including the provisions of this section.
- 2682 4. An evaluation of the time and likelihood of ultimate
 2683 success at trial on the merits of the claimant's action.
- 2684 5. An estimation of the costs and attorney's fees of
 2685 proceeding through trial.

2686 (4) The notice of intent to initiate litigation shall be
 2687 served within the time limits set forth in s. 95.11. However,
 2688 during the 120-day ~~90-day~~ period, the statute of limitations is
 2689 tolled as to all potential defendants. Upon stipulation by the
 2690 parties, the 120-day ~~90-day~~ period may be extended and the
 2691 statute of limitations is tolled during any such extension. Upon
 2692 receiving notice of termination of negotiations in an extended
 2693 period, the claimant shall have 60 days or the remainder of the
 2694 period of the statute of limitations, whichever is greater,
 2695 within which to file suit.

2696 (7) Informal discovery may be used by a party to obtain



2697 unsworn statements, the production of documents or things, and
 2698 physical and mental examinations, as follows:

2699 (a) *Unsworn statements.*--Any party may require other
 2700 parties to appear for the taking of an unsworn statement. Such
 2701 statements may be used only for the purpose of presuit screening
 2702 and are not discoverable or admissible in any civil action for
 2703 any purpose by any party. A party desiring to take the unsworn
 2704 statement of any party must give reasonable notice in writing to
 2705 all parties. The notice must state the time and place for taking
 2706 the statement and the name and address of the party to be
 2707 examined. Unless otherwise impractical, the examination of any
 2708 party must be done at the same time by all other parties. Any
 2709 party may be represented by counsel at the taking of an unsworn
 2710 statement. An unsworn statement may be recorded electronically,
 2711 stenographically, or on videotape. The taking of unsworn
 2712 statements is subject to the provisions of the Florida Rules of
 2713 Civil Procedure and may be terminated for abuses.

2714 (b) *Documents or things.*--Any party may request discovery
 2715 of documents or things. The documents or things must be
 2716 produced, at the expense of the requesting party, within 20 days
 2717 after the date of receipt of the request. A party is required to
 2718 produce discoverable documents or things within that party's
 2719 possession or control.

2720 (c) *Physical and mental examinations.*--A prospective
 2721 defendant may require an injured prospective claimant to appear
 2722 for examination by an appropriate health care provider. The
 2723 defendant shall give reasonable notice in writing to all parties
 2724 as to the time and place for examination. Unless otherwise
 2725 impractical, a prospective claimant is required to submit to
 2726 only one examination on behalf of all potential defendants. The



2727 practicality of a single examination must be determined by the
 2728 nature of the potential claimant's condition, as it relates to
 2729 the liability of each potential defendant. Such examination
 2730 report is available to the parties and their attorneys upon
 2731 payment of the reasonable cost of reproduction and may be used
 2732 only for the purpose of presuit screening. Otherwise, such
 2733 examination report is confidential and exempt from the
 2734 provisions of s. 119.07(1) and s. 24(a), Art. I of the State
 2735 Constitution.

2736 (d) Written questions.--Any party may request answers to
 2737 written questions, the number of which may not exceed 30,
 2738 including subparts. A response must be made within 20 days after
 2739 receipt of the questions.

2740 (13) Failure to cooperate on the part of any party during
 2741 the presuit investigation may be grounds to strike any claim
 2742 made, or defense raised, by such party in suit.

2743 (14) The claimant must execute a medical information
 2744 release that allows a defendant or his or her legal
 2745 representative to obtain unsworn statements of the claimant's
 2746 treating physicians, which statements must be limited to those
 2747 areas that are potentially relevant to the claim of personal
 2748 injury or wrongful death. A defendant must give reasonable
 2749 notice to the claimant before obtaining unsworn statements from
 2750 a claimant's treating physician.

2751 Section 46. Section 766.1065, Florida Statutes, is created
 2752 to read:

2753 766.1065 Mandatory staging of presuit investigation and
 2754 mandatory mediation.--

2755 (1) Within 30 days after service of the presuit notice of
 2756 intent to initiate medical malpractice litigation, each party



2757 shall voluntarily produce to all other parties, without being
 2758 requested, any and all medical, hospital, health care, and
 2759 employment records concerning the claimant in the disclosing
 2760 party's possession, custody, or control, and the disclosing
 2761 party shall affirmatively certify in writing that the records
 2762 produced include all records in that party's possession,
 2763 custody, or control or that the disclosing party has no medical,
 2764 hospital, health care, or employment records concerning the
 2765 claimant.

2766 (a) Subpoenas may be issued according to the Florida Rules
 2767 of Civil Procedure as though suit had been filed for the limited
 2768 purpose of obtaining copies of medical, hospital, health care,
 2769 and employment records of the claimant. The party shall indicate
 2770 on the subpoena that it is being issued in accordance with the
 2771 presuit procedures of this section and shall not be required to
 2772 include a case number.

2773 (b) Nothing in this section shall limit the ability of any
 2774 party to use any other available form of presuit discovery
 2775 available under this chapter or the Florida Rules of Civil
 2776 Procedure.

2777 (2) Within 60 days after service of the presuit notice of
 2778 intent to initiate medical malpractice litigation, all parties
 2779 must be made available for a sworn deposition. Such deposition
 2780 may not be used in a civil suit for medical negligence.

2781 (3) Within 90 days after service of the presuit notice of
 2782 intent to initiate medical malpractice litigation, each party's
 2783 corroborating expert, who will otherwise be tendered as the
 2784 expert complying with the affidavit provisions set forth in s.
 2785 766.203, must be made available for a sworn deposition.

2786 (a) The expenses associated with the expert's time and



2787 travel in preparing for and attending such deposition shall be
 2788 the responsibility of the party retaining such expert.

2789 (b) An expert shall be deemed available for deposition if
 2790 suitable accommodations can be made for appearance of said
 2791 expert via real-time video technology.

2792 Section 47. Section 766.1067, Florida Statutes, is created
 2793 to read:

2794 766.1067 Mandatory mediation after suit is filed.--Within
 2795 120 days after suit being filed, unless such period is extended
 2796 by mutual agreement of all parties, all parties shall attend in-
 2797 person mandatory mediation in accordance with s. 44.102 if
 2798 binding arbitration under s. 766.106 or s. 766.207 has not been
 2799 agreed to by the parties. The Florida Rules of Civil Procedure
 2800 shall apply to mediation held pursuant to this section.

2801 Section 48. Section 766.118, Florida Statutes, is created
 2802 to read:

2803 766.118 Determination of noneconomic damages.--

2804 (1) With respect to a cause of action for personal injury
 2805 or wrongful death arising from medical negligence by physicians
 2806 licensed under chapter 458 or chapter 459, regardless of the
 2807 number of such defendant physicians, noneconomic damages, as
 2808 defined in s. 766.202(7), shall not exceed \$250,000 per
 2809 claimant, provided that the total noneconomic damages
 2810 recoverable by all claimants from all such physicians shall not
 2811 exceed \$500,000.

2812 (2) With respect to a cause of action for personal injury
 2813 or wrongful death arising from medical negligence by defendants
 2814 other than physicians licensed under chapter 458 or chapter 459,
 2815 regardless of the number of such nonphysician defendants,
 2816 noneconomic damages, as defined in s. 766.202(7), shall not



2817 exceed \$250,000 per claimant, provided that the total
 2818 noneconomic damages recoverable by all claimants from all such
 2819 nonphysician defendants shall not exceed \$500,000.

2820 (3) Notwithstanding subsections (1) and (2), with respect
 2821 to a cause of action for personal injury or wrongful death
 2822 arising from medical negligence by physicians licensed under
 2823 chapter 458 or chapter 459 providing emergency services and
 2824 care, as defined in s. 395.002(10), regardless of the number of
 2825 such defendant physicians, noneconomic damages, as defined in s.
 2826 766.202(7), shall not exceed \$100,000 per claimant, provided
 2827 that the total noneconomic damages recoverable by all claimants
 2828 from all such physicians shall not exceed \$250,000.

2829 (4) Notwithstanding subsections (1) and (2), with respect
 2830 to a cause of action for personal injury or wrongful death
 2831 arising from medical negligence by defendants, other than
 2832 physicians licensed under chapter 458 or chapter 459, providing
 2833 emergency services and care pursuant to obligations imposed by
 2834 ss. 395.1041 and 401.45, regardless of the number of such
 2835 nonphysician defendants, noneconomic damages, as defined in s.
 2836 766.202(7), shall not exceed \$250,000 per claimant, provided
 2837 that the total noneconomic damages recoverable by all claimants
 2838 from all such nonphysician defendants shall not exceed \$500,000.

2839 (5) For the purpose of determining the limitations on
 2840 noneconomic damages set forth in this section, the term
 2841 "physician licensed under chapter 458 or chapter 459" includes
 2842 any person for whom a physician licensed under chapter 458 or
 2843 chapter 459 is vicariously liable and any person whose liability
 2844 is based solely on such person being vicariously liable for the
 2845 actions of a physician licensed under chapter 458 or chapter 459
 2846 or the actions of a person for whom a physician licensed under



2847 chapter 458 or chapter 459 is vicariously liable.

2848 (6) This section shall not apply to actions governed by s.
 2849 768.28.

2850 Section 49. Subsections (3), (5), (7), and (8) of section
 2851 766.202, Florida Statutes, are amended to read:

2852 766.202 Definitions; ss. 766.201-766.212.--As used in ss.
 2853 766.201-766.212, the term:

2854 (3) "Economic damages" means financial losses that ~~which~~
 2855 would not have occurred but for the injury giving rise to the
 2856 cause of action, including, but not limited to, past and future
 2857 medical expenses and 80 percent of wage loss and loss of earning
 2858 capacity, to the extent the claimant is entitled to recover such
 2859 damages under general law, including the Wrongful Death Act.

2860 (5) "Medical expert" means a person duly and regularly
 2861 engaged in the practice of his or her profession who holds a
 2862 health care professional degree from a university or college and
 2863 who meets the requirements of an expert witness as set forth in
 2864 s. 766.102 ~~has had special professional training and experience~~
 2865 ~~or one possessed of special health care knowledge or skill about~~
 2866 ~~the subject upon which he or she is called to testify or provide~~
 2867 ~~an opinion.~~

2868 (7) "Noneconomic damages" means nonfinancial losses which
 2869 would not have occurred but for the injury giving rise to the
 2870 cause of action, including pain and suffering, inconvenience,
 2871 physical impairment, mental anguish, disfigurement, loss of
 2872 capacity for enjoyment of life, and other nonfinancial losses,
 2873 to the extent the claimant is entitled to recover such damages
 2874 under general law, including the Wrongful Death Act.

2875 (8) "Periodic payment" means provision for the structuring
 2876 of future economic and future noneconomic damages payments, in



2877 whole or in part, over a period of time, as follows:

2878 (a) A specific finding must be made of the dollar amount
 2879 of periodic payments which will compensate for these future
 2880 damages after offset for collateral sources and after having
 2881 been reduced to present value ~~shall be made~~. A periodic payment
 2882 must be structured to last as long as the claimant lives ~~The~~
 2883 ~~total dollar amount of the periodic payments shall equal the~~
 2884 ~~dollar amount of all such future damages before any reduction to~~
 2885 ~~present value.~~

2886 (b) A defendant that elects to make periodic payments of
 2887 either or both future economic and future noneconomic losses may
 2888 contractually obligate a company that is authorized to do
 2889 business in this state to make those periodic payments on its
 2890 behalf. Upon a joint petition by the defendant and the company
 2891 that is contractually obligated to make the periodic payments,
 2892 the court shall discharge the defendant from any further
 2893 obligations to the claimant for those future economic and future
 2894 noneconomic damages that are to be paid by that company by
 2895 periodic payments.

2896 (c) A bond or security may not be required of any
 2897 defendant or company that is obligated to make periodic payments
 2898 pursuant to this section; however, if, upon petition by a
 2899 claimant who is receiving periodic payments pursuant to this
 2900 section, the court finds that there is substantial, competent
 2901 evidence that the defendant or the company that is responsible
 2902 for the periodic payments cannot adequately ensure full and
 2903 continuous payments thereof, and that doing so is in the best
 2904 interest of the claimant, the court may require the defendant or
 2905 the company that is obligated to make the periodic payments to
 2906 provide such additional financial security as the court



2907 determines to be reasonable under the circumstances.

2908 (d) The provision for the periodic payments must specify
 2909 the recipient or recipients of the payments, the address to
 2910 which the payments are to be delivered, and the amount and
 2911 intervals of the payments; however, in any one year, any payment
 2912 or payments may not exceed the amount intended by the trier of
 2913 fact to be awarded each year, offset for collateral sources. A
 2914 periodic payment may not be accelerated, deferred, increased, or
 2915 decreased, except by court order based upon the mutual consent
 2916 and agreement of the claimant, the defendant, whether or not
 2917 discharged, and the company that is obligated to make the
 2918 periodic payments, if any; nor may the claimant sell, mortgage,
 2919 encumber, or anticipate the periodic payments or any part
 2920 thereof, by assignment or otherwise. The defendant shall be
 2921 ~~required to post a bond or security or otherwise to assure full~~
 2922 ~~payment of these damages awarded. A bond is not adequate unless~~
 2923 ~~it is written by a company authorized to do business in this~~
 2924 ~~state and is rated A+ by Best's. If the defendant is unable to~~
 2925 ~~adequately assure full payment of the damages, all damages,~~
 2926 ~~reduced to present value, shall be paid to the claimant in a~~
 2927 ~~lump sum. No bond may be canceled or be subject to cancellation~~
 2928 ~~unless at least 60 days' advance written notice is filed with~~
 2929 ~~the court and the claimant. Upon termination of periodic~~
 2930 ~~payments, the security, or so much as remains, shall be returned~~
 2931 ~~to the defendant.~~

2932 ~~(c) The provision for payment of future damages by~~
 2933 ~~periodic payments shall specify the recipient or recipients of~~
 2934 ~~the payments, the dollar amounts of the payments, the interval~~
 2935 ~~between payments, and the number of payments or the period of~~
 2936 ~~time over which payments shall be made.~~



2937 Section 50. Subsections (2) and (3) of section 766.203,
 2938 Florida Statutes, are amended to read:

2939 766.203 Presuit investigation of medical negligence claims
 2940 and defenses by prospective parties.--

2941 (2) Prior to issuing notification of intent to initiate
 2942 medical malpractice litigation pursuant to s. 766.106, the
 2943 claimant shall conduct an investigation to ascertain that there
 2944 are reasonable grounds to believe that:

2945 (a) Any named defendant in the litigation was negligent in
 2946 the care or treatment of the claimant; and

2947 (b) Such negligence resulted in injury to the claimant.

2948
 2949 Corroboration of reasonable grounds to initiate medical
 2950 negligence litigation shall be provided by the claimant's
 2951 submission of a verified written medical expert opinion from a
 2952 medical expert as defined in s. 766.202(5), at the time the
 2953 notice of intent to initiate litigation is mailed, which
 2954 statement shall corroborate reasonable grounds to support the
 2955 claim of medical negligence. This opinion and statement are
 2956 subject to discovery.

2957 (3) Prior to issuing its response to the claimant's notice
 2958 of intent to initiate litigation, during the time period for
 2959 response authorized pursuant to s. 766.106, the defendant or the
 2960 defendant's insurer or self-insurer shall conduct an
 2961 investigation to ascertain whether there are reasonable grounds
 2962 to believe that:

2963 (a) The defendant was negligent in the care or treatment
 2964 of the claimant; and

2965 (b) Such negligence resulted in injury to the claimant.

2966



2967 Corroboration of lack of reasonable grounds for medical
 2968 negligence litigation shall be provided with any response
 2969 rejecting the claim by the defendant's submission of a verified
 2970 written medical expert opinion from a medical expert as defined
 2971 in s. 766.202(5), at the time the response rejecting the claim
 2972 is mailed, which statement shall corroborate reasonable grounds
 2973 for lack of negligent injury sufficient to support the response
 2974 denying negligent injury. This opinion and statement are subject
 2975 to discovery.

2976 Section 51. Section 766.206, Florida Statutes, is amended
 2977 to read:

2978 766.206 Presuit investigation of medical negligence claims
 2979 and defenses by court.--

2980 (1) After the completion of presuit investigation by the
 2981 parties pursuant to s. 766.203 and any informal discovery
 2982 pursuant to s. 766.106, any party may file a motion in the
 2983 circuit court requesting the court to determine whether the
 2984 opposing party's claim or denial rests on a reasonable basis.

2985 (2) If the court finds that the notice of intent to
 2986 initiate litigation mailed by the claimant is not in compliance
 2987 with the reasonable investigation requirements of ss. 766.201-
 2988 766.212, including a review of the claim and a verified written
 2989 medical expert opinion by a medical expert as defined in s.
 2990 766.202, the court shall dismiss the claim, and the person who
 2991 mailed such notice of intent, whether the claimant or the
 2992 claimant's attorney, shall be personally liable for all
 2993 attorney's fees and costs incurred during the investigation and
 2994 evaluation of the claim, including the reasonable attorney's
 2995 fees and costs of the defendant or the defendant's insurer.

2996 (3) If the court finds that the response mailed by a



2997 defendant rejecting the claim is not in compliance with the
 2998 reasonable investigation requirements of ss. 766.201-766.212,
 2999 including a review of the claim and a verified written medical
 3000 expert opinion by a medical expert as defined in s. 766.202, the
 3001 court shall strike the defendant's pleading. ~~response,~~ and The
 3002 person who mailed such response, whether the defendant, the
 3003 defendant's insurer, or the defendant's attorney, shall be
 3004 personally liable for all attorney's fees and costs incurred
 3005 during the investigation and evaluation of the claim, including
 3006 the reasonable attorney's fees and costs of the claimant.

3007 (4) If the court finds that an attorney for the claimant
 3008 mailed notice of intent to initiate litigation without
 3009 reasonable investigation, or filed a medical negligence claim
 3010 without first mailing such notice of intent which complies with
 3011 the reasonable investigation requirements, or if the court finds
 3012 that an attorney for a defendant mailed a response rejecting the
 3013 claim without reasonable investigation, the court shall submit
 3014 its finding in the matter to The Florida Bar for disciplinary
 3015 review of the attorney. Any attorney so reported three or more
 3016 times within a 5-year period shall be reported to a circuit
 3017 grievance committee acting under the jurisdiction of the Supreme
 3018 Court. If such committee finds probable cause to believe that
 3019 an attorney has violated this section, such committee shall
 3020 forward to the Supreme Court a copy of its finding.

3021 (5)(a) If the court finds that the corroborating written
 3022 medical expert opinion attached to any notice of claim or intent
 3023 or to any response rejecting a claim lacked reasonable
 3024 investigation, or that the medical expert submitting the opinion
 3025 did not meet the expert witness qualifications as set forth in
 3026 s. 766.202(5), the court shall report the medical expert issuing



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3027 such corroborating opinion to the Division of Medical Quality
 3028 Assurance or its designee. If such medical expert is not a
 3029 resident of the state, the division shall forward such report to
 3030 the disciplining authority of that medical expert.

3031 (b) The court shall ~~may~~ refuse to consider the testimony
 3032 or opinion attached to any notice of intent or to any response
 3033 rejecting a claim of ~~such~~ an expert who has been disqualified
 3034 three times pursuant to this section.

3035 Section 52. Subsections (2), (3), and (7) of section
 3036 766.207, Florida Statutes, are amended to read:

3037 766.207 Voluntary binding arbitration of medical
 3038 negligence claims.--

3039 (2) Upon the completion of presuit investigation with
 3040 preliminary reasonable grounds for a medical negligence claim
 3041 intact, the parties may elect to have damages determined by an
 3042 arbitration panel. Such election may be initiated by either
 3043 party by serving a request for voluntary binding arbitration of
 3044 damages within 120 ~~90~~ days after service of the claimant's
 3045 notice of intent to initiate litigation upon the defendant. The
 3046 evidentiary standards for voluntary binding arbitration of
 3047 medical negligence claims shall be as provided in ss.
 3048 120.569(2)(g) and 120.57(1)(c).

3049 (3) Upon receipt of a party's request for such
 3050 arbitration, the opposing party may accept the offer of
 3051 voluntary binding arbitration within 30 days. However, in no
 3052 event shall the defendant be required to respond to the request
 3053 for arbitration sooner than 120 ~~90~~ days after service of the
 3054 notice of intent to initiate litigation under s. 766.106. Such
 3055 acceptance within the time period provided by this subsection
 3056 shall be a binding commitment to comply with the decision of the



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3057 arbitration panel. The liability of any insurer shall be subject
3058 to any applicable insurance policy limits.

3059 (7) Arbitration pursuant to this section shall preclude
3060 recourse to any other remedy by the claimant against any
3061 participating defendant, and shall be undertaken with the
3062 understanding that damages shall be awarded as provided by
3063 general law, including the Wrongful Death Act, subject to the
3064 following limitations:

3065 (a) Net economic damages shall be awardable, including,
3066 but not limited to, past and future medical expenses and 80
3067 percent of wage loss and loss of earning capacity, offset by any
3068 collateral source payments.

3069 (b) Noneconomic damages shall be limited to a maximum of
3070 \$250,000 per incident, and shall be calculated on a percentage
3071 basis with respect to capacity to enjoy life, so that a finding
3072 that the claimant's injuries resulted in a 50-percent reduction
3073 in his or her capacity to enjoy life would warrant an award of
3074 not more than \$125,000 noneconomic damages.

3075 (c) Damages for future economic losses shall be awarded to
3076 be paid by periodic payments pursuant to s. 766.202(8) and shall
3077 be offset by future collateral source payments.

3078 (d) Punitive damages shall not be awarded.

3079 (e) The defendant shall be responsible for the payment of
3080 interest on all accrued damages with respect to which interest
3081 would be awarded at trial.

3082 (f) The defendant shall pay the claimant's reasonable
3083 attorney's fees and costs, as determined by the arbitration
3084 panel, but in no event more than 15 percent of the award,
3085 reduced to present value.

3086 (g) The defendant shall pay all the costs of the



3087 arbitration proceeding and the fees of all the arbitrators other
 3088 than the administrative law judge.

3089 (h) Each defendant who submits to arbitration under this
 3090 section shall be jointly and severally liable for all damages
 3091 assessed pursuant to this section.

3092 (i) The defendant's obligation to pay the claimant's
 3093 damages shall be for the purpose of arbitration under this
 3094 section only. A defendant's or claimant's offer to arbitrate
 3095 shall not be used in evidence or in argument during any
 3096 subsequent litigation of the claim following the rejection
 3097 thereof.

3098 (j) The fact of making or accepting an offer to arbitrate
 3099 shall not be admissible as evidence of liability in any
 3100 collateral or subsequent proceeding on the claim.

3101 (k) Any offer by a claimant to arbitrate must be made to
 3102 each defendant against whom the claimant has made a claim. Any
 3103 offer by a defendant to arbitrate must be made to each claimant
 3104 who has joined in the notice of intent to initiate litigation,
 3105 as provided in s. 766.106. A defendant who rejects a claimant's
 3106 offer to arbitrate shall be subject to the provisions of s.
 3107 766.209(3). A claimant who rejects a defendant's offer to
 3108 arbitrate shall be subject to the provisions of s. 766.209(4).

3109 (l) The hearing shall be conducted by all of the
 3110 arbitrators, but a majority may determine any question of fact
 3111 and render a final decision. The chief arbitrator shall decide
 3112 all evidentiary matters.

3113

3114 The provisions of this subsection shall not preclude settlement
 3115 at any time by mutual agreement of the parties.

3116 Section 53. Paragraph (a) of subsection (3) of section



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3117 766.209, Florida Statutes, is amended to read:

3118 766.209 Effects of failure to offer or accept voluntary
3119 binding arbitration.--

3120 (3) If the defendant refuses a claimant's offer of
3121 voluntary binding arbitration:

3122 (a) The claim shall proceed to trial ~~without limitation on~~
3123 ~~damages~~, and the claimant, upon proving medical negligence,
3124 shall be entitled to recover prejudgment interest, and
3125 reasonable attorney's fees up to 25 percent of the award reduced
3126 to present value. Noneconomic damages at trial are subject to
3127 the limitations in s. 766.118.

3128 Section 54. Section 766.213, Florida Statutes, is created
3129 to read:

3130 766.213 Periodic payment of damages upon death of
3131 claimant.--Any portion of a periodic payment made pursuant to a
3132 settlement or jury award or pursuant to mediation or arbitration
3133 which is attributable to medical expenses that have not yet been
3134 incurred shall terminate upon the death of the claimant. Any
3135 outstanding medical expenses incurred prior to the death of the
3136 claimant shall be paid from that portion of the periodic payment
3137 attributable to medical expenses.

3138 Section 55. Section 766.304, Florida Statutes, is amended
3139 to read:

3140 766.304 Administrative law judge to determine claims.--The
3141 administrative law judge shall hear and determine all claims
3142 filed pursuant to ss. 766.301-766.316 and shall exercise the
3143 full power and authority granted to her or him in chapter 120,
3144 as necessary, to carry out the purposes of such sections. The
3145 administrative law judge has exclusive jurisdiction to determine
3146 whether a claim filed under this act is compensable. No civil



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3147 action may be brought until the determinations under s. 766.309
 3148 have been made by the administrative law judge. If the
 3149 administrative law judge determines that the claimant is
 3150 entitled to compensation from the association, or if the
 3151 claimant accepts an award issued pursuant to s. 766.31, no civil
 3152 action may be brought or continued in violation of the
 3153 exclusiveness of remedy provisions of s. 766.303. If it is
 3154 determined that a claim filed under this act is not compensable,
 3155 neither the doctrine of collateral estoppel nor res judicata
 3156 shall prohibit the claimant from pursuing any and all civil
 3157 remedies available under common law and statutory law. The
 3158 findings of fact and conclusions of law of the administrative
 3159 law judge shall not be admissible in any subsequent proceeding;
 3160 however, the sworn testimony of any person and the exhibits
 3161 introduced into evidence in the administrative case are
 3162 admissible as impeachment in any subsequent civil action only
 3163 against a party to the administrative proceeding, subject to the
 3164 Rules of Evidence. An award ~~action~~ may not be awarded or paid
 3165 ~~brought~~ under ss. 766.301-766.316 if the claimant recovers under
 3166 a settlement or a final judgment is entered in a civil action.
 3167 The division may adopt rules to promote the efficient
 3168 administration of, and to minimize the cost associated with, the
 3169 prosecution of claims.

3170 Section 56. Section 766.305, Florida Statutes, is amended
 3171 to read:

3172 766.305 Filing of claims and responses; medical
 3173 disciplinary review.--

3174 (1) All claims filed for compensation under the plan shall
 3175 commence by the claimant filing with the division a petition



3176 seeking compensation. Such petition shall include the following
 3177 information:

3178 (a) The name and address of the legal representative and
 3179 the basis for her or his representation of the injured infant.

3180 (b) The name and address of the injured infant.

3181 (c) The name and address of any physician providing
 3182 obstetrical services who was present at the birth and the name
 3183 and address of the hospital at which the birth occurred.

3184 (d) A description of the disability for which the claim is
 3185 made.

3186 (e) The time and place the injury occurred.

3187 (f) A brief statement of the facts and circumstances
 3188 surrounding the injury and giving rise to the claim.

3189 ~~(g) All available relevant medical records relating to the
 3190 birth-related neurological injury, and an identification of any
 3191 unavailable records known to the claimant and the reasons for
 3192 their unavailability.~~

3193 ~~(h) Appropriate assessments, evaluations, and prognoses,
 3194 and such other records and documents as are reasonably necessary
 3195 for the determination of the amount of compensation to be paid
 3196 to, or on behalf of, the injured infant on account of the birth-
 3197 related neurological injury.~~

3198 ~~(i) Documentation of expenses and services incurred to
 3199 date, which indicates any payment made for such expenses and
 3200 services, and by whom.~~

3201 ~~(j) Documentation of any applicable private or
 3202 governmental source of services or reimbursement relative to the
 3203 impairments.~~

3204 (2) The claimant shall furnish the division with as many
 3205 copies of the petition as required for service upon the



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3206 association, any physician and hospital named in the petition,
 3207 and the Division of Medical Quality Assurance, along with a \$15
 3208 filing fee payable to the Division of Administrative Hearings.
 3209 Upon receipt of the petition, the division shall immediately
 3210 serve the association, by service upon the agent designated to
 3211 accept service on behalf of the association, by registered or
 3212 certified mail, and shall mail copies of the petition, by
 3213 registered or certified mail, to any physician, health care
 3214 provider, and hospital named in the petition, and furnish a copy
 3215 by regular mail to the Division of Medical Quality Assurance,
 3216 and the Agency for Health Care Administration.

3217 (3) The claimant shall furnish to the Florida Birth-Related
 3218 Neurological Injury Compensation Association one copy of the
 3219 following information which shall be filed with the association
 3220 within 10 days after the filing of the petition as set forth in
 3221 s. 766.305(1):

3222 (a) All available relevant medical records relating to the
 3223 birth-related neurological injury and an identification of any
 3224 unavailable records known to the claimant and the reasons for
 3225 their unavailability.

3226 (b) Appropriate assessments, evaluations, and prognoses and
 3227 such other records and documents as are reasonably necessary for
 3228 the determination of the amount of compensation to be paid to, or
 3229 on behalf of, the injured infant on account of the birth-related
 3230 neurological injury.

3231 (c) Documentation of expenses and services incurred to
 3232 date, which indicates any payment made for such expenses and
 3233 services and by whom.

3234 (d) Documentation of any applicable private or governmental
 3235 source of services or reimbursement relative to the impairments.



3236 The information contained in paragraphs (a)-(d) is confidential
 3237 and exempt pursuant to the provisions of s. 766.315(5)(b).

3238 (4)~~(3)~~ The association shall have 45 days from the date of
 3239 service of a complete claim, filed pursuant to subsections (1)
 3240 and (2), in which to file a response to the petition and to
 3241 submit relevant written information relating to the issue of
 3242 whether the injury alleged is a birth-related neurological
 3243 injury.

3244 (5)~~(4)~~ Upon receipt of such petition, the Division of
 3245 Medical Quality Assurance shall review the information therein
 3246 and determine whether it involved conduct by a physician
 3247 licensed under chapter 458 or an osteopathic physician licensed
 3248 under chapter 459 that is subject to disciplinary action, in
 3249 which case the provisions of s. 456.073 shall apply.

3250 (6)~~(5)~~ Upon receipt of such petition, the Agency for
 3251 Health Care Administration shall investigate the claim, and if
 3252 it determines that the injury resulted from, or was aggravated
 3253 by, a breach of duty on the part of a hospital in violation of
 3254 chapter 395, it shall take any such action consistent with its
 3255 disciplinary authority as may be appropriate.

3256 (7)~~(6)~~ Any claim which the association determines to be
 3257 compensable may be accepted for compensation, provided that the
 3258 acceptance is approved by the administrative law judge to whom
 3259 the claim for compensation is assigned.

3260 Section 57. Subsection (1) of section 766.31, Florida
 3261 Statutes, is amended to read:

3262 766.31 Administrative law judge awards for birth-related
 3263 neurological injuries; notice of award.--

3264 (1) Upon determining that an infant has sustained a birth-
 3265 related neurological injury and that obstetrical services were



3266 delivered by a participating physician at the birth, the
 3267 administrative law judge shall make an award providing
 3268 compensation for the following items relative to such injury:

3269 (a) Actual expenses for medically necessary and reasonable
 3270 medical and hospital, habilitative and training, family
 3271 residential or custodial care, professional residential, and
 3272 custodial care and service, for medically necessary drugs,
 3273 special equipment, and facilities, and for related travel.

3274 However, such expenses shall not include:

3275 1. Expenses for items or services that the infant has
 3276 received, or is entitled to receive, under the laws of any state
 3277 or the Federal Government, except to the extent such exclusion
 3278 may be prohibited by federal law.

3279 2. Expenses for items or services that the infant has
 3280 received, or is contractually entitled to receive, from any
 3281 prepaid health plan, health maintenance organization, or other
 3282 private insuring entity.

3283 3. Expenses for which the infant has received
 3284 reimbursement, or for which the infant is entitled to receive
 3285 reimbursement, under the laws of any state or the Federal
 3286 Government, except to the extent such exclusion may be
 3287 prohibited by federal law.

3288 4. Expenses for which the infant has received
 3289 reimbursement, or for which the infant is contractually entitled
 3290 to receive reimbursement, pursuant to the provisions of any
 3291 health or sickness insurance policy or other private insurance
 3292 program.

3293
 3294 Expenses included under this paragraph shall be limited to
 3295 reasonable charges prevailing in the same community for similar



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3296 treatment of injured persons when such treatment is paid for by
 3297 the injured person.

3298 (b)1. Periodic payments of an award to the parents or
 3299 legal guardians of the infant found to have sustained a birth-
 3300 related neurological injury, which award shall not exceed
 3301 \$100,000. However, at the discretion of the administrative law
 3302 judge, such award may be made in a lump sum.

3303 2. A death benefit for the infant in an amount of \$10,000
 3304 ~~Payment for funeral expenses not to exceed \$1,500.~~

3305 (c) Reasonable expenses incurred in connection with the
 3306 filing of a claim under ss. 766.301-766.316, including
 3307 reasonable attorney's fees, which shall be subject to the
 3308 approval and award of the administrative law judge. In
 3309 determining an award for attorney's fees, the administrative law
 3310 judge shall consider the following factors:

3311 1. The time and labor required, the novelty and difficulty
 3312 of the questions involved, and the skill requisite to perform
 3313 the legal services properly.

3314 2. The fee customarily charged in the locality for similar
 3315 legal services.

3316 3. The time limitations imposed by the claimant or the
 3317 circumstances.

3318 4. The nature and length of the professional relationship
 3319 with the claimant.

3320 5. The experience, reputation, and ability of the lawyer
 3321 or lawyers performing services.

3322 6. The contingency or certainty of a fee.

3323 Section 58. Subsection (4) and paragraph (a) of subsection
 3324 (5) of section 766.314, Florida Statutes, are amended to read:

3325 766.314 Assessments; plan of operation.--



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3326 (4) The following persons and entities shall pay into the
3327 association an initial assessment in accordance with the plan of
3328 operation:

3329 (a) On or before October 1, 1988, each hospital licensed
3330 under chapter 395 shall pay an initial assessment of \$50 per
3331 infant delivered in the hospital during the prior calendar year,
3332 as reported to the Agency for Health Care Administration;
3333 provided, however, that a hospital owned or operated by the
3334 state or a county, special taxing district, or other political
3335 subdivision of the state shall not be required to pay the
3336 initial assessment or any assessment required by subsection (5).
3337 The term "infant delivered" includes live births and not
3338 stillbirths, but the term does not include infants delivered by
3339 employees or agents of the board of trustees of a state
3340 university ~~Regents~~ or those born in a teaching hospital as
3341 defined in s. 408.07. The initial assessment and any assessment
3342 imposed pursuant to subsection (5) may not include any infant
3343 born to a charity patient (as defined by rule of the Agency for
3344 Health Care Administration) or born to a patient for whom the
3345 hospital receives Medicaid reimbursement, if the sum of the
3346 annual charges for charity patients plus the annual Medicaid
3347 contractals of the hospital exceeds 10 percent of the total
3348 annual gross operating revenues of the hospital. The hospital is
3349 responsible for documenting, to the satisfaction of the
3350 association, the exclusion of any birth from the computation of
3351 the assessment. Upon demonstration of financial need by a
3352 hospital, the association may provide for installment payments
3353 of assessments.

3354 (b)1. On or before October 15, 1988, all physicians
3355 licensed pursuant to chapter 458 or chapter 459 as of October 1,



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3356 1988, other than participating physicians, shall be assessed an
 3357 initial assessment of \$250, which must be paid no later than
 3358 December 1, 1988.

3359 2. Any such physician who becomes licensed after September
 3360 30, 1988, and before January 1, 1989, shall pay into the
 3361 association an initial assessment of \$250 upon licensure.

3362 3. Any such physician who becomes licensed on or after
 3363 January 1, 1989, shall pay an initial assessment equal to the
 3364 most recent assessment made pursuant to this paragraph,
 3365 paragraph (5)(a), or paragraph (7)(b).

3366 4. However, if the physician is a physician specified in
 3367 this subparagraph, the assessment is not applicable:

3368 a. A resident physician, assistant resident physician, or
 3369 intern in an approved postgraduate training program, as defined
 3370 by the Board of Medicine or the Board of Osteopathic Medicine by
 3371 rule;

3372 b. A retired physician who has withdrawn from the practice
 3373 of medicine but who maintains an active license as evidenced by
 3374 an affidavit filed with the Department of Health. Prior to
 3375 reentering the practice of medicine in this state, a retired
 3376 physician as herein defined must notify the Board of Medicine or
 3377 the Board of Osteopathic Medicine and pay the appropriate
 3378 assessments pursuant to this section;

3379 c. A physician who holds a limited license pursuant to s.
 3380 458.317 and who is not being compensated for medical services;

3381 d. A physician who is employed full time by the United
 3382 States Department of Veterans Affairs and whose practice is
 3383 confined to United States Department of Veterans Affairs
 3384 hospitals; or



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3385 e. A physician who is a member of the Armed Forces of the
3386 United States and who meets the requirements of s. 456.024.

3387 f. A physician who is employed full time by the State of
3388 Florida and whose practice is confined to state-owned
3389 correctional institutions, a county health department, or state-
3390 owned mental health or developmental services facilities, or who
3391 is employed full time by the Department of Health.

3392 (c) On or before December 1, 1988, each physician licensed
3393 pursuant to chapter 458 or chapter 459 who wishes to participate
3394 in the Florida Birth-Related Neurological Injury Compensation
3395 Plan and who otherwise qualifies as a participating physician
3396 under ss. 766.301-766.316 shall pay an initial assessment of
3397 \$5,000. However, if the physician is either a resident
3398 physician, assistant resident physician, or intern in an
3399 approved postgraduate training program, as defined by the Board
3400 of Medicine or the Board of Osteopathic Medicine by rule, and is
3401 supervised in accordance with program requirements established
3402 by the Accreditation Council for Graduate Medical Education or
3403 the American Osteopathic Association by a physician who is
3404 participating in the plan, such resident physician, assistant
3405 resident physician, or intern is deemed to be a participating
3406 physician without the payment of the assessment. Participating
3407 physicians also include any employee of the board of trustees of
3408 a state university ~~Regents~~ who has paid the assessment required
3409 by this paragraph and paragraph (5)(a), and any certified nurse
3410 midwife supervised by such employee. Participating physicians
3411 include any certified nurse midwife who has paid 50 percent of
3412 the physician assessment required by this paragraph and
3413 paragraph (5)(a) and who is supervised by a participating
3414 physician who has paid the assessment required by this paragraph



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3415 and paragraph (5)(a). Supervision for nurse midwives shall
3416 require that the supervising physician will be easily available
3417 and have a prearranged plan of treatment for specified patient
3418 problems which the supervised certified nurse midwife may carry
3419 out in the absence of any complicating features. Any physician
3420 who elects to participate in such plan on or after January 1,
3421 1989, who was not a participating physician at the time of such
3422 election to participate and who otherwise qualifies as a
3423 participating physician under ss. 766.301-766.316 shall pay an
3424 additional initial assessment equal to the most recent
3425 assessment made pursuant to this paragraph, paragraph (5)(a), or
3426 paragraph (7)(b).

3427 (d) Any hospital located in any county with a gross
3428 population in excess of 1.1 million as of January 1, 2003, as
3429 determined by the Agency for Health Care Administration, pursuant
3430 to the Health Care Responsibility Act, may elect to pay the fee
3431 for the participating physician and the certified nurse midwife
3432 if the hospital first determines that the primary motivating
3433 purpose for making such payment is to ensure coverage for the
3434 hospital's patients under the provisions of ss. 766.301-766.316,
3435 provided no hospital may restrict any participating physician or
3436 certified nurse midwife, directly or indirectly, from being on
3437 the staff of hospitals other than the staff of the hospital
3438 making such payment. Each hospital shall file with the
3439 association an affidavit setting forth specifically the reasons
3440 why such hospital elected to make such payment on behalf of each
3441 participating physician and certified nurse midwife. The payments
3442 authorized pursuant to this paragraph shall be in addition to the
3443 assessment set forth in paragraph (5)(a).



3444 (5)(a) Beginning January 1, 1990, the persons and entities
 3445 listed in paragraphs (4)(b) and (c), except those persons or
 3446 entities who are specifically excluded from said provisions, as
 3447 of the date determined in accordance with the plan of operation,
 3448 taking into account persons licensed subsequent to the payment
 3449 of the initial assessment, shall pay an annual assessment in the
 3450 amount equal to the initial assessments provided in paragraphs
 3451 (4)(b) and (c). If the payment of such annual assessment by a
 3452 participating physician is received by the association by
 3453 January 31 of any calendar year, the participating physician
 3454 shall qualify as a participating physician for that entire
 3455 calendar year. If the payment is received after January 31 of
 3456 any calendar year, the participating physician shall only
 3457 qualify as a participating physician for that calendar year from
 3458 the date the payment was received by the association. On January
 3459 1, 1991, and on each January 1 thereafter, the association shall
 3460 determine the amount of additional assessments necessary
 3461 pursuant to subsection (7), in the manner required by the plan
 3462 of operation, subject to any increase determined to be necessary
 3463 by the Department of Insurance pursuant to paragraph (7)(b). On
 3464 July 1, 1991, and on each July 1 thereafter, the persons and
 3465 entities listed in paragraphs (4)(b) and (c), except those
 3466 persons or entities who are specifically excluded from said
 3467 provisions, shall pay the additional assessments which were
 3468 determined on January 1. Beginning January 1, 1990, the entities
 3469 listed in paragraph (4)(a), including those licensed on or after
 3470 October 1, 1988, shall pay an annual assessment of \$50 per
 3471 infant delivered during the prior calendar year. The additional
 3472 assessments which were determined on January 1, 1991, pursuant



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3473 to the provisions of subsection (7) shall not be due and payable
 3474 by the entities listed in paragraph (4)(a) until July 1.

3475 Section 59. Subsection (4) is added to section 768.041,
 3476 Florida Statutes, to read:

3477 768.041 Release or covenant not to sue.--

3478 (4)(a) At trial pursuant to a suit filed under chapter
 3479 766, or at trial pursuant to s. 766.209, if any defendant shows
 3480 the court that the plaintiff, or his or her legal
 3481 representative, has delivered a written release or covenant not
 3482 to sue to any person in partial satisfaction of damages
 3483 resulting from the same injury or injuries, the court shall set
 3484 off this amount from the amount of any judgment to which the
 3485 plaintiff would otherwise be entitled at the time of rendering
 3486 judgment, regardless of whether the jury has allocated fault to
 3487 the settling defendant at trial.

3488 (b) The amount of the setoff must include all sums
 3489 received by the plaintiff, including economic and noneconomic
 3490 damages, costs, and attorney's fees, and shall be applied
 3491 against the total damages, after reduction for any comparative
 3492 negligence of the plaintiff, rather than against the apportioned
 3493 damages caused by a particular defendant.

3494 (c) A defendant entering into a settlement agreement with
 3495 a plaintiff may assign any right of contribution arising under
 3496 section 768.31, as a consequence of having paid more than his or
 3497 her proportionate share of the entire liability.

3498 Section 60. Subsection (2) of section 768.13, Florida
 3499 Statutes, is amended to read:

3500 768.13 Good Samaritan Act; immunity from civil
 3501 liability.--



3502 (2)(a) Any person, including those licensed to practice
 3503 medicine, who gratuitously and in good faith renders emergency
 3504 care or treatment either in direct response to emergency
 3505 situations related to and arising out of a public health
 3506 emergency declared pursuant to s. 381.00315, a state of
 3507 emergency which has been declared pursuant to s. 252.36 or at
 3508 the scene of an emergency outside of a hospital, doctor's
 3509 office, or other place having proper medical equipment, without
 3510 objection of the injured victim or victims thereof, shall not be
 3511 held liable for any civil damages as a result of such care or
 3512 treatment or as a result of any act or failure to act in
 3513 providing or arranging further medical treatment where the
 3514 person acts as an ordinary reasonably prudent person would have
 3515 acted under the same or similar circumstances.

3516 (b)1. Any health care provider, including a hospital
 3517 licensed under chapter 395, providing emergency services
 3518 pursuant to obligations imposed by 42 U.S.C. s. 1395dd, s.
 3519 395.401, s. 395.1041, or s. 401.45 ~~any employee of such hospital~~
 3520 ~~working in a clinical area within the facility and providing~~
 3521 ~~patient care, and any person licensed to practice medicine who~~
 3522 ~~in good faith renders medical care or treatment necessitated by~~
 3523 ~~a sudden, unexpected situation or occurrence resulting in a~~
 3524 ~~serious medical condition demanding immediate medical attention,~~
 3525 ~~for which the patient enters the hospital through its emergency~~
 3526 ~~room or trauma center, or necessitated by a public health~~
 3527 ~~emergency declared pursuant to s. 381.00315 shall not be held~~
 3528 ~~liable for any civil damages as a result of such medical care or~~
 3529 ~~treatment unless such damages result from providing, or failing~~
 3530 ~~to provide, medical care or treatment under circumstances~~



3531 demonstrating a reckless disregard for the consequences so as to
 3532 affect the life or health of another.

3533 2. The immunity provided by this paragraph applies ~~does~~
 3534 ~~not apply~~ to damages as a result of any act or omission of
 3535 providing medical care or treatment, including diagnosis:

3536 a. Which occurs prior to the time ~~after~~ the patient is
 3537 stabilized and is capable of receiving medical treatment as a
 3538 nonemergency patient, unless surgery is required as a result of
 3539 the emergency within a reasonable time after the patient is
 3540 stabilized, in which case the immunity provided by this
 3541 paragraph applies to any act or omission of providing medical
 3542 care or treatment which occurs prior to the stabilization of the
 3543 patient following the surgery. ~~;~~ ~~or~~

3544 b. Which is related ~~Unrelated~~ to the original medical
 3545 emergency.

3546 3. For purposes of this paragraph, "reckless disregard" as
 3547 it applies to a given health care provider rendering emergency
 3548 medical services shall be such conduct that ~~which~~ a health care
 3549 provider knew or should have known, at the time such services
 3550 were rendered, created an unreasonable risk of injury so as to
 3551 affect the life or health of another, and such risk was
 3552 substantially greater than that which is necessary to make the
 3553 conduct negligent. ~~would be likely to result in injury so as to~~
 3554 ~~affect the life or health of another, taking into account the~~
 3555 ~~following to the extent they may be present;~~

3556 a. ~~The extent or serious nature of the circumstances~~
 3557 ~~prevailing.~~

3558 b. ~~The lack of time or ability to obtain appropriate~~
 3559 ~~consultation.~~

3560 c. ~~The lack of a prior patient-physician relationship.~~



3561 ~~d. The inability to obtain an appropriate medical history~~
 3562 ~~of the patient.~~

3563 ~~e. The time constraints imposed by coexisting emergencies.~~

3564 4. Every emergency care facility granted immunity under
 3565 this paragraph shall accept and treat all emergency care
 3566 patients within the operational capacity of such facility
 3567 without regard to ability to pay, including patients transferred
 3568 from another emergency care facility or other health care
 3569 provider pursuant to Pub. L. No. 99-272, s. 9121. The failure of
 3570 an emergency care facility to comply with this subparagraph
 3571 constitutes grounds for the department to initiate disciplinary
 3572 action against the facility pursuant to chapter 395.

3573 (c) Any person who is licensed to practice medicine, while
 3574 acting as a staff member or with professional clinical
 3575 privileges at a nonprofit medical facility, other than a
 3576 hospital licensed under chapter 395, or while performing health
 3577 screening services, shall not be held liable for any civil
 3578 damages as a result of care or treatment provided gratuitously
 3579 in such capacity as a result of any act or failure to act in
 3580 such capacity in providing or arranging further medical
 3581 treatment, if such person acts as a reasonably prudent person
 3582 licensed to practice medicine would have acted under the same or
 3583 similar circumstances.

3584 Section 61. Paragraph (b) of subsection (9) of section
 3585 768.28, Florida Statutes, is amended, and paragraph (e) is added
 3586 to subsection (10) of said section, to read:

3587 768.28 Waiver of sovereign immunity in tort actions;
 3588 recovery limits; limitation on attorney fees; statute of
 3589 limitations; exclusions; indemnification; risk management
 3590 programs.--



3591 (9)

3592 (b) As used in this subsection, the term:

3593 1. "Employee" includes any volunteer firefighter.

3594 2. "Officer, employee, or agent" includes, but is not

3595 limited to, any employee of a medical school or other health

3596 care practitioner training program in a college or university

3597 that enters into an affiliation agreement or contract to allow

3598 its employees to provide patient services to patients treated at

3599 a public statutory teaching hospital or other health care

3600 facility owned by a governmental entity or at other locations

3601 under contract with a governmental entity to provide patient

3602 services to patients at such facility pursuant to paragraph

3603 (10)(e); any faculty member or other health care professional,

3604 practitioner, or ancillary caregiver or employee of a college or

3605 university or its medical school that enters into an affiliation

3606 agreement or a contract to provide comprehensive health care

3607 services with a public hospital or its governmental owner, and

3608 who provides patient services to patients of a public hospital

3609 pursuant to paragraph (10)(e); any health care provider when

3610 providing services pursuant to s. 766.1115; any member of the

3611 Florida Health Services Corps, as defined in s. 381.0302, who

3612 provides uncompensated care to medically indigent persons

3613 referred by the Department of Health; and any public defender

3614 or her or his employee or agent, including, among others, an

3615 assistant public defender and an investigator.

3616 (10)

3617 (e) Any not-for-profit college or university with a

3618 medical, dental, or nursing school, or any other academic

3619 program of medical education that is accredited by any

3620 association, agency, council, commission, or accrediting body



3621 recognized by the state as a condition for licensure of its
 3622 graduates, that has entered into an affiliation agreement or a
 3623 contract to allow its faculty, its health care professionals,
 3624 practitioners, and ancillary caregivers, and its employees to
 3625 provide patient services to hospital patients treated at a
 3626 public hospital shall, along with the employees of such medical
 3627 or other school or program, be deemed agents of the governmental
 3628 entity responsible for the public hospital for purposes of this
 3629 section and shall be immune from liability for torts in the same
 3630 manner and to the same extent as the state and its agencies and
 3631 subdivisions while providing patient services. For the purpose
 3632 of this paragraph, "public hospital" means a statutory teaching
 3633 hospital or any other health care facility owned or used by the
 3634 state or by a county, municipality, public authority, special
 3635 taxing district with health care responsibilities, or other
 3636 local governmental entity or at other locations under contract
 3637 with the governmental entity. For the purpose of this paragraph,
 3638 "patient services" includes comprehensive health care services
 3639 as defined in s. 641.19, including related administrative
 3640 services to patients of a public hospital and the supervision of
 3641 interns, residents, and fellows providing patient services to
 3642 patients of a public hospital and access to participation in
 3643 medical research protocols. No such employee or agent of a
 3644 college or university or their medical schools or other health
 3645 care practitioner educational schools or programs shall be
 3646 personally liable in tort or named as a party defendant in any
 3647 action arising from the provision of services to patients in a
 3648 public hospital, except as provided in paragraph (9)(a).

3649 Section 62. Section 768.77, Florida Statutes, is amended
 3650 to read:



3651 768.77 Itemized verdict.--

3652 (1) Except as provided in subsection (2), in any action to
 3653 which this part applies in which the trier of fact determines
 3654 that liability exists on the part of the defendant, the trier of
 3655 fact shall, as a part of the verdict, itemize the amounts to be
 3656 awarded to the claimant into the following categories of
 3657 damages:

3658 (a)~~(1)~~ Amounts intended to compensate the claimant for
 3659 economic losses;

3660 (b)~~(2)~~ Amounts intended to compensate the claimant for
 3661 noneconomic losses; and

3662 (c)~~(3)~~ Amounts awarded to the claimant for punitive
 3663 damages, if applicable.

3664 (2) In any action for damages based on personal injury or
 3665 wrongful death arising out of medical malpractice, whether in
 3666 tort or contract, to which this part applies in which the trier
 3667 of fact determines that liability exists on the part of the
 3668 defendant, the trier of fact shall, as a part of the verdict,
 3669 itemize the amounts to be awarded to the claimant into the
 3670 following categories of damages:

3671 (a) Amounts intended to compensate the claimant for:

3672 1. Past economic losses; and

3673 2. Future economic losses, not reduced to present value,
 3674 and the number of years or part thereof which the award is
 3675 intended to cover;

3676 (b) Amounts intended to compensate the claimant for:

3677 1. Past noneconomic losses; and

3678 2. Future noneconomic losses and the number of years or
 3679 part thereof which the award is intended to cover; and

3680 (c) Amounts awarded to the claimant for punitive damages,



3681 if applicable.

3682 Section 63. Subsection (2) and paragraph (a) of subsection
3683 (1) of section 768.78, Florida Statutes, is amended to read:

3684 768.78 Alternative methods of payment of damage awards.--

3685 (1)(a) In any action to which this part applies in which
3686 the court determines that an award to compensate the claimant
3687 includes future economic losses which exceed \$250,000, payment
3688 of amounts intended to compensate the claimant for these losses
3689 shall be made by one of the following means, unless an
3690 alternative method of payment of damages is provided in this
3691 section:

3692 1. The defendant may make a lump-sum payment for all
3693 damages so assessed, with future economic losses and expenses
3694 reduced to present value; or

3695 2. Subject to the provisions of this subsection, the court
3696 shall, at the request of either party, unless the court
3697 determines that manifest injustice would result to any party,
3698 enter a judgment ordering future economic damages, as itemized
3699 pursuant to s. 768.77(1)(a), in excess of \$250,000 to be paid in
3700 whole or in part by periodic payments rather than by a lump-sum
3701 payment.

3702 (2)(a) In any action for damages based on personal injury
3703 or wrongful death arising out of medical malpractice, whether in
3704 tort or contract, in which the trier of fact makes an award to
3705 compensate the claimant for future economic or future
3706 noneconomic losses, payment of amounts intended to compensate
3707 the claimant for these future losses shall be made by one of the
3708 following means:

3709 1. The defendant may elect to make a lump-sum payment for
3710 either or both the ~~all damages so assessed, with~~ future economic



3711 and future noneconomic losses after offset for collateral
3712 sources and after having been ~~and expenses~~ reduced to present
3713 value by the court based upon competent, substantial evidence
3714 presented to it by the parties; or

3715 2. The defendant, if determined by the court to be
3716 financially capable or adequately insured, may elect to use
3717 periodic payments to satisfy in whole or in part the assessed
3718 future economic and future noneconomic losses awarded by the
3719 trier of fact after offset for collateral sources for so long as
3720 the claimant lives, but without regard for the number of years
3721 awarded by the trier of fact. The court shall review and approve
3722 the amounts and schedule of the periodic payments proposed by
3723 the defendant, or modify such amounts and schedule, so that they
3724 are fair and equitable to the claimant under all the facts and
3725 circumstances.

3726 (b) A defendant that elects to make periodic payments of
3727 either or both future economic and future noneconomic losses may
3728 contractually obligate a company that is authorized to do
3729 business in this state to make those periodic payments on its
3730 behalf. Upon a joint petition by the defendant and the company
3731 that is contractually obligated to make the periodic payments,
3732 the court shall discharge the defendant from any further
3733 obligations to the claimant for those future economic and future
3734 noneconomic damages that are to be paid by that company by
3735 periodic payments.

3736 (c) Upon notice of a defendant's election to make periodic
3737 payments pursuant hereto, the claimant may request that the
3738 court modify the periodic payments to reasonably provide for
3739 attorney's fees; however, a court may not make any such
3740 modification that would increase the amount the defendant would



3741 have been obligated to pay had no such adjustment been made.

3742 (d) A bond or security may not be required of any
 3743 defendant or company that is obligated to make periodic payments
 3744 pursuant to this section; however, if, upon petition by a
 3745 claimant who is receiving periodic payments pursuant to this
 3746 section, the court finds that there is substantial, competent
 3747 evidence that the defendant or the company that is responsible
 3748 for the periodic payments cannot adequately ensure full and
 3749 continuous payments thereof, and that doing so is in the best
 3750 interest of the claimant, the court may require the defendant or
 3751 the company that is obligated to make the periodic payments to
 3752 provide such additional financial security as the court
 3753 determines to be reasonable under the circumstances.

3754 (e) The provision for the periodic payments must specify
 3755 the recipient or recipients of the payments, the address to
 3756 which the payments are to be delivered, and the amount and
 3757 intervals of the payments; however, in any one year, any payment
 3758 or payments may not exceed the amount intended by the trier of
 3759 fact to be awarded each year, offset for collateral sources. A
 3760 periodic payment may not be accelerated, deferred, increased, or
 3761 decreased, except by court order based upon the mutual consent
 3762 and agreement of the claimant, the defendant, whether or not
 3763 discharged, and the company that is obligated to make the
 3764 periodic payments, if any; nor may the claimant sell, mortgage,
 3765 encumber, or anticipate the periodic payments or any part
 3766 thereof, by assignment or otherwise.

3767 (f) For purposes of this section, the term "periodic
 3768 payment" means the payment of money or delivery of other
 3769 property to the claimant at regular intervals.

3770 (g) It is the intent of the Legislature to authorize and



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3771 encourage the payment of awards for future economic and future
 3772 noneconomic losses by periodic payments to meet the continuing
 3773 needs of the patient while eliminating the misdirection of such
 3774 funds for purposes not intended by the trier of fact court
 3775 ~~shall, at the request of either party, enter a judgment ordering~~
 3776 ~~future economic damages, as itemized pursuant to s. 768.77, to~~
 3777 ~~be paid by periodic payments rather than lump sum.~~

3778 ~~(b) For purposes of this subsection, "periodic payment"~~
 3779 ~~means provision for the spreading of future economic damage~~
 3780 ~~payments, in whole or in part, over a period of time, as~~
 3781 ~~follows:~~

3782 ~~1. A specific finding of the dollar amount of periodic~~
 3783 ~~payments which will compensate for these future damages after~~
 3784 ~~offset for collateral sources shall be made. The total dollar~~
 3785 ~~amount of the periodic payments shall equal the dollar amount of~~
 3786 ~~all such future damages before any reduction to present value.~~

3787 ~~2. The defendant shall be required to post a bond or~~
 3788 ~~security or otherwise to assure full payment of these damages~~
 3789 ~~awarded. A bond is not adequate unless it is written by a~~
 3790 ~~company authorized to do business in this state and is rated A+~~
 3791 ~~by Best's. If the defendant is unable to adequately assure full~~
 3792 ~~payment of the damages, all damages, reduced to present value,~~
 3793 ~~shall be paid to the claimant in a lump sum. No bond may be~~
 3794 ~~anceled or be subject to cancellation unless at least 60 days'~~
 3795 ~~advance written notice is filed with the court and the claimant.~~
 3796 ~~Upon termination of periodic payments, the security, or so much~~
 3797 ~~as remains, shall be returned to the defendant.~~

3798 ~~3. The provision for payment of future damages by periodic~~
 3799 ~~payments shall specify the recipient or recipients of the~~
 3800 ~~payments, the dollar amounts of the payments, the interval~~



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3801 ~~between payments, and the number of payments or the period of~~
 3802 ~~time over which payments shall be made.~~

3803 Section 64. Subsection (1) of section 766.112, Florida
 3804 Statutes, is amended to read:

3805 766.112 Comparative fault.--

3806 (1) Notwithstanding any provision of ~~anything in~~ law to
 3807 the contrary, in an action for damages for personal injury or
 3808 wrongful death arising out of medical malpractice, whether in
 3809 contract or tort, ~~when an apportionment of damages pursuant to~~
 3810 ~~this section is attributed to a teaching hospital as defined in~~
 3811 ~~s. 408.07,~~ the court shall enter judgment ~~against the teaching~~
 3812 ~~hospital~~ on the basis of each ~~such~~ party's percentage of fault
 3813 and not on the basis of the doctrine of joint and several
 3814 liability.

3815 Section 65. Subsection (5) of section 768.81, Florida
 3816 Statutes, is amended to read:

3817 768.81 Comparative fault.--

3818 (5) Notwithstanding any provision of ~~anything in~~ law to
 3819 the contrary, in an action for damages for personal injury or
 3820 wrongful death arising out of medical malpractice, whether in
 3821 contract or tort, ~~when an apportionment of damages pursuant to~~
 3822 ~~this section is attributed to a teaching hospital as defined in~~
 3823 ~~s. 408.07,~~ the court shall enter judgment ~~against the teaching~~
 3824 ~~hospital~~ on the basis of each ~~such~~ party's percentage of fault
 3825 and not on the basis of the doctrine of joint and several
 3826 liability.

3827 Section 66. Section 1004.08, Florida Statutes, is created
 3828 to read:

3829 1004.08 Patient safety instructional requirements.--Every
 3830 public school, college, and university that offers degrees in



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3831 medicine, nursing, and allied health shall include in the
3832 curricula applicable to such degrees material on patient safety,
3833 including patient safety improvement. Materials shall include,
3834 but need not be limited to, effective communication and
3835 teamwork; epidemiology of patient injuries and medical errors;
3836 vigilance, attention, and fatigue; checklists and inspections;
3837 automation and technological and computer support; psychological
3838 factors in human error; and reporting systems.

3839 Section 67. Section 1005.07, Florida Statutes, is created
3840 to read:

3841 1005.07 Patient safety instructional requirements.--Every
3842 nonpublic school, college, and university that offers degrees in
3843 medicine, nursing, and allied health shall include in the
3844 curricula applicable to such degrees material on patient safety,
3845 including patient safety improvement. Materials shall include,
3846 but need not be limited to, effective communication and
3847 teamwork; epidemiology of patient injuries and medical errors;
3848 vigilance, attention, and fatigue; checklists and inspections;
3849 automation and technological and computer support; psychological
3850 factors in human error; and reporting systems.

3851 Section 68. Paragraph (c) of subsection (2) of section
3852 1006.20, Florida Statutes, as amended by section 2 of chapter
3853 2003-129, Laws of Florida, is amended to read:

3854 1006.20 Athletics in public K-12 schools.--

3855 (2) ADOPTION OF BYLAWS.--

3856 (c) The organization shall adopt bylaws that require all
3857 students participating in interscholastic athletic competition
3858 or who are candidates for an interscholastic athletic team to
3859 satisfactorily pass a medical evaluation each year prior to
3860 participating in interscholastic athletic competition or



3861 engaging in any practice, tryout, workout, or other physical
 3862 activity associated with the student's candidacy for an
 3863 interscholastic athletic team. Such medical evaluation can only
 3864 be administered by a practitioner licensed under the provisions
 3865 of chapter 458, chapter 459, chapter 460, or s. 464.012, and in
 3866 good standing with the practitioner's regulatory board. The
 3867 bylaws shall establish requirements for eliciting a student's
 3868 medical history and performing the medical evaluation required
 3869 under this paragraph, which shall include a physical assessment
 3870 of the student's physical capabilities to participate in
 3871 interscholastic athletic competition as contained in a uniform
 3872 preparticipation physical evaluation and history form. The
 3873 evaluation form shall incorporate the recommendations of the
 3874 American Heart Association for participation cardiovascular
 3875 screening and shall provide a place for the signature of the
 3876 practitioner performing the evaluation with an attestation that
 3877 each examination procedure listed on the form was performed by
 3878 the practitioner or by someone under the direct supervision of
 3879 the practitioner. The form shall also contain a place for the
 3880 practitioner to indicate if a referral to another practitioner
 3881 was made in lieu of completion of a certain examination
 3882 procedure. The form shall provide a place for the practitioner
 3883 to whom the student was referred to complete the remaining
 3884 sections and attest to that portion of the examination. The
 3885 preparticipation physical evaluation form shall advise students
 3886 to complete a cardiovascular assessment and shall include
 3887 information concerning alternative cardiovascular evaluation and
 3888 diagnostic tests. ~~Practitioners administering medical~~
 3889 ~~evaluations pursuant to this subsection must, at a minimum,~~
 3890 ~~solicit all information required by, and perform a physical~~



3891 ~~assessment according to, the uniform preparticipation form~~
 3892 ~~referred to in this paragraph and must certify, based on the~~
 3893 ~~information provided and the physical assessment, that the~~
 3894 ~~student is physically capable of participating in~~
 3895 ~~interscholastic athletic competition. If the practitioner~~
 3896 ~~determines that there are any abnormal findings in the~~
 3897 ~~cardiovascular system, the student may not participate until a~~
 3898 ~~further cardiovascular assessment, which may include an EKG, is~~
 3899 ~~performed which indicates that the student is physically capable~~
 3900 ~~of participating in interscholastic athletic competition.~~
 3901 Results of such medical evaluation must be provided to the
 3902 school. No student shall be eligible to participate in any
 3903 interscholastic athletic competition or engage in any practice,
 3904 tryout, workout, or other physical activity associated with the
 3905 student's candidacy for an interscholastic athletic team until
 3906 the results of the medical evaluation ~~clearing the student for~~
 3907 ~~participation~~ have ~~has~~ been received and approved by the school.

3908 Section 69. Patient safety data privilege.--

3909 (1) As used in this section, the term:

3910 (a) "Patient safety data" means reports made to patient
 3911 safety organizations, including all health care data,
 3912 interviews, memoranda, analyses, root cause analyses, products
 3913 of quality assurance or quality improvement processes,
 3914 corrective action plans, or information collected or created by
 3915 a health care facility licensed under chapter 395 or a health
 3916 care practitioner as defined in section 456.001(4), Florida
 3917 Statutes, as a result of an occurrence related to the provision
 3918 of health care services which exacerbates an existing medical
 3919 condition or could result in injury, illness, or death.

3920 (b) "Patient safety organization" means any organization,



3921 group, or other entity that collects and analyzes patient safety
 3922 data for the purpose of improving patient safety and health care
 3923 outcomes and that is independent and not under the control of
 3924 the entity that reports patient safety data.

3925 (2) Patient safety data shall not be subject to discovery
 3926 or introduction into evidence in any civil or administrative
 3927 action. However, information, documents, or records otherwise
 3928 available from original sources are not immune from discovery or
 3929 use in any civil or administrative action merely because they
 3930 were also collected, analyzed, or presented to a patient safety
 3931 organization. Any person who testifies before a patient safety
 3932 organization or who is a member of such a group may not be
 3933 prevented from testifying as to matters within his or her
 3934 knowledge, but he or she may not be asked about his or her
 3935 testimony before a patient safety organization or the opinions
 3936 formed by him or her as a result of the hearings.

3937 (3) Unless otherwise provided by law, a patient safety
 3938 organization shall promptly remove all patient-identifying
 3939 information after receipt of a complete patient safety data
 3940 report unless such organization is otherwise permitted by state
 3941 or federal law to maintain such information. Patient safety
 3942 organizations shall maintain the confidentiality of all patient-
 3943 identifying information and may not disseminate such
 3944 information, except as permitted by state or federal law.

3945 (4) The exchange of patient safety data among health care
 3946 facilities licensed under chapter 395 or health care
 3947 practitioners as defined in section 456.001 (4), Florida
 3948 Statutes, or patient safety organizations which does not
 3949 identify any patient shall not constitute a waiver of any
 3950 privilege established in this section.



3951 (5) Reports of patient safety data to patient safety
 3952 organizations does not abrogate obligations to make reports to
 3953 the Department of Health, the Agency for Health Care
 3954 Administration, or other state or federal regulatory agencies.

3955 (6) An employer may not take retaliatory action against an
 3956 employee who in good faith makes a report of patient safety data
 3957 to a patient safety organization.

3958 Section 70. The Division of Administrative Hearings shall
 3959 designate at least two administrative law judges who shall
 3960 specifically preside over actions involving the Department of
 3961 Health or boards within the Department of Health. Each
 3962 designated administrative law judge must be a member of The
 3963 Florida Bar in good standing and must have legal, managerial, or
 3964 clinical experience in issues related to health care or have
 3965 attained board certification in health care law from The Florida
 3966 Bar.

3967 Section 71. (1) The Department of Health shall study and
 3968 report to the Legislature as to whether medical review panels
 3969 should be included as part of the presuit process in medical
 3970 malpractice litigation. Medical review panels review a medical
 3971 malpractice case during the presuit process and make judgments
 3972 on the merits of the case based on established standards of care
 3973 with the intent of reducing the number of frivolous claims. The
 3974 panel's report could be used as admissible evidence at trial or
 3975 for other purposes. The department's report should address:

3976 (a) Historical use of medical review panels and similar
 3977 pretrial programs in this state, including the mediation panels
 3978 created by chapter 75-9, Laws of Florida.

3979 (b) Constitutional issues relating to the use of medical
 3980 review panels.



3981 (c) The use of medical review panels or similar programs
 3982 in other states.

3983 (d) Whether medical review panels or similar panels should
 3984 be created for use during the presuit process.

3985 (e) Other recommendations and information that the
 3986 department deems appropriate.

3987 (f) In submitting its report with respect to (a)-(c), the
 3988 Department should identify at a minimum:

3989 1. The percentage of medical malpractice claims submitted
 3990 to the panels during the time period the panels were in
 3991 existence.

3992 2. The percentage of claims that were settled while the
 3993 panels were in existence and the percentage of claims that were
 3994 settled in the 3 years prior to the establishment of such panels
 3995 or, for each panel which no longer exists, 3 years after the
 3996 dissolution of such panels.

3997 3. In those state where panels have been discontinued,
 3998 whether additional safeguards have been implemented to avoid the
 3999 filing of frivolous lawsuits and what those additional
 4000 safeguards are.

4001 4. How the rates for medical malpractice insurance in
 4002 states utilizing such panels compares with the rates in states
 4003 not utilizing such panels.

4004 5. Whether, and to what extent, a finding by a panel is
 4005 subject to review and the burden of proof required to overcome a
 4006 finding by the panel.

4007 (2) If the department finds that medical review panels or
 4008 a similar structure should be created in this state, it shall
 4009 include draft legislation to implement its recommendations in
 4010 its report.



4011 (3) The department shall submit its report to the Speaker
 4012 of the House of Representatives and the President of the Senate
 4013 no later than December 31, 2003.

4014 Section 72. (1) The Agency for Health Care Administration
 4015 shall conduct or contract for a study to determine what
 4016 information is most feasible to provide to the public comparing
 4017 state-licensed hospitals on certain inpatient quality indicators
 4018 developed by the federal Agency for Healthcare Research and
 4019 Quality. Such indicators shall be designed to identify
 4020 information about specific procedures performed in hospitals for
 4021 which there is strong evidence of a link to quality of care. The
 4022 Agency for Health Care Administration or the study contractor
 4023 shall refer to the hospital quality reports published in New
 4024 York and Texas as guides during the evaluation.

4025 (2) The following concepts shall be specifically addressed
 4026 in the study report:

4027 (a) Whether hospital discharge data about services can be
 4028 translated into understandable and meaningful information for
 4029 the public.

4030 (b) Whether the following measures are useful consumer
 4031 guides relating to care provided in state-licensed hospitals:

- 4032 1. Inpatient mortality for medical conditions;
- 4033 2. Inpatient mortality for procedures;
- 4034 3. Utilization of procedures for which there are questions
 4035 of overuse, underuse, or misuse; and
- 4036 4. Volume of procedures for which there is evidence that a
 4037 higher volume of procedures is associated with lower mortality.

4038 (c) Whether there are quality indicators that are
 4039 particularly useful relative to the state's unique demographics.

4040 (d) Whether all hospitals should be included in the



4041 comparison.

4042 (e) The criteria for comparison.

4043 (f) Whether comparisons are best within metropolitan
4044 statistical areas or some other geographic configuration.

4045 (g) Identify several websites to which such a report
4046 should be published to achieve the broadest dissemination of the
4047 information.

4048 (3) The Agency for Health Care Administration shall
4049 consider the input of all interested parties, including
4050 hospitals, physicians, consumer organizations, and patients, and
4051 submit the final report to the Governor and the presiding
4052 officers of the Legislature by January 1, 2004.

4053 Section 73. Comprehensive study and report on the creation
4054 of a Patient Safety Authority.--

4055 (1) The Agency for Health Care Administration, in
4056 consultation with the Department of Health, is directed to study
4057 the need for, and the implementation requirements of,
4058 establishing a Patient Safety Authority. The authority would be
4059 responsible for performing activities and functions designed to
4060 improve patient safety and the quality of care delivered by
4061 health care facilities and health care practitioners.

4062 (2) In undertaking its study, the agency shall examine and
4063 evaluate a Patient Safety Authority that would, either directly
4064 or by contract:

4065 (a) Analyze information concerning adverse incidents
4066 reported to the Agency for Health Care Administration pursuant
4067 to s. 395.0197, Florida Statutes, for the purpose of
4068 recommending changes in practices and procedures that may be
4069 implemented by health care practitioners and health care
4070 facilities to prevent future adverse incidents.



4071 (b) Collect, analyze, and evaluate patient safety data
 4072 submitted voluntarily by a health care practitioner or health
 4073 care facility. The authority would communicate to health care
 4074 practitioners and health care facilities changes in practices
 4075 and procedures that may be implemented for the purpose of
 4076 improving patient safety and preventing future patient safety
 4077 events from resulting in serious injury or death. At a minimum,
 4078 the authority would:

4079 1. Be designed and operated by an individual or entity
 4080 with demonstrated expertise in health care quality data and
 4081 systems analysis, health information management, systems
 4082 thinking and analysis, human factors analysis, and
 4083 identification of latent and active errors.

4084 2. Include procedures for ensuring its confidentiality,
 4085 timeliness, and independence.

4086 (c) Foster the development of a statewide electronic
 4087 infrastructure, which would be implemented in phases over a
 4088 multiyear period, that is designed to improve patient care and
 4089 the delivery and quality of health care services by health care
 4090 facilities and practitioners. The electronic infrastructure
 4091 would be a secure platform for communication and the sharing of
 4092 clinical and other data, such as business data, among providers
 4093 and between patients and providers. The electronic
 4094 infrastructure would include a core electronic medical record.
 4095 Health care providers would have access to individual electronic
 4096 medical records, subject to the consent of the individual. The
 4097 right, if any, of other entities, including health insurers and
 4098 researchers, to access the records would need further
 4099 examination and evaluation by the agency.

4100 (d)1. As a statewide goal of reducing the occurrence of



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4101 medication error, inventory hospitals to determine the current
4102 status of implementation of computerized physician medication
4103 ordering systems, barcode point of care systems, or other
4104 technological patient safety implementation, and recommend a
4105 plan for expediting implementation statewide or, in hospitals
4106 where the agency determines that implementation of such systems
4107 is not practicable, alternative methods to reduce medication
4108 errors. The agency shall identify in its plan any barriers to
4109 statewide implementation and shall include recommendations to
4110 the Legislature of statutory changes that may be necessary to
4111 eliminate those barriers. The agency will review newly developed
4112 plans for compliance with statewide initiatives and to determine
4113 both the commitment of the health care facility staff and the
4114 capability of the facility to successfully coordinate and
4115 implement these plans, especially from a technological
4116 perspective.

4117 2. "Medication error" is any preventable event that may
4118 cause or lead to inappropriate medication use or patient harm
4119 while the medication is in the control of the health care
4120 professional, patient, or consumer. Such events may be related
4121 to professional practice, health care products, health care
4122 procedures, and health care systems, each of which may include
4123 the prescribing of medications and order communications; product
4124 labeling; product packaging; the nomenclature, compounding,
4125 dispensing, distribution, administration, and use of
4126 medications; and education and monitoring related thereto.

4127 (e) Implement paragraphs (c) and (d) as a demonstration
4128 project for Medicaid recipients.

4129 (f) Identify best practices and share this information
4130 with health care providers.



4131 (g) Engage in other activities that improve health care
 4132 quality, improve the diagnosis and treatment of diseases and
 4133 medical conditions, increase the efficiency of the delivery of
 4134 health care services, increase administrative efficiency, and
 4135 increase access to quality health care services.

4136 (3) The agency shall also consider ways in which a Patient
 4137 Safety Authority would be able to facilitate the development of
 4138 no-fault demonstration projects as means to reduce and prevent
 4139 medical errors and promote patient safety.

4140 (4) The agency shall seek information and advice from and
 4141 consult with hospitals, physicians, other health care providers,
 4142 attorneys, consumers, and individuals involved with and
 4143 knowledgeable about patient safety and quality-of-care
 4144 initiatives.

4145 (5) In evaluating the need for, and the operation of, a
 4146 Patient Safety Authority, the agency shall determine the costs
 4147 of implementing and administering an authority and suggest
 4148 funding sources and mechanisms.

4149 (6) The agency shall complete its study and issue a report
 4150 to the Legislature by February 1, 2004. In its report, the
 4151 agency shall include specific findings, recommendations, and
 4152 proposed legislation.

4153 Section 74. The Office of Program Policy Analysis and
 4154 Government Accountability shall complete a study of the
 4155 eligibility requirements for a birth to be covered under the
 4156 Florida Birth-Related Neurological Injury Compensation
 4157 Association and submit a report to the Legislature by January 1,
 4158 2004, recommending whether the statutory criteria for a claim to
 4159 qualify for referral to the Florida Birth-Related Neurological
 4160 Injury Compensation Association under s. 766.302, Florida



4161 Statutes, should be modified.

4162 Section 75. Civil immunity for members of or consultants
 4163 to certain boards, committees, or other entities.--

4164 (1) Each member of, or health care professional consultant
 4165 to, any committee, board, group, commission, or other entity
 4166 shall be immune from civil liability for any act, decision,
 4167 omission, or utterance done or made in performance of his or her
 4168 duties while serving as a member of or consultant to such
 4169 committee, board, group, commission, or other entity established
 4170 and operated for purposes of quality improvement review,
 4171 evaluation, and planning in a state-licensed health care
 4172 facility. Such entities must function primarily to review,
 4173 evaluate, or make recommendations relating to:

4174 (a) The duration of patient stays in health care
 4175 facilities;

4176 (b) The professional services furnished with respect to
 4177 the medical, dental, psychological, podiatric, chiropractic, or
 4178 optometric necessity for such services;

4179 (c) The purpose of promoting the most efficient use of
 4180 available health care facilities and services;

4181 (d) The adequacy or quality of professional services;

4182 (e) The competency and qualifications for professional
 4183 staff privileges;

4184 (f) The reasonableness or appropriateness of charges made
 4185 by or on behalf of health care facilities; or

4186 (g) Patient safety, including entering into contracts with
 4187 patient safety organizations.

4188 (2) Such committee, board, group, commission, or other
 4189 entity must be established in accordance with state law or in
 4190 accordance with requirements of the Joint Commission on



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4191 Accreditation of Healthcare Organizations, established and duly
 4192 constituted by one or more public or licensed private hospitals
 4193 or behavioral health agencies, or established by a governmental
 4194 agency. To be protected by this section, the act, decision,
 4195 omission, or utterance may not be made or done in bad faith or
 4196 with malicious intent.

4197 Section 76. The Office of Program Policy Analysis and
 4198 Government Accountability and the Office of the Auditor General
 4199 must jointly conduct an audit of the Department of Health's
 4200 health care practitioner disciplinary process and closed claims
 4201 that are filed with the department under section 627.912,
 4202 Florida Statutes. The Office of Program Policy Analysis and
 4203 Government Accountability and the Office of the Auditor General
 4204 shall submit a report to the Legislature by January 1, 2005.

4205 Section 77. No later than September 1, 2003, the
 4206 Department of Health shall convene a workgroup to study the
 4207 current health care practitioner disciplinary process. The
 4208 workgroup shall include a representative of the Administrative
 4209 Law section of The Florida Bar, a representative of the Health
 4210 Law section of The Florida Bar, a representative of the Florida
 4211 Medical Association, a representative of the Florida Osteopathic
 4212 Medical Association, a representative of the Florida Dental
 4213 Association, a member of the Florida Board of Medicine who has
 4214 served on the probable cause panel, a member of the Board of
 4215 Osteopathic Medicine who has served on the probable cause panel,
 4216 and a member of the Board of Dentistry who has served on the
 4217 probable cause panel. The workgroup shall also include one
 4218 consumer member of the Board of Medicine. The Department of
 4219 Health shall present the findings and recommendations to the
 4220 Governor, the President of the Senate, and the Speaker of the



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4221 House of Representatives no later than January 1, 2004. The
 4222 sponsoring organizations shall assume the costs of their
 4223 representatives.

4224 Section 78. The Legislature finds and declares it to be of
 4225 vital importance that emergency services and care be provided by
 4226 hospitals, physicians, and emergency medical services providers
 4227 to every person in need of such care. The Legislature finds that
 4228 providers of emergency medical services and care are critical
 4229 elements in responding to disaster and emergency situations that
 4230 might affect our local communities, state, and country. The
 4231 Legislature recognizes the importance of maintaining a viable
 4232 system of providing for the emergency medical needs of residents
 4233 of this state and visitors to this state. The Legislature and
 4234 the Federal Government have required such providers of emergency
 4235 medical services and care to provide emergency services and care
 4236 to all persons who present themselves to hospitals seeking such
 4237 care. The Legislature has further mandated that prehospital
 4238 emergency medical treatment or transport may not be denied by
 4239 emergency medical services providers to persons who have or are
 4240 likely to have an emergency medical condition. Such governmental
 4241 requirements have imposed a unilateral obligation for providers
 4242 of emergency medical services and care to provide services to
 4243 all persons seeking emergency care without ensuring payment or
 4244 other consideration for provision of such care. The Legislature
 4245 also recognizes that providers of emergency medical services and
 4246 care provide a significant amount of uncompensated emergency
 4247 medical care in furtherance of such governmental interest. A
 4248 significant proportion of the residents of this state who are
 4249 uninsured or are Medicaid or Medicare recipients are unable to
 4250 access needed health care because health care providers fear the



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4251 increased risk of medical malpractice liability. Such patients,
4252 in order to obtain medical care, are frequently forced to seek
4253 care through providers of emergency medical services and care.
4254 Providers of emergency medical services and care in this state
4255 have reported significant problems with both the availability
4256 and affordability of professional liability coverage. Medical
4257 malpractice liability insurance premiums have increased
4258 dramatically and a number of insurers have ceased providing
4259 medical malpractice coverage for emergency medical services and
4260 care in this state. This results in a functional unavailability
4261 of malpractice coverage for some providers of emergency medical
4262 services and care. The Legislature further finds that certain
4263 specialist physicians have resigned from serving on hospital
4264 staffs or have otherwise declined to provide on-call coverage to
4265 hospital emergency departments due to increased medical
4266 malpractice liability exposure created by treating such
4267 emergency department patients. It is the intent of the
4268 Legislature that hospitals, emergency medical services
4269 providers, and physicians be able to ensure that patients who
4270 might need emergency medical services treatment or
4271 transportation or who present themselves to hospitals for
4272 emergency medical services and care have access to such needed
4273 services.

4274 Section 79. Legislative intent.--The Legislature declares
4275 that reducing the burden of proof in medical disciplinary cases
4276 to the level of greater weight of the evidence is necessary to
4277 protect the health, safety, and welfare of medical patients in
4278 the state. The Legislature declares that there is an
4279 overwhelming public necessity to protect medical patients which
4280 far overrides any purported property interest in a license to



4281 practice in this state held by a licensed health care
 4282 practitioner. Furthermore, the Legislature declares that it is a
 4283 privilege, not a right, to practice as a health care
 4284 professional in this state and that disciplinary action relating
 4285 to scope of practice issues in particular is remedial and
 4286 protective, not penal, in nature. The Legislature specifically
 4287 reverses case law to the contrary.

4288 Section 80. For the purpose of incorporating the amendment
 4289 to section 624.155, Florida Statutes, in references thereto,
 4290 subsection (1) of section 624.488, Florida Statutes, is
 4291 reenacted to read:

4292 624.488 Applicability of related laws.--In addition to
 4293 other provisions of the code cited in ss. 624.460-624.488:

4294 (1) Sections 624.155, 624.308, 624.414, 624.415, and
 4295 624.416(4); ss. 624.418-624.4211, except s. 624.418(2)(f); and
 4296 s. 624.501;

4297
 4298 apply to self-insurance funds. Only those sections of the code
 4299 that are expressly and specifically cited in ss. 624.460-624.489
 4300 apply to self-insurance funds.

4301 Section 81. For the purpose of incorporating the amendment
 4302 to section 624.155, Florida Statutes, in references thereto,
 4303 subsection (1) of section 628.6016, Florida Statutes, is
 4304 reenacted to read:

4305 628.6016 Applicability of related laws.--In addition to
 4306 other provisions of the code cited in ss. 628.6011-628.6018:

4307 (1) Sections 624.155, 624.308, 624.414, 624.415, and
 4308 624.416(4); ss. 624.418-624.4211, except s. 624.418(2)(f); ss.
 4309 624.464, 624.468(1), (2), (4), (6), and (11), 624.472, 624.473,
 4310 624.474, 624.480, 624.482, 624.484, 624.486, and 624.501;



4311
 4312 apply to assessable mutual insurers; however, ss. 628.255,
 4313 628.411, and 628.421 do not apply. No section of the code not
 4314 expressly and specifically cited in ss. 628.6011-628.6018
 4315 applies to assessable mutual insurers. The term "assessable
 4316 mutual insurer" shall be substituted for the term "commercial
 4317 self-insurer" as appropriate.

4318 Section 82. For the purpose of incorporating the amendment
 4319 to section 624.155, Florida Statutes, in references thereto,
 4320 Subsection (11) of section 631.717, Florida Statutes, is
 4321 reenacted to read:

4322 631.717 Powers and duties of the association.--

4323 (11) The association shall not be liable for any civil
 4324 action under s. 624.155 arising from any acts alleged to have
 4325 been committed by a member insurer prior to its liquidation;
 4326 however, this subsection does not affect the association's
 4327 obligation to pay valid claims presented to it.

4328 Section 83. If any provision of this act or the
 4329 application thereof to any person or circumstance is held
 4330 invalid, the invalidity does not affect other provisions or
 4331 applications of the act which can be given effect without the
 4332 invalid provision or application, and to this end the provisions
 4333 of this act are declared severable.

4334 Section 84. If any law amended by this act was also
 4335 amended by a law enacted at the 2003 Regular Session, the 2003
 4336 Special Session A, or the 2003 Special Session B of the
 4337 Legislature, such laws shall be construed as if they had been
 4338 enacted at the same session of the Legislature, and full effect
 4339 shall be given to each if possible.

4340 Section 85. This act shall take effect upon becoming a law



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4341 and shall apply to any cause of action accruing under chapter
4342 766, Florida Statutes, after that date, unless otherwise
4343 provided herein, except that the amendments to section 624.155,
4344 Florida Statutes, provided in this act shall apply to any
4345 medical incident for which a notice of intent to initiate
4346 litigation is mailed on or after the effective date of this act.