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1 A bill to be entitled

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



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



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

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



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



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



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



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



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



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



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



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



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



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



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

401

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

403

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

407 Section 2. Findings.--

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

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

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

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



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421 nation.

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

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

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

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

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

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

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

450 (12) The Legislature finds that ensuring that physicians



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

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

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

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

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

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

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



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481 medical malpractice insurance.

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

484 120.65 Administrative law judges.--

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

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

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

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

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

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



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

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

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

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

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

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

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



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

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

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



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

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

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

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



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

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

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

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



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

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

648 (6) The center shall:

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

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

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

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



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

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

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

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

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

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

675 (a) Notwithstanding any law to the contrary, each health
676 insurer issued a certificate of authority under part VI, part
677 VII, or part VIII of chapter 627 shall, as a condition of
678 maintaining such certificate, make payment to the center on
679 April 1 of each year in the amount of \$1 for each individual
680 insured covered by an insurance policy issued by or on behalf of
681 such insurer during the previous calendar year. Accompanying any
682 payment shall be a certification under oath by the chief
683 executive officer that states the number of individuals on which
684 such payment was based. The health insurer may collect this \$1
685 from policyholders. The center may direct the insurer to provide
686 an independent audit of the certification that shall be
687 furnished within 90 days. If payment is not received by the
688 center within 30 days after April 1, interest at the annualized
689 rate of 18 percent shall begin to be charged on the amount due.
690 If payment has not been received within 60 days after interest



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

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



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721 authority.

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

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

750 Accompanying payment shall be a certification under oath by the



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

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

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

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

780 (10) Pursuant to s. 287.057(5)(f)6., state agencies may



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781 contract with the center on a sole source basis for projects to
782 improve the quality of program administration, including, but
783 not limited to, the implementation of an electronic medical
784 record for Medicaid program recipients.

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

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

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

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

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

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

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

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

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



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

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

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

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

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

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

832 395.004 Application for license, fees; expenses.--

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



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

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

850 395.0056 Litigation notice requirement.--Upon receipt of
851 a copy of a complaint filed against a hospital as a defendant in
852 a medical malpractice action as required by s. 766.106(2), the
853 agency shall:

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

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

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

863 395.0191 Staff membership and clinical privileges.--

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



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871 ~~taken in good faith and without intentional fraud in carrying~~
 872 ~~out the provisions of this section.~~

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

875 395.0193 Licensed facilities; peer review; disciplinary
 876 powers; agency or partnership with physicians.--

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

889 (a) Incompetence.

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

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

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

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



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

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

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

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

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

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

925 395.0194 Licensed facilities; quality assurance
926 responsibilities of governing board.--

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



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

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



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

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

976 395.0197 Internal risk management program.--

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

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

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

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

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



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

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

- 1006 a. Live visual observation;
- 1007 b. Electronic observation; or
- 1008 c. Any other reasonable measure taken to ensure patient
 1009 protection and privacy.

1010 3. A prohibition against an unlicensed person from
 1011 assisting or participating in any surgical procedure unless the
 1012 facility has authorized the person to do so following a
 1013 competency assessment, and such assistance or participation is
 1014 done under the direct and immediate supervision of a licensed
 1015 physician and is not otherwise an activity that may only be
 1016 performed by a licensed health care practitioner.

1017 4. Development, implementation, and ongoing evaluation of
 1018 procedures, protocols, and systems to accurately identify
 1019 patients, planned procedures, and the correct site of the



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1020 planned procedure so as to minimize the performance of a
1021 surgical procedure on the wrong patient, a wrong surgical
1022 procedure, a wrong-site surgical procedure, or a surgical
1023 procedure otherwise unrelated to the patient's diagnosis or
1024 medical condition.

1025 (c) The analysis of patient grievances that relate to
1026 patient care and the quality of medical services.

1027 (d) A system for informing a patient or a proxy authorized
1028 by law to make health care decisions on behalf of a patient that
1029 the patient was the subject of an adverse incident as defined in
1030 subsection (5). Such notice shall be given by the risk manager,
1031 or his or her designee, as soon as practicable to allow the
1032 patient an opportunity to minimize damage or injury.

1033 (e)-~~(d)~~ The development and implementation of an incident
1034 reporting system based upon the affirmative duty of all health
1035 care providers and all agents and employees of the licensed
1036 health care facility to report adverse incidents to the risk
1037 manager, or to his or her designee, within 3 business days after
1038 their occurrence.

1039 (f) The development of a facilitywide plan for reducing
1040 medication errors, which shall include:

1041 1. The development of effective reporting mechanisms to
1042 ensure that medication-related errors are reviewed.

1043 2. The establishment of a baseline assessment and a review
1044 to be conducted at least annually of the effectiveness of the
1045 plan to reduce medication-related errors.

1046 3. The use of technology.

1047
1048 Pertinent literature related to the reduction of medication-
1049 related errors shall be reviewed and utilized in the development



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1050 and ongoing review of the plan developed pursuant to this
1051 paragraph.

1052 (3) In addition to the programs mandated by this section,
1053 other innovative approaches intended to reduce the frequency and
1054 severity of medical malpractice and patient injury claims shall
1055 be encouraged and their implementation and operation
1056 facilitated. Such additional approaches may include extending
1057 internal risk management programs to health care providers'
1058 offices and the assuming of provider liability by a licensed
1059 health care facility for acts or omissions occurring within the
1060 licensed facility. Each licensed facility shall annually report
1061 to the agency and the Department of Health the name and
1062 judgments entered against each health care practitioner for
1063 which the facility assumes liability. The agency and the
1064 Department of Health, in their respective annual reports, shall
1065 include statistics that report the number of licensed facilities
1066 that assume such liability and the number of health care
1067 practitioners, by profession, for whom they assume liability.

1068 (7) The licensed facility shall notify the agency no later
1069 than 7 calendar days ~~1 business day~~ after the risk manager or
1070 his or her designee has received a report pursuant to paragraph
1071 (1)(d) and can determine within 7 calendar days ~~1 business day~~
1072 that any of the following adverse incidents has occurred,
1073 whether occurring in the licensed facility or arising from
1074 health care prior to admission in the licensed facility:

1075 (a) The death of a patient;

1076 (b) Brain or spinal damage to a patient;

1077 (c) The performance of a surgical procedure on the wrong
1078 patient;

1079 (d) The performance of a wrong-site surgical procedure; or



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1080 (e) The performance of a wrong surgical procedure.

1081

1082 The notification must be made in writing and be provided by
1083 facsimile device or overnight mail delivery. The notification
1084 must include information regarding the identity of the affected
1085 patient, the type of adverse incident, the initiation of an
1086 investigation by the facility, and whether the events causing or
1087 resulting in the adverse incident represent a potential risk to
1088 other patients.

1089 (8) Any of the following adverse incidents, whether
1090 occurring in the licensed facility or arising from health care
1091 prior to admission in the licensed facility, shall be reported
1092 by the facility to the agency within 15 calendar days after its
1093 occurrence:

1094 (a) The death of a patient;

1095 (b) Brain or spinal damage to a patient;

1096 (c) The performance of a surgical procedure on the wrong
1097 patient;

1098 (d) The performance of a wrong-site surgical procedure;

1099 (e) The performance of a wrong surgical procedure;

1100 (f) The performance of a surgical procedure that is
1101 medically unnecessary or otherwise unrelated to the patient's
1102 diagnosis or medical condition;

1103 (g) The surgical repair of damage resulting to a patient
1104 from a planned surgical procedure, where the damage is not a
1105 recognized specific risk, as disclosed to the patient and
1106 documented through the informed-consent process; or

1107 (h) The performance of procedures to remove unplanned
1108 foreign objects remaining from a surgical procedure.

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1110 The agency may grant extensions to this reporting requirement
 1111 for more than 15 days upon justification submitted in writing by
 1112 the facility administrator to the agency. The agency may require
 1113 an additional, final report. These reports shall not be
 1114 available to the public pursuant to s. 119.07(1) or any other
 1115 law providing access to public records, nor be discoverable or
 1116 admissible in any civil or administrative action, except in
 1117 disciplinary proceedings by the agency or the appropriate
 1118 regulatory board, nor shall they be available to the public as
 1119 part of the record of investigation for and prosecution in
 1120 disciplinary proceedings made available to the public by the
 1121 agency or the appropriate regulatory board. However, the agency
 1122 or the appropriate regulatory board shall make available, upon
 1123 written request by a health care professional against whom
 1124 probable cause has been found, any such records which form the
 1125 basis of the determination of probable cause. The agency may
 1126 investigate, as it deems appropriate, any such incident and
 1127 prescribe measures that must or may be taken in response to the
 1128 incident. The agency shall review each incident and determine
 1129 whether it potentially involved conduct by the health care
 1130 professional who is subject to disciplinary action, in which
 1131 case the provisions of s. 456.073 shall apply. Copies of all
 1132 reports of adverse incidents submitted to the agency by
 1133 hospitals and ambulatory surgical centers shall be forwarded to
 1134 the Florida Center for Excellence in Health Care, as defined in
 1135 s. 381.0409, for analysis by experts who may make
 1136 recommendations regarding the prevention of such incidents. Such
 1137 information shall remain confidential as otherwise provided by
 1138 law.

1139 (12) If appropriate, a licensed facility in which sexual



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1140 abuse occurs must offer the victim of sexual abuse testing for
1141 sexually transmissible diseases and shall provide all such
1142 testing at no cost to the victim.

1143 Section 11. Section 395.1012, Florida Statutes, is created
1144 to read:

1145 395.1012 Patient safety.--

1146 (1) Each licensed facility shall adopt a patient safety
1147 plan. A plan adopted to implement the requirements of 42 C.F.R.
1148 s. 482.21 shall be deemed to comply with this requirement.

1149 (2) Each licensed facility shall appoint a patient safety
1150 officer and a patient safety committee, which shall include at
1151 least one person who is neither employed by nor practicing in
1152 the facility, for the purpose of promoting the health and safety
1153 of patients, reviewing and evaluating the quality of patient
1154 safety measures used by the facility, and assisting in the
1155 implementation of the facility patient safety plan.

1156 Section 12. Section 395.1051, Florida Statutes, is created
1157 to read:

1158 395.1051 Duty to notify patients.-- Every licensed
1159 facility shall inform each patient, or an individual identified
1160 pursuant to s. 765.401(1), in person about unanticipated
1161 outcomes of care that result in serious harm to the patient.
1162 Notification of outcomes of care that result in harm to the
1163 patient under this section shall not constitute an
1164 acknowledgement or admission of liability, nor can it be
1165 introduced as evidence in any civil lawsuit.

1166 Section 13. Section 456.026, Florida Statutes, is amended
1167 to read:

1168 456.026 Annual report concerning finances, administrative
1169 complaints, disciplinary actions, and recommendations.-- The



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1170 department is directed to prepare and submit a report to the
1171 President of the Senate and the Speaker of the House of
1172 Representatives by November 1 of each year. The department shall
1173 publish the report on its Internet website simultaneously with
1174 delivery to the President of the Senate and the Speaker of the
1175 House of Representatives. The report must be directly accessible
1176 on the department's Internet homepage highlighted by easily
1177 identifiable links and buttons. In addition to finances and any
1178 other information the Legislature may require, the report shall
1179 include statistics and relevant information, profession by
1180 profession, detailing:

1181 (1) The number of health care practitioners licensed by
1182 the Division of Medical Quality Assurance or otherwise
1183 authorized to provide services in the state, if known to the
1184 department.

1185 (2)~~(1)~~ The revenues, expenditures, and cash balances for
1186 the prior year, and a review of the adequacy of existing fees.

1187 (3)~~(2)~~ The number of complaints received and investigated.

1188 (4)~~(3)~~ The number of findings of probable cause made.

1189 (5)~~(4)~~ The number of findings of no probable cause made.

1190 (6)~~(5)~~ The number of administrative complaints filed.

1191 (7)~~(6)~~ The disposition of all administrative complaints.

1192 (8)~~(7)~~ A description of disciplinary actions taken.

1193 (9) For licensees under chapter 458, chapter 459, chapter
1194 461, or chapter 466, the professional liability claims and
1195 actions reported by insurers, as provided in s. 627.912. This
1196 information must be provided in a separate section of the report
1197 restricted to providing professional liability claims and
1198 actions data.



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1199 (10)~~(8)~~ A description of any effort by the department to
 1200 reduce or otherwise close any investigation or disciplinary
 1201 proceeding not before the Division of Administrative Hearings
 1202 under chapter 120 or otherwise not completed within 1 year after
 1203 the initial filing of a complaint under this chapter.

1204 (11)~~(9)~~ The status of the development and implementation
 1205 of rules providing for disciplinary guidelines pursuant to s.
 1206 456.079.

1207 (12)~~(10)~~ Such recommendations for administrative and
 1208 statutory changes necessary to facilitate efficient and cost-
 1209 effective operation of the department and the various boards.

1210 Section 14. Paragraph (a) of subsection (1) of section
 1211 456.039, Florida Statutes, is amended to read:

1212 456.039 Designated health care professionals; information
 1213 required for licensure.--

1214 (1) Each person who applies for initial licensure as a
 1215 physician under chapter 458, chapter 459, chapter 460, or
 1216 chapter 461, except a person applying for registration pursuant
 1217 to ss. 458.345 and 459.021, must, at the time of application,
 1218 and each physician who applies for license renewal under chapter
 1219 458, chapter 459, chapter 460, or chapter 461, except a person
 1220 registered pursuant to ss. 458.345 and 459.021, must, in
 1221 conjunction with the renewal of such license and under
 1222 procedures adopted by the Department of Health, and in addition
 1223 to any other information that may be required from the
 1224 applicant, furnish the following information to the Department
 1225 of Health:

1226 (a)1. The name of each medical school that the applicant
 1227 has attended, with the dates of attendance and the date of
 1228 graduation, and a description of all graduate medical education



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1229 completed by the applicant, excluding any coursework taken to
 1230 satisfy medical licensure continuing education requirements.

1231 2. The name of each hospital at which the applicant has
 1232 privileges.

1233 3. The address at which the applicant will primarily
 1234 conduct his or her practice.

1235 4. Any certification that the applicant has received from
 1236 a specialty board that is recognized by the board to which the
 1237 applicant is applying.

1238 5. The year that the applicant began practicing medicine.

1239 6. Any appointment to the faculty of a medical school
 1240 which the applicant currently holds and an indication as to
 1241 whether the applicant has had the responsibility for graduate
 1242 medical education within the most recent 10 years.

1243 7. A description of any criminal offense of which the
 1244 applicant has been found guilty, regardless of whether
 1245 adjudication of guilt was withheld, or to which the applicant
 1246 has pled guilty or nolo contendere. A criminal offense committed
 1247 in another jurisdiction which would have been a felony or
 1248 misdemeanor if committed in this state must be reported. If the
 1249 applicant indicates that a criminal offense is under appeal and
 1250 submits a copy of the notice for appeal of that criminal
 1251 offense, the department must state that the criminal offense is
 1252 under appeal if the criminal offense is reported in the
 1253 applicant's profile. If the applicant indicates to the
 1254 department that a criminal offense is under appeal, the
 1255 applicant must, upon disposition of the appeal, submit to the
 1256 department a copy of the final written order of disposition.

1257 8. A description of any final disciplinary action taken
 1258 within the previous 10 years against the applicant by the agency



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1259 regulating the profession that the applicant is or has been
1260 licensed to practice, whether in this state or in any other
1261 jurisdiction, by a specialty board that is recognized by the
1262 American Board of Medical Specialties, the American Osteopathic
1263 Association, or a similar national organization, or by a
1264 licensed hospital, health maintenance organization, prepaid
1265 health clinic, ambulatory surgical center, or nursing home.
1266 Disciplinary action includes resignation from or nonrenewal of
1267 medical staff membership or the restriction of privileges at a
1268 licensed hospital, health maintenance organization, prepaid
1269 health clinic, ambulatory surgical center, or nursing home taken
1270 in lieu of or in settlement of a pending disciplinary case
1271 related to competence or character. If the applicant indicates
1272 that the disciplinary action is under appeal and submits a copy
1273 of the document initiating an appeal of the disciplinary action,
1274 the department must state that the disciplinary action is under
1275 appeal if the disciplinary action is reported in the applicant's
1276 profile.

1277 9. Relevant professional qualifications as defined by the
1278 applicable board.

1279 Section 15 Section 456.041, Florida Statutes, is amended
1280 to read:

1281 456.041 Practitioner profile; creation.--

1282 (1)(a) Beginning July 1, 1999, the Department of Health
1283 shall compile the information submitted pursuant to s. 456.039
1284 into a practitioner profile of the applicant submitting the
1285 information, except that the Department of Health may develop a
1286 format to compile uniformly any information submitted under s.
1287 456.039(4)(b). Beginning July 1, 2001, the Department of Health
1288 may, and beginning July 1, 2004, shall, compile the information



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1289 submitted pursuant to s. 456.0391 into a practitioner profile of
 1290 the applicant submitting the information.

1291 (b) Each practitioner licensed under chapter 458 or
 1292 chapter 459 must report to the Department of Health and the
 1293 Board of Medicine or the Board of Osteopathic Medicine,
 1294 respectively, all final disciplinary actions, sanctions by a
 1295 governmental agency or a facility or entity licensed under state
 1296 law, and claims or actions, as provided under s. 456.051, to
 1297 which he or she is subject no later than 15 calendar days after
 1298 such action or sanction is imposed. Failure to submit the
 1299 requisite information within 15 calendar days in accordance with
 1300 this paragraph shall subject the practitioner to discipline by
 1301 the Board of Medicine or the Board of Osteopathic Medicine and a
 1302 fine of \$100 for each day that the information is not submitted
 1303 after the expiration of the 15-day reporting period.

1304 (c) Within 15 days after receiving a report under
 1305 paragraph (b), the department shall update the practitioner's
 1306 profile in accordance with the requirements of subsection (7).

1307 (2) On the profile published under subsection (1), the
 1308 department shall indicate whether ~~if~~ the information provided
 1309 under s. 456.039(1)(a)7. or s. 456.0391(1)(a)7. is or is not
 1310 corroborated by a criminal history check conducted according to
 1311 this subsection. ~~If the information provided under s.~~
 1312 ~~456.039(1)(a)7. or s. 456.0391(1)(a)7. is corroborated by the~~
 1313 ~~criminal history check, the fact that the criminal history check~~
 1314 ~~was performed need not be indicated on the profile.~~ The
 1315 department, or the board having regulatory authority over the
 1316 practitioner acting on behalf of the department, shall
 1317 investigate any information received by the department or the
 1318 board when it has reasonable grounds to believe that the



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1319 practitioner has violated any law that relates to the
1320 practitioner's practice.

1321 (3) The Department of Health shall ~~may~~ include in each
1322 practitioner's practitioner profile that criminal information
1323 that directly relates to the practitioner's ability to
1324 competently practice his or her profession. The department must
1325 include in each practitioner's practitioner profile the
1326 following statement: "The criminal history information, if any
1327 exists, may be incomplete; federal criminal history information
1328 is not available to the public." The department shall provide in
1329 each practitioner profile, for every final disciplinary action
1330 taken against the practitioner, a narrative description, written
1331 in plain English, that explains the administrative complaint
1332 filed against the practitioner and the final disciplinary action
1333 imposed on the practitioner. The department shall include a
1334 hyperlink to each final order listed on its Internet website
1335 report of dispositions of recent disciplinary actions taken
1336 against practitioners.

1337 (4) The Department of Health shall include, with respect
1338 to a practitioner licensed under chapter 458 or chapter 459, a
1339 statement of how the practitioner has elected to comply with the
1340 financial responsibility requirements of s. 458.320 or s.
1341 459.0085. The department shall include, with respect to
1342 practitioners subject to s. 456.048, a statement of how the
1343 practitioner has elected to comply with the financial
1344 responsibility requirements of that section. The department
1345 shall include, with respect to practitioners licensed under
1346 chapter 458, chapter 459, or chapter 461, information relating
1347 to liability actions which has been reported under s. 456.049 or
1348 s. 627.912 within the previous 10 years for any paid claim of



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1349 \$50,000 or more ~~that exceeds \$5,000~~. Such claims information
1350 shall be reported in the context of comparing an individual
1351 practitioner's claims to the experience of other practitioners
1352 within the same specialty, or profession if the practitioner is
1353 not a specialist, ~~to the extent such information is available to~~
1354 ~~the Department of Health~~. The department shall include a
1355 hyperlink to all such comparison reports in such practitioner's
1356 profile on its Internet website. If information relating to a
1357 liability action is included in a practitioner's practitioner
1358 profile, the profile must also include the following statement:
1359 "Settlement of a claim may occur for a variety of reasons that
1360 do not necessarily reflect negatively on the professional
1361 competence or conduct of the practitioner. A payment in
1362 settlement of a medical malpractice action or claim should not
1363 be construed as creating a presumption that medical malpractice
1364 has occurred."

1365 (5) The Department of Health shall ~~may not~~ include the
1366 date of a disciplinary action taken by a licensed hospital or an
1367 ambulatory surgical center, in accordance with the requirements
1368 of s. 395.0193, in the practitioner profile. Any practitioner
1369 disciplined under paragraph (1)(b) must report to the department
1370 the date the disciplinary action was imposed. The department
1371 shall state whether the action is related to professional
1372 competence and whether it is related to the delivery of services
1373 to a patient.

1374 (6) The Department of Health may include in the
1375 practitioner's practitioner profile any other information that
1376 is a public record of any governmental entity and that relates
1377 to a practitioner's ability to competently practice his or her
1378 profession. However, the department must consult with the board



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1379 having regulatory authority over the practitioner before such
1380 information is included in his or her profile.

1381 (7) Upon the completion of a practitioner profile under
1382 this section, the Department of Health shall furnish the
1383 practitioner who is the subject of the profile a copy of it. The
1384 practitioner has a period of 30 days in which to review the
1385 profile and to correct any factual inaccuracies in it. The
1386 Department of Health shall make the profile available to the
1387 public at the end of the 30-day period. The department shall
1388 make the profiles available to the public through the World Wide
1389 Web and other commonly used means of distribution.

1390 (8) The Department of Health shall provide in each profile
1391 an easy-to-read explanation of any disciplinary action taken and
1392 the reason the sanction or sanctions were imposed.

1393 (9)~~(8)~~ Making a practitioner profile available to the
1394 public under this section does not constitute agency action for
1395 which a hearing under s. 120.57 may be sought.

1396 Section 15. Section 456.042, Florida Statutes, is amended
1397 to read:

1398 456.042 Practitioner profiles; update.--A practitioner
1399 must submit updates of required information within 15 days after
1400 the final activity that renders such information a fact. The
1401 Department of Health shall update each practitioner's
1402 practitioner profile periodically. An updated profile is subject
1403 to the same requirements as an original profile with respect to
1404 the period within which the practitioner may review the profile
1405 for the purpose of correcting factual inaccuracies.

1406 Section 16. Subsection (1) of section 456.049, Florida
1407 Statutes, is amended, and subsection (3) is added to said
1408 section, to read:



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1409 456.049 Health care practitioners; reports on professional
 1410 liability claims and actions.--

1411 (1) Any practitioner of medicine licensed pursuant to the
 1412 provisions of chapter 458, practitioner of osteopathic medicine
 1413 licensed pursuant to the provisions of chapter 459, podiatric
 1414 physician licensed pursuant to the provisions of chapter 461, or
 1415 dentist licensed pursuant to the provisions of chapter 466 shall
 1416 report to the department any claim or action for damages for
 1417 personal injury alleged to have been caused by error, omission,
 1418 or negligence in the performance of such licensee's professional
 1419 services or based on a claimed performance of professional
 1420 services without consent if ~~the claim was not covered by an~~
 1421 ~~insurer required to report under s. 627.912 and the claim~~
 1422 resulted in:

1423 (a) A final judgment of \$50,000 or more or, with respect
 1424 to a dentist licensed pursuant to chapter 466, a final judgment
 1425 of \$25,000 or more in any amount.

1426 (b) A settlement of \$50,000 or more or, with respect to a
 1427 dentist licensed pursuant to chapter 466, a settlement of
 1428 \$25,000 or more in any amount.

1429 (c) A final disposition not resulting in payment on behalf
 1430 of the licensee.

1431
 1432 Reports shall be filed with the department no later than 60 days
 1433 following the occurrence of any event listed in paragraph (a),
 1434 paragraph (b), or paragraph (c).

1435 (3) The department shall forward the information collected
 1436 under this section to the Office of Insurance Regulation.

1437 Section 17. Section 456.051, Florida Statutes, is amended
 1438 to read:



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1439 456.051 Reports of professional liability actions;
 1440 bankruptcies; Department of Health's responsibility to
 1441 provide.--

1442 (1) The report of a claim or action for damages for
 1443 personal injury which is required to be provided to the
 1444 Department of Health under s. 456.049 or s. 627.912 is public
 1445 information except for the name of the claimant or injured
 1446 person, which remains confidential as provided in ss.
 1447 456.049(2)(d) and 627.912(2)(e). The Department of Health shall,
 1448 upon request, make such report available to any person. The
 1449 department shall make such report available as a part of the
 1450 practitioner's profile within 45 calendar days after receipt.

1451 (2) Any information in the possession of the Department of
 1452 Health which relates to a bankruptcy proceeding by a
 1453 practitioner of medicine licensed under chapter 458, a
 1454 practitioner of osteopathic medicine licensed under chapter 459,
 1455 a podiatric physician licensed under chapter 461, or a dentist
 1456 licensed under chapter 466 is public information. The Department
 1457 of Health shall, upon request, make such information available
 1458 to any person. The department shall make such report available
 1459 as a part of the practitioner's profile within 45 calendar days
 1460 after receipt.

1461 Section 18. Paragraph (a) of subsection (7) of section
 1462 456.057, Florida Statutes, is amended to read:

1463 456.057 Ownership and control of patient records; report
 1464 or copies of records to be furnished.--

1465 (7)(a)1. The department may obtain patient records
 1466 pursuant to a subpoena without written authorization from the
 1467 patient if the department and the probable cause panel of the
 1468 appropriate board, if any, find reasonable cause to believe that



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1469 a health care practitioner has excessively or inappropriately
1470 prescribed any controlled substance specified in chapter 893 in
1471 violation of this chapter or any professional practice act or
1472 that a health care practitioner has practiced his or her
1473 profession below that level of care, skill, and treatment
1474 required as defined by this chapter or any professional practice
1475 act and also find that appropriate, reasonable attempts were
1476 made to obtain a patient release.

1477 2. The department may obtain patient records and insurance
1478 information pursuant to a subpoena without written authorization
1479 from the patient if the department and the probable cause panel
1480 of the appropriate board, if any, find reasonable cause to
1481 believe that a health care practitioner has provided inadequate
1482 medical care based on termination of insurance and also find
1483 that appropriate, reasonable attempts were made to obtain a
1484 patient release.

1485 3. The department may obtain patient records, billing
1486 records, insurance information, provider contracts, and all
1487 attachments thereto pursuant to a subpoena without written
1488 authorization from the patient if the department and probable
1489 cause panel of the appropriate board, if any, find reasonable
1490 cause to believe that a health care practitioner has submitted a
1491 claim, statement, or bill using a billing code that would result
1492 in payment greater in amount than would be paid using a billing
1493 code that accurately describes the services performed, requested
1494 payment for services that were not performed by that health care
1495 practitioner, used information derived from a written report of
1496 an automobile accident generated pursuant to chapter 316 to
1497 solicit or obtain patients personally or through an agent
1498 regardless of whether the information is derived directly from



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1499 the report or a summary of that report or from another person,
1500 solicited patients fraudulently, received a kickback as defined
1501 in s. 456.054, violated the patient brokering provisions of s.
1502 817.505, or presented or caused to be presented a false or
1503 fraudulent insurance claim within the meaning of s.
1504 817.234(1)(a), and also find that, within the meaning of s.
1505 817.234(1)(a), patient authorization cannot be obtained because
1506 the patient cannot be located or is deceased, incapacitated, or
1507 suspected of being a participant in the fraud or scheme, and if
1508 the subpoena is issued for specific and relevant records.

1509 4. Notwithstanding subparagraphs 1.-3., when the
1510 department investigates a professional liability claim or
1511 undertakes action pursuant to s. 456.049 or s. 627.912, the
1512 department may obtain patient records pursuant to a subpoena
1513 without written authorization from the patient if the patient
1514 refuses to cooperate or attempts to obtain a patient release and
1515 failure to obtain the patient records would be detrimental to
1516 the investigation.

1517 Section 19. Section 456.0575, Florida Statutes, is created
1518 to read:

1519 456.0575 Duty to notify patients.--Every licensed health
1520 care practitioner shall inform each patient, or an individual
1521 identified pursuant to s. 765.401(1), in person about adverse
1522 incidents that result in serious harm to the patient.

1523 Notification of outcomes of care that result in harm to the
1524 patient under this section shall not constitute an
1525 acknowledgement of admission of liability, nor can such
1526 notifications be introduced as evidence in any civil lawsuit.

1527 Section 20. Patient safety discount.--A health care
1528 facility licensed pursuant to chapter 395, Florida Statutes, may



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1529 apply to the Department of Financial Services for certification
 1530 of any program that is recommended by the Florida Center for
 1531 Excellence in Health Care to reduce adverse incidents, as
 1532 defined in s. 395.0197, Florida Statutes, which result in the
 1533 reduction of serious events at that facility. The department
 1534 shall develop criteria for such certification. Insurers shall
 1535 file with the department a discount in the rate or rates
 1536 applicable for insurance coverage to reflect the effect of a
 1537 certified program. A health care facility shall receive a
 1538 discount in the rate or rates applicable for mandated basic
 1539 insurance coverage required by law. In reviewing filings under
 1540 this section, the department shall consider whether, and the
 1541 extent to which, the program certified under this section is
 1542 otherwise covered under a program of risk management offered by
 1543 an insurance company or exchange or self-insurance plan
 1544 providing medical professional liability coverage.

1545 Section 21. Subsection (4) is added to section 456.063,
 1546 Florida Statutes, to read:

1547 456.063 Sexual misconduct; disqualification for license,
 1548 certificate, or registration.--

1549 (4) Each board, or the department if there is no board,
 1550 may adopt rules to implement the requirements for reporting
 1551 allegations of sexual misconduct, including rules to determine
 1552 the sufficiency of the allegations.

1553 Section 22. Subsection (4) of section 456.072, Florida
 1554 Statutes, is amended, and subsection (7) is added to said
 1555 section, to read:

1556 456.072 Grounds for discipline; penalties; enforcement.--

1557 (4) In any addition to any other discipline imposed
 1558 ~~through~~ final order, or citation, entered on or after July 1,



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1559 2001, that imposes a penalty or other form of discipline
 1560 pursuant to this section or discipline imposed through final
 1561 order, or citation, entered on or after July 1, 2001, for a
 1562 violation of any practice act, the board, or the department when
 1563 there is no board, shall assess costs related to the
 1564 investigation and prosecution of the case, including costs
 1565 associated with an attorney's time. The amount of costs to be
 1566 assessed shall be determined by the board, or the department
 1567 when there is no board, following its consideration of an
 1568 affidavit of itemized costs and any written objections thereto.
 1569 In any case in which ~~where the board or the department imposes~~ a
 1570 fine or assessment of costs imposed by the board or department
 1571 ~~and the fine or assessment~~ is not paid within a reasonable time,
 1572 such reasonable time to be prescribed in the rules of the board,
 1573 or the department when there is no board, or in the order
 1574 assessing such fines or costs, the department or the Department
 1575 of Legal Affairs may contract for the collection of, or bring a
 1576 civil action to recover, the fine or assessment.

1577 (7) In any formal administrative hearing conducted under
 1578 s. 120.57(1), the board or department shall establish grounds
 1579 for the discipline of a licensee by the greater weight of the
 1580 evidence.

1581 Section 23. Subsections (1) and (5) of section 456.073,
 1582 Florida Statutes, are amended to read:

1583 456.073 Disciplinary proceedings.-- Disciplinary
 1584 proceedings for each board shall be within the jurisdiction of
 1585 the department.

1586 (1) The department, for the boards under its jurisdiction,
 1587 shall cause to be investigated any complaint that is filed
 1588 before it if the complaint is in writing, signed by the



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1589 complainant, and legally sufficient. A complaint is legally
1590 sufficient if it contains ultimate facts that show that a
1591 violation of this chapter, of any of the practice acts relating
1592 to the professions regulated by the department, or of any rule
1593 adopted by the department or a regulatory board in the
1594 department has occurred. In order to determine legal
1595 sufficiency, the department may require supporting information
1596 or documentation. The department may investigate, and the
1597 department or the appropriate board may take appropriate final
1598 action on, a complaint even though the original complainant
1599 withdraws it or otherwise indicates a desire not to cause the
1600 complaint to be investigated or prosecuted to completion. The
1601 department may investigate an anonymous complaint if the
1602 complaint is in writing and is legally sufficient, if the
1603 alleged violation of law or rules is substantial, and if the
1604 department has reason to believe, after preliminary inquiry,
1605 that the violations alleged in the complaint are true. The
1606 department may investigate a complaint made by a confidential
1607 informant if the complaint is legally sufficient, if the alleged
1608 violation of law or rule is substantial, and if the department
1609 has reason to believe, after preliminary inquiry, that the
1610 allegations of the complainant are true. The department may
1611 initiate an investigation if it has reasonable cause to believe
1612 that a licensee or a group of licensees has violated a Florida
1613 statute, a rule of the department, or a rule of a board. The
1614 department may investigate information filed pursuant to s.
1615 456.041(4) relating to liability actions with respect to health
1616 care practitioners licensed under chapter 458 and chapter 459
1617 which have been reported under s. 456.049 or s. 627.912 within
1618 the previous 5 years for any paid claim that exceeds \$50,000.



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1619 Except as provided in ss. 458.331(9), 459.015(9), 460.413(5),
1620 and 461.013(6), when an investigation of any subject is
1621 undertaken, the department shall promptly furnish to the subject
1622 or the subject's attorney a copy of the complaint or document
1623 that resulted in the initiation of the investigation. The
1624 subject may submit a written response to the information
1625 contained in such complaint or document within 20 days after
1626 service to the subject of the complaint or document. The
1627 subject's written response shall be considered by the probable
1628 cause panel. The right to respond does not prohibit the issuance
1629 of a summary emergency order if necessary to protect the public.
1630 However, if the secretary, or the secretary's designee, and the
1631 chair of the respective board or the chair of its probable cause
1632 panel agree in writing that such notification would be
1633 detrimental to the investigation, the department may withhold
1634 notification. The department may conduct an investigation
1635 without notification to any subject if the act under
1636 investigation is a criminal offense.

1637 (5)(a) A formal hearing before an administrative law judge
1638 from the Division of Administrative Hearings shall be held
1639 pursuant to chapter 120 if there are any disputed issues of
1640 material fact. The administrative law judge shall issue a
1641 recommended order pursuant to chapter 120. If any party raises
1642 an issue of disputed fact during an informal hearing, the
1643 hearing shall be terminated and a formal hearing pursuant to
1644 chapter 120 shall be held.

1645 (b) Notwithstanding s. 120.569(2), the department shall
1646 notify the Division of Administrative Hearings within 45 days
1647 after receipt of a petition or request for a hearing that the



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1648 department has determined requires a formal hearing before an
1649 administrative law judge.

1650 Section 24. Subsections (1) and (2) of section 456.077,
1651 Florida Statutes, are amended to read:

1652 456.077 Authority to issue citations.--

1653 (1) Notwithstanding s. 456.073, the board, or the
1654 department if there is no board, shall adopt rules to permit the
1655 issuance of citations. The citation shall be issued to the
1656 subject and shall contain the subject's name and address, the
1657 subject's license number if applicable, a brief factual
1658 statement, the sections of the law allegedly violated, and the
1659 penalty imposed. The citation must clearly state that the
1660 subject may choose, in lieu of accepting the citation, to follow
1661 the procedure under s. 456.073. If the subject disputes the
1662 matter in the citation, the procedures set forth in s. 456.073
1663 must be followed. However, if the subject does not dispute the
1664 matter in the citation with the department within 30 days after
1665 the citation is served, the citation becomes a public final
1666 order and does not constitute ~~constitutes~~ discipline for a first
1667 offense, but does constitute discipline for a second or
1668 subsequent offense. The penalty shall be a fine or other
1669 conditions as established by rule.

1670 (2) The board, or the department if there is no board,
1671 shall adopt rules designating violations for which a citation
1672 may be issued. Such rules shall designate as citation violations
1673 those violations for which there is no substantial threat to the
1674 public health, safety, and welfare or no violation of standard
1675 of care involving injury to a patient. Violations for which a
1676 citation may be issued shall include violations of continuing
1677 education requirements; failure to timely pay required fees and



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1678 fines; failure to comply with the requirements of ss. 381.026
 1679 and 381.0261 regarding the dissemination of information
 1680 regarding patient rights; failure to comply with advertising
 1681 requirements; failure to timely update practitioner profile and
 1682 credentialing files; failure to display signs, licenses, and
 1683 permits; failure to have required reference books available; and
 1684 all other violations that do not pose a direct and serious
 1685 threat to the health and safety of the patient or involve a
 1686 violation of standard of care that has resulted in injury to a
 1687 patient.

1688 Section 25. Subsections (1) and (2) of section 456.078,
 1689 Florida Statutes, are amended to read:

1690 456.078 Mediation.--

1691 (1) Notwithstanding the provisions of s. 456.073, the
 1692 board, or the department when there is no board, shall adopt
 1693 rules to designate which violations of the applicable
 1694 professional practice act are appropriate for mediation. The
 1695 board, or the department when there is no board, shall ~~may~~
 1696 designate as mediation offenses those complaints where harm
 1697 caused by the licensee is economic in nature, except any act or
 1698 omission involving intentional misconduct, ~~or~~ can be remedied by
 1699 the licensee, is not a standard of care violation involving any
 1700 type of injury to a patient, or does not result in an adverse
 1701 incident. For the purposes of this section, an "adverse
 1702 incident" means an event that results in:

1703 (a) The death of a patient;

1704 (b) Brain or spinal damage to a patient;

1705 (c) The performance of a surgical procedure on the wrong
 1706 patient;

1707 (d) The performance of a wrong-site surgical procedure;



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1708 (e) The performance of a surgical procedure that is
1709 medically unnecessary or otherwise unrelated to the patient's
1710 diagnosis or medical condition;

1711 (f) The surgical repair of damage to a patient resulting
1712 from a planned surgical procedure, which damage is not a
1713 recognized specific risk as disclosed to the patient and
1714 documented through the informed-consent process;

1715 (g) The performance of a procedure to remove unplanned
1716 foreign objects remaining from a surgical procedure; or

1717 (h) The performance of any other surgical procedure that
1718 breached the standard of care.

1719 (2) After the department determines a complaint is legally
1720 sufficient and the alleged violations are defined as mediation
1721 offenses, the department or any agent of the department may
1722 conduct informal mediation to resolve the complaint. If the
1723 complainant and the subject of the complaint agree to a
1724 resolution of a complaint within 14 days after contact by the
1725 mediator, the mediator shall notify the department of the terms
1726 of the resolution. The department or board shall take no further
1727 action unless the complainant and the subject each fail to
1728 record with the department an acknowledgment of satisfaction of
1729 the terms of mediation within 60 days of the mediator's
1730 notification to the department. A successful mediation which
1731 results in an award of \$50,000 or less shall not constitute
1732 discipline. In the event the complainant and subject fail to
1733 reach settlement terms or to record the required acknowledgment,
1734 the department shall process the complaint according to the
1735 provisions of s. 456.073.

1736 Section 26. Civil immunity for members of or consultants
1737 to certain boards, committees, or other entities.--



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1738 (1) Each member of, or health care professional consultant
 1739 to, any committee, board, group, commission, or other entity
 1740 shall be immune from civil liability for any act, decision,
 1741 omission, or utterance done or made in performance of his or her
 1742 duties while serving as a member of or consultant to such
 1743 committee, board, group, commission, or other entity established
 1744 and operated for purposes of quality improvement review,
 1745 evaluation, and planning in a state-licensed health care
 1746 facility. Such entities must function primarily to review,
 1747 evaluate, or make recommendations relating to:

1748 (a) The duration of patient stays in health care
 1749 facilities;

1750 (b) The professional services furnished with respect to
 1751 the medical, dental, psychological, podiatric, chiropractic, or
 1752 optometric necessity for such services;

1753 (c) The purpose of promoting the most efficient use of
 1754 available health care facilities and services;

1755 (d) The adequacy or quality of professional services;

1756 (e) The competency and qualifications for professional
 1757 staff privileges;

1758 (f) The reasonableness or appropriateness of charges made
 1759 by or on behalf of health care facilities; or

1760 (g) Patient safety, including entering into contracts with
 1761 patient safety organizations.

1762 (2) Such committee, board, group, commission, or other
 1763 entity must be established in accordance with state law or in
 1764 accordance with requirements of the Joint Commission on
 1765 Accreditation of Healthcare Organizations, established and duly
 1766 constituted by one or more public or licensed private hospitals
 1767 or behavioral health agencies, or established by a governmental



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1768 agency. To be protected by this section, the act, decision,
 1769 omission, or utterance may not be made or done in bad faith or
 1770 with malicious intent.

1771 Section 27. Patient safety data privilege.--

1772 (1) As used in this section, the term:

1773 (a) "Patient safety data" means reports made to patient
 1774 safety organizations, including all health care data,
 1775 interviews, memoranda, analyses, root cause analyses, products
 1776 of quality assurance or quality improvement processes,
 1777 corrective action plans, or information collected or created by
 1778 a health care facility licensed under chapter 395, Florida
 1779 Statutes, or a health care practitioner as defined in s.
 1780 456.001(4), Florida Statutes, as a result of an occurrence
 1781 related to the provision of health care services which
 1782 exacerbates an existing medical condition or could result in
 1783 injury, illness, or death.

1784 (b) "Patient safety organization" means any organization,
 1785 group, or other entity that collects and analyzes patient safety
 1786 data for the purpose of improving patient safety and health care
 1787 outcomes and that is independent and not under the control of
 1788 the entity that reports patient safety data.

1789 (2) Patient safety data shall not be subject to discovery
 1790 or introduction into evidence in any civil or administrative
 1791 action.

1792 (3) Unless otherwise provided by law, a patient safety
 1793 organization shall promptly remove all patient-identifying
 1794 information after receipt of a complete patient safety data
 1795 report unless such organization is otherwise permitted by state
 1796 or federal law to maintain such information. Patient safety
 1797 organizations shall maintain the confidentiality of all patient-



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1798 identifying information and may not disseminate such
 1799 information, except as permitted by state or federal law.

1800 (4) The exchange of patient safety data among health care
 1801 facilities licensed under chapter 395, Florida Statutes, or
 1802 health care practitioners as defined in s. 456.001(4), Florida
 1803 Statutes, or patient safety organizations which does not
 1804 identify any patient shall not constitute a waiver of any
 1805 privilege established in this section.

1806 (5) Reporting of patient safety data to patient safety
 1807 organizations does not abrogate obligations to make reports to
 1808 the Department of Health, the Agency for Health Care
 1809 Administration, or other state or federal regulatory agencies.

1810 (6) An employer may not take retaliatory action against an
 1811 employee who in good faith makes a report of patient safety data
 1812 to a patient safety organization.

1813 Section 28. Each board within the Department of Health
 1814 which has jurisdiction over health care practitioners who are
 1815 authorized to prescribe drugs may adopt by rule standards of
 1816 practice for health care practitioners who are under that
 1817 board's jurisdiction for the safe and ethical prescription of
 1818 drugs to patients via the Internet or other electronic means.

1819 Section 29. The Office of Program Policy Analysis and
 1820 Government Accountability and the Office of the Auditor General
 1821 must jointly conduct an audit of the Department of Health's
 1822 health care practitioner disciplinary process and closed claims
 1823 that are filed with the department under s. 627.912, Florida
 1824 Statutes. The Office of Program Policy Analysis and Government
 1825 Accountability and the Office of the Auditor General shall
 1826 submit a report to the Legislature by January 1, 2004.

1827 Section 30. Subsection (10) is added to section 458.320,



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1828 Florida Statutes, subsection (8) of said section is renumbered
1829 as subsection (9), and a new subsection (8) is added to said
1830 section, to read:

1831 458.320 Financial responsibility.--

1832 (8) Notwithstanding any other provision of this section,
1833 the department shall suspend the license of any physician who
1834 does not have insurance as required by this section against whom
1835 has been entered a final judgment, arbitration award, or other
1836 order or who has entered into a settlement agreement to pay
1837 damages arising out of a claim for medical malpractice, if all
1838 appellate remedies have been exhausted and payment up to the
1839 amounts required by this section has not been made within 30
1840 days after the entering of such judgment, award, order, or
1841 agreement, until proof of payment is received by the department
1842 or a payment schedule has been agreed upon by the physician and
1843 the claimant and presented to the department. This subsection
1844 does not apply to a physician who has met the financial
1845 responsibility requirements in paragraphs (1)(b) and (2)(b).

1846 (10) Nothing in this section shall be construed as
1847 creating a civil cause of action against any hospital as a
1848 result of the failure of any physician with staff privileges to
1849 comply with the requirements of this section.

1850 Section 31. Paragraph (t) of subsection (1) and
1851 subsections (3) and (6) of section 458.331, Florida Statutes,
1852 are amended to read:

1853 458.331 Grounds for disciplinary action; action by the
1854 board and department.--

1855 (1) The following acts constitute grounds for denial of a
1856 license or disciplinary action, as specified in s. 456.072(2):



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1857 (t) Gross or repeated malpractice or the failure to
1858 practice medicine with that level of care, skill, and treatment
1859 which is recognized by a reasonably prudent similar physician as
1860 being acceptable under similar conditions and circumstances. The
1861 board shall give great weight to the provisions of s. 766.102
1862 when enforcing this paragraph. As used in this paragraph,
1863 "repeated malpractice" includes, but is not limited to, three or
1864 more claims for medical malpractice within the previous 5-year
1865 period resulting in indemnities being paid in excess of \$50,000
1866 ~~\$25,000~~ each to the claimant in a judgment or settlement and
1867 which incidents involved negligent conduct by the physician. As
1868 used in this paragraph, "gross malpractice" or "the failure to
1869 practice medicine with that level of care, skill, and treatment
1870 which is recognized by a reasonably prudent similar physician as
1871 being acceptable under similar conditions and circumstances,"
1872 shall not be construed so as to require more than one instance,
1873 event, or act. Nothing in this paragraph shall be construed to
1874 require that a physician be incompetent to practice medicine in
1875 order to be disciplined pursuant to this paragraph.

1876 (3) In any administrative action against a physician ~~which~~
1877 ~~does not involve revocation or suspension of license~~, the
1878 division shall have the burden, by the greater weight of the
1879 evidence, to establish the existence of grounds for disciplinary
1880 action. ~~The division shall establish grounds for revocation or~~
1881 ~~suspension of license by clear and convincing evidence.~~

1882 (6) Upon the department's receipt from an insurer or self-
1883 insurer of a report of a closed claim against a physician
1884 pursuant to s. 627.912 or from a health care practitioner of a
1885 report pursuant to s. 456.049, or upon the receipt from a
1886 claimant of a presuit notice against a physician pursuant to s.



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1887 766.106, the department shall review each report and determine
 1888 whether it potentially involved conduct by a licensee that is
 1889 subject to disciplinary action, in which case the provisions of
 1890 s. 456.073 shall apply. However, if it is reported that a
 1891 physician has had three or more claims with indemnities
 1892 exceeding \$50,000 ~~\$25,000~~ each within the previous 5-year
 1893 period, the department shall investigate the occurrences upon
 1894 which the claims were based and determine if action by the
 1895 department against the physician is warranted.

1896 Section 32. Section 458.3311, Florida Statutes, is created
 1897 to read:

1898 458.3311 Emergency procedures for disciplinary action.--
 1899 Notwithstanding any other provision of law to the contrary:

1900 (1) Each physician must report to the Department of Health
 1901 any judgment for medical negligence levied against the
 1902 physician. The physician must make the report no later than 15
 1903 days after the exhaustion of the last opportunity for any party
 1904 to appeal the judgment or request a rehearing.

1905 (2) No later than 30 days after a physician has, within a
 1906 60-month period, made three reports as required by subsection
 1907 (1), the Department of Health shall initiate an emergency
 1908 investigation and the Board of Medicine shall conduct an
 1909 emergency probable cause hearing to determine whether the
 1910 physician should be disciplined for a violation of s.
 1911 458.331(1)(t) or any other relevant provision of law.

1912 Section 33. Subsection (11) is added to section 459.0085,
 1913 Florida Statutes, subsection (9) of said section is renumbered
 1914 as subsection (10), and a new subsection (9) is added to said
 1915 section, to read:

1916 459.0085 Financial responsibility.--



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1917 (9) Notwithstanding any other provision of this section,
 1918 the department shall suspend the license of any osteopathic
 1919 physician who does not have insurance as required by this
 1920 section against whom has been entered a final judgment,
 1921 arbitration award, or other order or who has entered into a
 1922 settlement agreement to pay damages arising out of a claim for
 1923 medical malpractice, if all appellate remedies have been
 1924 exhausted and payment up to the amounts required by this section
 1925 has not been made within 30 days after the entering of such
 1926 judgment, award, order, or agreement, until proof of payment is
 1927 received by the department or a payment schedule has been agreed
 1928 upon by the osteopathic physician and the claimant and presented
 1929 to the department. This subsection does not apply to an
 1930 osteopathic physician who has met the financial responsibility
 1931 requirements in paragraphs (1)(b) and (2)(b).

1932 (11) Nothing in this section shall be construed as
 1933 creating a civil cause of action against any hospital as a
 1934 result of the failure of any physician with staff privileges to
 1935 comply with the requirements of this section.

1936 Section 34. Paragraph (x) of subsection (1) and
 1937 subsections (3) and (6) of section 459.015, Florida Statutes,
 1938 are amended to read:

1939 459.015 Grounds for disciplinary action; action by the
 1940 board and department.--

1941 (1) The following acts constitute grounds for denial of a
 1942 license or disciplinary action, as specified in s. 456.072(2):

1943 (x) Gross or repeated malpractice or the failure to
 1944 practice osteopathic medicine with that level of care, skill,
 1945 and treatment which is recognized by a reasonably prudent
 1946 similar osteopathic physician as being acceptable under similar



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1947 conditions and circumstances. The board shall give great weight
 1948 to the provisions of s. 766.102 when enforcing this paragraph.
 1949 As used in this paragraph, "repeated malpractice" includes, but
 1950 is not limited to, three or more claims for medical malpractice
 1951 within the previous 5-year period resulting in indemnities being
 1952 paid in excess of \$50,000 ~~\$25,000~~ each to the claimant in a
 1953 judgment or settlement and which incidents involved negligent
 1954 conduct by the osteopathic physician. As used in this paragraph,
 1955 "gross malpractice" or "the failure to practice osteopathic
 1956 medicine with that level of care, skill, and treatment which is
 1957 recognized by a reasonably prudent similar osteopathic physician
 1958 as being acceptable under similar conditions and circumstances"
 1959 shall not be construed so as to require more than one instance,
 1960 event, or act. Nothing in this paragraph shall be construed to
 1961 require that an osteopathic physician be incompetent to practice
 1962 osteopathic medicine in order to be disciplined pursuant to this
 1963 paragraph. A recommended order by an administrative law judge or
 1964 a final order of the board finding a violation under this
 1965 paragraph shall specify whether the licensee was found to have
 1966 committed "gross malpractice," "repeated malpractice," or
 1967 "failure to practice osteopathic medicine with that level of
 1968 care, skill, and treatment which is recognized as being
 1969 acceptable under similar conditions and circumstances," or any
 1970 combination thereof, and any publication by the board shall so
 1971 specify.

1972 (3) In any administrative action against a physician ~~which~~
 1973 ~~does not involve revocation or suspension of license~~, the
 1974 division shall have the burden, by the greater weight of the
 1975 evidence, to establish the existence of grounds for disciplinary



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1976 action. ~~The division shall establish grounds for revocation or~~
 1977 ~~suspension of license by clear and convincing evidence.~~

1978 (6) Upon the department's receipt from an insurer or self-
 1979 insurer of a report of a closed claim against an osteopathic
 1980 physician pursuant to s. 627.912 or from a health care
 1981 practitioner of a report pursuant to s. 456.049, or upon the
 1982 receipt from a claimant of a presuit notice against an
 1983 osteopathic physician pursuant to s. 766.106, the department
 1984 shall review each report and determine whether it potentially
 1985 involved conduct by a licensee that is subject to disciplinary
 1986 action, in which case the provisions of s. 456.073 shall apply.
 1987 However, if it is reported that an osteopathic physician has had
 1988 three or more claims with indemnities exceeding \$50,000 ~~\$25,000~~
 1989 each within the previous 5-year period, the department shall
 1990 investigate the occurrences upon which the claims were based and
 1991 determine if action by the department against the osteopathic
 1992 physician is warranted.

1993 Section 35. Section 459.0151, Florida Statutes, is created
 1994 to read:

1995 459.0151 Emergency procedures for disciplinary action.--
 1996 Notwithstanding any other provision of law to the contrary:

1997 (1) Each osteopathic physician must report to the
 1998 Department of Health any judgment for medical negligence levied
 1999 against the physician. The osteopathic physician must make the
 2000 report no later than 15 days after the exhaustion of the last
 2001 opportunity for any party to appeal the judgment or request a
 2002 rehearing.

2003 (2) No later than 30 days after an osteopathic physician
 2004 has, within a 60-month period, made three reports as required by
 2005 subsection (1), the Department of Health shall initiate an



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2006 emergency investigation and the Board of Osteopathic Medicine
 2007 shall conduct an emergency probable cause hearing to determine
 2008 whether the physician should be disciplined for a violation of
 2009 s. 459.015(1)(x) or any other relevant provision of law.

2010 Section 36. Paragraph (s) of subsection (1) and paragraph
 2011 (a) of subsection (5) of section 461.013, Florida Statutes, are
 2012 amended to read:

2013 461.013 Grounds for disciplinary action; action by the
 2014 board; investigations by department.--

2015 (1) The following acts constitute grounds for denial of a
 2016 license or disciplinary action, as specified in s. 456.072(2):

2017 (s) Gross or repeated malpractice or the failure to
 2018 practice podiatric medicine at a level of care, skill, and
 2019 treatment which is recognized by a reasonably prudent podiatric
 2020 physician as being acceptable under similar conditions and
 2021 circumstances. The board shall give great weight to the
 2022 standards for malpractice in s. 766.102 in interpreting this
 2023 section. As used in this paragraph, "repeated malpractice"
 2024 includes, but is not limited to, three or more claims for
 2025 medical malpractice within the previous 5-year period resulting
 2026 in indemnities being paid in excess of \$50,000 ~~\$10,000~~ each to
 2027 the claimant in a judgment or settlement and which incidents
 2028 involved negligent conduct by the podiatric physicians. As used
 2029 in this paragraph, "gross malpractice" or "the failure to
 2030 practice podiatric medicine with the level of care, skill, and
 2031 treatment which is recognized by a reasonably prudent similar
 2032 podiatric physician as being acceptable under similar conditions
 2033 and circumstances" shall not be construed so as to require more
 2034 than one instance, event, or act.



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2035 (5)(a) Upon the department's receipt from an insurer or
 2036 self-insurer of a report of a closed claim against a podiatric
 2037 physician pursuant to s. 627.912, or upon the receipt from a
 2038 claimant of a presuit notice against a podiatric physician
 2039 pursuant to s. 766.106, the department shall review each report
 2040 and determine whether it potentially involved conduct by a
 2041 licensee that is subject to disciplinary action, in which case
 2042 the provisions of s. 456.073 shall apply. However, if it is
 2043 reported that a podiatric physician has had three or more claims
 2044 with indemnities exceeding \$50,000 ~~\$25,000~~ each within the
 2045 previous 5-year period, the department shall investigate the
 2046 occurrences upon which the claims were based and determine if
 2047 action by the department against the podiatric physician is
 2048 warranted.

2049 Section 37. Paragraph (x) of subsection (1) of section
 2050 466.028, Florida Statutes, is amended to read:

2051 466.028 Grounds for disciplinary action; action by the
 2052 board.--

2053 (1) The following acts constitute grounds for denial of a
 2054 license or disciplinary action, as specified in s. 456.072(2):

2055 (x) Being guilty of incompetence or negligence by failing
 2056 to meet the minimum standards of performance in diagnosis and
 2057 treatment when measured against generally prevailing peer
 2058 performance, including, but not limited to, the undertaking of
 2059 diagnosis and treatment for which the dentist is not qualified
 2060 by training or experience or being guilty of dental malpractice.
 2061 For purposes of this paragraph, it shall be legally presumed
 2062 that a dentist is not guilty of incompetence or negligence by
 2063 declining to treat an individual if, in the dentist's
 2064 professional judgment, the dentist or a member of her or his



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2065 clinical staff is not qualified by training and experience, or
 2066 the dentist's treatment facility is not clinically satisfactory
 2067 or properly equipped to treat the unique characteristics and
 2068 health status of the dental patient, provided the dentist refers
 2069 the patient to a qualified dentist or facility for appropriate
 2070 treatment. As used in this paragraph, "dental malpractice"
 2071 includes, but is not limited to, three or more claims within the
 2072 previous 5-year period which resulted in indemnity being paid,
 2073 or any single indemnity paid in excess of \$25,000 ~~\$5,000~~ in a
 2074 judgment or settlement, as a result of negligent conduct on the
 2075 part of the dentist.

2076 Section 38. Subsection (2) of section 624.462, Florida
 2077 Statutes, is amended to read:

2078 624.462 Commercial self-insurance funds.--

2079 (2) As used in ss. 624.460-624.488, "commercial self-
 2080 insurance fund" or "fund" means a group of members, operating
 2081 individually and collectively through a trust or corporation,
 2082 that must be:

2083 (a) Established by:

2084 1. A not-for-profit trade association, industry
 2085 association, or professional association of employers or
 2086 professionals which has a constitution or bylaws, which is
 2087 incorporated under the laws of this state, and which has been
 2088 organized for purposes other than that of obtaining or providing
 2089 insurance and operated in good faith for a continuous period of
 2090 1 year;

2091 2. A self-insurance trust fund organized pursuant to s.
 2092 627.357 and maintained in good faith for a continuous period of
 2093 1 year for purposes other than that of obtaining or providing
 2094 insurance pursuant to this section. Each member of a commercial



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2095 self-insurance trust fund established pursuant to this
2096 subsection must maintain membership in the self-insurance trust
2097 fund organized pursuant to s. 627.357; ~~or~~

2098 3. A group of 10 or more health care providers, as defined
2099 in s. 627.351(4)(h); or

2100 ~~4.3-~~ A not-for-profit group comprised of no less than 10
2101 condominium associations as defined in s. 718.103(2), which is
2102 incorporated under the laws of this state, which restricts its
2103 membership to condominium associations only, and which has been
2104 organized and maintained in good faith for a continuous period
2105 of 1 year for purposes other than that of obtaining or providing
2106 insurance.

2107 (b)1. In the case of funds established pursuant to
2108 subparagraph (a)2. or subparagraph (a)~~4.3-~~, operated pursuant to
2109 a trust agreement by a board of trustees which shall have
2110 complete fiscal control over the fund and which shall be
2111 responsible for all operations of the fund. The majority of the
2112 trustees shall be owners, partners, officers, directors, or
2113 employees of one or more members of the fund. The trustees shall
2114 have the authority to approve applications of members for
2115 participation in the fund and to contract with an authorized
2116 administrator or servicing company to administer the day-to-day
2117 affairs of the fund.

2118 2. In the case of funds established pursuant to
2119 subparagraph (a)1. or subparagraph (a)3., operated pursuant to a
2120 trust agreement by a board of trustees or as a corporation by a
2121 board of directors which board shall:

2122 a. Be responsible to members of the fund or beneficiaries
2123 of the trust or policyholders of the corporation;



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- 2124 b. Appoint independent certified public accountants, legal
- 2125 counsel, actuaries, and investment advisers as needed;
- 2126 c. Approve payment of dividends to members;
- 2127 d. Approve changes in corporate structure; and
- 2128 e. Have the authority to contract with an administrator
- 2129 authorized under s. 626.88 to administer the day-to-day affairs
- 2130 of the fund including, but not limited to, marketing,
- 2131 underwriting, billing, collection, claims administration, safety
- 2132 and loss prevention, reinsurance, policy issuance, accounting,
- 2133 regulatory reporting, and general administration. The fees or
- 2134 compensation for services under such contract shall be
- 2135 comparable to the costs for similar services incurred by
- 2136 insurers writing the same lines of insurance, or where available
- 2137 such expenses as filed by boards, bureaus, and associations
- 2138 designated by insurers to file such data. A majority of the
- 2139 trustees or directors shall be owners, partners, officers,
- 2140 directors, or employees of one or more members of the fund.

2141 Section 39. Paragraph (a) of subsection (6) of section

2142 627.062, Florida Statutes, is amended, and subsections (7), (8),

2143 (9), and (10) are added to said section, to read:

2144 627.062 Rate standards.--

2145 (6)(a) After any action with respect to a rate filing that

2146 constitutes agency action for purposes of the Administrative

2147 Procedure Act, except for a rate filing for medical malpractice

2148 insurance, an insurer may, in lieu of demanding a hearing under

2149 s. 120.57, require arbitration of the rate filing. Arbitration

2150 shall be conducted by a board of arbitrators consisting of an

2151 arbitrator selected by the department, an arbitrator selected by

2152 the insurer, and an arbitrator selected jointly by the other two

2153 arbitrators. Each arbitrator must be certified by the American



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2154 Arbitration Association. A decision is valid only upon the
2155 affirmative vote of at least two of the arbitrators. No
2156 arbitrator may be an employee of any insurance regulator or
2157 regulatory body or of any insurer, regardless of whether or not
2158 the employing insurer does business in this state. The
2159 department and the insurer must treat the decision of the
2160 arbitrators as the final approval of a rate filing. Costs of
2161 arbitration shall be paid by the insurer.

2162 (7) Notwithstanding any other provision of this section,
2163 in matters relating to professional liability insurance coverage
2164 for medical negligence, any portion of a judgment entered as a
2165 result of a statutory or common-law bad faith action and any
2166 portion of a judgment entered that awards punitive damages
2167 against an insurer may not be included in the insurer's rate
2168 base and may not be used to justify a rate or rate change. In
2169 matters relating to professional liability insurance coverage
2170 for medical negligence, any portion of a settlement entered as a
2171 result of a statutory or common-law bad faith action identified
2172 as such and any portion of a settlement wherein an insurer
2173 agrees to pay specific punitive damages may not be used to
2174 justify a rate or rate change. The portion of the taxable costs
2175 and attorney's fees that is identified as being related to the
2176 bad faith and punitive damages in these judgments and
2177 settlements may not be included in the insurer's rate base and
2178 may not be utilized to justify a rate or rate change.

2179 (8) Each insurer writing professional liability insurance
2180 coverage for medical negligence must make a rate filing under
2181 this section with the Office of Insurance Regulation at least
2182 once each calendar year.

2183 (9) Medical malpractice insurance companies shall submit a



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2184 rate filing to the Office of Insurance Regulation no earlier
2185 than 30 days, but no later than 120 days, after the date upon
2186 which this act becomes law.

2187 (10)(a) The provisions of this subsection apply only with
2188 respect to rates for medical malpractice insurance and shall
2189 control to the extent of any conflict with other provisions of
2190 this section.

2191 (b) Any portion of a judgment entered or settlement paid
2192 as a result of a statutory or common-law bad faith action and
2193 any portion of a judgment entered which awards punitive damages
2194 against an insurer may not be included in the insurer's rate
2195 base and shall not be used to justify a rate or rate change. Any
2196 common-law bad faith action identified as such and any portion
2197 of a settlement entered as a result of a statutory or portion of
2198 a settlement wherein an insurer agrees to pay specific punitive
2199 damages may not be used to justify a rate or rate change. The
2200 portion of the taxable costs and attorney's fees which is
2201 identified as being related to the bad faith and punitive
2202 damages in these judgments and settlements may not be included
2203 in the insurer's rate base and may not be utilized to justify a
2204 rate or rate change.

2205 (c) Upon reviewing a rate filing and determining whether
2206 the rate is excessive, inadequate, or unfairly discriminatory,
2207 the Office of Insurance Regulation shall consider, in accordance
2208 with generally accepted and reasonable actuarial techniques,
2209 past and present prospective loss experience, either using loss
2210 experience solely for this state or giving greater credibility
2211 to this state's loss data.

2212 (d) Rates shall be deemed excessive if, among other
2213 standards established by this section, the rate structure



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2214 provides for replenishment of reserves or surpluses from
2215 premiums when the replenishment is attributable to investment
2216 losses.

2217 (e) The insurer must apply a discount or surcharge based
2218 on the health care provider's loss experience or shall establish
2219 an alternative method giving due consideration to the provider's
2220 loss experience. The insurer must include in the filing a copy
2221 of the surcharge or discount schedule or a description of the
2222 alternative method used and must provide a copy of such schedule
2223 or description, as approved by the office, to policyholders at
2224 the time of renewal and to prospective policyholders at the time
2225 of application for coverage.

2226 Section 40. Section 627.0662, Florida Statutes, is created
2227 to read:

2228 627.0662 Excessive profits for medical liability insurance
2229 prohibited.--

2230 (1) As used in this section:

2231 (a) "Medical liability insurance" means insurance that is
2232 written on a professional liability insurance policy issued to a
2233 health care practitioner or on a liability insurance policy
2234 covering medical malpractice claims issued to a health care
2235 facility.

2236 (b) "Medical liability insurer" means any insurance
2237 company or group of insurance companies writing medical
2238 liability insurance in this state and does not include any self-
2239 insurance fund or other nonprofit entity writing such insurance.

2240 (2) Each medical liability insurer shall file with the
2241 Office of Insurance Regulation, prior to July 1 of each year on
2242 forms prescribed by the office, the following data for medical
2243 liability insurance business in this state. The data shall



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2244 include both voluntary and joint underwriting association

2245 business, as follows:

2246 (a) Calendar-year earned premium.

2247 (b) Accident-year incurred losses and loss adjustment
2248 expenses.

2249 (c) The administrative and selling expenses incurred in
2250 this state or allocated to this state for the calendar year.

2251 (d) Policyholder dividends incurred during the applicable
2252 calendar year.

2253 (3)(a) Excessive profit has been realized if there has
2254 been an underwriting gain for the 3 most recent calendar-
2255 accident years combined which is greater than the anticipated
2256 underwriting profit plus 5 percent of earned premiums for those
2257 calendar-accident years.

2258 (b) As used in this subsection with respect to any 3-year
2259 period, "anticipated underwriting profit" means the sum of the
2260 dollar amounts obtained by multiplying, for each rate filing of
2261 the insurer group in effect during such period, the earned
2262 premiums applicable to such rate filing during such period by
2263 the percentage factor included in such rate filing for profit
2264 and contingencies, such percentage factor having been determined
2265 with due recognition to investment income from funds generated
2266 by business in this state. Separate calculations need not be
2267 made for consecutive rate filings containing the same percentage
2268 factor for profits and contingencies.

2269 (4) Each medical liability insurer shall also file a
2270 schedule of medical liability insurance loss in this state and
2271 loss adjustment experience for each of the 3 most recent
2272 accident years. The incurred losses and loss adjustment expenses
2273 shall be valued as of March 31 of the year following the close



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2274 of the accident year, developed to an ultimate basis, and at two
2275 12-month intervals thereafter, each developed to an ultimate
2276 basis, to the extent that a total of three evaluations is
2277 provided for each accident year. The first year to be so
2278 reported shall be accident year 2004, such that the reporting of
2279 3 accident years will not take place until accident years 2005
2280 and 2006 have become available.

2281 (5) Each insurer group's underwriting gain or loss for
2282 each calendar-accident year shall be computed as follows: the
2283 sum of the accident-year incurred losses and loss adjustment
2284 expenses as of March 31 of the following year, developed to an
2285 ultimate basis, plus the administrative and selling expenses
2286 incurred in the calendar year, plus policyholder dividends
2287 applicable to the calendar year, shall be subtracted from the
2288 calendar-year earned premium to determine the underwriting gain
2289 or loss.

2290 (6) For the 3 most recent calendar-accident years, the
2291 underwriting gain or loss shall be compared to the anticipated
2292 underwriting profit.

2293 (7) If the medical liability insurer has realized an
2294 excessive profit, the office shall order a return of the
2295 excessive amounts to policyholders after affording the insurer
2296 an opportunity for hearing and otherwise complying with the
2297 requirements of chapter 120. Such excessive amounts shall be
2298 refunded to policyholders in all instances unless the insurer
2299 affirmatively demonstrates to the office that the refund of the
2300 excessive amounts will render the insurer or a member of the
2301 insurer group financially impaired or will render it insolvent.

2302 (8) The excessive amount shall be refunded to
2303 policyholders on a pro rata basis in relation to the final



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2304 compilation year earned premiums to the voluntary medical
2305 liability insurance policyholders of record of the insurer group
2306 on December 31 of the final compilation year.

2307 (9) Any return of excessive profits to policyholders under
2308 this section shall be provided in the form of a cash refund or a
2309 credit towards the future purchase of insurance.

2310 (10)(a) Cash refunds to policyholders may be rounded to
2311 the nearest dollar.

2312 (b) Data in required reports to the office may be rounded
2313 to the nearest dollar.

2314 (c) Rounding, if elected by the insurer group, shall be
2315 applied consistently.

2316 (11)(a) Refunds to policyholders shall be completed as
2317 follows:

2318 1. If the insurer elects to make a cash refund, the refund
2319 shall be completed within 60 days after entry of a final order
2320 determining that excessive profits have been realized; or

2321 2. If the insurer elects to make refunds in the form of a
2322 credit to renewal policies, such credits shall be applied to
2323 policy renewal premium notices which are forwarded to insureds
2324 more than 60 calendar days after entry of a final order
2325 determining that excessive profits have been realized. If an
2326 insurer has made this election but an insured thereafter cancels
2327 his or her policy or otherwise allows the policy to terminate,
2328 the insurer group shall make a cash refund not later than 60
2329 days after termination of such coverage.

2330 (b) Upon completion of the renewal credits or refund
2331 payments, the insurer shall immediately certify to the office
2332 that the refunds have been made.



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2333 (12) Any refund or renewal credit made pursuant to this
 2334 section shall be treated as a policyholder dividend applicable
 2335 to the year in which it is incurred, for purposes of reporting
 2336 under this section for subsequent years.

2337 Section 41. Subsection (10) of section 627.357, Florida
 2338 Statutes, is amended to read:

2339 627.357 Medical malpractice self-insurance.--

2340 (10)(a) An application to form a self-insurance fund under
 2341 this section must be filed with the Office of Insurance
 2342 Regulation.

2343 (b) The Office of Insurance Regulation must ensure that
 2344 self-insurance funds remain solvent and provide insurance
 2345 coverage purchased by participants. The Financial Services
 2346 Commission may adopt rules pursuant to ss. 120.536(1) and 120.54
 2347 to implement this subsection ~~A self-insurance fund may not be~~
 2348 ~~formed under this section after October 1, 1992.~~

2349 Section 42. Section 627.3575, Florida Statutes, is created
 2350 to read:

2351 627.3575 Health Care Professional Liability Insurance
 2352 Facility.--

2353 (1) FACILITY CREATED; PURPOSE; STATUS.--There is created
 2354 the Health Care Professional Liability Insurance Facility. The
 2355 facility is intended to meet ongoing availability and
 2356 affordability problems relating to liability insurance for
 2357 health care professionals by providing an affordable, self-
 2358 supporting source of excess insurance coverage for those
 2359 professionals who are willing and able to self-insure for
 2360 smaller losses. The facility shall operate on a not-for-profit
 2361 basis. The facility is self-funding and is intended to serve a



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2362 public purpose but is not a state agency or program, and no
2363 activity of the facility shall create any state liability.

2364 (2) GOVERNANCE; POWERS.--

2365 (a) The facility shall operate under a seven-member board
2366 of governors consisting of the Secretary of Health, three
2367 members appointed by the Governor, and three members appointed
2368 by the Chief Financial Officer. The board shall be chaired by
2369 the Secretary of Health. The secretary shall serve by virtue of
2370 his or her office, and the other members of the board shall
2371 serve terms concurrent with the term of office of the official
2372 who appointed them. Any vacancy on the board shall be filled in
2373 the same manner as the original appointment. Members serve at
2374 the pleasure of the official who appointed them. Members are not
2375 eligible for compensation for their service on the board, but
2376 the facility may reimburse them for per diem and travel expenses
2377 at the same levels as are provided in s. 112.061 for state
2378 employees.

2379 (b) The facility shall have such powers as are necessary
2380 to operate as an insurer, including the power to:

2381 1. Sue and be sued.

2382 2. Hire such employees and retain such consultants,
2383 attorneys, actuaries, and other professionals as it deems
2384 appropriate.

2385 3. Contract with such service providers as it deems
2386 appropriate.

2387 4. Maintain offices appropriate to the conduct of its
2388 business.

2389 5. Take such other actions as are necessary or appropriate
2390 in fulfillment of its responsibilities under this section.

2391 (3) COVERAGE PROVIDED.-- The facility shall provide



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2392 liability insurance coverage for health care professionals. The
2393 facility shall allow policyholders to select from policies with
2394 deductibles of \$25,000 per claim, \$50,000 per claim, and
2395 \$100,000 per claim and with coverage limits of \$250,000 per
2396 claim and \$750,000 annual aggregate and \$1 million per claim and
2397 \$3 million annual aggregate. To the greatest extent possible,
2398 the terms and conditions of the policies shall be consistent
2399 with terms and conditions commonly used by professional
2400 liability insurers. The facility shall offer policies to cover
2401 health care professionals who have retired from practice or
2402 maintain a part-time practice as set forth herein. For health
2403 care professionals who meet the following requirements, the
2404 premiums for such policies shall be no more than 50 percent of
2405 the cost of premiums for similar specialties for health care
2406 professionals who meet each of the following requirements:

2407 (a) The health care professional has held an active
2408 license to practice in this state or another state or some
2409 combination thereof for more than 15 years.

2410 (b) The health care professional has either retired from
2411 the practice of medicine or maintains a part-time practice of no
2412 more than 1,000 patient contact hours per year.

2413 (c) The health care professional has had no more than two
2414 claims for medical malpractice resulting in an indemnity
2415 exceeding \$50,000 each within the previous 5-year period.

2416 (d) The health care professional has not been convicted
2417 of, or pled guilty or nolo contendere to, any criminal violation
2418 specified in this chapter or the medical practice act of any
2419 other state.

2420 (e) The health care professional has not been subject
2421 within the last 10 years of practice to license revocation or



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2422 suspension for any period of time; probation for a period of 3
2423 years or longer; or a fine of \$500 or more for a violation of
2424 this chapter or the medical practice act of another
2425 jurisdiction. The regulatory agency's acceptance of a health
2426 care professional's relinquishment of a license, stipulation,
2427 consent order, or other settlement, offered in response to or in
2428 anticipation of the filing of administrative charges against the
2429 health care professional's license, shall be construed as action
2430 against the health care professional's license for the purposes
2431 of this paragraph.

2432 (f) The health care professional has submitted a form
2433 supplying necessary information as required by the department
2434 and an affidavit affirming compliance with the provisions of
2435 this subsection.

2436 (g) The health care professional submits biennially to the
2437 facility certification stating compliance with the provisions of
2438 this subsection. The health care professional shall, upon
2439 request, demonstrate to the facility information verifying
2440 compliance with this subsection.

2441 (4) ELIGIBILITY; TERMINATION.--

2442 (a) Any health care professional is eligible for coverage
2443 provided by the facility if the professional at all times
2444 maintains either:

2445 1. An escrow account consisting of cash or assets eligible
2446 for deposit under s. 625.52 in an amount equal to the deductible
2447 amount of the policy; or

2448 2. An unexpired, irrevocable letter of credit, established
2449 pursuant to chapter 675, in an amount not less than the
2450 deductible amount of the policy. The letter of credit shall be
2451 payable to the health care professional as beneficiary upon



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2452 presentment of a final judgment indicating liability and
2453 awarding damages to be paid by the health care professional or
2454 upon presentment of a settlement agreement signed by all parties
2455 to such agreement when such final judgment or settlement is a
2456 result of a claim arising out of the rendering of, or the
2457 failure to render, medical care and services. Such letter of
2458 credit shall be nonassignable and nontransferable. Such letter
2459 of credit shall be issued by any bank or savings association
2460 organized and existing under the laws of this state or any bank
2461 or savings association organized under the laws of the United
2462 States that has its principal place of business in this state or
2463 has a branch office which is authorized under the laws of this
2464 state or of the United States to receive deposits in this state.

2465 (b) The eligibility of a health care professional for
2466 coverage terminates upon:

2467 1. The failure of the professional to comply with
2468 paragraph (a);

2469 2. The failure of the professional to timely pay premiums
2470 or assessments; or

2471 3. The commission of any act of fraud in connection with
2472 the policy, as determined by the board of governors.

2473 (c) The board of governors, in its discretion, may
2474 reinstate the eligibility of a health care professional whose
2475 eligibility has terminated pursuant to paragraph (b) upon
2476 determining that the professional has subsequently complied with
2477 paragraph (a) or has paid the overdue premiums or assessments.
2478 Eligibility may be reinstated in the case of fraud only if the
2479 board determines that its initial determination of fraud was in
2480 error.

2481 (5) PREMIUMS; ASSESSMENTS.--



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2482 (a) The facility shall charge the actuarially indicated
2483 premium for the coverage provided and shall retain the services
2484 of consulting actuaries to prepare its rate filings. The
2485 facility shall not provide dividends to policyholders, and, to
2486 the extent that premiums are more than the amount required to
2487 cover claims and expenses, such excess shall be retained by the
2488 facility for payment of future claims. In the event of
2489 dissolution of the facility, any amounts not required as a
2490 reserve for outstanding claims shall be transferred to the
2491 policyholders of record as of the last day of operation.

2492 (b) To ensure that the facility has the funds to pay
2493 claims, the facility shall receive:

2494 1. From each judgment awarded and settlement agreed to
2495 from which a claim will be paid in whole or in part by the
2496 facility, the facility shall retain 1 percent of its portion of
2497 the award or settlement for deposit into a separate account for
2498 guaranteeing payment of claims.

2499 2. A surcharge of \$100 on each medical malpractice policy
2500 issued or renewed after July 1, 2003.

2501 (6) REGULATION; APPLICABILITY OF OTHER STATUTES.--

2502 (a) The facility shall operate pursuant to a plan of
2503 operation approved by order of the Office of Insurance
2504 Regulation of the Financial Services Commission. The board of
2505 governors may at any time adopt amendments to the plan of
2506 operation and submit the amendments to the Office of Insurance
2507 Regulation for approval.

2508 (b) The facility is subject to regulation by the Office of
2509 Insurance Regulation of the Financial Services Commission in the
2510 same manner as other insurers, except that, in recognition of
2511 the fact that its ability to levy assessments against its own



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2512 policyholders is a substitute for the protections ordinarily
2513 afforded by such statutory requirements, the facility is exempt
2514 from statutory requirements relating to surplus as to
2515 policyholders.

2516 (c) The facility is not subject to part II of chapter 631,
2517 relating to the Florida Insurance Guaranty Association.

2518 (7) STARTUP PROVISIONS.--

2519 (a) It is the intent of the Legislature that the facility
2520 begin providing coverage no later than January 1, 2004.

2521 (b) The Governor and the Chief Financial Officer shall
2522 make their appointments to the board of governors of the
2523 facility no later than August 1, 2003. Until the board is
2524 appointed, the Secretary of Health may perform ministerial acts
2525 on behalf of the facility as chair of the board of governors.

2526 (c) Until the facility is able to hire permanent staff and
2527 enter into contracts for professional services, the office of
2528 the Secretary of Health shall provide support services to the
2529 facility.

2530 (d) In order to provide startup funds for the facility,
2531 the board of governors may incur debt or enter into agreements
2532 for lines of credit, provided that the sole source of funds for
2533 repayment of any debt is future premium revenues of the
2534 facility. The amount of such debt or lines of credit may not
2535 exceed \$10 million.

2536 Section 43. Section 627.358, Florida Statutes, is created
2537 to read:

2538 627.358 Medical malpractice insurance; part-time
2539 coverage.--Insurance carriers shall be permitted to offer
2540 policies to cover health care professionals who have retired
2541 from practice or maintain a part-time practice as set forth



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2542 herein. For health care professionals who meet each of the
2543 following requirements, the premiums for such policies shall be
2544 no more than 50 percent of the cost of premiums for similar
2545 specialties for health care professionals who meet each of the
2546 following requirements:

2547 (1) The health care professional has held an active
2548 license to practice in this state or another state or some
2549 combination thereof for more than 15 years.

2550 (2) The health care professional has either retired from
2551 the practice of medicine or maintains a part-time practice of no
2552 more than 1,000 patient contact hours per year.

2553 (3) The health care professional has had no more than two
2554 claims for medical malpractice resulting in an indemnity
2555 exceeding \$50,000 each within the previous 5-year period.

2556 (4) The health care professional has not been convicted
2557 of, or pled guilty or nolo contendere to, any criminal violation
2558 specified in this chapter or the medical practice act of any
2559 other state.

2560 (5) The health care professional has not been subject
2561 within the last 10 years of practice to license revocation or
2562 suspension for any period of time; probation for a period of 3
2563 years or longer; or a fine of \$500 or more for a violation of
2564 this chapter or the medical practice act of another
2565 jurisdiction. The regulatory agency's acceptance of a health
2566 care professional's relinquishment of a license, stipulation,
2567 consent order, or other settlement, offered in response to or in
2568 anticipation of the filing of administrative charges against the
2569 health care professional's license, shall be construed as action
2570 against the health care professional's license for the purposes
2571 of this subsection.



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2572 (6) The health care professional has submitted a form
2573 supplying necessary information as required by the department
2574 and an affidavit affirming compliance with the provisions of
2575 this section.

2576 (7) The health care professional submits biennially to his
2577 or her insurance provider certification stating compliance with
2578 the provisions of this section. The health care professional
2579 shall, upon request, demonstrate to the Office of Insurance
2580 Regulation information verifying compliance with this section.

2581 Section 44. Section 627.359, Florida Statutes, is created
2582 to read:

2583 627.359 Discounts on medical malpractice liability
2584 insurance.--

2585 (1)(a) Medical malpractice insurance providers, including
2586 the Health Care Professional Liability Insurance Facility, shall
2587 provide a 20-percent discount on premiums for health care
2588 professionals who implement a system wherein the professional
2589 enters medication orders using a computer linked to prescribing
2590 error prevention software.

2591 (b) The Office of Insurance Regulation shall designate
2592 software vendors who meet the requirements of paragraph (a).

2593 (2)(a) Medical malpractice insurance providers, including
2594 the Health Care Professional Liability Insurance Facility, shall
2595 provide a 10-percent discount on premiums for health care
2596 professionals who implement a system wherein patients are only
2597 referred to a hospital based on scientifically valid criteria.

2598 (b) The Agency for Health Care Administration shall
2599 develop criteria that meet the requirements of paragraph (a).

2600 Section 45. Paragraph (c) of subsection (1) and subsection
2601 (3) of section 627.4147, Florida Statutes, are amended, and



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2602 paragraph (d) is added to subsection (1) of said section, to
 2603 read:

2604 627.4147 Medical malpractice insurance contracts.--

2605 (1) In addition to any other requirements imposed by law,
 2606 each self-insurance policy as authorized under s. 627.357 or
 2607 insurance policy providing coverage for claims arising out of
 2608 the rendering of, or the failure to render, medical care or
 2609 services, including those of the Florida Medical Malpractice
 2610 Joint Underwriting Association, shall include:

2611 (c) A clause requiring the insurer or self-insurer to
 2612 notify the insured no less than 90 ~~60~~ days prior to the
 2613 effective date of cancellation of the policy or contract and, in
 2614 the event of a determination by the insurer or self-insurer not
 2615 to renew the policy or contract, to notify the insured no less
 2616 than 90 ~~60~~ days prior to the end of the policy or contract
 2617 period. If cancellation or nonrenewal is due to nonpayment or
 2618 loss of license, 10 days' notice is required.

2619 (d) A clause requiring the insurer or self-insurer to
 2620 notify the insured no less than 60 days prior to the effective
 2621 date of a rate increase. The provisions of s. 627.4133 shall
 2622 apply to such notice and to the failure of the insurer to
 2623 provide such notice to the extent not in conflict with this
 2624 section.

2625 (3) This section shall apply to all policies issued or
 2626 renewed after October 1, 2003 ~~1985~~.

2627 Section 46. Section 627.41491, Florida Statutes, is
 2628 created to read:

2629 627.41491 Medical malpractice rate comparison.--The
 2630 Office of Insurance Regulation shall annually publish a
 2631 comparison of the rate in effect for each medical malpractice



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2632 insurer and self-insurer and the Florida Medical Malpractice
 2633 Joint Underwriting Association. Such rate comparison shall be
 2634 made available to the public through the Internet and other
 2635 commonly used means of distribution no later than July 1 of each
 2636 year.

2637 Section 47. Section 627.41492, Florida Statutes, is
 2638 created to read:

2639 627.41492 Annual medical malpractice report.--The Office
 2640 of Insurance Regulation shall prepare an annual report by
 2641 October 1 of each year, which shall be available to the public
 2642 and posted on the Internet, which includes the following
 2643 information:

2644 (1) A summary and analysis of the closed claim information
 2645 required to be reported pursuant to s. 627.912.

2646 (2) A summary and analysis of the annual and quarterly
 2647 financial reports filed by each insurer writing medical
 2648 malpractice insurance in the state.

2649 Section 48. Section 627.41493, Florida Statutes, is
 2650 created to read:

2651 627.41493 Insurance rate rollback.--

2652 (1) For medical malpractice insurance policies issued or
 2653 renewed on or after July 1, 2003, and before July 1, 2004, every
 2654 insurer, including the Florida Medical Malpractice Joint
 2655 Underwriting Association, shall reduce its rates and premiums by
 2656 25 percent. The lower rates must be in effect for at least 12
 2657 months and may not be raised by more than 15 percent after the
 2658 expiration of those 12 months. Thereafter, there will be
 2659 consideration for a physician, hospital, other health care
 2660 professional, or other health care facility to receive a credit
 2661 against the rate or rates applicable to its medical malpractice



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2662 insurance, consistent with the level of such discount set in
2663 rule by the Financial Services Commission. In developing such
2664 rules, the commission may consider whether, and the extent to
2665 which, the types of programs approved under this act are
2666 otherwise covered under a program of risk management offered by
2667 the insurer.

2668 (2) The Financial Services Commission may adopt rules to
2669 implement the provisions of this section.

2670 Section 49. The Office of Program Policy Analysis and
2671 Government Accountability shall complete a study of the
2672 eligibility requirements for a birth to be covered under the
2673 Florida Birth-Related Neurological Injury Compensation
2674 Association and submit a report to the Legislature by January 1,
2675 2004, recommending whether the statutory criteria for a claim to
2676 qualify for referral to the Florida Birth-Related Neurological
2677 Injury Compensation Association under s. 766.302, Florida
2678 Statutes, should be modified.

2679 Section 50. Subsections (1) and (4) and paragraph (n) of
2680 subsection (2) of section 627.912, Florida Statutes, are amended
2681 to read:

2682 627.912 Professional liability claims and actions; reports
2683 by insurers.--

2684 (1)(a) Each self-insurer authorized under s. 627.357 and
2685 each insurer or joint underwriting association providing
2686 professional liability insurance to a practitioner of medicine
2687 licensed under chapter 458, to a practitioner of osteopathic
2688 medicine licensed under chapter 459, to a podiatric physician
2689 licensed under chapter 461, to a dentist licensed under chapter
2690 466, to a hospital licensed under chapter 395, to a crisis
2691 stabilization unit licensed under part IV of chapter 394, to a



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2692 health maintenance organization certificated under part I of
 2693 chapter 641, to clinics included in chapter 390, to an
 2694 ambulatory surgical center as defined in s. 395.002, or to a
 2695 member of The Florida Bar shall report in duplicate to the
 2696 Department of Insurance any claim or action for damages for
 2697 personal injuries claimed to have been caused by error,
 2698 omission, or negligence in the performance of such insured's
 2699 professional services or based on a claimed performance of
 2700 professional services without consent, if the claim resulted in:

- 2701 1.(a) A final judgment in any amount.
- 2702 2.(b) A settlement in any amount.

2703
 2704 Reports shall be filed with the department.

2705 (b) In addition to the requirements of paragraph (a), if
 2706 the insured party is licensed under chapter 395, chapter 458,
 2707 chapter 459, chapter 461, or chapter 466, the insurer shall
 2708 report in duplicate to the Office of Insurance Regulation any
 2709 other disposition of the claim, including, but not limited to, a
 2710 dismissal. If the insured is licensed under chapter 458, chapter
 2711 459, or chapter 461, any claim that resulted in a final judgment
 2712 or settlement in the amount of \$50,000 or more shall be reported
 2713 to the Department of Health no later than 30 days following the
 2714 occurrence of that event. If the insured is licensed under
 2715 chapter 466, any claim that resulted in a final judgment or
 2716 settlement in the amount of \$25,000 or more shall be reported to
 2717 the Department of Health no later than 30 days following the
 2718 occurrence of that event and, if the insured party is licensed
 2719 under chapter 458, chapter 459, chapter 461, or chapter 466,
 2720 with the Department of Health, no later than 30 days following
 2721 the occurrence of any event listed in paragraph (a) or paragraph



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2722 ~~(b)~~. The Department of Health shall review each report and
 2723 determine whether any of the incidents that resulted in the
 2724 claim potentially involved conduct by the licensee that is
 2725 subject to disciplinary action, in which case the provisions of
 2726 s. 456.073 shall apply. The Department of Health, as part of the
 2727 annual report required by s. 456.026, shall publish annual
 2728 statistics, without identifying licensees, on the reports it
 2729 receives, including final action taken on such reports by the
 2730 Department of Health or the appropriate regulatory board.

2731 (2) The reports required by subsection (1) shall contain:

2732 (n) Any other information required by the department to
 2733 analyze and evaluate the nature, causes, location, cost, and
 2734 damages involved in professional liability cases. The Financial
 2735 Services Commission shall adopt by rule requirements for
 2736 additional information to assist the Office of Insurance
 2737 Regulation in its analysis and evaluation of the nature, causes,
 2738 location, cost, and damages involved in professional liability
 2739 cases reported by insurers under this section.

2740 (4) There shall be no liability on the part of, and no
 2741 cause of action of any nature shall arise against, any insurer
 2742 reporting hereunder or its agents or employees or the department
 2743 or its employees for any action taken by them under this
 2744 section. The department shall ~~may~~ impose a fine of \$250 per day
 2745 per case, but not to exceed a total of \$10,000 ~~\$1,000~~ per case,
 2746 against an insurer that violates the requirements of this
 2747 section. This subsection applies to claims accruing on or after
 2748 October 1, 1997.

2749 Section 51. Section 627.9121, Florida Statutes, is created
 2750 to read:

2751 627.9121 Required reporting of claims; penalties.--Each



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2752 entity that makes payment under a policy of insurance, self-
 2753 insurance, or otherwise in settlement, partial settlement, or
 2754 satisfaction of a judgment in a medical malpractice action or
 2755 claim that is required to report information to the National
 2756 Practitioner Data Bank under 42 U.S.C. s. 11131 must also report
 2757 the same information to the Office of Insurance Regulation. The
 2758 office shall include such information in the data that it
 2759 compiles under s. 627.912. The office must compile and review
 2760 the data collected pursuant to this section and must assess an
 2761 administrative fine on any entity that fails to fully comply
 2762 with such reporting requirements.

2763 Section 52. Section 766.102, Florida Statutes, is amended
 2764 to read:

2765 766.102 Medical negligence; standards of recovery.--

2766 (1) In any action for recovery of damages based on the
 2767 death or personal injury of any person in which it is alleged
 2768 that such death or injury resulted from the negligence of a
 2769 health care provider as defined in s. 766.101(1)(b)
 2770 ~~768.50(2)(b)~~, the claimant shall have the burden of proving by
 2771 the greater weight of evidence that the alleged actions of the
 2772 health care provider represented a breach of the prevailing
 2773 professional standard of care for that health care provider. The
 2774 prevailing professional standard of care for a given health care
 2775 provider shall be that level of care, skill, and treatment
 2776 which, in light of all relevant surrounding circumstances, is
 2777 recognized as acceptable and appropriate by reasonably prudent
 2778 similar health care providers.

2779 ~~(2)(a) If the health care provider whose negligence is~~
 2780 ~~claimed to have created the cause of action is not certified by~~
 2781 ~~the appropriate American board as being a specialist, is not~~



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2782 ~~trained and experienced in a medical specialty, or does not hold~~
2783 ~~himself or herself out as a specialist, a "similar health care~~
2784 ~~provider" is one who:~~

2785 ~~1. Is licensed by the appropriate regulatory agency of~~
2786 ~~this state;~~

2787 ~~2. Is trained and experienced in the same discipline or~~
2788 ~~school of practice; and~~

2789 ~~3. Practices in the same or similar medical community.~~

2790 ~~(b) If the health care provider whose negligence is~~
2791 ~~claimed to have created the cause of action is certified by the~~
2792 ~~appropriate American board as a specialist, is trained and~~
2793 ~~experienced in a medical specialty, or holds himself or herself~~
2794 ~~out as a specialist, a "similar health care provider" is one~~
2795 ~~who:~~

2796 ~~1. Is trained and experienced in the same specialty; and~~

2797 ~~2. Is certified by the appropriate American board in the~~
2798 ~~same specialty.~~

2799
2800 ~~However, if any health care provider described in this paragraph~~
2801 ~~is providing treatment or diagnosis for a condition which is not~~
2802 ~~within his or her specialty, a specialist trained in the~~
2803 ~~treatment or diagnosis for that condition shall be considered a~~
2804 ~~"similar health care provider."~~

2805 ~~(c) The purpose of this subsection is to establish a~~
2806 ~~relative standard of care for various categories and~~
2807 ~~classifications of health care providers. Any health care~~
2808 ~~provider may testify as an expert in any action if he or she:~~

2809 ~~1. Is a similar health care provider pursuant to paragraph~~
2810 ~~(a) or paragraph (b); or~~



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2811 ~~2. Is not a similar health care provider pursuant to~~
2812 ~~paragraph (a) or paragraph (b) but, to the satisfaction of the~~
2813 ~~court, possesses sufficient training, experience, and knowledge~~
2814 ~~as a result of practice or teaching in the specialty of the~~
2815 ~~defendant or practice or teaching in a related field of~~
2816 ~~medicine, so as to be able to provide such expert testimony as~~
2817 ~~to the prevailing professional standard of care in a given field~~
2818 ~~of medicine. Such training, experience, or knowledge must be as~~
2819 ~~a result of the active involvement in the practice or teaching~~
2820 ~~of medicine within the 5-year period before the incident giving~~
2821 ~~rise to the claim.~~

2822 (2)~~(3)~~(a) If the injury is claimed to have resulted from
2823 the negligent affirmative medical intervention of the health
2824 care provider, the claimant must, in order to prove a breach of
2825 the prevailing professional standard of care, show that the
2826 injury was not within the necessary or reasonably foreseeable
2827 results of the surgical, medicinal, or diagnostic procedure
2828 constituting the medical intervention, if the intervention from
2829 which the injury is alleged to have resulted was carried out in
2830 accordance with the prevailing professional standard of care by
2831 a reasonably prudent similar health care provider.

2832 (b) The provisions of this subsection shall apply only
2833 when the medical intervention was undertaken with the informed
2834 consent of the patient in compliance with the provisions of s.
2835 766.103.

2836 (3)~~(4)~~ The existence of a medical injury shall not create
2837 any inference or presumption of negligence against a health care
2838 provider, and the claimant must maintain the burden of proving
2839 that an injury was proximately caused by a breach of the
2840 prevailing professional standard of care by the health care



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2841 provider. However, the discovery of the presence of a foreign
 2842 body, such as a sponge, clamp, forceps, surgical needle, or
 2843 other paraphernalia commonly used in surgical, examination, or
 2844 diagnostic procedures, shall be prima facie evidence of
 2845 negligence on the part of the health care provider.

2846 ~~(4)~~(5) The Legislature is cognizant of the changing trends
 2847 and techniques for the delivery of health care in this state and
 2848 the discretion that is inherent in the diagnosis, care, and
 2849 treatment of patients by different health care providers. The
 2850 failure of a health care provider to order, perform, or
 2851 administer supplemental diagnostic tests shall not be actionable
 2852 if the health care provider acted in good faith and with due
 2853 regard for the prevailing professional standard of care.

2854 (5) A person may not give expert testimony concerning the
 2855 prevailing professional standard of care unless that person is a
 2856 licensed health care provider and meets the following criteria:

2857 (a) If the party against whom or on whose behalf the
 2858 testimony is offered is a specialist, the expert witness must:

2859 1. Specialize in the same specialty as the party against
 2860 whom or on whose behalf the testimony is offered; or

2861 2. Specialize in a similar specialty that includes the
 2862 evaluation, diagnosis, or treatment of the medical condition
 2863 that is the subject of the claim and have prior experience
 2864 treating similar patients.

2865 (b) Have devoted professional time during the 3 years
 2866 immediately preceding the date of the occurrence that is the
 2867 basis for the action to:

2868 1. The active clinical practice of, or consulting with
 2869 respect to, the same or similar health profession as the health
 2870 care provider against whom or on whose behalf the testimony is



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2871 offered and, if that health care provider is a specialist, the
 2872 active clinical practice of, or consulting with respect to, the
 2873 same or similar specialty that includes the evaluation,
 2874 diagnosis, or treatment of the medical condition that is the
 2875 subject of the claim and have prior experience treating similar
 2876 patients;

2877 2. The instruction of students in an accredited health
 2878 professional school or accredited residency program in the same
 2879 or similar health profession in which the health care provider
 2880 against whom or on whose behalf the testimony is offered and, if
 2881 that health care provider is a specialist, an accredited health
 2882 professional school or accredited residency or clinical research
 2883 program in the same or similar specialty; or

2884 3. A clinical research program that is affiliated with an
 2885 accredited medical school or teaching hospital and that is in
 2886 the same or similar health profession as the health care
 2887 provider against whom or on whose behalf the testimony is
 2888 offered and, if that health care provider is a specialist, a
 2889 clinical research program that is affiliated with an accredited
 2890 health professional school or accredited residency or clinical
 2891 research program in the same or similar specialty.

2892 (c) If the party against whom or on whose behalf the
 2893 testimony is offered is a general practitioner, the expert
 2894 witness must have devoted professional time during the 5 years
 2895 immediately preceding the date of the occurrence that is the
 2896 basis for the action to:

2897 1. Active clinical practice or consultation as a general
 2898 practitioner;

2899 2. Instruction of students in an accredited health
 2900 professional school or accredited residency program in the



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2901 general practice of medicine; or

2902 3. A clinical research program that is affiliated with an
 2903 accredited medical school or teaching hospital and that is in
 2904 the general practice of medicine.

2905 (6) A physician licensed under chapter 458 or chapter 459
 2906 who qualifies as an expert witness under subsection (5) and who,
 2907 by reason of active clinical practice or instruction of
 2908 students, has knowledge of the applicable standard of care for
 2909 nurses, nurse practitioners, certified registered nurse
 2910 anesthetists, certified registered nurse midwives, physician
 2911 assistants, or other medical support staff may give expert
 2912 testimony in a medical malpractice action with respect to the
 2913 standard of care of such medical support staff.

2914 (7) Notwithstanding subsection (5), in a medical
 2915 malpractice action against a hospital, health care facility, or
 2916 medical facility, a person may give expert testimony on the
 2917 appropriate standard of care as to administrative and other
 2918 nonclinical issues if the person has substantial knowledge, by
 2919 virtue of his or her training and experience, concerning the
 2920 standard of care among hospitals, health care facilities, or
 2921 medical facilities of the same type as the hospital, health care
 2922 facility, or medical facility whose acts or omissions are the
 2923 subject of the testimony and which are located in the same or
 2924 similar communities at the time of the alleged act giving rise
 2925 to the cause of action.

2926 (8) If a health care provider described in subsection (5),
 2927 subsection (6), or subsection (7) is providing evaluation,
 2928 treatment, or diagnosis for a condition that is not within his
 2929 or her specialty, a specialist trained in the evaluation,
 2930 treatment, or diagnosis for that condition shall be considered a



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2931 similar health care provider.

2932 (9)~~(6)~~(a) In any action for damages involving a claim of
 2933 negligence against a physician licensed under chapter 458,
 2934 osteopathic physician licensed under chapter 459, podiatric
 2935 physician licensed under chapter 461, or chiropractic physician
 2936 licensed under chapter 460 providing emergency medical services
 2937 in a hospital emergency department, the court shall admit expert
 2938 medical testimony only from physicians, osteopathic physicians,
 2939 podiatric physicians, and chiropractic physicians who have had
 2940 substantial professional experience within the preceding 5 years
 2941 while assigned to provide emergency medical services in a
 2942 hospital emergency department.

2943 (b) For the purposes of this subsection:

2944 1. The term "emergency medical services" means those
 2945 medical services required for the immediate diagnosis and
 2946 treatment of medical conditions which, if not immediately
 2947 diagnosed and treated, could lead to serious physical or mental
 2948 disability or death.

2949 2. "Substantial professional experience" shall be
 2950 determined by the custom and practice of the manner in which
 2951 emergency medical coverage is provided in hospital emergency
 2952 departments in the same or similar localities where the alleged
 2953 negligence occurred.

2954 (10) In any action alleging medical malpractice, an expert
 2955 witness may not testify on a contingency fee basis.

2956 (11) Any attorney who proffers a person as an expert
 2957 witness pursuant to this section must certify that such person
 2958 has not been found guilty of fraud or perjury in any
 2959 jurisdiction.

2960 (12) Any person who serves as an expert witness under



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2961 subsection (5) may not receive remuneration in excess of \$300
2962 per hour.

2963 (13) This section does not limit the power of the trial
2964 court to disqualify or qualify an expert witness on grounds
2965 other than the qualifications in this section.

2966 Section 53. Subsections (2), (3), and (4) and paragraph
2967 (a) of subsection (10) of section 766.106, Florida Statutes, are
2968 amended, and subsections (13), (14), and (15) are added to said
2969 section, to read:

2970 766.106 Notice before filing action for medical
2971 malpractice; presuit screening period; offers for admission of
2972 liability and for arbitration; informal discovery; review.--

2973 (2)(a) After completion of presuit investigation pursuant
2974 to s. 766.203 and prior to filing a claim for medical
2975 malpractice, a claimant shall notify each prospective defendant
2976 by certified mail, return receipt requested, of intent to
2977 initiate litigation for medical malpractice. Notice to each
2978 prospective defendant must include, if available, a list of all
2979 known health care providers seen by the claimant for the
2980 injuries complained of subsequent to the alleged act of
2981 malpractice, a list of all known health care providers during
2982 the 2-year period prior to the alleged act of malpractice who
2983 treated or evaluated the claimant, and copies of all of the
2984 medical records relied upon by the expert in signing the
2985 affidavit. The requirement of providing the list of known health
2986 care providers may not serve as grounds for imposing sanctions
2987 for failure to provide presuit discovery.

2988 (b) Following the initiation of a suit alleging medical
2989 malpractice with a court of competent jurisdiction, and service
2990 of the complaint upon a defendant, the claimant shall provide a



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2991 copy of the complaint to the Department of Health and, if the
2992 complaint involves a facility licensed under chapter 395, the
2993 Agency for Health Care Administration. The requirement of
2994 providing the complaint to the Department of Health or the
2995 Agency for Health Care Administration does not impair the
2996 claimant's legal rights or ability to seek relief for his or her
2997 claim. The Department of Health or the Agency for Health Care
2998 Administration shall review each incident that is the subject of
2999 the complaint and determine whether it involved conduct by a
3000 licensee which is potentially subject to disciplinary action, in
3001 which case the provisions of s. 456.073 or s. 395.1046 apply.

3002 (3)(a) No suit may be filed for a period of 150 ~~90~~ days
3003 after notice is mailed to any prospective defendant. During the
3004 150-day ~~90-day~~ period, the prospective defendant's insurer or
3005 self-insurer shall conduct a review to determine the liability
3006 of the defendant. Each insurer or self-insurer shall have a
3007 procedure for the prompt investigation, review, and evaluation
3008 of claims during the 150-day ~~90-day~~ period. This procedure shall
3009 include one or more of the following:

- 3010 1. Internal review by a duly qualified claims adjuster;
- 3011 2. Creation of a panel comprised of an attorney
3012 knowledgeable in the prosecution or defense of medical
3013 malpractice actions, a health care provider trained in the same
3014 or similar medical specialty as the prospective defendant, and a
3015 duly qualified claims adjuster;
- 3016 3. A contractual agreement with a state or local
3017 professional society of health care providers, which maintains a
3018 medical review committee;
- 3019 4. Any other similar procedure which fairly and promptly
3020 evaluates the pending claim.



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3021
3022 Each insurer or self-insurer shall investigate the claim in good
3023 faith, and both the claimant and prospective defendant shall
3024 cooperate with the insurer in good faith. If the insurer
3025 requires, a claimant shall appear before a pretrial screening
3026 panel or before a medical review committee and shall submit to a
3027 physical examination, if required. Unreasonable failure of any
3028 party to comply with this section justifies dismissal of claims
3029 or defenses. There shall be no civil liability for participation
3030 in a pretrial screening procedure if done without intentional
3031 fraud.

3032 (b) At or before the end of the 150 ~~90~~ days, the insurer
3033 or self-insurer shall provide the claimant with a response:

- 3034 1. Rejecting the claim;
3035 2. Making a settlement offer; or
3036 3. Making an offer to arbitrate, in which case liability
3037 is deemed admitted and arbitration will be held only of
3038 ~~admission of liability and for arbitration~~ on the issue of
3039 damages. This offer may be made contingent upon a limit of
3040 general damages.

3041 (c) The response shall be delivered to the claimant if not
3042 represented by counsel or to the claimant's attorney, by
3043 certified mail, return receipt requested. Failure of the
3044 prospective defendant or insurer or self-insurer to reply to the
3045 notice within 150 ~~90~~ days after receipt shall be deemed a final
3046 rejection of the claim for purposes of this section.

3047 (d) Within 30 days after ~~of~~ receipt of a response by a
3048 prospective defendant, insurer, or self-insurer to a claimant
3049 represented by an attorney, the attorney shall advise the
3050 claimant in writing of the response, including:



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3051 1. The exact nature of the response under paragraph (b).

3052 2. The exact terms of any settlement offer, or admission
3053 of liability and offer of arbitration on damages.

3054 3. The legal and financial consequences of acceptance or
3055 rejection of any settlement offer, or admission of liability,
3056 including the provisions of this section.

3057 4. An evaluation of the time and likelihood of ultimate
3058 success at trial on the merits of the claimant's action.

3059 5. An estimation of the costs and attorney's fees of
3060 proceeding through trial.

3061 (4) The notice of intent to initiate litigation shall be
3062 served within the time limits set forth in s. 95.11. However,
3063 during the 150-day ~~90-day~~ period, the statute of limitations is
3064 tolled as to all potential defendants. Upon stipulation by the
3065 parties, the 150-day ~~90-day~~ period may be extended and the
3066 statute of limitations is tolled during any such extension. Upon
3067 receiving notice of termination of negotiations in an extended
3068 period, the claimant shall have 60 days or the remainder of the
3069 period of the statute of limitations, whichever is greater,
3070 within which to file suit.

3071 (10) If a prospective defendant makes an offer to admit
3072 liability and for arbitration on the issue of damages, the
3073 claimant has 50 days from the date of receipt of the offer to
3074 accept or reject it. The claimant shall respond in writing to
3075 the insurer or self-insurer by certified mail, return receipt
3076 requested. If the claimant rejects the offer, he or she may then
3077 file suit. Acceptance of the offer of admission of liability and
3078 for arbitration waives recourse to any other remedy by the
3079 parties, and the claimant's written acceptance of the offer
3080 shall so state.



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3081 (a) If rejected, the offer to admit liability and for
3082 arbitration on damages is not admissible in any subsequent
3083 litigation. Upon rejection of the offer to admit liability and
3084 for arbitration, the claimant has 60 days from receipt of the
3085 rejection of the offer to admit liability and for arbitration,
3086 60 days from the date of the declaration of impasse during
3087 presuit mediation conducted pursuant to s. 766.1065, or the
3088 remainder of the period of the statute of limitations, whichever
3089 period is greater, in which to file suit.

3090 (13) In matters relating to professional liability
3091 insurance coverage for medical negligence, an insurer shall not
3092 be held in bad faith for failure to timely pay its policy limits
3093 if it tenders its policy limits and meets all other conditions
3094 of settlement prior to the conclusion of the presuit screening
3095 period.

3096 (14) Failure to cooperate on the part of any party during
3097 the presuit investigation may be grounds to strike any claim
3098 made, or defense raised, by such party in suit.

3099 (15) In all matters relating to professional liability
3100 insurance coverage for medical negligence, and in determining
3101 whether the insurer has acted in good faith, the following
3102 factors may be considered, along with all of the other
3103 circumstances of the case:

3104 (a) Whether the damages recoverable against the insured
3105 are large or small.

3106 (b) Whether the liability against the insured is
3107 relatively clear.

3108 (c) Whether the insurance companies or its agents were
3109 negligent in handling the claim.

3110 (d) Whether the carrier acted as a reasonable person would



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3111 who was facing the prospect of paying the entire loss.

3112 (e) Whether the insurance company made a fair offer as
3113 soon as a reasonable investigation would reveal that liability
3114 was reasonably clear and that the damages were greater than the
3115 policy limits.

3116 (f) Whether the insurer violated the unfair claims
3117 practice standards.

3118 (g) Whether the insurer's communications with its insureds
3119 were actually honest, candid, and complete.

3120 (h) Whether the insurer violated the adjuster's code of
3121 ethics in handling the claim.

3122 (i) Whether the insurer fully documented its claims-
3123 handling activities and the reasons for its decisions.

3124 (j) Whether the insurer or its agents properly trained its
3125 adjusters and provided adequate written standards for the
3126 adjustment of claims.

3127 (k) Whether the insurer used the policy benefits available
3128 to the insurer to extinguish as much of the insured's liability
3129 as possible.

3130 (l) Whether the attorney appointed by the insurer to
3131 defend the insured was competent, independent, and faithfully
3132 representing the interests of the insured.

3133 Section 54. Section 766.1065, Florida Statutes, is created
3134 to read:

3135 766.1065 Mandatory staging of presuit investigation;
3136 mandatory mediation.--

3137 (1) Within 30 days after service of the presuit notice of
3138 intent to initiate medical malpractice litigation, each party
3139 shall voluntarily produce to all other parties, without being
3140 requested, any and all medical, hospital, health care, and



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3141 employment records concerning the claimant in the disclosing
3142 party's possession, custody, or control, and the disclosing
3143 party shall affirmatively certify in writing that the records
3144 produced include all records in that party's possession,
3145 custody, or control or that the disclosing party has no medical,
3146 hospital, health care, or employment records concerning the
3147 claimant.

3148 (a) Subpoenas may be issued according to the Florida Rules
3149 of Civil Procedure as though suit had been filed for the limited
3150 purpose of obtaining copies of medical, hospital, health care,
3151 and employment records of the claimant. The party shall indicate
3152 on the subpoena that it is being issued in accordance with the
3153 presuit procedures of this section and shall not be required to
3154 include a case number.

3155 (b) Nothing in this section shall limit the ability of any
3156 party to use any other available form of presuit discovery
3157 available under this chapter or the Florida Rules of Civil
3158 Procedure.

3159 (2) Within 60 days after service of the presuit notice of
3160 intent to initiate medical malpractice litigation, all parties
3161 must be made available for a sworn deposition. Such deposition
3162 may not be used in a civil suit for medical negligence.

3163 (3) Within 120 days after service of the presuit notice of
3164 intent to initiate medical malpractice litigation, each party's
3165 corroborating expert, who will otherwise be tendered as the
3166 expert complying with the affidavit provisions set forth in s.
3167 766.203, must be made available for a sworn deposition.

3168 (a) The expenses associated with the expert's time and
3169 travel in preparing for and attending such deposition shall be
3170 the responsibility of the party retaining such expert.



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3171 (b) An expert shall be deemed available for deposition if
3172 suitable accommodations can be made for appearance of said
3173 expert via real-time video technology.

3174 (4) Within 150 days after service of the presuit notice of
3175 intent to initiate medical malpractice litigation, all parties
3176 shall attend in-person mandatory mediation in accordance with s.
3177 44.102 if binding arbitration under s. 766.106 or s. 766.207 has
3178 not been agreed to by the parties. The Florida Rules of Civil
3179 Procedure shall apply to mediation held pursuant to this
3180 section.

3181 (5) If the parties declare an impasse during the mandatory
3182 mediation required in subsection (4), the plaintiff shall
3183 request, via certified mail, a hearing of a presuit screening
3184 panel which shall be convened pursuant to s. 766.1066.

3185 Section 55. Section 766.1066, Florida Statutes, is created
3186 to read:

3187 766.1066 Office of Presuit Screening Administration;
3188 presuit screening panels.--

3189 (1)(a) There is created within the Department of Health
3190 the Office of Presuit Screening Administration, which shall be
3191 responsible for administering the presuit screening program.

3192 (b) The Office of Presuit Screening Administration shall
3193 develop and maintain a database of physicians, attorneys, and
3194 consumers to serve as members of presuit screening panels as
3195 described in this section.

3196 (c) The Office of Presuit Screening Administration shall
3197 develop an application by September 1, 2003, that can be
3198 submitted in writing and via the Internet for physicians,
3199 attorneys, and consumers to volunteer for the panels.

3200 (d) Funding for the Office of Presuit Screening



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3201 Administration shall come from:

3202 1. A fee equal to 0.5 percent of, and assessed against,
3203 all judgments and settlements in medical malpractice liability
3204 cases. The defendant shall remit such fee to the Office of
3205 Presuit Administration.

3206 2. An annual fee of \$1 on all medical malpractice
3207 liability insurance policies issued to physicians licensed by
3208 the Department of Health, which shall be collected by the
3209 insurer and submitted by the insurer to the Office of Presuit
3210 Administration.

3211 (e)1. Physicians, attorneys, and consumers who volunteer
3212 for the panels shall be obligated to serve on a panel for no
3213 longer than 2 calendar days per selection.

3214 2. Every person applying to serve on a panel shall
3215 designate in advance any time period during which he or she will
3216 not be available to serve on a panel.

3217 3. When a plaintiff requests a hearing of a presuit
3218 screening panel, the Office of Presuit Screening Administration
3219 shall randomly select members for a panel as provided in
3220 subsection (2) from among the available persons in the
3221 appropriate categories who have not served on a panel in the
3222 past 12 months. If there are no other potential panelists
3223 available, a panelist may be asked to serve on another panel
3224 within 12 months.

3225 (f) If a physician, attorney, or consumer is selected to
3226 serve on a panel, he or she shall not be obligated to serve for
3227 a period exceeding 2 days.

3228 (g) All persons serving on a panel shall receive
3229 reimbursement for their travel expenses.

3230 (h) Physicians who are selected to serve on a panel:



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3231 1. Shall receive credit for 20 hours of continuing medical
 3232 education for his or her service.

3233 2. Must reside and practice at least 50 miles from the
 3234 location of the injury alleged by the plaintiff.

3235 3. Must have had no more than three judgments for medical
 3236 malpractice liability against him or her within the preceding 5
 3237 years and no more than 10 claims of medical malpractice filed
 3238 against him or her within the preceding 3 years.

3239 4. Must have an active license with the Department of
 3240 Health and be in good standing.

3241 (i) Attorneys who are selected to serve on a panel:

3242 1. Shall receive credit for 20 hours of continuing legal
 3243 education and credit towards pro bono requirements for his or
 3244 her service.

3245 2. Must reside and practice at least 50 miles from the
 3246 location of the injury alleged by the plaintiff.

3247 3. Must have had no judgments of filing a frivolous
 3248 lawsuit within the preceding 5 years.

3249 4. Must have an active license with The Florida Bar and be
 3250 in good standing.

3251 (2)(a) A presuit screening panel shall be composed of five
 3252 persons, consisting of:

3253 1. One physician board certified in the same specialty as
 3254 the defendant physician.

3255 2. One physician who is a general practitioner, family
 3256 practitioner, or an internist or one physician who serves as a
 3257 full-time member in the faculty of an accredited public or
 3258 private medical school in the state.

3259 3. One attorney who has served as a plaintiff's attorney,
 3260 with 5 years' experience in medical malpractice liability cases



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3261 including at least one jury trial.

3262 4. One attorney who has served as a defendant's attorney,
3263 with 5 years' experience in medical malpractice liability cases
3264 including at least one jury trial.

3265 5. One consumer who shall not have a professional or
3266 financial relationship with either a health care provider or an
3267 attorney.

3268 (b) In cases with more than one physician defendant, the
3269 plaintiff shall designate the subject areas in which both
3270 physician members of the panel shall be board certified.

3271 (c) Any panelist who knowingly has a conflict of interest
3272 or potential conflict of interest must disclose such conflict of
3273 interest prior to the hearing.

3274 (d) A plaintiff or a defendant may challenge any panel
3275 member for a conflict of interest and ask that the panelist be
3276 replaced by the Office of Presuit Screening Administration.

3277 (3) The Office of Presuit Screening Administration shall
3278 provide an administrator for the panel.

3279 (4) The plaintiff shall be allowed 8 hours to present his
3280 or her case. The defendants shall be allowed a total of 8 hours
3281 to present their case. No hearing shall exceed a total of 16
3282 hours; however, the panel may hear the case over the course of 2
3283 calendar days.

3284 (5) A presuit screening panel shall, by a majority vote
3285 for each defendant, make its findings in regards to reasonable
3286 grounds for liability of the defendant based on the
3287 preponderance of the evidence.

3288 (a) If a panel finds that there are no reasonable grounds
3289 for liability on the part of a defendant for the injury alleged,
3290 the defendant may, within 10 days, request voluntary binding



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3291 arbitration pursuant to s. 766.207.

3292 (b) If a panel finds that there are reasonable grounds for
3293 liability on the part of a defendant for the injury alleged, the
3294 parties may elect to have damages determined by voluntary
3295 binding arbitration pursuant to s. 766.207.

3296 (c) If a panel finds that there are no reasonable grounds
3297 for liability on the part of a defendant for the injury alleged
3298 and the defendant does not request arbitration, or if a panel
3299 finds that there are reasonable grounds for liability on the
3300 part of a defendant for the injury alleged and either a
3301 defendant or the plaintiff do not agree to voluntary binding
3302 arbitration pursuant to s. 766.207, the claim shall proceed to
3303 trial or to any available legal alternative such as offer of
3304 judgment and demand for judgment under s. 768.79 or offer of
3305 settlement under s. 45.061. The damages that may be awarded
3306 during such trial are subject to the limitations included in s.
3307 766.118.

3308 Section 56. Section 766.1067, Florida Statutes, is created
3309 to read:

3310 766.1067 Structured judgments.--For cases that are decided
3311 in a trial, the judgment may be structured as follows:

3312 (1) If the noneconomic damages awarded to the plaintiff
3313 are equal to or greater than \$500,000 and the jury finds the
3314 life expectancy of the plaintiff to be 20 years or greater, the
3315 defendant may compel a structured judgment for 50 percent of the
3316 noneconomic damages to be paid over the remaining life of the
3317 plaintiff. Such payments shall terminate upon the plaintiff's
3318 death.

3319 (2) If the economic damages awarded to the plaintiff are
3320 equal to or greater than \$250,000 and the jury finds the



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3321 plaintiff would otherwise have been able to work for 20 years or
 3322 more, the defendant may compel a structured judgment for 75
 3323 percent of the future economic damages to be paid over the years
 3324 in which the jury finds the plaintiff would otherwise have been
 3325 able to work. Any unpaid portion of a structured judgment made
 3326 under this subsection which is attributable to medical expenses
 3327 that have not yet been incurred shall terminate upon the death
 3328 of the plaintiff. Any outstanding medical expenses incurred
 3329 prior to the death of the plaintiff shall be paid from that
 3330 portion of the structured judgment attributable to medical
 3331 expenses.

3332 Section 57. Section 766.1068, Florida Statutes, is created
 3333 to read:

3334 766.1068 Proposal for settlement; timing.--Notwithstanding
 3335 any other provision of law, any party may serve another party in
 3336 a medical malpractice suit with a proposal for settlement at any
 3337 time after the filing of the complaint. If a claimant rejects
 3338 the proposal for settlement, then either loses at trial or
 3339 prevails at trial while receiving an award for damages less than
 3340 the most recent proposal for settlement, the court may require
 3341 the claimant to pay the attorney's fees and costs of the
 3342 defendant from whom the claimant will receive the award. If a
 3343 defendant rejects the proposal for settlement, then loses at
 3344 trial while receiving a judgment greater than the most resent
 3345 proposal for settlement, the court may require the defendant to
 3346 pay the attorney's fees and costs of the claimant to whom the
 3347 judgment is awarded.

3348 Section 58. Subsections (3), (4), (5), and (6) are added
 3349 to section 766.110, Florida Statutes, to read:

3350 766.110 Liability of health care facilities.--



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3351 (3)(a) Members of the medical staff of a hospital licensed
3352 under chapter 395 and any professional group comprised of such
3353 persons shall be immune from liability for noneconomic damages
3354 in excess of \$250,000 per emergency room admission arising from
3355 medical injuries to a patient resulting from negligent acts or
3356 omissions of such medical staff members in the performance of
3357 emergency medical services as defined in s. 768.13(2) prior to
3358 the patient's condition being sufficiently stable, and no member
3359 of the medical staff of a hospital and no professional group
3360 comprised of such persons shall be liable to pay noneconomic
3361 damages in excess of \$250,000 to any person or persons for any
3362 single incident of medical negligence that causes injuries to a
3363 patient or patients in the performance of emergency medical
3364 services.

3365 (b) For the purposes of paragraph (a), a patient's
3366 condition shall be deemed to be sufficiently stable when that
3367 patient could reasonably be transferred to another health care
3368 facility without causing further injury, whether or not the
3369 patient is in fact transferred.

3370 (4)(a) No person or persons may recover damages from a
3371 public family practice teaching hospital licensed under chapter
3372 395 and designated under s. 398.806, or its insurer, or any
3373 health care professional who is a full-time member of the
3374 faculty of an accredited public medical school, or his or her
3375 insurer, in excess of \$250,000 per emergency room admission
3376 arising from medical injuries to a patient or patients caused by
3377 negligent acts or omissions on the part of the hospital or
3378 members of the hospital's medical staff in the performance of
3379 emergency medical services as defined in s. 768.13(2) prior to
3380 the patient's condition being sufficiently stable.



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3381 (b) For the purposes of paragraph (a), a patient's
3382 condition shall be deemed to be sufficiently stable when that
3383 patient could reasonably be transferred to another health care
3384 facility without causing further injury, whether or not the
3385 patient is in fact transferred.

3386 (5)(a) Other than as provided in paragraph (c), when a
3387 subsequent injury occurs after a patient's condition is
3388 sufficiently stable, no person or persons may recover
3389 noneconomic damages from any health care professional who is a
3390 member of the medical staff of such facility, or his or her
3391 insurer, in excess of \$250,000 per injury arising from medical
3392 injury to a patient caused by negligent acts or omissions on the
3393 part of the hospital or members of the hospital's medical staff
3394 in the performance of emergency medical services as defined in
3395 s. 768.13(2) until the patient's condition returns to
3396 sufficiently stable.

3397 (b) For the purposes of paragraph (a), a patient's
3398 condition shall be deemed to be sufficiently stable when that
3399 patient could reasonably be transferred to another health care
3400 facility without causing further injury, whether or not the
3401 patient is in fact transferred.

3402 (c) A person or persons may recover damages from the
3403 health care professional who caused the subsequent injury in
3404 paragraph (a) and the hospital licensed under chapter 395, or
3405 its insurer, where the injury occurred.

3406 (6) The limits established in this section shall be
3407 adjusted annually in accordance with the changes in the Consumer
3408 Price Index as issued by the United States Department of Labor
3409 Bureau of Labor Statistics. The Florida Supreme Court shall
3410 determine and publish the new limits on July 1 of each year.



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3411 Section 59. Section 766.118, Florida Statutes, is created
3412 to read:

3413 766.118 Determination of noneconomic damages.--With
3414 respect to a cause of action for personal injury or wrongful
3415 death resulting from an occurrence of medical negligence,
3416 including actions pursuant to s. 766.209, damages recoverable
3417 for noneconomic losses to compensate for pain and suffering,
3418 inconvenience, physical impairment, mental anguish,
3419 disfigurement, loss of capacity for enjoyment of life, and all
3420 other noneconomic damages shall be determined as follows:

3421 (1) The award for noneconomic damages from the jury shall
3422 be reviewed by the judge to determine the appropriateness of the
3423 award.

3424 (2) In reviewing the award, the judge shall utilize the
3425 Florida Jury Verdict Database as provided in s. 766.26.

3426 (3)(a) The judge shall examine all cases where the
3427 injuries alleged and the economic damages awarded are
3428 substantially similar.

3429 (b) The judge shall adopt a presumptively reasonable range
3430 of similar awards that shall be one standard deviation above and
3431 below the mean award for similar cases. The judge shall then
3432 subtract the economic damages awarded by the jury from the valid
3433 range to find the valid range for noneconomic damages.

3434 (c) If the award for noneconomic damages is outside of the
3435 presumptively reasonable range for noneconomic damages based on
3436 similar cases, the judge may elect to change the award so that
3437 it falls within said range, which is subject to appeal based on
3438 abuse of discretion standards, or the judge may elect to leave
3439 the amount as awarded by providing findings of fact on the
3440 record, which shall be subject to appeal based on clear and



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3441 convincing evidence standards.

3442 (4) If a health care professional does not meet his or her
3443 financial responsibility requirements as provided in s.
3444 458.320(1)(b) or s. 459.0085(1)(b), as applicable, by July 1,
3445 2004, the limits on damages established in this section shall
3446 not apply and awards for economic and noneconomic damages shall
3447 not be limited during arbitration or at trial.

3448 Section 60. Section 766.185, Florida Statutes, is created
3449 to read:

3450 766.185 Apportionment of fault in medical negligence
3451 actions.--

3452 (1) In an action for damages for personal injury or
3453 wrongful death arising out of medical negligence, whether in
3454 contract or tort, when a defendant asserts an affirmative
3455 defense that one or more nonparties is liable, in whole or in
3456 part, for damages arising out of medical negligence, such
3457 defendant must join the nonparties into the action by means of a
3458 third-party complaint asserting a cause of action for
3459 comparative fault in medical negligence against the nonparties,
3460 except with respect to a nonparty who meets one of the following
3461 criteria:

3462 (a) The nonparty has entered into a settlement with each
3463 of the plaintiffs;

3464 (b) The nonparty has complete immunity from suit;

3465 (c) The statute of limitations involving the nonparty
3466 expired prior to filing of the presuit notice of intent to
3467 initiate medical malpractice litigation; or

3468 (d) The nonparty cannot be otherwise legally joined to the
3469 suit.

3470 (2) If the defendant has reasonable grounds to believe



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3471 during the presuit investigation that one or more nonparties are
 3472 liable, in whole or in part, for damages arising out of medical
 3473 negligence and that such nonparties would be joinable into the
 3474 action under this section, the defendant must notify the
 3475 claimant in writing of the identity and reasonable grounds for
 3476 inclusions of such nonparty in the action within 10 days after
 3477 obtaining such information.

3478 (3) If the defendant fails to comply with the provisions
 3479 set forth in this section, then the defendant shall be estopped
 3480 from asserting the negligence of the nonparty who should have
 3481 otherwise been joined into the action.

3482 (4) Any third party joined into the action under the
 3483 provisions of this section shall be liable to the plaintiff for
 3484 any damages adjudicated by the trier of fact subject to the
 3485 provisions of this chapter.

3486 Section 61. Subsection (5) of section 766.202, Florida
 3487 Statutes, is amended to read:

3488 766.202 Definitions; ss. 766.201-766.212.-- As used in ss.
 3489 766.201-766.212, the term:

3490 (5) "Medical expert" means a person duly and regularly
 3491 engaged in the practice of his or her profession who holds a
 3492 health care professional degree from a university or college and
 3493 who meets the requirements of an expert witness as set forth in
 3494 s. 766.102 ~~has had special professional training and experience~~
 3495 ~~or one possessed of special health care knowledge or skill about~~
 3496 ~~the subject upon which he or she is called to testify or provide~~
 3497 ~~an opinion.~~

3498 Section 62. Subsections (2) and (3) of section 766.203,
 3499 Florida Statutes, are amended to read:

3500 766.203 Presuit investigation of medical negligence claims



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3501 and defenses by prospective parties.--

3502 (2) Prior to issuing notification of intent to initiate
3503 medical malpractice litigation pursuant to s. 766.106, the
3504 claimant shall conduct an investigation to ascertain that there
3505 are reasonable grounds to believe that:

3506 (a) Any named defendant in the litigation was negligent in
3507 the care or treatment of the claimant; and

3508 (b) Such negligence resulted in injury to the claimant.

3509

3510 Corroboration of reasonable grounds to initiate medical
3511 negligence litigation shall be provided by the claimant's
3512 submission of a verified written medical expert opinion from a
3513 medical expert as defined in s. 766.202(5), at the time the
3514 notice of intent to initiate litigation is mailed, which
3515 statement shall corroborate reasonable grounds to support the
3516 claim of medical negligence. This opinion and statement are
3517 subject to discovery.

3518 (3) Prior to issuing its response to the claimant's notice
3519 of intent to initiate litigation, during the time period for
3520 response authorized pursuant to s. 766.106, the defendant or the
3521 defendant's insurer or self-insurer shall conduct an
3522 investigation to ascertain whether there are reasonable grounds
3523 to believe that:

3524 (a) The defendant was negligent in the care or treatment
3525 of the claimant; and

3526 (b) Such negligence resulted in injury to the claimant.

3527

3528 Corroboration of lack of reasonable grounds for medical
3529 negligence litigation shall be provided with any response
3530 rejecting the claim by the defendant's submission of a verified



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3531 written medical expert opinion from a medical expert as defined
3532 in s. 766.202(5), at the time the response rejecting the claim
3533 is mailed, which statement shall corroborate reasonable grounds
3534 for lack of negligent injury sufficient to support the response
3535 denying negligent injury. This opinion and statement are subject
3536 to discovery.

3537 Section 63. Subsections (2), (3), and (5) of section
3538 766.206, Florida Statutes, are amended to read:

3539 766.206 Presuit investigation of medical negligence claims
3540 and defenses by court.--

3541 (2) If the court finds that the notice of intent to
3542 initiate litigation mailed by the claimant is not in compliance
3543 with the reasonable investigation requirements of ss. 766.201-
3544 766.212, including a review of the claim and a verified written
3545 medical expert opinion by an expert witness as defined in s.
3546 766.202, the court shall dismiss the claim, and the person who
3547 mailed such notice of intent, whether the claimant or the
3548 claimant's attorney, shall be personally liable for all
3549 attorney's fees and costs incurred during the investigation and
3550 evaluation of the claim, including the reasonable attorney's
3551 fees and costs of the defendant or the defendant's insurer.

3552 (3) If the court finds that the response mailed by a
3553 defendant rejecting the claim is not in compliance with the
3554 reasonable investigation requirements of ss. 766.201-766.212,
3555 including a review of the claim and a verified written medical
3556 expert opinion by an expert witness as defined in s. 766.202,
3557 the court shall strike the defendant's pleading. ~~response, and~~
3558 The person who mailed such response, whether the defendant, the
3559 defendant's insurer, or the defendant's attorney, shall be
3560 personally liable for all attorney's fees and costs incurred



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3561 during the investigation and evaluation of the claim, including
 3562 the reasonable attorney's fees and costs of the claimant.

3563 (5)(a) If the court finds that the corroborating written
 3564 medical expert opinion attached to any notice of claim or intent
 3565 or to any response rejecting a claim lacked reasonable
 3566 investigation, or that the medical expert submitting the opinion
 3567 did not meet the expert witness qualifications as set forth in
 3568 s. 766.202(5), the court shall report the medical expert issuing
 3569 such corroborating opinion to the Division of Medical Quality
 3570 Assurance or its designee. If such medical expert is not a
 3571 resident of the state, the division shall forward such report to
 3572 the disciplining authority of that medical expert.

3573 (b) The court shall ~~may~~ refuse to consider the testimony
 3574 or opinion attached to any notice of intent or to any response
 3575 rejecting a claim of ~~such~~ an expert who has been disqualified
 3576 three times pursuant to this section.

3577 Section 64. Section 766.207, Florida Statutes, is amended
 3578 to read:

3579 766.207 Voluntary binding arbitration of medical
 3580 negligence claims.--

3581 (1) Voluntary binding arbitration pursuant to this section
 3582 and ss. 766.208-766.212 shall not apply to rights of action
 3583 involving the state or its agencies or subdivisions, or the
 3584 officers, employees, or agents thereof, pursuant to s. 768.28.

3585 (2)(a) Upon the completion of the hearing of a presuit
 3586 screening panel pursuant to s. 706.1066 ~~investigation with~~
 3587 ~~preliminary reasonable grounds for a medical negligence claim~~
 3588 ~~intact~~, the parties may elect to have damages determined by an
 3589 arbitration panel. Such election may be initiated by either
 3590 party by serving a request for voluntary binding arbitration of



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3591 damages within 10 ~~90~~ days after the hearing of a presuit
3592 screening panel ~~service of the claimant's notice of intent to~~
3593 ~~initiate litigation upon the defendant~~. The evidentiary
3594 standards for voluntary binding arbitration of medical
3595 negligence claims shall be as provided in ss. 120.569(2)(g) and
3596 120.57(1)(c).

3597 (b) If the presuit screening panel pursuant to s. 766.1066
3598 found that the defendant was not liable by unanimous vote and
3599 the plaintiff refuses arbitration, damages that can be awarded
3600 during a trial shall not exceed a total of \$350,000, as adjusted
3601 herein, per defendant for both future economic and all
3602 noneconomic damages. If the presuit screening panel pursuant to
3603 s. 766.1066 found that the defendant was not liable by majority
3604 vote and the plaintiff refuses arbitration, damages that can be
3605 awarded during a trial for all noneconomic damages shall not
3606 exceed a total of \$350,000, as adjusted herein, per defendant.

3607 (3) Upon receipt of a party's request for such
3608 arbitration, the opposing party may accept the offer of
3609 voluntary binding arbitration within 30 days, and such
3610 arbitration shall be held within 120 days after acceptance of
3611 the offer of voluntary binding arbitration. However, in no event
3612 shall the defendant be required to respond to the request for
3613 arbitration sooner than 90 days after service of the notice of
3614 intent to initiate litigation under s. 766.106. Such acceptance
3615 within the time period provided by this subsection shall be a
3616 binding commitment to comply with the decision of the
3617 arbitration panel. The liability of any insurer shall be subject
3618 to any applicable insurance policy limits.

3619 (4) The arbitration panel shall be a presuit screening
3620 panel selected by the Office of Presuit Screening Administration



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3621 as provided in s. 766.1066. The Florida Rules of Civil Procedure
 3622 shall apply to discovery, except as follows:

3623 (a) Any 30-day deadline provided in such rules shall be
 3624 shortened to 10 business days.

3625 (b) Depositions of expert witnesses shall be permitted for
 3626 no more than five experts per side.

3627
 3628 Discovery disputes shall be resolved by an administrative law
 3629 judge assigned by the Division of Administrative Hearings until
 3630 arbitration is completed ~~composed of three arbitrators, one~~
 3631 ~~selected by the claimant, one selected by the defendant, and one~~
 3632 ~~an administrative law judge furnished by the Division of~~
 3633 ~~Administrative Hearings who shall serve as the chief arbitrator.~~
 3634 ~~In the event of multiple plaintiffs or multiple defendants, the~~
 3635 ~~arbitrator selected by the side with multiple parties shall be~~
 3636 ~~the choice of those parties. If the multiple parties cannot~~
 3637 ~~reach agreement as to their arbitrator, each of the multiple~~
 3638 ~~parties shall submit a nominee, and the director of the Division~~
 3639 ~~of Administrative Hearings shall appoint the arbitrator from~~
 3640 ~~among such nominees.~~

3641 (5) The panel ~~arbitrators~~ shall be independent of all
 3642 parties, witnesses, and legal counsel, and no officer, director,
 3643 affiliate, subsidiary, or employee of a party, witness, or legal
 3644 counsel may serve as a panelist ~~an arbitrator~~ in the proceeding.

3645 (6) The rate of compensation for arbitration panelists
 3646 shall be the same as for members of a presuit screening panel as
 3647 outlined in s. 766.1066 ~~medical negligence claims arbitrators~~
 3648 ~~other than the administrative law judge shall be set by the~~
 3649 ~~chief judge of the appropriate circuit court by schedule~~
 3650 ~~providing for compensation of not less than \$250 per day nor~~



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3651 ~~more than \$750 per day or as agreed by the parties. In setting~~
3652 ~~the schedule, the chief judge shall consider the prevailing~~
3653 ~~rates charged for the delivery of professional services in the~~
3654 ~~community.~~

3655 (7) Arbitration pursuant to this section shall preclude
3656 recourse to any other remedy by the claimant against any
3657 participating defendant, and shall be undertaken with the
3658 understanding that:

3659 (a) If the presuit screening panel established pursuant to
3660 s. 766.1066 found that the defendant was not liable by unanimous
3661 vote, the damages that can be awarded during arbitration shall
3662 not exceed a total of \$250,000, as adjusted herein, per
3663 defendant for both future economic and all noneconomic damages.
3664 If the presuit screening panel established pursuant to s.
3665 766.1066 found that the defendant was not liable by majority
3666 vote, the damages that can be awarded during arbitration for all
3667 noneconomic damages shall not exceed a total of \$250,000, as
3668 adjusted herein, per defendant.

3669 (b) If the presuit screening panel established pursuant to
3670 s. 766.1066 found that the defendant was liable, the following
3671 conditions shall apply:

3672 1.(a) Net economic damages shall be awardable, including,
3673 but not limited to, past and future medical expenses and 80
3674 percent of wage loss and loss of earning capacity, offset by any
3675 collateral source payments, beginning at the time the injury
3676 occurred and extended to a work-life expectancy as determined by
3677 the jury. Net economic damages shall also include interest on
3678 all economic damages occurring prior to trial.

3679 2.(b) Noneconomic damages shall be limited to a maximum of
3680 \$250,000, as adjusted herein, per incident, and shall be



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3681 calculated on a percentage basis with respect to capacity to
3682 enjoy life, so that a finding that the claimant's injuries
3683 resulted in a 50-percent reduction in his or her capacity to
3684 enjoy life would warrant an award of not more than \$125,000
3685 noneconomic damages. The limits on damages established in this
3686 subparagraph shall be adjusted annually in accordance with the
3687 changes in the Consumer Price Index as issued by the United
3688 States Department of Labor Bureau of Labor Statistics. The
3689 Florida Supreme Court shall determine and publish the new limits
3690 on July 1 of each year.

3691 3.(e) Damages for future economic losses shall be awarded
3692 to be paid by periodic payments pursuant to s. 766.1067(2)
3693 ~~766.202(8)~~ and shall be offset by future collateral source
3694 payments.

3695 4.(d) Punitive damages shall not be awarded.

3696 5.(e) The defendant shall be responsible for the payment
3697 of interest on all accrued damages with respect to which
3698 interest would be awarded at trial.

3699 6.(f) The defendant shall pay the claimant's reasonable
3700 attorney's fees and costs, as determined by the arbitration
3701 panel, but in no event more than 15 percent of the award,
3702 reduced to present value.

3703 ~~(g) The defendant shall pay all the costs of the~~
3704 ~~arbitration proceeding and the fees of all the arbitrators other~~
3705 ~~than the administrative law judge.~~

3706 ~~(h) Each defendant who submits to arbitration under this~~
3707 ~~section shall be jointly and severally liable for all damages~~
3708 ~~assessed pursuant to this section.~~

3709 7.(i) The defendant's obligation to pay the claimant's
3710 damages shall be for the purpose of arbitration under this



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3711 section only. A defendant's or claimant's offer to arbitrate
3712 shall not be used in evidence or in argument during any
3713 subsequent litigation of the claim following the rejection
3714 thereof.

3715 8.~~(j)~~ The fact of making or accepting an offer to
3716 arbitrate shall not be admissible as evidence of liability in
3717 any collateral or subsequent proceeding on the claim.

3718 9.~~(k)~~ Any offer by a claimant to arbitrate must be made to
3719 each defendant against whom the claimant has made a claim. Any
3720 offer by a defendant to arbitrate must be made to each claimant
3721 who has joined in the notice of intent to initiate litigation,
3722 as provided in s. 766.106. A defendant who rejects a claimant's
3723 offer to arbitrate shall be subject to the provisions of
3724 subsection (11) ~~s. 766.209(3)~~. A claimant who rejects a
3725 defendant's offer to arbitrate shall be subject to the
3726 provisions of subsection (12) ~~s. 766.209(4)~~.

3727 10.~~(l)~~ The hearing shall be conducted by the panel ~~all of~~
3728 ~~the arbitrators~~, but a majority may determine any question of
3729 fact and render a final decision. ~~The chief arbitrator shall~~
3730 ~~decide all evidentiary matters.~~

3731
3732 The provisions of this subsection shall not preclude settlement
3733 at any time by mutual agreement of the parties.

3734 (8) Any issue between the defendant and the defendant's
3735 insurer or self-insurer as to who shall control the defense of
3736 the claim and any responsibility for payment of an arbitration
3737 award, shall be determined under existing principles of law;
3738 provided that the insurer or self-insurer shall not offer to
3739 arbitrate or accept a claimant's offer to arbitrate without the
3740 written consent of the defendant.



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3741 (9) The Division of Administrative Hearings is authorized
3742 to promulgate rules to effect the orderly and efficient
3743 processing of the arbitration procedures of ss. 766.201-766.212.

3744 (10) Rules promulgated by the Division of Administrative
3745 Hearings pursuant to this section, s. 120.54, or s. 120.65 may
3746 authorize any reasonable sanctions except contempt for violation
3747 of the rules of the division or failure to comply with a
3748 reasonable order issued by an administrative law judge, which is
3749 not under judicial review.

3750 (11) If the defendant refuses a claimant's offer of
3751 voluntary binding arbitration:

3752 (a) The claim shall proceed to trial without limitation on
3753 damages and the claimant, upon proving medical negligence, shall
3754 be entitled to recover prejudgment interest and reasonable
3755 attorney's fees up to 25 percent of the award reduced to present
3756 value.

3757 (b) The claimant's award at trial shall be reduced by any
3758 damages recovered by the claimant from arbitrating codefendants
3759 following arbitration.

3760 (c) The claimant shall be entitled to recover prejudgement
3761 interest on economic damages incurred prior to trial.

3762 (12) If the claimant rejects a defendant's offer to enter
3763 voluntary binding arbitration:

3764 (a) The damages awardable at trial shall be limited to net
3765 economic damages, plus noneconomic damages not to exceed
3766 \$350,000, as adjusted herein, per incident. The Legislature
3767 expressly finds that such conditional limit on noneconomic
3768 damages is warranted by the claimant's refusal to accept
3769 arbitration, and represents an appropriate balance between the
3770 interests of all patients who ultimately pay for medical



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3771 negligence losses and the interests of those patients who are
3772 injured as a result of medical negligence. The limits on damages
3773 established in this paragraph shall be adjusted annually in
3774 accordance with the changes in the Consumer Price Index as
3775 issued by the United States Department of Labor Bureau of Labor
3776 Statistics. The Florida Supreme Court shall determine and
3777 publish the new limits on July 1 of each year. Net economic
3778 damages shall also include interest on all economic damages
3779 occurring prior to trial.

3780 (b) Net economic damages reduced to present value shall be
3781 awardable, including, but not limited to, past and future
3782 medical expenses and 80 percent of wage loss and loss of earning
3783 capacity, offset by any collateral source payments.

3784 (c) Damages for future economic losses shall be awarded to
3785 be paid by periodic payments pursuant to s. 766.202(8) and shall
3786 be offset by future collateral source payments.

3787 (13) The arbitration panel shall allocate financial
3788 responsibility among all defendants named in the notice of
3789 intent to initiate litigation, regardless of whether the
3790 defendant has submitted to arbitration. The defendants in the
3791 arbitration proceeding shall pay their proportionate share of
3792 the economic and noneconomic damages awarded by the arbitration
3793 panel. All defendants in the arbitration proceeding shall be
3794 jointly and severally liable for any damages assessed in
3795 arbitration. The determination of the percentage of fault of any
3796 defendant not in the arbitration case shall neither be binding
3797 against that defendant, nor shall it be admissible in any
3798 subsequent legal proceeding.

3799 (14) Payment by the defendants of the damages awarded by
3800 the arbitration panel shall extinguish those defendants'



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3801 liability to the claimant and shall also extinguish those
 3802 defendants' liability for contribution to any defendants who did
 3803 not participate in arbitration.

3804 (15) Any defendant paying damages assessed pursuant to
 3805 this section shall have an action for contribution against any
 3806 nonarbitrating person whose negligence contributed to the
 3807 injury.

3808 (16)(a) If a health care professional does not meet his or
 3809 her financial responsibility requirements as provided in s.
 3810 458.320(1)(b) or s. 459.0085(1)(b), as applicable, by July 1,
 3811 2004, the limits on damages established in this section shall
 3812 not apply and awards for economic and noneconomic damages shall
 3813 not be limited during arbitration or at trial.

3814 (b) It is the intent of the Legislature to provide relief
 3815 from rising medical malpractice insurance premiums to those
 3816 physicians who pay premiums on medical malpractice liability
 3817 insurance. Physicians who do not carry medical malpractice
 3818 liability insurance and hence do not pay premiums require no
 3819 relief from the crisis referred to in the findings provided in
 3820 this act.

3821 (17) Jury trials shall proceed in accordance with existing
 3822 principles of law.

3823 Section 65. Sections 766.208 and 766.209, Florida
 3824 Statutes, are repealed.

3825 Section 66. Section 766.112, Florida Statutes, is amended
 3826 to read:

3827 766.112 Comparative fault.--

3828 (1) Notwithstanding any provision of law to the contrary,
 3829 in an action for damages for personal injury or wrongful death
 3830 arising out of medical malpractice, whether in contract or tort,



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3831 the court shall enter judgment on the basis of each party's
 3832 percentage of fault and not on the basis of the doctrine of
 3833 joint and several liability.

3834 (2)~~(1)~~ Notwithstanding any provision of ~~anything in~~ law to
 3835 the contrary, in an action for damages for personal injury or
 3836 wrongful death arising out of medical malpractice, whether in
 3837 contract or tort, when an apportionment of damages pursuant to
 3838 this section is attributed to a teaching hospital as defined in
 3839 s. 408.07, the court shall enter judgment against the teaching
 3840 hospital on the basis of such party's percentage of fault and
 3841 not on the basis of the doctrine of joint and several liability.

3842 (3)~~(2)~~ In an action for damages for personal injury or
 3843 wrongful death arising out of medical malpractice, whether in
 3844 contract or tort, when an apportionment of damages pursuant to
 3845 s. 768.81 is attributed to a board of trustees of a state
 3846 university, the court shall enter judgment against the board of
 3847 trustees on the basis of the board's percentage of fault and not
 3848 on the basis of the doctrine of joint and several liability. The
 3849 sole remedy available to a claimant to collect a judgment or
 3850 settlement against a board of trustees, subject to the
 3851 provisions of this subsection, shall be pursuant to s. 768.28.

3852 (4) In the trial of any action for medical malpractice
 3853 which follows a settlement between the plaintiff and one or more
 3854 defendants or potential defendants for the same injury, the
 3855 plaintiff shall be estopped from denying that the fault on the
 3856 part of any such settled defendant or prospective defendant
 3857 contributed to causing the plaintiff's injuries with respect to
 3858 any such settled defendant or prospective defendant who has been
 3859 identified by way of affirmative defense or joined by a
 3860 nonsettling defendant as a party who is liable, in whole or in



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3861 part, for the plaintiff's damages.

3862 Section 67. Section 766.25, Florida Statutes, is created
3863 to read:

3864 766.25 Itemized verdict.--

3865 (1) In any action for damages based on personal injury or
3866 wrongful death arising out of medical malpractice, whether in
3867 tort or contract, to which this part applies in which the trier
3868 of fact determines that liability exists on the part of the
3869 defendant, the trier of fact shall, as a part of the verdict,
3870 itemize the amounts to be awarded to the claimant into the
3871 following categories of damages:

3872 (a) Amounts intended to compensate the claimant for:

3873 1. Past economic losses; and

3874 2. Future economic losses, not reduced to present value,
3875 and the number of years or part thereof which the award is
3876 intended to cover;

3877 (b) Amounts intended to compensate the claimant for:

3878 1. Past noneconomic losses;

3879 2. Future noneconomic losses and the number of years or
3880 part thereof which the award is intended to cover; and

3881 (c) Amounts awarded to the claimant for punitive damages,
3882 if applicable.

3883 Section 68. Section 766.26, Florida Statutes, is created
3884 to read:

3885 766.26 Florida Jury Verdict Database.--

3886 (1) The Agency for Health Care Administration shall
3887 maintain the Florida Jury Verdict Database. For the initial
3888 database, the department shall utilize information and
3889 categories provided by a nationwide jury verdict research
3890 database of plaintiff and defense verdicts and settlements



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3891 resulting from medical malpractice claims. The data to be used
3892 must be reported, tabulated, and analyzed to determine values,
3893 trends, and deviations for injuries and liabilities including
3894 medical malpractice.

3895 (2) Beginning September 1, 2003, all awards under
3896 subsection (1) shall be reported by the Clerk of the Court in
3897 the circuit in which the judgment was entered to the agency
3898 within 3 business days for compilation into the Florida Jury
3899 Verdict Database. The agency, in conjunction with the Clerks of
3900 the Court, shall develop a format for the clerks to use in
3901 reporting the information required for the categories utilized
3902 by the database in subsection (1).

3903 (3) Beginning July 1, 2007, the department shall only
3904 utilize reports concerning cases within the state in the Florida
3905 Jury Verdict Database.

3906 (4) The awards reported by the Clerks of the Court shall
3907 be adjusted annually in accordance with the changes in the
3908 Consumer Price Index as issued by the United States Department
3909 of Labor Bureau of Labor Statistics. The Agency for Health Care
3910 Administration shall adjust all previously reported awards in
3911 the Florida Jury Verdict Database as provided herein prior to
3912 July 1 of each year. Only those awards reported from courts in
3913 this state after September 1, 2003, shall be adjusted.

3914 Section 69. Section 766.27, Florida Statutes, is created
3915 to read:

3916 766.27 Sanctions for frivolous medical malpractice
3917 lawsuits.--Any attorney who receives three judgments of filing a
3918 frivolous medical malpractice lawsuit in any 5-year period shall
3919 be precluded from filing a medical malpractice lawsuit for 3
3920 years. Such preclusion shall prohibit him or her from serving as



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3921 co-counsel on any medical malpractice lawsuit.

3922 Section 70. Office of Insurance Regulation; closed claim
3923 forms; report required.--The Office of Insurance Regulation
3924 shall revise its closed claim form for readability at the ninth-
3925 grade level. The office shall compile annual statistical reports
3926 that provide data summaries of all closed claims, including, but
3927 not limited to, the number of closed claims on file pertaining
3928 to the referent health care professional or health care entity,
3929 the nature of the errant conduct, the size of payments, and the
3930 frequency and size of noneconomic damage awards. The office
3931 shall develop annualized historical statistical summaries
3932 beginning with the 1976 state fiscal year and publish these
3933 reports on its Internet website no later than the 2005 state
3934 fiscal year. The form must accommodate the following minimum
3935 requirements:

3936 (1) A practitioner of medicine licensed pursuant to
3937 chapter 458, Florida Statutes, or a practitioner of osteopathic
3938 medicine licensed pursuant to chapter 459, Florida Statutes,
3939 shall report to the Office of Insurance Regulation and the
3940 Department of Health any claim or action for damages for
3941 personal injury alleged to have been caused by error, omission,
3942 or negligence in the performance of such licensee's professional
3943 services or based on a claimed performance of professional
3944 services without consent if the claim was not covered by an
3945 insurer required to report under s. 627.912, Florida Statutes,
3946 is not a claim for medical malpractice that is subject to the
3947 provisions of s. 766.106, Florida Statutes, and the claim
3948 resulted in:

3949 (a) A final judgment in any amount.

3950 (b) A settlement in any amount.



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3951 (c) A final disposition not resulting in payment on behalf
3952 of the licensee. Reports shall be filed with the Office of
3953 Insurance Regulation no later than 60 days following the
3954 occurrence of any event listed in this subsection.

3955 (2) Health professional reports must contain:

3956 (a) The name and address of the licensee.

3957 (b) The alleged occurrence.

3958 (c) The date of the alleged occurrence.

3959 (d) The date the claim or action was reported to the
3960 licensee.

3961 (e) The name and address of the opposing party.

3962 (f) The date of suit, if filed.

3963 (g) The injured person's age and sex.

3964 (h) The total number and names of all defendants involved
3965 in the claim.

3966 (i) The date and amount of judgment or settlement, if any,
3967 including the itemization of the verdict, together with a copy
3968 of the settlement or judgment.

3969 (j) In the case of a settlement, any information required
3970 by the Office of Insurance Regulation concerning the injured
3971 person's incurred and anticipated medical expense, wage loss,
3972 and other expenses.

3973 (k) The loss adjustment expense paid to defense counsel
3974 and all other allocated loss adjustment expenses paid.

3975 (l) The date and reason for final disposition, if there
3976 was no judgment or settlement.

3977 (m) A summary of the occurrence that created the claim,
3978 which must include:

3979 1. The name of the institution, if any, and the location
3980 within such institution at which the injury occurred.



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3981 2. The final diagnosis for which treatment was sought or
3982 rendered, including the patient's actual condition.

3983 3. A description of the misdiagnosis made, if any, of the
3984 patient's actual condition.

3985 4. The operation or the diagnostic or treatment procedure
3986 causing the injury.

3987 5. A description of the principal injury giving rise to
3988 the claim.

3989 6. The safety management steps that have been taken by the
3990 licensee to make similar occurrences or injuries less likely in
3991 the future.

3992 (n) Any other information required by the Office of
3993 Insurance Regulation to analyze and evaluate the nature, causes,
3994 location, cost, and damages involved in professional liability
3995 cases.

3996 Section 71. Subsection (8) of section 768.21, Florida
3997 Statutes, is amended to read:

3998 768.21 Damages.-- All potential beneficiaries of a
3999 recovery for wrongful death, including the decedent's estate,
4000 shall be identified in the complaint, and their relationships to
4001 the decedent shall be alleged. Damages may be awarded as
4002 follows:

4003 (8) Notwithstanding any other provision of law to the
4004 contrary, for purposes of a wrongful death action arising out of
4005 medical negligence, adult individuals named as beneficiaries
4006 under a testamentary estate may recover noneconomic damages as
4007 though they were within that class of survivors identified in
4008 this section when a health care practitioner commits an
4009 intentional tort or is convicted of a crime which resulted in
4010 the death of the benefactor. The personal representative of the



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4011 estate shall be entitled to assert a cause of action on behalf
4012 of the class of beneficiaries for the noneconomic damages of
4013 such beneficiaries which shall be in addition to any other
4014 damages that the estate would otherwise be entitled to assert.
4015 However, in no event shall the total amount of noneconomic
4016 damages for the entire class of beneficiaries exceed any
4017 limitation on noneconomic damages imposed under s. 766.118 ~~The~~
4018 ~~damages specified in subsection (3) shall not be recoverable by~~
4019 ~~adult children and the damages specified in subsection (4) shall~~
4020 ~~not be recoverable by parents of an adult child with respect to~~
4021 ~~claims for medical malpractice as defined by s. 766.106(1).~~

4022 Section 72. Subsection (5) of section 768.81, Florida
4023 Statutes, is amended to read:

4024 768.81 Comparative fault.--

4025 (5)(a) Notwithstanding any provision of law to the
4026 contrary, in an action for damages for personal injury or
4027 wrongful death arising out of medical malpractice, whether in
4028 contract or tort, the court shall enter judgment on the basis of
4029 each party's percentage of fault and not on the basis of the
4030 doctrine of joint and several liability.

4031 (b) Notwithstanding any provision of ~~anything in~~ law to
4032 the contrary, in an action for damages for personal injury or
4033 wrongful death arising out of medical malpractice, whether in
4034 contract or tort, when an apportionment of damages pursuant to
4035 this section is attributed to a teaching hospital as defined in
4036 s. 408.07, the court shall enter judgment against the teaching
4037 hospital on the basis of such party's percentage of fault and
4038 not on the basis of the doctrine of joint and several liability.

4039 (c) In the trial of any action for medical malpractice
4040 which follows a settlement between the plaintiff and one or more



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4041 defendants or potential defendants for the same injury, the
4042 plaintiff shall be estopped from denying that the fault on the
4043 part of any such settled defendant or prospective defendant
4044 contributed to causing the plaintiff's injuries with respect to
4045 any such settled defendant or prospective defendant who has been
4046 identified by way of affirmative defense or joined by a
4047 nonsettling defendant as a party who is liable, in whole or in
4048 part, for the plaintiff's damages.

4049 Section 73. Section 1004.08, Florida Statutes, is created
4050 to read:

4051 1004.08 Patient safety instructional requirements.--Every
4052 public school, college, and university that offers degrees in
4053 medicine, nursing, and allied health shall include in the
4054 curricula applicable to such degrees material on patient safety,
4055 including patient safety improvement. Materials shall include,
4056 but need not be limited to, effective communication and
4057 teamwork; epidemiology of patient injuries and medical errors;
4058 vigilance, attention, and fatigue; checklists and inspections;
4059 automation and technological and computer support; psychological
4060 factors in human error; and reporting systems.

4061 Section 74. Section 1004.085, Florida Statutes, is created
4062 to read:

4063 1004.085 Informed consent standardization project.--Every
4064 public school, college, and university that offers degrees in
4065 medicine, nursing, and allied health shall work with the
4066 Department of Health to develop bilingual, multimedia methods
4067 for communicating the risks of treatment options for the 100
4068 medical procedures from which arise the most claims of medical
4069 malpractice. Such materials shall be provided to patients and
4070 their families in an effort to educate them and to obtain the



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4071 informed consent to prescribe a treatment procedure. The agency
4072 shall develop a list of treatment procedures based on
4073 significance of risk and frequency of performance.

4074 Section 75. Section 1005.07, Florida Statutes, is created
4075 to read:

4076 1005.07 Patient safety instructional requirements.--Every
4077 nonpublic school, college, and university that offers degrees in
4078 medicine, nursing, and allied health shall include in the
4079 curricula applicable to such degrees material on patient safety,
4080 including patient safety improvement. Materials shall include,
4081 but need not be limited to, effective communication and
4082 teamwork; epidemiology of patient injuries and medical errors;
4083 vigilance, attention, and fatigue; checklists and inspections;
4084 automation and technological and computer support; psychological
4085 factors in human error; and reporting systems.

4086 Section 76. Section 1005.075, Florida Statutes, is created
4087 to read:

4088 1005.075 Informed consent standardization project.--Every
4089 nonpublic school, college, and university that offers degrees in
4090 medicine, nursing, and allied health shall work with the
4091 Department of Health to develop bilingual, multimedia methods
4092 for communicating the risks of treatment options for the 100
4093 medical procedures from which arise the most claims of medical
4094 malpractice. Such materials shall be provided to patients and
4095 their families in an effort to educate them and to obtain the
4096 informed consent to prescribe a treatment procedure. The agency
4097 shall develop a list of treatment procedures based on
4098 significance of risk and frequency of performance.

4099 Section 77. (1) The Agency for Health Care Administration
4100 shall conduct or contract for a study to determine what



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4101 information is most feasible to provide to the public comparing
4102 state-licensed hospitals on certain inpatient quality indicators
4103 developed by the federal Agency for Healthcare Research and
4104 Quality. Such indicators shall be designed to identify
4105 information about specific procedures performed in hospitals for
4106 which there is strong evidence of a link to quality of care. The
4107 Agency for Health Care Administration or the study contractor
4108 shall refer to the hospital quality reports published in New
4109 York and Texas as guides during the evaluation.

4110 (2) The following concepts shall be specifically addressed
4111 in the study report:

4112 (a) Whether hospital discharge data about services can be
4113 translated into understandable and meaningful information for
4114 the public.

4115 (b) Whether the following measures are useful consumer
4116 guides relating to care provided in state-licensed hospitals:

4117 1. Inpatient mortality for medical conditions.

4118 2. Inpatient mortality for procedures.

4119 3. Utilization of procedures for which there are questions
4120 of overuse, underuse, or misuse.

4121 4. Volume of procedures for which there is evidence that a
4122 higher volume of procedures is associated with lower mortality.

4123 (c) Whether there are quality indicators that are
4124 particularly useful relative to the state's unique demographics.

4125 (d) Whether all hospitals should be included in the
4126 comparison.

4127 (e) The criteria for comparison.

4128 (f) Whether comparisons are best within metropolitan
4129 statistical areas or some other geographic configuration.

4130 (g) Identification of several Internet websites on which



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4131 such a report should be published to achieve the broadest
4132 dissemination of the information.

4133 (3) The Agency for Health Care Administration shall
4134 consider the input of all interested parties, including
4135 hospitals, physicians, consumer organizations, and patients, and
4136 submit the final report to the Governor and the presiding
4137 officers of the Legislature by January 1, 2004.

4138 Section 78. No later than September 1, 2003, the
4139 Department of Health shall convene a workgroup to study the
4140 current health care practitioner disciplinary process. The
4141 workgroup shall include a representative of the Administrative
4142 Law section of The Florida Bar, a representative of the Health
4143 Law section of The Florida Bar, a representative of the Florida
4144 Medical Association, a representative of the Florida Osteopathic
4145 Medical Association, a representative of the Florida Dental
4146 Association, a member of the Florida Board of Medicine who has
4147 served on the probable cause panel, a member of the Board of
4148 Osteopathic Medicine who has served on the probable cause panel,
4149 and a member of the Board of Dentistry who has served on the
4150 probable cause panel. The workgroup shall also include one
4151 consumer member of the Board of Medicine. The Department of
4152 Health shall present the findings and recommendations to the
4153 Governor, the President of the Senate, and the Speaker of the
4154 House of Representatives no later than January 1, 2004. The
4155 sponsoring organizations shall assume the costs of their
4156 representatives.

4157 Section 79. The sum of \$687,786 is appropriated from the
4158 Medical Quality Assurance Trust Fund to the Department of
4159 Health, and seven positions are authorized for the purpose of
4160 implementing this act during the 2003-2004 fiscal year. The sum



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4161 of \$452,122 is appropriated from the General Revenue Fund to the
4162 Agency for Health Care Administration, and five positions are
4163 authorized for the purpose of implementing this act during the
4164 2003-2004 fiscal year.

4165 Section 80. If any provision of this act or the
4166 application thereof to any person or circumstance is held
4167 invalid, the invalidity does not affect other provisions or
4168 applications of the act which can be given effect without the
4169 invalid provision or application, and to this end the provisions
4170 of this act are declared severable.

4171 Section 81. All provisions of this act shall be repealed
4172 on July 1, 2007, unless the Legislature otherwise directs.

4173 Section 82. If any law amended by this act was also
4174 amended by a law enacted at the 2003 Regular Session, the 2003
4175 Special Session A, or the 2003 Special Session B of the
4176 Legislature, such laws shall be construed as if they had been
4177 enacted at the same session of the Legislature, and full effect
4178 shall be given to each if possible.

4179 Section 83. This act shall take effect upon becoming a law
4180 and shall apply to any cause of action accruing under chapter
4181 766, Florida Statutes, after that date, unless otherwise
4182 provided herein.