HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 1713 (PCB HC 03-03) Medical Incidents
SPONSOR(S): Committee on Health Care and Farkas
TIED BILLS: None. **IDEN./SIM. BILLS:**

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR
1) Health Care	15 Y, 6 N	Mitchell	Collins
2)			
3)			
4)			
5)			

SUMMARY ANALYSIS

Reports by the House Select Committee on Medical Liability Insurance and the Governor's Select Task Force on Healthcare Professional Liability Insurance present information from stakeholders and experts regarding the need to address rising medical liability rates, the reasons for rising costs and actions the Legislature may take.

Evidence demonstrates that Florida is among the states with the highest medical malpractice insurance premiums in the nation. Current increases are forcing many physicians to stop performing high-risk procedures, practice without liability insurance, close their practices or leave Florida. It is impacting people's access to quality care. Stakeholders debate the causes of past and current insurance crises, but generally presented two reasons: cyclical insurance market rates; and rising cost of settlements. In addition, research shows improvements in patient safety can reduce medical errors that drive malpractice insurance rates.

The bill provides an interrelated approach to the complex factors contributing to the current medical liability insurance crisis through improved health care quality, tort reform and insurance reform.
Improved Health Care Quality: The bill addresses long term improvements in the quality of care and patient safety, and improves discipline of practitioners who cause negligent injuries. The bill provides for facilities to have patient safety plans and to notify patients in person if they are harmed. The bill requires: medical instruction in patient safety; a study of information relevant to consumers; and a study to evaluate options for a patient safety infrastructure to share information and support safety improvements. Physician discipline is addressed through: improved physician profiles for consumers; improved access to patient records for handling of cases; inclusion of attorney costs in penalties; more time to resolve cases before referral to administrative hearings; making first offense citations and successful mediation not reportable as discipline; emergency disciplinary proceedings for repeat negligence; and increased consumer representation on medical boards.
Tort Reform: The bill provides several changes to immediately address the high costs and unpredictability of settlements that contribute to the rising cost of liability insurance. These include: alternate dispute resolution, such as presuit mediation and mandatory mediation; increased time for the presuit process; and qualified medical experts. The bill includes: caps on noneconomic damages; provides for comparative fault; and removes the restriction on recovery of damages by an adult child for wrongful death of a parent or by parents of an adult child due to medical negligence.
Insurance reform: The bill addresses the need to expand the market of available liability insurance by establishing alternate forms of insurance, and improving the regulation of the insurance industry with more information about current claims. The bill also provides situations for which an insurer will not be held liable for bad faith.

The effective date of the bill is upon becoming law and shall apply to all actions filed after the effective date.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. DOES THE BILL:

1. Reduce government?	Yes[]	No[]	N/A[x]
2. Lower taxes?	Yes[]	No[]	N/A[x]
3. Expand individual freedom?	Yes[]	No[]	N/A[x]
4. Increase personal responsibility?	Yes[]	No[]	N/A[x]
5. Empower families?	Yes[]	No[]	N/A[x]

For any principle that received a "no" above, please explain:

B. EFFECT OF PROPOSED CHANGES:

BACKGROUND INFORMATION

Reports by the House Select Committee on Medical Liability Insurance and the Governor's Select Task Force on Healthcare Professional Liability Insurance present information from stakeholders and experts regarding the need to address rising medical liability rates, the reasons for the rise in costs, and actions the Legislature may take to address the problem. House Speaker Johnnie Byrd charged the Select Committee to examine issues relating to the availability of liability insurance for health care providers in Florida and the impact on health care cost, access and quality for Florida's citizens.

High Cost and Limited Availability of Medical Liability Insurance

Evidence presented to both the Select Committee and the Task Force demonstrates that Florida is among the states with the highest medical malpractice insurance premiums in the nation. Both groups heard evidence that during the past three years, numerous health care liability insurance carriers in Florida have been liquidated, forced into rehabilitation, or have decided to stop selling medical malpractice insurance in Florida. In the late 1990s, there was an industry high of sixty-six insurance companies active in Florida. Since that time, the number of companies has decreased to only twelve, with apparently only four carriers continuing to regularly write policies. Those remaining companies are quickly reaching capacity and are unable to expand their risk base to cover the physicians whose policies are being terminated by other companies.

The record of the public hearings conducted by the Select Committee on February 13th and 14th in four cities across the state is replete with references by health care providers to the detrimental impact of either rising insurance costs or the cancellation of coverage in the current environment, with the inability of service providers to secure adequate replacement coverage. This increase in health care liability insurance rates is forcing physicians to practice medicine without professional liability insurance, leave Florida, not perform high-risk procedures, or retire early from the practice of medicine.

Cost Squeeze on Physicians

According to the Select Committee report, while the problems associated with the availability and affordability of medical liability insurance are not new, it is difficult this time to separate the impact of rising insurance rates from the other burdens placed upon Florida's health care practitioners. The Select Committee heard reports that reduced rates of reimbursement to physicians for their services by managed care programs and by government reimbursement programs restrict their ability to cover the rising medical malpractice insurance costs through charges for services.

Reduced Access and Quality of Care

Physicians testified they have reached the saturation point of shortening patient visit times and extending their office hours to cover rising costs and reduced reimbursement. The Select Committee report cites an Agency for Health Care Administration study which found that there are critical

shortages of Medicaid participating physicians throughout the state, especially in the areas of emergency medicine, OB/GYN, Pediatrics and Pathology.

One surgeon testified to the Select Committee that he had never had a malpractice case in all his years of practice and yet his rates have climbed 115% in the past two years. He has adjusted his practice, to the detriment of the citizens in his area, as he no longer will accept Medicaid patients and has dropped participation in any managed care programs. In this case, those least able to pay must seek other providers in an apparently shrinking service provision environment.

One result is that patients get less time and quality care when there is a need to vastly increase the number of patients served in order to meet "bottom line" requirements. Less time spent with each patient brings an attendant lack of patient history knowledge and focus with an increased risk of potential error and "bad will" between patient and doctor. This in turn might ultimately be a causative factor in increasing cases of medical error and medical malpractice suits.

MANY FACTORS CONTRIBUTE TO HIGH MEDICAL LIABILITY INSURANCE RATES

The Select Committee heard that the causes of the current crisis in medical liability insurance rate increases are driven by interrelated forces. The current crisis of high insurance rates is not new. Previous crises occurred in the mid-1970s and the mid-1980s. Stakeholders aggressively debated the causes of past and current insurance crises before the committee, but generally the arguments fall into two categories: cyclical insurance market rates; and rising cost of settlements.

Cyclical Insurance Market Rates

One explanation for the high cost and limited availability of medical liability insurance is that lower interest rates and the declining stock market have led to lower investment returns due to a reduced rate of return on insurance company investment of premiums, which follows a period of competitive under pricing of insurance during the 1990's to gain market share in better economic times. While rate setting does not incorporate losses from investments, the ability to gain earnings helped keep premiums low.

Rising Cost of Settlements and Awards from Litigation

The other main explanation for high insurance rates is underwriting loss due to increases in the frequency (number) of claims, increases in the severity (size) of claims, and uncertainty due to the "long tail" (claims against a single year's policy are not all made and paid until a certain number of years later). These factors make insurance less predictable and more expensive.

Complicating Factors

Another factor related to the problem of rising insurance costs is the overall increase in cost of health care, from increased demand from an aging population and increased costs of medical technology that also have to be absorbed by the industry. The cost containment strategies of government agencies, health insurance organizations and purchasers in response to these rising costs have reduced doctors' ability to absorb or pass on to consumers the dramatic liability rate increases.

The increased use of sophisticated and expensive technology used in medical care has also created an increasingly complex and changing health care delivery system that adds to the strain on health care practitioners. More difficult medical conditions are now treatable, but the situations in which practitioners work are more complex and difficult, and contribute to the possibility of errors and bad outcomes that can result in litigation.

PREVENTION OF MEDICAL ERRORS

According to national research, state improvements in patient safety have the potential to reduce medical malpractice insurance by helping reduce the incidence of medical errors. The National Institute of Medicine report, 1999, estimated medical errors are responsible for injury in as many as 1 out of every 25 hospital patients. Medical errors are estimated to be the eighth leading cause of death in this country; higher than motor vehicle accidents.

Examples of medical errors include: a patient inadvertently given the wrong medication; a clinician misreading the results of a test; and a person with ambiguous symptoms (shortness of breath, abdominal pain, and dizziness) whose heart attack is not diagnosed by emergency room staff.

According to the Institute of Medicine, preventable health care-related injuries cost the economy from $17 to $29 billion annually, of which half are health care costs. A recent article in the New England Journal of Medicine reported that many physicians (35 percent) and members of the public (42 percent) reported errors in their own or a family member's care. (Blendon, RJ, Views of Practicing Physicians and the Public on Medical Errors, 347(24), 2002.)

PAST LEGISLATION IN FLORIDA AND OTHER STATES

This crisis is not restricted to Florida as many states across the country face similar problems of reduced or non-existent coverage due to the retreat of carriers from the market. To address past crises, a series of tort reforms were implemented. Reforms aimed at the size of recoveries (severity) included caps on awards, periodic payments of damages, collateral source offset, joint and several liability changes, and punitive damage limits. Reforms aimed at the number of suits (frequency) included pretrial screening panels, arbitration, statutes of limitations, attorney fee contracts, certificates of merit, and costs awardable. Past insurance reforms have included patient compensation funds, joint underwriting associations, limits on insurance cancellation, mandates for liability coverage, and reporting requirements.

In Florida, many of these tort and insurance reforms have also been adopted in one variation or another. The most concerted recent legislative efforts to address the crises occurred in 1986 and again in 1988.

In 1986, the Legislature passed a law limiting non-economic damages to $450,000 in all tort actions (not just medical malpractice). The Florida Supreme Court ruled that limitation unconstitutional in 1987. Also, in 1986, the Legislature created the Academic Task Force for Review of the Insurance and Tort Systems which issued several recommendations upon which the Legislature acted in Special Session in 1988. Among other provisions relating to medical malpractice, the Legislature established a pre-suit investigation process to eliminate frivolous claims and a voluntary binding arbitration process to encourage settlement of claims. As part of the arbitration process, a cap of $250,000 on non-economic damages was established, if parties agreed to arbitration, and a cap of $350,000 was established at trial if the plaintiff refused arbitration. These provisions have been upheld as constitutional by the Florida Supreme Court.

The Legislature also created the Florida Birth-Related Neurological Injury Compensation Association (NICA) in 1988. It is a no-fault plan that covers catastrophic birth-related neurological injuries. As a no-fault system, negligence does not have to be proven, blame is not levied, and compensation is provided.

In 2000, the Legislature created the Florida Commission on Excellence in Health Care to facilitate the development of a comprehensive statewide strategy for improving the health care delivery system through meaningful reporting standards, data collection and review, and quality measurement. In 2001, the Legislature adopted many of the recommendations of the Commission including: specifying acts such as wrong site surgery for which a physician may be disciplined; requiring hospitals and ambulatory surgical centers to implement risk management programs; establishing practitioner profiles for consumers with information related to professional competence; and continuing education in patient safety. A proposed Center for Patient Safety to analyze data on adverse incidents and “near misses,” and to develop practice guidelines with stakeholders was not implemented.

Notwithstanding these reforms, the present Governor’s Task Force and the House Select Committee heard reports that when faced with escalating medical malpractice premiums, many providers are modifying their scope of practice, leaving the state, or retiring. Difficulty in recruiting new physicians to

Florida has also been reported as has the increased numbers of current medical students who are being trained in Florida but choosing to move to other states to practice medicine.

EFFECT OF PROPOSED CHANGES AND CURRENT SITUATION

INTERRELATED APPROACH TO MEDICAL LIABILITY

The Select Committee's report states that the task for the Legislature is not to simply find means of reducing insurance costs for service providers. Forcing reduced premiums in a market where no company is compelled to sell a product would not be effective. Instead the proposed bill addresses the complex factors contributing to the current medical liability insurance crisis through interrelated approaches.

Improve Health Care Quality

The bill addresses long term improvements in the quality of health care and patient safety to reduce the errors that result in injury and liability, and provides for better disciplining of practitioners who are found to cause injuries through negligence.

Tort Reform

The bill provides several changes to immediately address the high costs and unpredictability of settlements that contribute to the rising cost of liability insurance. It includes a cap on non-economic damages and reforms joint and several liability. The bill reforms the pre-suit process and provides improvements for mediation that can divert cases from going to court and result in more prompt, fair and less costly resolution for all parties.

Insurance reform

The bill addresses the need to expand the market of available liability insurance by establishing alternate forms of insurance and improving the regulation of the insurance industry by providing more information about current claims.

FINDINGS

Section 1 of this bill establishes findings of the Legislature.

The findings of the Legislature include: that Florida is in the midst of a medical malpractice insurance crisis that threatens the quality and availability of health care for all Florida citizens; that the increase in medical malpractice liability insurance rates is forcing physicians to practice medicine without professional liability insurance, to leave Florida, to not perform high-risk procedures, or to retire early; and health care liability insurance carriers have been liquidated, forced into rehabilitation, or have decided to stop selling medical malpractice insurance in Florida.

The Legislature finds the report of the Governor's Select Task Force on Healthcare Professional Liability Insurance shows that making high quality health care available to citizens; ensuring physicians continue to practice; and ensuring the availability of affordable professional liability insurance for physicians are overwhelming public necessities.

The Legislature finds that: each of the provisions in this act are naturally and logically connected to each other and to the purpose of making quality health care available to the citizens of Florida; and each of the provisions of this act are necessary to alleviate the crisis relating to medical malpractice insurance.

HEALTH CARE QUALITY

The bill provides for facilities to have patient safety plans and to notify patients in person if they are harmed. The bill requires: medical instruction in patient safety; a study of information relevant to consumers; and a study to evaluate options for a patient safety infrastructure to share information and support safety improvements. Physician discipline is addressed through: improved physician profiles for

consumers; improved access to patient records for handling of cases; inclusion of attorney costs in penalties; more time to resolve cases before referral to administrative hearings; making first offense citations and successful mediation not reportable as discipline; emergency disciplinary proceedings for repeat negligence; and increased consumer representation on medical boards.

PATIENT SAFETY

Facility Patient Safety Plans:

Section 2 of this bill creates s. 395.1012, F.S., relating to patient safety. This bill requires each licensed facility (hospitals, ambulatory surgical centers and mobile surgical facilities) to have a patient safety officer and patient safety committee to promote patient health and safety, including review of facility safety measures and implementation of the facility patient safety plan. The section provides that implementation of federal requirements for participation in Medicare and Medicaid under 42 CFR 482.21, "Condition of Participation: Quality Assurance," shall meet the requirements of this provision.

Under s. 395.0197, F.S., each hospital, ambulatory surgical center, and mobile surgical facility is already required to establish an internal risk management program. An internal risk management program must provide for: investigation and analysis of causes of adverse incidents causing injury to patients, appropriate measures to minimize the risk of injuries and adverse incidents to patients; analysis of patient grievances that relate to patient care and the quality of medical services; and implementation of an incident reporting system based upon the affirmative duty of all health care providers and all agents and employees of the licensed facility to report adverse incidents. Risk managers may oversee programs at more than one facility. A facility's governing board is responsible for the internal risk management program. Similar risk management programs are required for Nursing Homes, s. 400.147 F.S., Assisted Living Facilities, s. 400.423, F.S., and Health Maintenance Organizations, s. 641.55, F.S.

The provisions of this section would enhance existing risk management efforts and ensure that there is dedicated leadership and responsibility for patient safety plans in each facility.

Notify Patients in Person if Caused Harm:

Section 3 of this bill creates s. 395.1051, F.S., relating to duty to notify patients--facilities. The bill requires licensed facilities (hospitals, ambulatory surgical centers and mobile surgical facilities) to inform in person, patients, or their family, guardians or others under s. 765.401(1), about unanticipated outcomes of care that result in serious harm to the patient. This notification of outcomes of care that result in harm to the patient does not constitute an acknowledgement or admission of liability, nor can it be introduced as evidence in any civil lawsuit.

Section 12 of this bill creates s. 456.085, F.S., relating to duty to notify patients--physicians. The bill requires medical and osteopathic physicians, licensed under ch. 458 and 459 respectively, to inform in person, patients or their family, guardians or others under s. 765.401(1), about unanticipated outcomes of care that result in serious harm to the patient. This notification of outcomes of care that result in harm to the patient does not constitute an acknowledgement or admission of liability, nor can it be introduced as evidence in any civil lawsuit.

Current Situation:

Patient safety standards established by the Joint Commission on Accreditation of Healthcare Organizations in 2001 now require organizations to inform patients, when appropriate, about the outcomes of care, whether anticipated or unanticipated. A recent survey found that large portions of both physicians and the public believe medical errors should be reported to the patient or family. Patients presume that their doctor will tell them the truth, and they feel angry and betrayed if not informed of a mistake which contributes to litigation.

Instruction in Patient Safety:

Section 34 of this bill creates s. 1004.08, F.S., relating to patient safety instruction--public. It requires every public school, college and university that offers degrees in medicine, nursing, and allied

health to include patient safety improvement in their curricula, including: team communication; epidemiology of injuries and errors; technological support; psychological factors in human error; and error reporting.

Section 35 of this bill creates section 1005.07, F.S., relating to patient safety instruction—nonpublic. It requires inclusion of patient safety improvement in the curriculum of every nonpublic school, college and university that offers degrees in medicine, nursing, and allied health, as is required in the section above.

Current Situation:
Statutes already require continuing education in prevention of medical errors required for licensure and renewal (s. 456.013(7), F.S.) This provision will ensure that patient safety is a part of the education health care professionals receive before they are licensed to begin practice.

Information to Consumers:
Section 36 of this bill directs the Agency for Health Care Administration (AHCA) to study the kinds of information the public would find relevant in their selection of hospitals. The agency shall review and recommend methods to collect, analyze and disseminate information and report its findings to the Legislature by January 15, 2004.

Current Situation:
This provision reflects recommendations that encourage market forces of choice and competition to improve patient safety (see Institute of Medicine, 1999, and the Fortune 500, Leapfrog Group health care purchasing initiative, Leapfrog Fact Sheet, 2003) Providing information regarding safety and standards to consumers so they can make informed choices and compare providers to their competition will help place an external cost on errors that will encourage providers to take action and improve safety. A study will allow AHCA to find ways to avoid conflicts between public accountability and learning from errors that are created by simple “report cards.”

Evaluate Options to Implement a Patient Safety Infrastructure:
Section 37 of this bill directs the Agency for Health Care Administration (AHCA) to study the need for, and the implementation requirements of a Patient Safety Authority to improve patient safety, in consultation with the Department of Health (DOH). The study is required to examine the following aspects of an Authority.

The Patient Safety Authority (PSA) would directly or by contract, analyze adverse incident data that is already reported to AHCA as required by s. 395.0197, for the purpose of identifying patterns of errors, and recommending changes in health care practices to practitioners and facilities to prevent future adverse incidents, and collect and analyze confidential and independent information voluntarily submitted by practitioners and facilities for the same purpose. The PSA would also foster development of a statewide electronic infrastructure to share clinical and other data, including a core electronic medical record. It would help develop a computerized physician medication ordering system as part of the infrastructure and would implement a demonstration project of the infrastructure. The PSA would identify best practices to share with providers and engage in other activities to improve health care quality. The bill provides that AHCA should also consider ways to facilitate “no fault” demonstration projects to prevent medical errors.

In preparing the report, the agency shall consult with all stakeholders and shall determine the costs and suggest funding sources for implementing and administering the PSA. AHCA is required to complete the study and issue a report to the Legislature by February 1, 2004.

Current Situation:
These provisions of the bill are based on recommendations of national research to improve patient safety and quality of care, including the Institute of Medicine report, “To Err Is Human: Building a Safer Health System,” released in 1999, which found most medical mistakes are preventable. Errors are most

often caused by systems that break down and don't support the highly qualified and dedicated hospital caregivers the way they should. Similar proposals are included in recent legislation in Pennsylvania, the Medical Care Availability and Reduction of Error Act (Act 13, March, 2002) that provides a comprehensive approach to medical professional liability reform through tort reform, catastrophic insurance fund reform, and patient safety. The Legislature addressed creating a patient safety center last year in HB 1219. The bill passed the House 117-0. It and SB 2294 (its companion) died in the Senate.

Because these options must be integrated into ongoing quality improvement efforts by the health care industry and may be expensive, the bill proposes to first explore them through a study. Existing research and quality assurance resources of both AHCA and DOH should be sufficient to prepare the report.

PHYSICIAN DISCIPLINE
Physician Profiles to Inform Consumers:
Section 4 of this bill amends s. 456.041, F.S., relating to creation of physician profiles. Subsection (1)(a) is amended to require the Department of Health to compile practitioner profiles for advanced registered nurse practitioners beginning July 1, 2004. Subsection (1)(b) is created to require practitioners licensed under chapters 458 and 459, F.S., (medical and osteopathic physicians, respectively) to report within 15 days, all final disciplinary actions by an agency or licensed facility, to the Department of Health and the Board of Medicine or Board of Osteopathic Medicine, respectively, as provided under s. 456.051, F.S. Failure to submit information within 15 days is subject to a fine of $100 per day. Subsection (1)(c) is created to require the department to update the practitioner's profile within 15 business days.

Subsection (2) is amended to provide that information in the profile should indicate whether it is or is not corroborated by a criminal history check. Subsection (3) is amended to require the department to provide an understandable narrative description in each profile that explains the administrative complaint filed against the practitioner and the final disciplinary action imposed, and to include a hyperlink to the final order (currently this is optional).

Subsection (4) is amended to increase the limit of paid liability claims that must be reported by practitioners, from those above $5,000, to those above $50,000. The subsection requires the department to include in the practitioner's profile a hyperlink to comparison reports of claims against comparable practitioners.

Subsection (5) is amended to require the department to include in the profile the date of a facility disciplinary action. It requires the practitioner to report the date of the discipline to the department, and whether it related to professional competence and patient services.

Subsection (8) is inserted to require the department to provide in each profile an easy-to-read explanation of any disciplinary action and the reason for any sanctions.

Section 5 of this bill amends section 456.042, F.S., relating to updates of physician profiles to require a practitioner to submit updates of required information within 15 days after a final action.

Practitioner profiles are maintained by the Division of Medical Quality Assurance of the Department of Health that provides administrative support for licensure and discipline by practitioner boards. The profiles include information obtained from physicians, podiatrists, chiropractors, osteopathic physicians, and advanced registered nurse practitioners at the time of licensure or license renewal. The information includes the practitioner's educational and professional background, and a description of any final disciplinary actions taken against him or her within the last 10 years by the profession's regulatory agency or board. Profiles for 58,781 licensed practitioners can be accessed on Medical Quality Assurance, Physician Profiling website (www.doh.state.fl.us/mqa/Profiling/index.html).

The provisions of the bill address concerns that provider profiles do not include information of disciplinary actions by facilities, which may be more reflective of a practitioner's professional competence, and that the information is not updated on a timely basis and presented in a way consumers can understand and use in making choices about their providers of health care. (Governor's Task Force, p. 182-183.) At the same time, practitioners are concerned that information in the profiles is not presented in a context that gives a fair picture of their competence.

Higher Threshold for Reporting Liability Claims and Investigation of Repeat Malpractice:
Section 6 of this bill amends s. 456.049(1) and adds (3), F.S., relating to health care practitioner reports on professional liability claims and actions. Subsection (1) adds a threshold amount for required reporting to the Department of Health of final judgments and awards for personal injury claims and damages caused by error or negligence by certain health care practitioners. The threshold is set at $50,000 or more for medical, osteopathic and podiatric physicians, and $25,000 or more for dentists. Subsection (3) requires the department to forward the information to the Office of Insurance Regulation.

Currently, s. 456.049, F.S., does not specify any threshold for the size of claims that must be reported by medical professionals licensed pursuant to ch. 458, 459, 461 and 466, F.S., (medical, osteopathic and podiatric physicians and dentists). Section 627.9121, F.S., relating to required reporting of claims, requires insurers to report all professional liability claims to the Department of Insurance (now the Office of Insurance Regulation). It also does not specify any threshold amounts. It requires insurers of the specified medical professionals (medical, osteopathic and podiatric physicians and dentists) to also file the reports with the Department of Health.

Setting a specific high threshold for the medical professionals creates enforceable criteria for reporting information. Amounts above the new threshold better reflect actual malpractice that should be investigated for licensure discipline, rather than many small settlements of nuisance claims by insurers. This will help focus use of the DOH resources for investigating and handling of disciplinary cases.

Forwarding the information to the Office of Insurance Regulation will help improve the information contained in the Closed Claims Database that is being increasingly used to assess the condition of the medical malpractice insurance market. The Select Committee heard concerns regarding the integrity of the Closed Claim Database and the use of this data as a barometer of the current medical malpractice market. (Select Committee Report, p. 80-82.) These issues are also addressed in provisions for insurance reform as part of this bill.

Access to Patient Records to Facilitate Handling of Cases:
Section 7 of this bill amends s. 456.057, F.S., relating to ownership and control of patient records. It adds subparagraph 4. to subsection (7)(a) to allow the Department of Health to obtain patient records pursuant to a subpoena when the department is investigating a professional liability claim or undertakes disciplinary action, without written authorization from the patient, if the patient refuses to cooperate or if attempts to obtain a patient release would be detrimental to the investigation.

Currently, s. 456.057, F.S., provides for exceptions to provisions for the confidentiality of patient records, control of them by a practitioner, and the right to access them by a patient. Exceptions include use of the records in criminal actions, research and other specified uses. Subsection (7) provides for exceptions related to licensure and other investigations by the department. Access to the records pursuant to a subpoena without authorization of the patient are provided for in (7)(a) for use in probable cause hearings. There is no provision for access to records for disciplinary investigations related to liability claims.

The Medical Quality Assurance (MQA) program of the Department of Health is responsible for health care practitioner enforcement activities, including a consumer complaint call center, investigation, and legal services. The program investigates complaints and assesses probable cause for each case. Cases are then presented to licensing boards or department for final action. If a board finds that an allegation is justified, it may take disciplinary action pursuant to s. 456.073, F.S. If a practitioner

contests a finding of probable cause, the case is heard by an administrative law judge. Disciplinary measures can range from a reprimand and fine to suspension or revocation of the practitioner's license. (MQA Annual Report 2001-2002.) In 2001-2002, MQA received over 32,000 complaints and reports against practitioners. The investigative unit, with 11 offices located throughout the state, investigated over 5,400 of these complaints that were determined to be legally sufficient. The MQA prosecutorial unit in Tallahassee, which provides the legal support to the health care boards, resolved over 7,000 complaints.

This provision addresses concerns that problems getting access to patient records has hindered the department's investigation of liability claims against practitioners for disciplinary proceedings. According to testimony to the Governor's Task Force, p. 182, if a patient refused to cooperate in giving their consent to release patient records, the department would not be able to prove the case and the matter could not be pursued.

Inclusion of Attorney Costs in Penalty Assessments:
Section 8 of this bill amends s. 456.072(4), F.S., relating to grounds of discipline and penalties. The bill provides that for any final order or citation for violation of a practice act, costs assessed relating to investigation and prosecution shall include costs associated with an attorney's time. The amount of costs assessed shall be determined by the board or department when there is no board, following consideration of itemized costs and any written objections to the costs.

Currently, s. 456.072, F.S., already provides for costs related to investigation and prosecution when assessing penalties.

This change provides clarifying language that specifies attorney costs are included in the assessment of costs. It will help cover the costs of disciplinary proceeding.

Additional Time to Resolve Cases Before Referred to Administrative Hearings:
Section 9 of this bill amends s. 456.073, F.S., relating to disciplinary proceedings. The bill adds paragraph (b) to subsection (5) to require the Department of Health to notify the Division of Administrative Hearings (DOAH) within 45 days when it receives a request for a hearing and the department determines that will require a formal hearing before an administrative law judge.

Currently, s. 456.073(5), F.S., requires an administrative law judge from DOAH to formally hear any disputed issues of material fact in a disciplinary proceeding. Section 120.569(2), F.S., which establishes requirements for all agencies to have DOAH administrative judge hearings for questions regarding material fact, currently requires agencies to notify DOAH within 15 days.

The provision in this bill addresses recommendations made in testimony to the Governor's Task Force, p 182, states that 95% of disciplinary cases are settled. The additional time will allow the department resolve such issues before their referral to DOAH for more timely resolutions.

First Offense Citations not to be Considered Discipline for Reporting Purposes:
Section 10 of this bill amends s. 456.077(1) & (2), F.S., relating to authority to issue citations. The bill provides that a citation for a certain first offense is not considered discipline. It also provides that violations involving a standard of care involving injury to a patient are included with other direct and serious threats to the health and safety of the patient and may not be handled with a citation.

Currently, s. 456.077, F.S., provides for a board or the department if there is no board with authority to issue citations in lieu of disciplinary proceedings under s. 456.073, F.S., for violations that do not involve substantial threat to the public health and safety. Such violations include failure to meet continuing education requirements, or failure to pay required fees or update practitioner profiles on time. If the practitioner challenges the citation disciplinary proceedings are initiated.

The National Practitioner Data Bank (NPDB) (42 U.S.C section 11131) serves as a nationwide system to assist state licensing boards, hospitals, and other health care entities to investigate the qualifications of health care practitioners they seek to license, hire or grant clinical privileges. The NPDB collects information on specific areas of the practitioner's licensure, malpractice payment history and record of adverse actions on clinical privileges. Only eligible entities, defined by statute and regulations, may report and query the NPDB. It is not open to the general public.

This provision addresses recommendations presented in testimony to the Governor's Task Force, p 182, that if physicians were allowed to have a free pass for minor violations that would not be considered discipline to be reported to national databases, they would settle those cases more quickly and allow limited resources of the department to be used for more serious violations.

Successful Mediation of Complaints against Practitioners not Reported as Discipline:
Section 11 of this bill amends s. 456.078(1) & (2), F.S., relating to mediation. The bill requires complaints where harm caused by the licensee is economic in nature and can be remedied by the licensee, to be designated as mediation offenses, except for any act or omission involving intentional misconduct. Complaints that are violations of standards of care involving injury to a patient, or that result in an adverse incident, are not mediation offenses. The bill also provides that successful mediation shall not constitute discipline.

The definition of adverse incident for which mediation can not be used is similar to that used in the risk management reporting requirements of s. 395.0197(8), F.S., except for the addition of surgical procedures which breach the standard of care.

These provisions encourage the use of mediation to handle complaints against practitioners by providing that successful mediation will not be considered discipline that is required to be reported to national databases, as discussed in provisions for first offense citations. At the same time the provisions clarify which serious complaints may not be handled by mediation.

Increased Consumer Representation on Medical Boards:
Section 13 of this bill amends s. 458.307, F.S., relating to the Board of Medicine. The bill changes the size and composition of the board. Six board members must be physicians and seven must be residents of the state, who have never been licensed health care practitioners.

Currently, s. 458.307, F.S., establishes a board composed of 15 members with 12 members being licensed physicians and 3 members state residents who have never been licensed health care practitioners.

Section 16 of this bill amends s. 459.004, F.S., relating to the Board of Osteopathic Medicine. The bill changes the composition of the board to three members who must be osteopathic physicians and four who must be residents of the state, who have never been licensed health care practitioners.

Currently, s. 459.004, F.S., establishes a board with 5 members who are licensed osteopathic physicians and 2 members who are state residents, who have never been licensed health care practitioners.

Each health care profession is governed by a statutorily appointed board or council, with members appointed by the Governor or the Secretary of the Department of Health. The board is comprised of both individuals licensed within that profession and consumer members. The boards review licensure cases related to disciplinary action against health care practitioners and determine probable cause in disciplinary actions.

Both section 13 and 16 of the bill address issues heard in testimony by the Governor's Task Force that a major cause of the high rates of medical malpractice is the ineffective regulation of the medical profession, because of the "secrecy" of the proceedings and its effect on the number of physicians

disciplined. (Governors Task Force Report, p. 183.) Increasing consumer representation on the boards should reinforce the purpose of disciplinary proceedings to protect the public.

Higher Reporting Threshold for Claims and Disciplinary Investigations of Repeated Malpractice:
Section 14 of this bill amends s. 458.331(t)(1) and (6), F.S., relating to grounds for disciplinary actions—for allopathic physicians. The bill raises the threshold for required reporting of malpractice claims by allopathic physicians to $50,000 or more, from the current threshold of $25,000. It requires investigation of gross or repeated malpractice for three or more such claims within five years. These changes conform to threshold changes in s. 456.049, F.S. made by section 6 of the bill.

Section 17 of this bill amends s. 459.015(6), F.S., relating to grounds for disciplinary actions—for osteopathic physicians. The bill raises the threshold for required reporting of malpractice claims by osteopathic physicians to $50,000 or more, from the current threshold of $25,000. It requires investigation of gross or repeated malpractice for three or more such claims within five years. These changes conform to threshold changes in s. 456.049, F.S. made by section 6 of the bill.

Section 19 of this bill amends s. 461.013(1)(s) and (5), F.S., relating to grounds for disciplinary actions—for podiatric physicians. The bill raises the threshold for required reporting of malpractice claims by osteopathic physicians to $50,000 or more, from the current threshold of $25,000. It requires investigation of gross or repeated malpractice for three or more such claims within five years. These changes conform to threshold changes in s. 456.049, F.S. made by section 6 of the bill.

This higher threshold for investigating disciplinary action as a result of malpractice claims will reduce the number of claims that have to be investigated and establish a criteria that is more enforceable. Amounts above the new threshold better reflect actual malpractice that should be investigated for licensure discipline, rather than smaller settlements of nuisance claims by insurers. This will help focus use of the DOH resources for investigating and handling of disciplinary cases.

Emergency Disciplinary Procedures for Gross or Repeated Malpractice:
Section 15 of this bill creates s. 458.3311, F.S., relating to emergency procedures for disciplinary action—medical physicians. The bill requires medical physicians to report any judgment against them for medical negligence to the Department of Health. The report must be made within 15 days of the exhaustion of appeal or rehearing. The department must start an emergency investigation and the Board of Medicine must conduct a probable cause disciplinary hearing for gross or repeated malpractice within 30 days, under s. 458.331(1)(t), F.S., if a physician has made three such reports within 60 months.

Currently, s. 458.331(1)(t), F.S., relating to grounds for disciplinary action by the board and department, establishes gross or repeated malpractice or the failure to practice medicine with the level of care, skill, and treatment, which is recognized by a reasonably prudent similar physician as being acceptable under similar conditions and circumstances. "Repeated malpractice" includes three or more claims within the previous five years resulting in indemnities in excess of $25,000 each.

Section 18 of this bill creates s. 459.0151, F.S., relating to emergency procedures for disciplinary action—osteopathic physicians. The bill provides the same requirements for emergency discipline of osteopathic physicians as required of medical physicians in the bill for grounds repeat malpractice as provided for under s. 459.015(1)(x), F.S.

TORT REFORM

The bill provides several changes to immediately address the high costs and unpredictability of settlements that contribute to the rising cost of liability insurance. These include: alternate dispute resolution, such as presuit mediation and mandatory mediation; increased time for the presuit process and protection against bad faith for settlement; and qualified medical experts. The bill includes caps on

noneconomic damages, provides for comparative fault and release of parties, and removes the restriction on recovery of damages by an adult child for wrongful death of a parent.

PRESUIT PROCESS AND ALTERNATE DISPUTE RESOLUTION

Extend Time Period for Presuit Process and Provide Insurers Protection From Bad Faith Actions:
Section 25 of this bill amends s. 766.106 (3) and (4), F.S., relating to the presuit process, to extend the time that the statute of limitations is tolled during the presuit process from 90 to 150 days. The bill provides that an insurer shall not be held in bad faith for failure to timely pay its policy limits for medical liability coverage, if it tenders its policy limits and meets all other conditions of settlement within this extended presuit time period.

It has been argued that the current 90 day presuit period does not give the defendant adequate time to investigate the case and settle it without being exposed to future litigation for bad faith.

PreSuit Mediation:
Section 26 of this bill creates s. 766.1065, F.S., relating to presuit mediation. This bill provides that the parties may mediate the case during the presuit process and that information disclosed in the mediation will be confidential. Under the bill, after the completion of presuit investigation by the parties and any informal discovery, the parties or their designated representatives may submit the matter to presuit mediation to discuss the issues of liability and damages.

This bill also provides that the presuit mediation shall be confidential as provided in s. 44.102, F.S.

Current Situation:
Currently, Florida requires the parties in a medical malpractice action to take various actions prior to filing suit. This is known as the presuit investigation. The purpose of these presuit requirements is to encourage the settlement of meritorious claims early in the process and to prevent the filing of claims without merit.[1] Prior to filing suit, the claimant must conduct an investigation to determine whether there are reasonable grounds to believe the defendant was negligent and whether the negligence resulted in harm to the claimant.[2] As part of the investigation, the claimant must obtain a verified written medical expert opinion which shall corroborate reasonable grounds to support the claim of negligence.[3]

After the completion of the presuit investigation, the claimant must notify, by certified mail, each prospective defendant of its intent to initiate a medical malpractice action.[4] The notice must contain corroboration by a medical expert.[5] No suit may be filed within 90 days of the mailing of the notice of intent.[6]

Upon receipt of the notice to initiate, all parties must make discoverable information available to the other party. Informal discovery may be used by a party to obtain unsworn statements, the production of documents or things, and physical and mental examinations. This informal discovery process allows the parties to investigate the case during the presuit process.[7]

[1] See s. 766.201(2)(a), F.S.
[2] See s. 766.203(2), F.S.
[3] See s. 766.203(2), F.S.
[4] See s. 766.106(2), F.S.
[5] See s. s. 766.203(2), F.S.
[6] See s. 766.106(3)(a), F.S.
[7] See ss. 766.106(6), 766.106(7), F.S.

Information generated during the presuit process is inadmissible in future proceedings.[8] Since so much information is privileged, it can be argued that the presuit process actually requires the parties to perform discovery twice: once in the presuit period and once as the parties prepare for trial.

A potential defendant is required to conduct its own presuit investigation during the 90 day period. Before the end of the 90 days, the potential defendant shall provide the claimant with a response:

1. rejecting the claim;
2. making a settlement offer; or
3. making an offer of admission of liability and for arbitration on the issue of damages.[9]

The presuit process can be extended by agreement of the parties. If the process is extended, the statute of limitations is tolled during that period.[10]

If the case is not settled during the presuit process, the claimant files suit and the case proceeds. A mandatory settlement conference is held at least 3 weeks before the date set for trial.[11]

In many civil cases, mediation is often used to attempt to settle the dispute early in the process. Chapter 44, F.S., and the Florida Rules of Civil Procedure govern mediation in civil cases. Section 44.102(3), F.S., makes information revealed in mediation confidential and inadmissible in future court proceedings. The statute provides:

> Each party involved in a court-ordered mediation proceeding has a privilege to refuse to disclose, and to prevent any person present at the proceeding from disclosing, communications made during such proceeding. All oral or written communications in a mediation proceeding, other than an executed settlement agreement, shall be exempt from the requirements of chapter 119 and shall be confidential and inadmissible as evidence in any subsequent legal proceeding, unless all parties agree otherwise.

Mandatory Mediation:
Section 27 of this bill creates s. 766.1067, F.S., relating to mandatory mediation. This bill creates a mandatory mediation provision in the medical malpractice statute. It requires that the parties conduct mediation in accordance with s. 44.102, F.S. within 120 days of suit being filed. The mediation will be governed by the Florida Rules of Civil Procedure. During the mediation, each party shall make a demand for judgment or an offer of settlement. At the conclusion of the mediation, the mediator shall record the final demand and final offer to provide to the court upon the rendering of a judgment.

Effect of a Claimant's Rejection of an Offer of Settlement:
If a claimant rejects a final offer of settlement made during the mediation and does not obtain a judgment more favorable than the offer, this bill requires the court to assess the mediation costs and reasonable costs, expenses, and attorneys fees which were incurred after the date of mediation against the claimant. This assessment shall attach to the proceeds of the claimant attributable to any defendant whose final offer was more favorable than the judgment.

Effect of a Defendant's Rejection of a Demand for Judgment:
If the judgment obtained at trial is not more favorable to a defendant than the final demand for judgment made by the claimant to the defendant during mediation, this bill requires the court to assess against the defendant the mediation costs, and reasonable costs, expenses, and attorneys fees which were incurred after the date of mediation. Prejudgment interest at the rate established in s. 55.03 from the date of the final demand shall also be assessed. The defendant and the insurer of the defendant, if shall be liable for the costs, fees, and interest.

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[8] See ss. 766.106(5), 766.205, F.S.
[9] See s. 766.106(3)(b), F.S.
[10] See s. 766.106(4), F.S.
[11] See s. 766.108, F.S.

Other Provisions:
The final offer and final demand made during the mediation shall be the only offer and demand considered by the court in assessing costs, expenses, and attorneys fees and prejudgment interest. No subsequent offer or demand by either party shall apply in the determination of whether sanctions will be assessed by the court.

This bill provides that s. 45.061, F.S., and s. 768.79, F.S., will not be applicable to medical negligence causes of action. The procedure provided by this bill will replace those procedures in medical malpractice cases.

Current Situation:
Currently: s. 768.79, F.S., deals with offers of judgment to settle the case. The statute provides that if a defendant files an offer of judgment which is not accepted by the plaintiff within 30 days, the defendant is entitled to recover reasonable costs and attorney's fees from the date of filing of the offer if:

(1) the judgment is one of no liability; or
(2) the judgment obtained by the plaintiff is at least 25 percent less than such offer.[12]

If a plaintiff files a demand for judgment which is not accepted by the defendant within 30 days and the plaintiff recovers a judgment in an amount at least 25 percent greater than the offer, the plaintiff is entitled to recover reasonable costs and attorney's fees incurred from the date of the filing of the demand.[13] The offer of judgment statute provides guidance for a trial court when it assesses fees and costs pursuant to the statute.[14]

Mediation is not required in medical malpractice actions. However, interested parties submitted proposals to the House of Representatives Select Committee on Medical Liability Insurance for a mandatory mediation system in medical malpractice cases. Opponents of a mandatory mediation plan could argue that such a plan imposes a governmental barrier that must be crossed before the case can be tried. If mediation is an effective tool for resolving cases, it can be argued that the parties will use it without the need for governmental coercion. Proponents of mandatory mediation believe that cases are not being reviewed early in the process. They contend this leads to increased costs in discovery that would be avoided if the case was valued and resolved early in the process.

Medical Experts:
Section 29 amends s. 766.202(5), F.S., relating to pre-suit definitions, to require that the medical expert who prepares the presuit affidavit be "familiar with the evaluation, diagnosis or treatment of the medical condition at issue." The expert must certify that he or she has similar credentials and expertise in the defendant's area of practice or specialty.

Currently, s. 766.202(5), F.S., defines "medical expert" for purposes of the ss. 766.201-766.212, F.S.:

> "Medical Expert" means a person duly and regularly engaged in the practice of his or her profession who holds a health care professional degree from a university or college and has had special professional training and experience or one possessed of special health care knowledge or skill about the subject upon which he or she is called to testify or provide an opinion.

An expert, as defined by the above definition, must provide corroboration of reasonable grounds to support a claim of medical negligence.[15] It has been argued that this definition allows experts who may

[12] See s. 768.79(1), F.S.
[13] See s. 768.79(1), F.S.
[14] See ss. 768.79(6) and 768.79(7), F.S.
[15] See s. 766.203, F.S.

not be qualified to render an opinion, perhaps because they practice in a different specialty, about a particular topic to serve as experts in the presuit process.[16]

Discoverability and Admissibility of Presuit Expert Affidavit:
Section 30 of this bill amends s. 766.203(2), F.S., relating to pre-suit investigations. This bill makes the presuit affidavit of the expert subject to discovery and admissible in future proceedings subject to s. 90.403, F.S., which relates to exclusion of relevant evidence on grounds of prejudice or confusion.

Currently, s. 766.205(4), F.S., provides, in pertinent part:

> No statement, discussion, written document, report, or other work product generated solely by the presuit investigation process is discoverable or admissible in any civil action for any purpose by the opposing party.

In Cohen v. Dauphinee,[17] the Florida Supreme Court held that the presuit affidavit was protected by s. 768.205(4), F.S., and that "an opposing party may not impeach an expert witness in a medical malpractice action with a corroborative affidavit prepared by that witness".[18] The court wrote:

> Furthermore, the legislature recognized that the corroborative affidavit, by definition, would have to be prepared at a point when not all relevant information would be available to the expert. The legislature understood that as the case progressed important information might become available, both through informal discovery during the presuit screening process and through formal discovery after the actual initiation of litigation. As this information becomes available, an expert's opinion will likely change. Thus, to subject an affiant to impeachment based upon information contained in the corroborative affidavit would unfairly prejudice the affiant for information subsequently revealed during both the informal and formal discovery phases.[19]

In dissent, Justice Anstead criticized the holding:

> In fact, it would appear that public policy concerns would call for precisely the opposite conclusion. The majority correctly points out that the prevailing policy of this State relative to medical malpractice actions is to encourage the early settlement of meritorious claims and to screen out frivolous ones. [citation omitted]. However, what better way do courts have to ensure compliance with this policy than by making it known that an expert's opinion will not go unchecked or unchallenged at trial? It is this expert's verified written medical opinion which permits medical malpractice litigation to be initiated in the first place. If this same expert, in sworn testimony in the ensuing litigation, testifies to something inconsistent with the presuit affidavit, there may be legitimate concern as to whether there was valid cause to initiate the litigation in the first instance. Surely, legislative policy would favor the disclosure and evaluation of any material changes in the initial expert's opinion. Our contrary holding will allow abuses, whether intentional or neglectful, to go unchecked.[20]

Extend Presuit Period for Electing Voluntary Binding Arbitration
Section 31 of this bill amends s. 766.207(2) and (3), F.S., relating to voluntary binding arbitration of medical malpractice claims. This changes the time period during which voluntary binding arbitration can be elected within the presuit period to 150 days to conform to other changes in the bill.

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[16] See Report of the Governor's Select Task Force on Healthcare Professional Liability Insurance p. 274.
[17] 739 So. 2d 68 (Fla. 1999).
[18] Cohen, 739 So. 2d at 73.
[19] Cohen, 739 So. 2d at 72.
[20] Cohen, 739 So. 2d at 76 (Anstead, J., dissenting).

Study Use of Medical Review Panels in Presuit Process:
Section 32 of this bill directs the Department of Health to study whether medical review panels should be included as part of the presuit process in medical malpractice litigation and report to the Legislature. Medical review panels review a medical malpractice case during the presuit process and make judgments on the merits of the case based on established standards of care with the intent of reducing the number of frivolous claims. The panel's report could be used as admissible evidence at trial or for other purposes. If the department finds that medical review panels or a similar structure should be created in Florida, it shall include draft legislation to implement its recommendations in its report. The department shall submit its report to the Speaker of the House of Representatives and the President of the Senate no later than December 31, 2003.

Current Situation:
Medical review panels provide pre-trial screening to determine the merits of a case and divert medical malpractice cases to either mediation or arbitration. Such panels existed in the past in Florida and could be re-established. Such panel assist in the resolution of cases by making both parties aware of the likely success of a malpractice suit if it were taken to court. Such pre-trial screening panels help to weed out and hopefully discourage frivolous lawsuits

Florida had a medical review panel statute in the 1970s. The statute was upheld against constitutional challenge in Carter v. Sparkman[21] in 1976. In 1980, the court reconsidered its decision and held that while the statute on its face was constitutional, it was in practice unconstitutional because the delay some parties encountered in having a hearing.[22] Those issues would have to be considered if the Legislature were to re-establish medical review panels

DAMAGES

Caps on Noneconomic Damages:
Section 28 of this bill creates s. 766.118, F.S., relating to determination of noneconomic damages. This bill provides that in any action for personal injury or wrongful death due to medical negligence, including actions pursuit to s. 766.209, F.S., noneconomic losses shall not exceed $250,000 regardless of the number of claimants or defendants involved. Noneconomic losses include "pain and suffering, inconvenience, physical impairment, mental anguish, disfigurement, loss of capacity to for enjoyment of life, and all other noneconomic damages."

It can be argued that the findings contained in this bill and the record before the legislature, including reports and proceedings of the Governor's Select Task Force on Healthcare Professional Liability Insurance and the House of Representatives Select Committee on Medical Liability Insurance, demonstrate an overwhelming public necessity to impose the cap proposed in this bill and show that no reasonable alternative exists. In addition, the Florida Supreme Court has held that containing the costs of health care and making health care more accessible to the citizens of the state provides a rational basis for the legislature to create a system where some claimants might recover greater damages than others.[23] Accordingly, a court may hold a cap does not implicate the equal protection concerns noted in St. Mary's.

Current Situation:
Currently, the Florida Constitution places limits on the Legislature's ability to cap damages in tort cases or otherwise restrict a litigant's access to courts. In Kluger v. White,[24] the Florida Supreme Court considered the Legislature's power to abolish causes of action. At issue in Kluger was a statute which abolished causes of action to recover for property damage caused by an automobile accident unless

[21] 335 So. 2d 802 (Fla. 1976).
[22] See Aldana v. Holub, 381 So. 2d 231 (Fla. 1980).
[23] See Mizrahi v. North Miami Medical Center, Inc., 761 So. 2d 1040 (Fla. 2000).
[24] 281 So. 2d 1 (Fla. 1973).

the damage exceeded $550.[25] The court held that the statute violated the access to courts provision of the state constitution.

The "access to courts provision" of the declaration of rights in the Florida Constitution requires that the courts "be open to every person for redress of any injury". [26] In Kluger, the court held that where a right to access to the courts for redress for a particular injury predates the adoption of the declaration of rights in the 1968 state constitution, the legislature cannot abolish the right without providing a reasonable alternative unless the legislature can show (1) an overpowering public necessity to abolish the right and (2) no alternative method of meeting such public necessity.[27] Because the right to recover for property damage caused by auto accidents predated the 1968 adoption of the declaration of rights, the court held that the restriction on that cause of action violated the access to courts provision of the state constitution.

The court applied the Kluger test in Smith v. Department of Insurance.[28] In 1986, the legislature passed comprehensive tort reform legislation that included a cap of $450,000 on noneconomic damages. The cap on damages was challenged on the basis that it violated the access to courts provision of the state constitution. The Florida Supreme Court held that the right to sue for unlimited economic damages existed at the time the constitution was adopted.[29] The court said that a cap on noneconomic damages must meet the Kluger test in order to pass constitutional muster.[30] If the legislature wishes to cap noneconomic damages, it must (1) provide a reasonable alternative remedy or commensurate benefit; or (2) show an overpowering public necessity for the abolishment of the right to recover unlimited damages and show that no alternative method of meeting the public necessity.[31]

The Smith court held that the legislature did not provide an alternative remedy or commensurate benefit in exchange for limited the right to recover damages and noted that the parties did not assert that an overwhelming public necessity existed.[32] Accordingly, the court held that the $450,000 cap on noneconomic damages violated the access to courts provision of the Florida Constitution.

The issue of caps on noneconomic damages arose again in University of Miami v. Echarte.[33] In 1988, the legislature instituted a voluntary binding arbitration process in medical malpractice cases. Under the arbitration process, a defendant could decline to contest liability and request binding arbitration on the issue of damages. If a defendant requested arbitration, noneconomic damages were capped at $250,000 per incident if the plaintiff agreed to arbitration.[34] In exchange for the cap, the plaintiff was guaranteed prompt payment of any award, joint and several liability against the defendants, and payment of attorney's fees and costs by the defendant.[35] If the plaintiff rejected a defendant's offer to arbitrate, the plaintiff could proceed to trial but noneconomic damages were capped at $350,000.[36]

The Florida Supreme Court applied the Kluger test and found that arbitration statute provided a commensurate benefit for the loss of the right to recover full noneconomic damages.[37] While the plaintiff lost the right to recover full damages, the plaintiff gained (1) the benefit of not having to prove liability; (2) joint and several liability; (3) relaxed evidentiary standards provided in an arbitration

[25] See Kluger, 281 So. 2d at 2-3.
[26] Art. I, s. 21, Fla. Const.
[27] See Kluger, 281 So. 2d at 4.
[28] 507 So. 2d 1080 (Fla. 1987).
[29] See Smith, 507 So. 2d at 1087
[30] See Smith, 507 So. 2d at 1087-1088.
[31] See Smith, 507 So. 2d at 1088.
[32] See Smith, 507 So. 2d at 1089.
[33] 618 So. 2d 189 (Fla. 1993).
[34] See Echarte, 618 So. 2d at 193.
[35] See Echarte, 618 So. 2d at 193.
[36] See Echarte, 618 So. 2d at 193.
[37] See Echarte, 618 So. 2d at 194.

proceeding; (4) prompt payment of damages; (5) payment of attorney's fees and costs; and (6) limited appellate review of the award.[38]

In addition, the Echarte court found that the legislature had shown an overpowering public necessity for instituting the caps and that there was no reasonable alternative.[39] The legislature made factual findings, relying on a study by an academic task force, to show that without reform, many persons would be unable to purchase liability insurance and claimants would be unable to recover any damages if providers were not insured.[40] The court, relying on information presented to the academic task force, agreed that there was no reasonable alternative.[41] Based on these findings, the court upheld the statute.

The arbitration statute states that damages are capped at $250,000 "per incident" but has other language referring to individual claimants. In St. Mary's Hospital, Inc. v. Phillipe,[42] the Florida Supreme Court considered whether the "per incident" language meant that each claimant could recover the full $250,000 or whether all claimants in a single incident must divide $250,000. In St. Mary's, a woman died during childbirth due to medical malpractice.[43] After arbitration under the medical malpractice statute, her husband was awarded $250,000 in noneconomic damages and each of her four surviving children was awarded $175,000.[44] The court had to decide whether the statute permitted that award or whether the total noneconomic damages were capped at $250,000.

The court held that the statute meant that each claimant was entitled to recover up to $250,000 per incident.[45] To hold otherwise, the court said, would raise equal protection concerns because a claimant's recovery would be limited simply because there were multiple claimants in a given case.[46] Accordingly, each claimant in a medical malpractice arbitration may recover up to $250,000 per incident of medical malpractice.

Another issue raised in the St. Mary's case is whether, in a medical malpractice arbitration, economic damages are determined under the medical malpractice statute or under the wrongful death statute. Under the medical malpractice statute, "economic damages" is defined as "including, but not limited to, past and future medical expenses and 80 percent of wage loss and loss of earning capacity."[47] In addition, the statute provides that arbitration shall be undertaken with the understanding that "[n]et economic damages shall be awardable, including, but not limited to, past and future medical expenses and 80 percent of wage loss and loss of earning capacity, offset by any collateral source payments."[48] The court explained that the Wrongful Death Act does not provide the same economic damages:

> Unlike the Medical Malpractice Act, the Wrongful Death Act does not provide claimants with such a full range of economic damages. Under section 768.21(1) of the Wrongful Death Act, each survivor may recover the value of lost support and services from the date of the decedent's injury, and under section 768.21(6), the estate may recover the decedent's loss of earnings, loss of prospective net accumulations, and medical and funeral expenses.[49]

The court held that, in a medical malpractice arbitration, the medical malpractice statute should determine how economic damages are calculated. The court stated that the plain language of the statute "indicates that the full range of economic damages is available to claimants as an incentive to

[38] See Echarte, 618 So. 2d 194.
[39] See Echarte, 618 So. 2d at 195-97.
[40] See Echarte, 618 So. 2d at 197.
[41] See Echarte, 618 So. 2d at 197.
[42] 769 So. 2d 961 (Fla. 2000).
[43] See St. Mary's, 769 So. 2d at 963.
[44] See St. Mary's, 769 So. 2d at 963.
[45] See St. Mary's, 769 So. 2d at 967-971.
[46] See St. Mary's, 769 So. 2d at 971-973.
[47] St. Mary's, 769 So. 2d at 973.
[48] St. Mary's, 769 So. 2d at 973.
[49] St. Mary's, 769 So. 2d at 973.

forego a jury trial."[50] The court reasoned that if the legislature had intended for the Wrongful Death Act to apply, it would have expressly stated that it should be applied.[51]

Liability Based on Percentage of Fault:
Section 33 of this bill amends s. 768.81(5), F.S., relating to comparative fault. The change would have the effect of requiring a court to enter judgment based on percentage of fault in all cases arising out of medical malpractice.

Current Situation:
Section 768.81, Florida Statutes, requires the court to enter judgment based on fault of the parties rather than joint and several liability in negligence cases. Section 761.81(4)(a), F.S., defines "negligence" cases as including "civil actions for damages based upon theories of negligence, strict liability, products liability, professional malpractice whether couched in terms of contract or tort, or breach of warranty and like theories." Section 761.81(4)(b), F.S., states that the comparative fault statute does not apply to actions "based on an intentional tort."

Florida has used different methods of apportioning damages in tort cases. Under contributory negligence, any fault on the part of the plaintiff barred recovery.[52] The court receded from the doctrine of contributory negligence in Hoffman v. Jones[53] and made clear that joint and several liability would apply in Florida. Under joint and several liability, each defendant is responsible for all of the plaintiff's damages caused by all defendants, regardless of the extent of each defendant's fault in causing the accident.[54] For example, in Walt Disney World v. Wood,[55] one defendant was found 85% liable for an accident, co-defendant Disney was found 1% liable, and the plaintiff was found 14% liable. The court found that, under joint and several liability, Disney was liable for 86% of the plaintiff's damages even though Disney was only 1% at fault.[56] The court declined to abolish joint and several liability in Walt Disney World, stating that such a decision should be made by the Legislature.[57]

Florida abolished joint and several liability when it passed its comparative fault statute. Section 768.81, Florida Statutes, is Florida's comparative fault statute. The statute requires the court to enter judgment against a party in appropriate civil actions on the basis of fault rather than on the basis of contributory negligence or joint and several liability.

In cases where the statute is applicable, the court is required to enter judgment on the basis of each party's percentage of fault and not on the basis of joint and several liability.[58] The statute provides a formula for apportioning damages when the plaintiff is found to be at fault. Section 768.81(3), F.S., reads:

> (a) Where a plaintiff is found to be at fault, the following shall apply:
> 1. Any defendant found 10 percent or less at fault shall not be subject to joint and several liability.
> 2. For any defendant found more than 10 percent but less than 25 percent at fault, joint and several liability shall not apply to that portion of economic damages in excess of $200,000.
> 3. For any defendant found at least 25 percent but not more than 50 percent at fault, joint and several liability shall not apply to that portion of economic damages in excess of $500,000.
> 4. For any defendant found more than 50 percent at fault, joint and several liability shall not apply to that portion of economic damages in excess of $1 million.

[50] St. Mary's, 769 So. 2d at 973.
[51] See St. Mary's, 769 So. 2d at 973.
[52] See Fabre v. Marin, 623 So. 2d 1182, 1184 (Fla. 1993).
[53] 280 So. 2d 431 (Fla. 1973).
[54] See Fabre, 623 So. 2d at 1184.
[55] 515 So. 2d 198 (Fla. 1987).
[56] See Walt Disney World, 515 So. 2d at 198-202.
[57] See Walt Disney World, 515 So. 2d at 202.
[58] See s. 768.81(3), F.S.

For any defendant under subparagraph 2., subparagraph 3., or subparagraph 4., the amount of economic damages calculated under joint and several liability shall be in addition to the amount of economic and noneconomic damages already apportioned to that defendant based on that defendant's percentage of fault.

(b) Where a plaintiff is found to be without fault, the following shall apply:
1. Any defendant found less than 10 percent at fault shall not be subject to joint and several liability.
2. For any defendant found at least 10 percent but less than 25 percent at fault, joint and several liability shall not apply to that portion of economic damages in excess of $500,000.
3. For any defendant found at least 25 percent but not more than 50 percent at fault, joint and several liability shall not apply to that portion of economic damages in excess of $1 million.
4. For any defendant found more than 50 percent at fault, joint and several liability shall not apply to that portion of economic damages in excess of $2 million.
For any defendant under subparagraph 2., subparagraph 3., or subparagraph 4., the amount of economic damages calculated under joint and several liability shall be in addition to the amount of economic and noneconomic damages already apportioned to that defendant based on that defendant's percentage of fault.

(c) With respect to any defendant whose percentage of fault is less than the fault of a particular plaintiff, the doctrine of joint and several liability shall not apply to any damages imposed against the defendant.

(d) In order to allocate any or all fault to a nonparty, a defendant must affirmatively plead the fault of a nonparty and, absent a showing of good cause, identify the nonparty, if known, or describe the nonparty as specifically as practicable, either by motion or in the initial responsive pleading when defenses are first presented, subject to amendment any time before trial in accordance with the Florida Rules of Civil Procedure.

(e) In order to allocate any or all fault to a nonparty and include the named or unnamed nonparty on the verdict form for purposes of apportioning damages, a defendant must prove at trial, by a preponderance of the evidence, the fault of the nonparty in causing the plaintiff's injuries.

Remove Restriction on Recovery of Damages by Adult Child for Wrongful Death of Parent: Section 38 of this bill repeals s. 768.21(8), F.S., relating to damages. This would permit adult children to recover damages for lost parental companionship, instruction, and guidance and for mental pain and suffering for the wrongful death of their parents caused by medical malpractice, if there is no surviving spouse. It would also permit parents of adult children to recover for mental pain and suffering, if there are no other survivors, for the wrongful death of their children caused by medical malpractice.

Current Situtation:
Section 768.21(8), F.S., limits the noneconomic damages that can be recovered by adult children in situations where medical malpractice is the cause of a parent's death. The statute provides:

> The damages specified in subsection (3) shall not be recoverable by adult children and the damages specified in subsection (4) shall not be recoverable by parents of an adult child with respect to claims for medical malpractice as defined by s. 766.106(1).

Section 768.21(3), F.S., states, in pertinent part:

> Minor children of the decedent, and all children of the decedent if there is no surviving spouse, may also recover for lost parental companionship, instruction, and guidance and for mental pain and suffering from the date of injury.

Section 768.21(4), F.S., states:

> Each parent of a deceased minor child may also recover for mental pain and suffering from the date of injury. Each parent of an adult child may also recover for mental pain and suffering if there are no other survivors.

Accordingly, adult children cannot recover for mental pain and suffering for the wrongful death of their parent if the death results from medical malpractice. Similarly, parents of adult children cannot recover mental pain and suffering if their adult child's death results from medical malpractice.

Section 768.21(8), F.S., has been upheld against various constitutional challenges. The Florida Supreme Court held that s. 768.21(8), F.S., did not violate equal protection in Mizrahi v. North Miami Medical Center, Ltd.[59]. The court found that the legislature had a rational basis (controlling the costs of liability insurance) for excluding recovery in cases of medical malpractice while recovery might be allowed in other incidents of wrongful death.[60] The First District Court of Appeal held that s. 768.21(8), F.S., did not violate equal protection or the access to courts provision[61] of the Florida Constitution in Stewart v. Price.[62] The Stewart court explained the history of the right of adult children to recover for the wrongful death of their parent:

> Our analysis first begins with the recognition that under the common law an adult, who has not been dependent on a parent, was not entitled to recover damages for the wrongful death of a parent. Prior to the enactment of chapter 90-14, Laws of Florida, under section 768.21(3) only minor children could recover damages for their pain and suffering upon the wrongful death of a parent. In chapter 90-14, the legislature amended section 768.21(3), among other things, to expand the definition of "survivors" who may recover for the wrongful death of a parent. Thus, in addition to minor children, chapter 90-14 authorized all children of the decedent to recover for lost parental companionship, instruction and guidance and for mental pain or suffering, when there is no surviving spouse. At the same time, however, in chapter 90-14 the legislature precluded the application of this expanded "survivors" definition to adult children where the cause of the wrongful death is the result of medical malpractice. Thus, chapter 90-14 treated adult children of a person who dies as a result of medical malpractice differently than adult children whose parent dies as a result of a cause other than medical malpractice.[63]

The Stewart court explained that the wrongful death statute "closed no courthouse doors. Rather it opened, albeit only for some, those doors by creating a limited right of recovery where no recovery had previously existed at all."[64]

The limitation on recovery in s. 768.21(8), F.S., has been criticized. In Mizrahi, Justice Pariente wrote:

> All other adult children who lose their parents as a result of other negligent conduct have the right to recover pain and suffering damages if their parent died without a spouse. However, in the case of adult children of medical malpractice victims, the Legislature has denied compensation for mental pain and suffering not because the claims of the adult children are meritless, but because of the adult children's age and because their parents died as a result of medical malpractice.[65]

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[59] 761 So. 2d 1040 (Fla. 2000).
[60] See Mizrahi, 761 So. 2d at 1042-43.
[61] Art. I, s. 21, Fla. Const.
[62] 718 So. 2d 205 (Fla. 1st DCA 1998), approved, 762 So. 2d 465 (Fla. 2000).
[63] Stewart, 718 So. 2d at 209 (case citations omitted).
[64] Stewart, 718 So. 2d at 210.
[65] Mizrahi, 761 So. 2d at 1043 (citation omitted).

She continued:

> In sum, there is no indication that the distinction drawn by the statute bears a reasonable relationship to a legitimate state interest associated with ensuring accessible health care. Further, there is no indication that the medical malpractice crisis that formed the basis for treating this class of survivors differently than all other adult children even continues to this day. I therefore believe that the challengers of this statute have met their burden and have demonstrated that the distinction drawn by the Legislature is arbitrary.
>
> Finally, regardless of the constitutional question, I urge the Legislature to reconsider this exclusion and provide to adult children of parents who die as a result of medical malpractice the same rights afforded to the victims of every other tort action.[66]

Conforming Cross References to Repeal of s. 768.21(8), F.S., Damages for Wrongful Death
Section 39 of this bill amends s. 400.023(7), F.S., to delete cross reference to repealed s. 768.21(8), F.S.
Section 40 of this bill amends s. 400.235, F.S., to delete cross reference to repealed s. 768.21(8), F.S.
Section 41 of this bill amends s. 400.4295, F.S., to delete cross reference to repealed s. 768.21(8), F.S.

INSURANCE REFORM

The bill addresses the need to expand the market of available liability insurance by establishing alternate forms of insurance and improving the regulation of the insurance industry with more information about current claims.

INSURANCE REGULATION AND ALTERNATE PRODUCTS

Requires Annual Rate Filing and Prohibits Inclusion of Bad Faith Losses in Rate Standards:
Section 20 of this bill creates s. 627.062(7) and (8), F.S., relating to rate standards. The bill prohibits the inclusion of use of any portion of a judgment entered for bad faith and any portion for punitive damages against an insurer in the insurer's base rate or use to justify rates and rate changes for medical malpractice liability insurance. It specifically prohibits use of any portion identified for bad faith or specifically agreed to punitive damages and any taxable costs and attorney's fees identified as related to bad faith and punitive damages. The bill also requires each insurer to file their rates with the Office of Insurance Regulation for review at least once a year.

Current Situation:
Currently, s. 627.062, F.S., provides for setting insurance rates. Insurers file their rates and any proposed changes with the Department of Insurance (now the Office of Insurance Regulation, OIR) at least 90 days before the rates are to take effect, for review to determine if a rate is excessive, inadequate, or unfairly discriminatory. OIR is required to make that determination in accordance with generally accepted and reasonable actuarial techniques based on factors specified in statute. The factors include: past and prospective loss experience and expenses; competition among insurers; investment income; loss reserves; cost of reinsurance; trend factors; a reasonable margin for underwriting profit and contingencies; the cost of medical services; and other relevant factors which impact upon the frequency or severity of claims or upon expenses. Currently there is no provision in statute that prohibits insurance companies providing medical malpractice insurance from considering bad faith awards or punitive damage awards in determining rates.

[66] Mizrahi, 761 So. 2d at 1044.

Another statute, s. 627.651(12), F.S. relating to automobile insurance, does prohibit motor vehicle insurers from including bad faith or punitive damage awards in their base rate or their justification of rate or rate changes.

The Governor's Task Force (p. 333) heard testimony from the Department of Insurance (now the Office of Insurance Regulation) that bad faith and punitive damages against insurers should not be included in claim loses when considering a rate increase. The Legislature has heard testimony that the changes in the bill may not immediately reduce insurance rates.

These provisions addresses recommendations that bad faith damages against malpractice insurers not be included to drive up insurance rates, and that provisions of the bill that may reduce insurance rates should be filed and reviewed annually to ensure they take effect as soon as possible.

Self Insurance:
Section 21 of this bill amends s. 627.357(10), F.S., relating to medical malpractice self-insurance. This removes the provision that a self insurance fund may not be formed after October 1992 to allow creation of new self insurance funds. It adds the provision that an application to form a self-insurance fund must be filed with the Office of Insurance Regulation (OIR). It requires the OIR to ensure that self-insurance funds remain solvent and provide coverage purchased by participants. It authorizes the Financial Services Commission to adopt rules to implement the subsection.

The Legislature, in 1975, in response to medical liability insurance not being sufficiently available, established three methods other than traditional commercial insurance for obtaining medical malpractice coverage as part of the Medical Malpractice Reform Act. The three means of alternate malpractice coverage are self insurance, the Medical Malpractice Joint Underwriting Association, and the Patient's Compensation Fund. (see Select Committee Report p. 70-72.)

Current Situation:
Currently, s. 627.357 F. S. authorizes a group or association of health care providers to self-insure against medical malpractice claims. The entity may self-insure upon obtaining approval from the Department of Insurance (now the Office of Insurance Regulation) and upon (1) establishing a medical malpractice risk management trust fund to provide coverage against professional medical malpractice liability and (2) employing a professional consultant for loss prevention and claims management coordination under a risk management program. To ensure solvency subsection (7) sets forth the provisions for the liability of each member of a fund for the obligations of the fund, and assessments against members in the event of liquidation of the fund or a deficiency in it. The trust fund may periodically assess members and also assess them in the event of a liquidation of the fund. Subsection (10) currently prohibits the formation of a self-insurance fund after October 1, 1992.

During the late 1980's and early 1990's, medical malpractice insurance in the commercial market became more available and affordable. That event, coupled with the assessability feature of the self-insurance funds, led to decreased interest in utilizing the funds as an alternative to the commercial markets.

On February 4, 2003, the Select Committee on Medical Liability Insurance heard testimony regarding the Florida Hospital Trust Fund, formed in 1975 pursuant to s.627.357, F.S. The fund operated very successfully with up to 42 hospitals participating. All claims are now closed and $30 million dollars will be refunded. According to testimony based upon the experience of the fund, self-insurance offers the following benefits: 1) a much lower expense ratio than insurance companies due to not needing to advertise or utilize agents, for example; 2) parties have a proprietary interest in the plan's operation and success, especially given the possibilities of assessments and refunds; 3) better risk management programs, 4) better control over claims; and 5) easier to form than an insurance company because, with assessability, one does not have the initial capital requirements.

Health Care Professional Liability Insurance Facility:
Section 22 of this bill creates s. 627.3575, F.S., creating the Care Professional Liability Insurance Facility. New section 627.3575, F.S., creates the nonprofit Health Care Professional Liability Insurance Facility. The facility is intended to provide professionals who are willing to self-insure for smaller claims with an affordable source of insurance for larger claims.

The facility will allow applicants to choose from professional liability insurance policies with deductibles of $25,000, $50,000, and $100,000 and coverage limits of $250,000 and $1 million. In order to qualify for coverage, the insured will be required to maintain an escrow account or letter of credit at all times equal to the selected deductible amount.

The facility will charge actuarially indicated premiums for the coverage provided. When premiums, together with investment income and reinsurance recoveries, are not sufficient to pay losses, policyholders' premiums would be subject to assessment. The facility is not a state agency and does not create any state liability, nor does it have the power to levy assessments on anyone other than its own policyholders.

The facility will operate under a board of governors consisting of the Secretary of the Department of Health, who will serve as board chair, three members appointed by the Governor, and three members appointed by the Chief Financial Officer. The board will adopt a plan of operation that must be submitted to the Office of Insurance Regulation for approval. The facility will be subject to regulation by the Office of Insurance Regulation as to rates and policy forms in the same manner as a private sector insurance company.

Current Situation:
See discussion of self-insurance provisions above:

Reporting of Additional Closed Claims Information:
Section 23 of this bill amends s. 627.912(1) & (2), F.S., relating to insurer reports of professional liability claims and actions. These changes add to the requirement that claims or damages for personal injuries caused by error or negligence must be reported to the Department of Insurance (now the Office of Insurance Regulation).

(1)(b) Requires any other disposition of the claim, including dismissal to be reported for specified medical professionals licensed under chapters 458, 459, 461 or 466, F.S. (medical, osteopathic and podiatric physicians and dentists). For these same medical professionals any claim resulting in a final judgment of $50,000 or more must be reported within 30 days.

(2)(b) Requires the Financial Service Commission to adopt rules to require additional information to assist the Office of Insurance Regulation in its analysis and evaluation of professional liability cases reported by insurers, including causes, costs, and damages.

Currently, s. 627.912, F.S., requires that certain providers of professional liability insurance report specific information on closed claims to the Department of Insurance (now the Office of Insurance Regulation). These are recorded in the Closed Claim Database. The database is being increasingly relied upon to draw conclusions about the current state of the medical malpractice market.

The provisions of this section address some of the issues identified by the Select Committee relating to the limitations of currently reported closed claims information. The Select Committee heard concerns regarding the integrity of the Closed Claim Database and the use of this data as a barometer of the current medical malpractice market. (Select Committee Report, p. 80-82)

The database reflects claims that have been closed as of any one point in time. The injuries may have occurred many years prior to the claims' closures. While it is the number and severity of claims currently being incurred that most concern the insurance industry, these are not reflected in the Closed

Claim Database. Looking in the database at the number and size of claims that have recently been closed provides an incomplete picture of trends in severity and frequency that affect rates.

In the absence of this information, if the industry establishes increased reserves in reaction to perceived increased claims and higher settlements or awards, reported losses (for income purposes) effectively rise, and rate increases naturally follow - or insurers reduce their willingness to provide the coverage - or the insurers even leave the State altogether.

The Office of Insurance Regulation (OIR) contends that while the information in the Database is not without value, the contents do not reflect a current, comprehensive picture of the medical malpractice market that is needed to regulate the industry.

OIR notes that the data is not validated. Not all entities providing medical malpractice in Florida are required to report closed claims to the Office. Moreover, it cannot be assured that all of the insurance entities required to report to the Database have consistently done so.

It is the contention of the OIR that there is a better way to more timely appreciate changes in the medical malpractice insurance market. This will require that insurers provide a different type of information to the Office: information that will measure what is currently going on right in the market. Insurers may not want to part with some of this information, as they may have concern this may disclose business practices considered proprietary.

Required Reporting of Closed Claims Information:
Section 24 of this bill creates s. 627.9121, F.S., relating penalties for required reporting of claims. These changes require each entity that makes a claims payment for medical malpractice under an insurance policy, self-insurance or otherwise, and that is required to report the information to the National Practitioner Data Bank, under 42 U.C.S. section 11131, to also report the information to the Office of Insurance Regulation (OIR). OIR is required to include such information in the data on professional liability claims required by s. 627.912, F.S. OIR is also required to compile and review the date and assess an administrative fine on entities that fail to fully comply with the reporting requirements.

Current Situation:
The National Practitioner Data Bank (NPDB) (42 U.S.C section 11131) serves as a nationwide system to assist state licensing boards, hospitals, and other health care entities to investigate the qualifications of health care practitioners they seek to license, hire or grant clinical privileges. The NPDB collects information on specific areas of the practitioner's licensure, malpractice payment history and record of adverse actions on clinical privileges.

These provisions address the same issues as the changes to s. 627.912(1) & (2), F.S., above; to improve the information available to assess the condition of the medical malpractice insurance market.

Provide Insurers Protection From Bad Faith Actions:
Section 25 of this bill amends s. 766.106 (3) and (4), F.S., relating to the presuit process, to extend the time that the statute of limitations is tolled during the presuit process from 90 to 150 days. The bill provides that an insurer shall not be held in bad faith for failure to timely pay its policy limits for medical liability coverage, if it tenders its policy limits and meets all other conditions of settlement within this extended presuit time period.

It has been argued that the current 90 day presuit period does not give the defendant adequate time to investigate the case and settle it without being exposed to future litigation for bad faith.

SEVERABILITY PROVISION

Section 42 of this bill provides a severability clause that if one provision of the act is invalidated it does not affect others.

EFFECTIVE DATE

Section 43 of this bill establishes the act shall take effect upon becoming law and shall apply to all actions filed after the effective date of the act.

C. SECTION DIRECTORY:

Section 1. Provides Legislative findings.
Section 2. Creates s. 395.1012, F.S.; requires hospitals, ambulatory and mobile surgical centers to establish patient safety plans and committees.
Section 3. Creates s. 395.1051, F.S., requires facilities to notify patients and family if harmed.
Section 4. Amends s. 456.041, F.S.; requires reporting of paid liability claims and additional information in health care practitioner profiles.
Section 5. Amends s. 456.042, F.S.; requires times for updating practitioner profiles.
Section 6. Amends s. 459.049, F.S.; requirements for the reporting of paid liability claims.
Section 7. Amends s. 456.057, F.S.; authorizes the Department of Health to utilize subpoenas to obtain patient records without patient's consent.
Section 8. Amends s. 456.072, F.S.; authorizes the Department of Health to determine administrative costs in disciplinary actions.
Section 9. Amends s. 456.073, F.S.; extends time for the Department of Health to refer to an administrative hearing.
Section 10. Amends s. 456.077, F.S.; provides for certain citation violations.
Section 11. Amends s. 456.078, F.S.; provides for designation of certain mediation offenses.
Section 12. Creates s. 456.085, F.S., requires facilities to notify patients and family if harmed.
Section 13. Amends s. 458.307, F.S.; changes membership of Board of Medicine.
Section 14. Amends s. 458.331, F.S.; increases the amount of liability claims paid by allopathic physicians requiring disciplinary investigation.
Section 15. Creates s. 458.3311, F.S.; establishes emergency procedures for medical physician disciplinary actions.
Section 16. Amends s. 459.004, F.S.; changes membership of Board of Osteopathic Medicine.
Section 17. Amends s. 459.015, F.S.; increases the amount of liability claims paid by osteopathic physicians requiring disciplinary investigation.
Section 18. Creates s. 459.0151, F.S.; establishes emergency procedures for disciplinary actions for osteopathic physicians.
Section 19. Amends s. 461.013, F.S.; increases the amount of liability claims paid by podiatric physicians requiring disciplinary investigation.
Section 20. Amends s. 627.062, F.S.; prohibits inclusion of payments made by insurers for bad faith claims in an insurer's rate base.
Section 21. Amends s. 627.357, F.S.; repeals prohibition against the formation of medical malpractice self-insurance funds.
Section 22. Creates s. 627.3575, F.S.; creates the Health Care Professional Liability Insurance Facility.
Section 23. Amends s. 627.912, F.S.; requires and sets amounts of claims information to be filed with the Office of Insurance Regulation and the Department of Health; providing for rulemaking by the Financial Services Commission.
Section 24. Creates s. 627.9121, F.S.; provides that certain information relating to medical malpractice be reported to the Office of Insurance Regulation.
Section 25. Amends s. 766.106, F.S.; extends timeframes for presuit investigation and limitation on bad faith if offered within presuit period.
Section 26. Creates s. 766.1065, F.S.; authorizes presuit mediation in medical negligence cases and confidentiality of information.

Section 27. Creates s. 766.1067, F.S.; requires mandatory mediation in medical negligence cause of actions and requires offers of settlement.
Section 28. Creates s. 766.118, F.S.; provides a limitation on non-economic damages which can be awarded in medical negligence cases.
Section 29. Amends s. 766.202, F.S.; provides requirements for medical experts.
Section 30. Amends s.766.203, F.S.; provides for discovery and admissibility of opinions and statements during presuit investigation.
Section 31. Amends s.766.207, F.S.; conforms the extended presuit time frame for electing voluntary binding arbitration.
Section 32. Requires study and report by the Department of Health of the efficacy and constitutionality of medical review panels.
Section 33. Amends s. 768.81, F.S.; provides that a defendant's liability for damages in medical negligence cases be several only.
Section 34. Creates s. 1004.08, F.S.; requires patient safety instruction for certain students in public schools, colleges and universities.
Section 35. Creates s. 1005.07, F.S.; requires patient safety instruction for certain students in nonpublic schools, colleges and universities.
Section 36. Directs Agency for Health Care Administration to study and report on information to be provided to health care consumers.
Section 37. Directs Agency for Health Care Administration to study and report on options to establish a Patient Safety Authority.
Section 38. Repeals s. 768.21(8), F.S.; removes prohibition against certain parties from bringing suit for wrongful death as a result of medical negligence.
Section 39. Amends s. 400.023(7), F.S., to remove cross reference to deleted s. 768.21(8), F.S.
Section 40. Amends s. 400.235, F.S., to remove cross reference to deleted s. 768.21(8), F.S.
Section 41. Amends s. 400.4295, F.S., to remove cross reference to deleted s. 768.21(8), F.S.
Section 42. Provides a severability clause that if one provision of the act is invalidated it does not affect others.
Section 43. Provides an effective date of upon becoming law and shall apply to all actions filed after the effective date of the act.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   See Fiscal Comments below.

2. Expenditures:

   See Fiscal Comments below.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

See Fiscal Comments below.

D. FISCAL COMMENTS:

There may be additional expenses for the Department of Health, the Agency for Health Care Administration, and the Office of Insurance Regulation with increase reporting requirements, but these may be offset by improved access to information and more efficient procedures allowed by the bill.

It is not anticipated that there will be additional costs due of the studies AHCA is directed to perform by Sections 36 and 37 related to information the public would find relevant in their selection of hospitals, and implementation requirements for a Patient Safety Authority.

Schools and universities are not expected to have increased costs due to Sections 34 and 35 requiring instruction in patient safety in public and non-public medical education programs.

Private health care providers, both facilities and practitioners may have additional expenses related to reporting and procedures required by the bill but these may be offset by reduced liability costs as required in Section 2 in which hospitals are required to have facility patient safety plans.

Health care practitioners are required to report disciplinary actions:
- Section 4 requires medical and osteopathic physician disciplinary actions to be reported to DOH for inclusion in physician profiles.
- Section 5 requires updates of required information within 15 days of a final action.

These costs are likely to be offset by higher threshold for disciplinary action:
- Section 6 sets a higher threshold for liability amounts that must be reported to disciplinary boards by medical, osteopathic and podiatric physicians and dentists, and Section 14 sets threshold for allopathic physicians.
- Section 17 sets a higher threshold of malpractice claims against an osteopathic physician that are required to be investigated for disciplinary action.

The bill establishes improved and less costly handling of disciplinary actions by the Department of Health and practitioners, though:
- Section 7 provides better access to patient records to facilitate handling of cases.
- Section 8 requires inclusion of attorney costs in penalty assessments.
- Section 9 provides additional time to resolve cases before referred to administrative hearings.
- Section 10 requires first offense citations not to be considered discipline for reporting purposes.
- Section 11 provides that successful mediation of complaints against practitioners not be reported as discipline.

Consumers will have more access to information from profiles.

Sections 13 and 16 provide increased consumer participation on professional boards.

The bill provides reduced cost of tort resolution for consumers and practitioners:
- Section 25 provides extended time period for presuit process.
- Section 26 presuit mediation.
- Section 27 mandatory mediation.
- Section 28 establishes cap on non-economic damages.
- Section 29 requires medical expert qualifications.
- Section 30 requires use of information from presuit experts for discoverability and admissibility.
- Section 33 provides comparative fault.
- Section 38 removes restriction on recovery of damages by adult child for wrongful death of parent.
-

Insurance companies and practitioners benefit from reduce costs of medical liability insurance:
- Section 20 requires annual rate review and prohibits inclusion of bad faith losses in rate standards.

- Section 21 allows creation of new self insurance funds.
- Section 24 reports additional closed claims information for better oversight of insurance rates.
- Section 25 provides for protection from bad faith action.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

   This bill does not require counties or municipalities to spend funds or to take an action requiring the expenditure of funds. This bill does not reduce the percentage of a state tax shared with counties or municipalities. This bill does not reduce the authority that municipalities have to raise revenues.

2. Other:

   Some sections of the bill raise constitutional issues. Each constitutional issue is addressed in the section of this bill analysis relating to that section of the bill.

B. RULE-MAKING AUTHORITY:

Section 23. Amends s. 627.912, F.S.; requires claims information to be filed with the Office of Insurance Regulation and the Department of Health and provides for rulemaking by the Financial Services Commission.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/COMMITTEE SUBSTITUTE CHANGES