SENATE STAFF ANALYSIS AND ECONOMIC IMPACT STATEMENT

(This document is based on the provisions contained in the legislation as of the latest date listed below.)

BILL: CS/SB 2-B

SPONSOR: Health, Aging, and Long-Term Care Committee and Senators Jones and Saunders

SUBJECT: Medical Malpractice

DATE: June 17, 2003 REVISED: _____ _____ _____ _____

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Munroe	Wilson	HC	Favorable/CS
2.				
3.				
4.				
5.				
6.				

I. Summary:

Patient Safety and Improved Quality of Health Care

This bill revises regulations regarding health care facilities to:

- Require patient safety plans, including appointment of patient safety officers and committees, in hospitals, ambulatory surgical centers, and mobile surgical facilities;
- Provide for certification of patient safety programs in these facilities and for a discount on liability insurance rates for use of the same;
- Add mental and physical abuse of a nurse or other staff member to the listing of grounds for discipline by a health care facility;
- Limit monetary liability of a party who engaged in or was a subject of peer review to $250,000;
- Revise internal risk management requirements in hospitals, ambulatory surgical centers, and mobile surgical facilities;
- Require a hospital, ambulatory surgical center, or mobile surgical facility to provide testing for sexually transmissible diseases without charge to a victim of sexual abuse which occurred at the facility;
- Require informing patients or their representatives of adverse medical incidents that result in harm to the patient; and
- Make activities done pursuant to quality improvement review, evaluation, and planning in a state-licensed health care facility immune from civil liability.

This bill revises licensure requirements and regulations regarding health care professionals to:

- Remove provisions that limit the Department of Health (DOH's) or board's authority to set license renewal fees which are no more than 10 percent greater than the fee imposed

during the previous 2-year licensure period and that are no more than 10 percent greater than the actual cost to regulate a profession;
- Require informing patients or their representatives of adverse medical incidents that result in harm to the patient;
- Revise practitioner profile elements and reporting requirements for physicians;
- Revise reporting requirements concerning professional liability claims against a licensee alleging medical malpractice; and
- Require the suspension of the license of a medical or osteopathic physician when judgments, arbitration awards, or settlement amounts have not been paid pursuant to statutory requirements.
- Revise financial responsibility requirements for medical and osteopathic physicians.

This bill revises the following state agency duties to:
- Revise administrative procedures used by the DOH and boards, to shift the burden of proof to prove a disciplinary violation from a "clear and convincing evidence" standard to the "greater weight of the evidence" standard in disciplinary cases;
- Revise assessment of costs associated with a disciplinary action;
- Require that the administrative law judge presiding over health care disciplinary cases have expertise in certain areas;
- Revise the rights of a respondent licensee in disciplinary cases to affirmatively require election of a formal hearing within 45 days after service of the administrative complaint rather than any circumstance during a proceeding in which a party raises an issue of disputed fact during an informal hearing;
- Require the Agency for Health Care Administration (AHCA) to review copies of complaints filed against hospitals alleging negligence for noncompliance by the hospital with adverse incident reporting and licensure requirements and to proceed with disciplinary actions against such hospitals for noncompliance;
- Require AHCA to deliver copies of hospital and ambulatory surgical center adverse incident reports to the Florida Center for Excellence in Health Care;
- Require several reports to be prepared concerning health care professionals and claims against those licensees;
- Give DOH additional subpoena power in prosecuting disciplinary cases;
- Require DOH and health care professional boards to adopt rules concerning the reporting of an allegation of sexual misconduct;
- Require DOH and health care professional boards to adopt rules governing the prescribing of drugs to patients via the Internet;
- Direct DOH and health care professional boards to identify the types of standard-of-care cases that are eligible for mediation;
- Revise the monetary thresholds for what constitutes gross or repeated malpractice for disciplinary purposes; and
- Require DOH to study the current health care practitioner disciplinary process and report by January 1, 2004.

This bill also does the following:
- Creates the Florida Center for Excellence in Health Care to design improvements in patient safety and health care quality, contingent on the enactment of a companion public

records exemption. The center's duties include a requirement to analyze patient safety data for the purpose of recommending changes in practices and procedures to prevent patient safety events and adverse incidents, to foster development of a statewide electronic infrastructure and a "core" electronic medical record, and to establish a simulation center for high technology intervention surgery and intensive care for use by all hospitals. Immunity from liability for lawful actions is extended to center employees and agents and no liability or cause of action may arise against a health care practitioner or facility when they act in reliance on any advice or information provided by the center. A funding mechanism that involves assessments on health insurers, health maintenance organizations (HMOs), health care facilities, and health care practitioners is established for the center to finance its operations;

- Requires AHCA to conduct or contract for a study to determine if it is feasible to provide information to the public that will help them make better health care decisions regarding their choice of a hospital based on that facility's patient safety and quality performance;
- Authorizes patient safety organizations and protects patient safety data obtained by such organizations from disclosure;
- Requires the Office of Program Policy Analysis and Government Accountability (OPPAGA) and the Auditor General to conduct a study of practitioner disciplinary cases and closed claims; and
- Requires medical, nursing, and allied health training programs to include instruction in patient safety.

Medical Malpractice Insurance

This bill contains provisions relating to medical malpractice insurance that:

- Require medical malpractice insurers to reduce premiums for policies issued or renewed between July 1, 2003 and July 1, 2004, to levels that were in effect on January 1, 2002, unless the Office of Insurance Regulation finds that the rate would result in an inadequate rate;
- Creates a state fund to sell medical malpractice insurance to medical and osteopathic physicians, which shall begin offering coverage if insurers with a combined market share of 50 percent or greater do not reduce rates to the level specified above, or propose increases of greater than 15 percent for either of the following 2 years;
- Require medical and osteopathic physicians to maintain minimum insurance coverage if the state medical malpractice fund begins offering coverage;
- Require medical malpractice insurers to notify insureds at least 60 days prior to the effective date of a rate increase and at least 90 days prior to cancellation or non-renewal;
- Require medical malpractice insurers to notify policyholders of a rate filing that would result in an average statewide increase of 25 percent or more and require the Office of Insurance Regulation to hold a public hearing on the filing upon the request of any policyholder;
- Require DOH to forward to the Office of Insurance Regulation information that it collects from Florida-licensed physicians and dentists regarding professional liability claims that are not otherwise reported to the Office of Insurance Regulation;
- Authorize a group of 10 or more health care providers to establish a commercial self-insurance fund;

- Revise the rating standards for medical malpractice insurance to prohibit the inclusion of payments made by insurers for bad faith or punitive damages in the insurer's rate base. Such payments shall not be used to justify a rate or rate change;
- Eliminate an existing prohibition against creating new medical malpractice self-insurance funds and authorize the Financial Services Commission to adopt rules relating to medical malpractice self-insurance funds;
- Require the Office of Insurance Regulation to adopt rules regarding information about professional liability closed claims that will assist the office in analyzing the nature, causes, location, cost, and damages involved in such claims and require the office to impose a fine against insurers for violations of the closed claims reporting requirements. The bill requires additional entities to report medical malpractice actions or claims to the Office of Insurance Regulation and requires the office to post on the Internet a report analyzing professional liability closed claim information and medical malpractice insurer quarterly reports;
- Prohibit excessive profits by medical malpractice insurers;
- Require the Office of Insurance Regulation to provide the public with a comparison of medical malpractice insurance rates;
- Require medical malpractice insurers to submit rate filings to reflect changes contained in malpractice legislation enacted in 2003, which must be reviewed by the Office of Insurance Regulation; and
- Require OPPAGA to study the eligibility requirements for a birth to be covered under the Florida Birth-Related Neurological Injury Compensation Association (NICA) and report to the Legislature by January 1, 2004.

Medical Malpractice Liability

The bill revises requirements for the awarding of damages in medical malpractice actions, as follows:

- Impose an aggregate cap for noneconomic damages of $500,000 per defendant, regardless of the number of claimants for a claim arising out of the same medical negligence. This aggregate cap applies whether the parties go directly to trial, go to medical negligence arbitration or go to trial following failure to offer or accept arbitration. The aggregate cap may be "pierced" or waived by the trier of fact in those cases involving catastrophic injuries including death, coma, paralysis, quadriplegia, paraplegia, blindness, permanent vegetative state, or severe and permanent brain injury, the trier of fact may "pierce" this "soft cap" and award an amount in excess of $500,000;
- If any defendant shows the court or arbitration panel a written release not to sue any person in partial satisfaction of damages sued for, all sums received by the claimant, including economic and noneconomic damages, costs, and attorney's fees, must be set off;
- The following statement must be included in all settlements of medical malpractice claims: "The decision to settle a case may reflect the economic practicalities pertaining to the cost of litigation and is not, alone, an admission that the insured failed to meet the required standard of care applicable to the patient's treatment. The decision to settle a case may be made by the insurance company without consulting its client for input unless otherwise provided by the insurance policy;"

- The claimant in a medical malpractice suit is required to provide to AHCA copies of complaints alleging negligence against facilities licensed under ch. 395, F.S.;
- A professional liability insurer, for insuring medical negligence, may not be held to have acted in bad faith for failure to timely pay policy limits if it tenders its policy limits and meets all other conditions of settlement before the conclusion of the presuit screening period or extension thereof, during a 270-day period thereafter, or during a 90-day period after the filing of an amended medical malpractice complaint alleging new facts previously unknown to the insurer and upon other specified conditions;
- The definition of "similar health care provider" is revised for purposes of establishing the prevailing professional standard of care by expert witnesses under the Medical Malpractice Act and expert witnesses may not testify on a contingency fee basis;
- The Office of Presuit Screening Administration is established within the Department of Health. Presuit screening panels are created to review medical negligence claims under specified conditions.
- Presuit requirements are revised to require parties to within 30 days after service of the presuit notice of intent to initiate medical malpractice litigation, each party must produce medical, hospital, health care, and employment records concerning the claimant and affirmatively certify in writing that the produced records are all available records on the claimant to all other parties;
- Parties to a medical negligence action are required to submit to mandatory mediation as outlined in the bill;
- In medical malpractice voluntary binding arbitration, the claimant's recovery is limited to the damages the claimant is entitled to recover under general law, including the Wrongful Death Act;
- The definition of "periodic payment" is revised to provide that any portion of the periodic payment which is attributable to medical expenses that have not yet been incurred shall terminate upon the death of the claimant and any outstanding medical expenses incurred prior to death of the claimant must be paid from that portion of the periodic payment attributable to medical expenses;
- Provisions for the trier of fact to itemize damages, as part of a verdict for medical malpractice actions, are revised to include future losses;
- For medical negligence actions, the trier of fact shall apportion the total fault only among the claimant and all the joint tortfeasors who are parties to the action when the case is submitted to the jury for deliberation and rendition of the verdict;
- The Good Samaritan Act is amended to revise the circumstances under which immunity from civil liability is extended to any health care practitioner who is in a hospital and who voluntarily responds to provide care or treatment to a patient with whom the practitioner has no preexisting provider-patient relationship, when such care or treatment is necessitated by a sudden or unexpected situation or by an occurrence that demands immediate medical attention. The provision extending immunity to physicians acting as staff members or with clinical privileges at a nonprofit medical facility other than a hospital or while performing health screening services and providing treatment or care gratuitously is deleted.

This bill substantially amends ss. 46.015, 395.004, 395.0193, 395.0197, 456.025, 456.026, 456.039, 456.041, 456.042, 456.049, 456.051, 456.057, 456.063, 456.072, 456.073, 456.077,

456.078, 458.320, 459.0085, 458.331, 459.015, 460.413, 461.013, 466.028, 624.462, 627.062, 627.0645, 627.357, 627.4147, 627.912, 766.102, 766.106, 766.108, 766.110, 766.202, 766.206, 766.207, 768.041, 768.13, 768.77, and 768.81, F.S.

This bill creates ss. 381.0409, 395.0056, 395.1012, 395.1051, 456.0575, 627.0662, 627.41491, 627.41492, 627.41493, 627.41495, 627.9121, 766.1065, 766.1066, 766.118, 1004.08, and 1005.07, F.S., and 21 undesignated sections of law.

II. Present Situation:

Availability and Affordability of Medical Malpractice Insurance

Medical malpractice insurance covers doctors and other professionals in the medical field for liability claims arising from their treatment of patients. Rapidly rising medical malpractice insurance premiums and the departure of many insurance companies from the medical malpractice market have created a crisis of affordability and availability in many areas of the country, including Florida.

After almost a decade of essentially flat prices, medical malpractice insurance premiums began rising in 2000. According to the Department of Insurance, rate increases for physicians and surgeons from the top 15 professional liability insurers (ranked by direct written premium in Florida as reported 12/31/01) ranged from a minimum of 33.5 percent to a maximum of 149.9 percent from 1/1/01 through 1/1/03. There was a 73 percent average rate increase, weighted for market share. Rate increases for the top three insurers ranged from 74.3 percent to 81.3 percent for the two-year period.

In October, 2002, the Department of Insurance surveyed 18 insurers (top 15 malpractice writers in Florida and three other insurers known to be writing coverage) to determine the status of insurers departing the state and the status of insurers writing new business. Of the 18 insurers, five medical malpractice insurers had decided to no longer write any new or renewal business in Florida. Four additional insurers were not accepting any new business from physicians. Nine remaining insurers were still accepting new business in October, 2002. As of February 28, 2003, the largest medical malpractice insurer in the state, which had not been writing new business in October, 2002, decided to resume writing new business.

While there is general agreement that medical malpractice insurance premiums have risen sharply and that physicians are having a more difficult time obtaining medical malpractice insurance coverage, there appears to be little agreement on the causes of these problems. Insurers and doctors blame "predatory" trial attorneys, "frivolous" law suits, and "out of control" juries for the spike in insurance premiums. Consumer groups accuse insurance companies of "price gouging" and cite "exorbitant" rates of medical errors. Plaintiffs' attorneys also point to medical errors, and to "predatory" pricing practices and bad business decisions of insurers during the 1990s.

There is also disagreement about possible solutions to these problems. Insurers and physicians demand tort reform: changes in the legal system that will limit the frequency of litigation and the amount of damage awards. Attorneys argue that past legal reform has unfairly blocked victims'

access to the courts while doing nothing to bring down the costs of malpractice insurance. They see the solution in regulation of the insurance industry. Patient advocates focus on safety and suggest mandatory reporting of medical errors and a no-fault approach to victim compensation.

Whatever the causes and solutions, the effects of the rising cost of medical malpractice insurance and the reduction in the availability of such coverage are being felt in Florida's health care system. There have been numerous reports of doctors discontinuing doing risky procedures, retiring prematurely, practicing without insurance, and leaving litigious areas of the state in an effort to deal with the price of liability coverage. In some cases, the decision of high risk specialists to reduce or eliminate their services has led to further reductions in services by hospitals. Some hospitals are discontinuing services such as maternity services and trauma services because of the high cost of malpractice coverage for the specialists needed to provide these services.

Reporting of Professional Liability Closed Claims

Certain insurers providing professional liability insurance to health care practitioners, and certain physicians and dentists licensed in Florida, are required to report liability claims, once they are closed, to various governmental agencies under state and federal law.

Section 627.912, F.S., requires each medical malpractice self-insurer and each insurer or joint underwriting association providing professional liability insurance to specified health care practitioners and facilities, health maintenance organizations, and members of the Florida Bar to report to the Department of Insurance any claim or action for damages for personal injuries claimed to have been caused by error, omission, or negligence in the performance of such insured's professional services or based on a claimed performance of professional services without consent, if the claim resulted in:

- A final judgment in any amount; or
- A settlement in any amount.

The Department of Insurance has applied the closed claim reporting requirements to those insurers over which they have regulatory control, i.e. authorized insurers that have a Certificate of Authority from the Department of Insurance to write insurance in Florida. To the extent that health care providers are obtaining medical malpractice insurance through risk retention groups, surplus lines insurers, or offshore insurers, their closed claims are not being reported under s. 627.912, F.S. Also, claims attributable to health care practitioners who are not insured are not reported to the Department of Insurance.

Under s. 456.049, F.S., Florida-licensed physicians and dentists must report to DOH any claim or action for damages for personal injury alleged to have been caused by error, omission, or negligence in the performance of such licensee's professional services or based on a claimed performance of professional services without consent if the claim was not covered by an insurer required to report under s. 627.912, F.S., and the claim resulted in:

- A final judgment in any amount;
- A settlement in any amount; or

- A final disposition not resulting in payment on behalf of the licensee.

The Health Care Quality Improvement Act of 1986 requires reporting of medical malpractice payments, sanctions taken by Boards of Medical Examiners, and professional review actions taken by health care entities to the National Practitioner Data Bank. Under 42 U.S.C. section 11131, each entity (including an insurance company) which makes payment under a policy of insurance, self-insurance, or otherwise in settlement (or partial settlement) of, or in satisfaction of a judgment in, a medical malpractice action or claim shall report information respecting the payment and circumstances thereof. The information to be reported includes:

- The name of any physician or licensed health care practitioner for whose benefit the payment is made;
- The amount of the payment;
- The name (if known) of any hospital with which the physician or practitioner is affiliated or associated;
- A description of the acts or omissions and injuries or illnesses upon which the action or claim was based; and
- Any other information that the Secretary of the U.S. Department of Health and Human Services determines is required for appropriate interpretation of the information reported.

Good Faith Dealings between an Insurer and Its Insured

Insurance policies which impose an obligation on the insurer to defend and indemnify its insured against liability obligate the insurer to a duty of good faith in the handling of the defense or settlement of claims against the insured.[1] If the insurer breaches its good faith duty, it may be liable for the amount of the judgment rendered against the insured which exceeds the limits of coverage under the insurance policy or contract with the insured. Florida law provides civil remedies by statute and at common law[2] for aggrieved litigants damaged by an insurer's failure to handle the defense of or settle a claim of the insured. At common law as early as 1938, Florida courts have allowed third party bad faith actions. Even though the tort of bad faith occurred between the insurer and its insured, Florida courts have permitted the injured third party to bring a bad faith action directly against the first party insurer because the injured third-party, as the beneficiary to the bad faith claim, is the real party in interest.[3]

In 1962, the Legislature enacted section 624.155, F.S., which provides civil remedies to any person who has been damaged by an insurer who has not attempted to settle and pay a claim for policy benefits in good faith. Section 624.155(7), F.S., provides that the civil remedy in this section does not preempt any other remedy or cause of action provided for pursuant to any other statute or pursuant to the common law of this state. Any person may obtain a judgment under either the common-law remedy of bad faith or the statutory remedy, but shall not be entitled to a

[1] See *Boston Old Colony Insurance Company v. Guitierrez*, 386 So.2d 459 (Fla. 1985).
[2] See *Thompson v. Commercial Union Insurance Co. of New York*, 250 So.2d 259 (Fla. 1971). The Florida Supreme Court declared that an insured or injured plaintiff has the right to sue and recover damages against the insurer for an excess of the policy limits, based on the alleged fraud or bad faith of the insurer in the conduct or handling of the defense of the insured's suit.
[3] See *Auto Mutual Indemnity Co. v. Shaw*, 134 Fla. 815, 184 So. 852 (1938) and *State Farm Mutual Automobile Ins. Co. v. Laforet*, 658 So.2d 55, 58 (Fla. 1995).

judgment under both remedies. In addition, the section has been interpreted to allow a litigant to choose between his common law and statutory remedies for bad faith. Under s. 624.155(4), F.S., punitive damages are recoverable for the acts of the insurer which give rise to violation in such frequency as to indicate a general business practice and if the acts: are willful, wanton, and malicious; in reckless disregard for the rights of any insured; or in reckless disregard for the rights of the beneficiary under a life insurance contract.

Insurance Rate Standards

All property and casualty insurers authorized to do business in the state are required to file rates for approval with the Department of Insurance either 90 days before the proposed effective date ("file and use") or 30 days after the rate filing is implemented ("use and file").[4] Under the file and use option, the department may finalize its review by issuing a notice of intent to approve or disapprove within 90 days after receipt of the filing. These notices are "agency action" for purposes of the Administrative Procedure Act, and give the insurer the right to choose an administrative hearing or binding arbitration. Prior to approving or disapproving a rate filing, the department may request additional supporting information for the filing from the insurer, but such a request does not toll the 90-day review period. If the department fails to issue a notice of intent to approve or disapprove within the 90-day review period, the filing is deemed approved. Under the "use and file" option, an insurance company may be ordered by the department to refund a portion of the rate to the policyholders in the form of a credit or refund if it is found to be excessive.

The department may disapprove a rate filing if it determines such rates to be "excessive, inadequate, or unfairly discriminatory." These terms are defined in the Florida Statutes in the following manner:[5]

(a) Rates are "excessive" if they are likely to produce a profit from Florida business that is unreasonably high in relation to the risk involved in the class of business or if expenses are unreasonably high in relation to services rendered.[6]

(b) Rates are "inadequate" if they are clearly insufficient, together with investment income attributable to them, to sustain projected losses and expenses in the class of business to which they apply. Also, rates are deemed "inadequate" as to premium charged to a risk if discounts or credits are allowed which exceed a reasonable reflection of expense savings and expected loss experience from the risk.

(c) Rates are "unfairly discriminatory" as to a risk if the application of premium discounts, credits, or surcharges among such risks does not bear a reasonable relationship to the expected loss and expense experience among the various risks.[7]

[4] See s. 627.062, F.S.
[5] See s. 627.062, F.S.
[6] Rates are also *excessive* if, among other things, the rate structure established by a stock company provides for replenishment of surpluses from premiums, when the replenishment is attributable to investment losses.
[7] A rating plan, including discounts, credits, or surcharges, shall be deemed *unfairly discriminatory* if it fails to clearly and equitably reflect consideration of the policyholder's participation in a risk management program.

In making its rating decision, the department must consider, in accordance with generally accepted and reasonable actuarial techniques, thirteen factors which affect the insurer's rate filing including: past and prospective loss experience, expenses, market competition for the risk insured, investment income, the reasonableness of the judgment reflected in the rate filing, dividends, the adequacy of loss reserves, cost of reinsurance, trend factors, catastrophe hazards, profits, medical services (if applicable), and other relevant factors which impact upon the frequency or severity of claims or upon expenses.

Medical Malpractice Self-Insurance Funds

Section 627.357, F.S., once authorized the establishment of medical malpractice self-insurance funds. In 1992, the statute was amended to provide that no such funds could be formed after October 1, 1992. Currently there are only two funds in existence: the South Pinellas Medical Malpractice Risk Management Trust Fund, and the Central Dade Medical Malpractice Risk Management Trust Fund.

A Medical Malpractice Risk Management Trust Fund is authorized to purchase insurance, specific excess insurance, and aggregate excess insurance. The fund is authorized to hire consultants for loss prevention and claims management coordination, and pay claims; the "prudent" investment of trust funds is also authorized. The Department of Insurance is directed to adopt rules to implement the section including ensuring the funds meet a requirement that a trust fund maintain sufficient reserve to cover contingent liabilities in the event of dissolution.

The funding of a Medical Malpractice Risk Management Trust Fund is provided by premiums paid by members. Additionally, each member has a contingent assessment liability to pay actual losses when there is a deficiency due to claims or liquidation. The Department of Insurance must review and approve all expense factors related to rates before a new rate can be implemented. For the department to approve rates and the associated expense factors, the rates must be justified and reasonable for the benefits and services provided.

The Governor's Select Task Force on Healthcare Professional Liability Insurance found that removing the limitation on the creation of Medical Malpractice Risk Management Trust Funds would provide an additional opportunity for medical facilities and providers to have insurance rather than go without insurance, quit practicing medicine, or reduce services provided. Additionally, the creation of these funds would increase the opportunities to ensure that injured parties are compensated.

The current law also allows for the formation of commercial self-insurance funds pursuant to ss. 624.460-624.488, F.S., as approved by the Department of Insurance (now, the Office of Insurance Regulation). These funds may be formed for property and casualty insurance, including medical malpractice, but in practice have been limited to providing workers' compensation coverage. No such funds have been formed to provide medical malpractice insurance. The law allows a medical malpractice self-insurance trust fund organized under s. 627.357, F.S., (discussed above) to form a commercial self-insurance fund. Otherwise, such funds may be formed only by: a not-for-profit trade association, industry association, or professional association of employers or professionals which has a constitution or bylaws, which is incorporated in Florida, and which has been organized for purposes other than that of

obtaining or providing insurance and operated in good faith for a continuous period of 1 year (or by at least 10 condominium associations meeting certain requirements). In general, there are greater solvency-related requirements for forming a commercial self-insurance fund, as compared to the former medical malpractice self-insurance trust funds.

A commercial self-insurance fund must be operated by a board of trustees which must be responsible for appointing independent certified public accountants, legal counsel, actuaries, and investment advisers as needed; for approving payment of dividends to members; and for contracting with an administrator authorized under s. 626.88, F.S., to administer the affairs of the fund. A majority of the trustees or directors must be owners, partners, officers, directors, or employees of one or more members of the fund. Requirements also include: (1) an indemnity agreement binding each fund member to individual, several, and proportionate liability; (2) a plan of risk management which has established measures to minimize the frequency and severity of losses; (3) proof of competent and trustworthy persons to administer or service the fund; (4) an aggregate net worth of all members of at least $500,000; (5) a combined ratio of current assets to current liabilities of more than 1 to 1; (6) a deposit of cash or securities, or a surety bond, of $100,000; (7) specific and aggregate excess insurance with limits and retention levels satisfactory to the department (office); (8) a fidelity bond or insurance providing coverage of at least 10 percent of the funds handled annually by the fund; (9) a plan of operation designed to provide sufficient revenues to pay current and future liabilities, as determined in accordance with sound actuarial principles, and a statement by an actuary to that effect; and (10) such additional information as the department may reasonably require. After certification, additional requirements are imposed related to restrictions on premiums that may be written, annual reports, dividends, assessments, and approval of forms and rates. Rates may not be excessive, inadequate, or unfairly discriminatory and must be filed with the department (now, office) for approval. But, the standard for excessiveness is limited to a determination of whether the expense factors are not justified or are not reasonable for the benefits and services provided. A fund has the burden of proving that a rate filed is adequate if, during the first 5 years of issuing policies, the fund files a rate that is below the rate for loss and loss adjustment expenses for the same type and classification of insurance that has been filed by the Insurance Services Office and approved by the department (office). (ss. 625.460-624.482, F.S.)

Florida Birth-Related Neurological Injury Compensation Association

The Tort and Insurance Reform Act of 1986 created the Academic Task Force for Review of the Insurance and Tort Systems. A major concern of the Task Force was the increasing unavailability of obstetric services to the women of Florida. The significant increase in malpractice insurance premiums caused many physicians to cease the practice of obstetrics, creating a shortage of professionals to provide care for expectant mothers. To combat this health care delivery crisis, the Task Force recommended that the Legislature implement a no-fault plan of compensation for catastrophic birth-related neurological injuries.

In response to the recommendations, the Legislature enacted the Florida Birth-Related Neurological Injury Compensation Act in 1988 (ss. 766.301-766.316, F.S.). NICA provides compensation, regardless of fault, for specific birth-related neurological injuries.

Participating hospitals and physicians are immune from liability under medical malpractice for claims covered by NICA. A birth-related neurological injury is defined to mean:

> [I]njury to the brain or spinal cord of a live infant weighing at least 2,500 grams for a single gestation or, in the case of a multiple gestation, a live infant weighing at least 2,000 grams at birth caused by oxygen deprivation or mechanical injury occurring in the course of labor, delivery, or resuscitation in the immediate post delivery period in a hospital, which renders the infant permanently and substantially mentally and physically impaired. This definition shall apply to live births only and shall not include disability or death caused by genetic or congenital abnormality.

The Florida Supreme Court has ruled that in order for an infant to qualify under the above definition, the infant must be both mentally and physically impaired, not just one or the other.[8] If the administrative law judge finds that the statutory criteria are satisfied, then the infant, as well as the infant's parents or legal guardians, are entitled to the award of specifically defined, but limited, financial benefits without regard to fault (s. 766.31, F.S.).

In the fourteen years NICA has been in place, 161 cases have been accepted and there are presently 87 current open cases. Reports reflect an average of $3 million dollars per case is set aside based on actuarial data evaluating the lifetime care of the child, the medical fragility of the child, and the premise that as the child ages, care becomes more expensive.

The Governor's Select Task Force on Healthcare Professional Liability Insurance heard testimony about the high premium costs for medical malpractice coverage for obstetricians and the effects that high premium costs are having on these physicians and hospitals. The Task Force suggested that modifications to the eligibility requirements for NICA, such as changing the birth weights and changing the requirement that the infant be "mentally *and* physically" impaired to "mentally *or* physically" impaired might encourage greater participation. The broadening of the definition of eligible claimants may provide a reasonable alternative and likewise create a stopgap to the insurance crisis facing physicians providing obstetrical services. However, any changes that open the program up to more claims would have to be evaluated for the level of financial assessments that would be required on hospitals and physicians.

Notices of Intent and Unsworn Statements in Medical Malpractice Actions

Chapter 766, F.S., entitled Medical Malpractice and Related Matters, provides for recovery of damages in medical negligence cases. Section 766.106, F.S., provides a statutory scheme for presuit screening of medical malpractice claims. After completion of the presuit investigation pursuant to s. 766.203, F.S., a claimant must notify each prospective defendant of the claimant's intent to initiate litigation for medical malpractice prior to filing a lawsuit. Under s. 766.106(3), F.S., a suit may not be filed for a period of 90 days after the notice of intent is mailed to any prospective defendant. During the 90-day period, the defendant's insurer is required to conduct a review to determine the liability of the defendant. To facilitate the review, s. 766.106(6), F.S., requires the parties to engage in fairly extensive informal discovery.

[8] See *Florida Birth-Related Neurological Injury Compensation Association v. Florida Division of Administrative Hearings,* 686 So.2d 1349, (1997).

One of the mechanisms of informal discovery is the taking of unsworn statements as provided in s. 766.106(7)(a), F.S. Currently, any party may require other parties to appear for the taking of an unsworn statement. Such statements may be used only for the purpose of presuit screening and are not discoverable or admissible in any civil action by any party. Non-parties cannot be required to have their unsworn statements taken.

At or before the end of the 90-day presuit screening period, the defendant's insurer must, pursuant to s. 766.106(3)(b), F.S., respond to the claimant by rejecting the claim, making a settlement offer, or making an offer of admission of liability and for arbitration on the issue of damages. If the defendant makes an offer to arbitrate, the claimant has 50 days, pursuant to s. 766.106(10), F.S., to accept or reject the offer. The claimant cannot force the defendant to arbitrate under s. 766.106, F.S. Acceptance of the offer waives recourse to any other remedy by the parties. The parties then have 30 days to settle the amount of damages and, if they cannot reach a settlement, they must proceed to binding arbitration to determine the amount of damages.

Pursuant to s. 766.106(12), F.S., the provisions of the Florida Arbitration Code contained in chapter 682, F.S., are applicable to the arbitration proceeding. The parties then provide written arguments to the arbitration panel and a one day hearing is subsequently held, wherein the rules of evidence and civil procedure do not apply. No later than two weeks after the hearing the arbitrators are required to notify the parties of their award and the court has jurisdiction to enforce any award.

Voluntary Binding Arbitration under Chapter 766, Florida Statutes

In 1988, the Legislature enacted sweeping medical malpractice reforms. Sections 48-59 of chapter 88-1, Laws of Florida, currently located in ss. 766.201-766.212, F.S., created additional presuit requirements and voluntary binding arbitration of medical negligence claims. The Legislature expressed its intent that arbitration provide:

- Substantial incentives for both claimants and defendants to submit their cases to binding arbitration, thus reducing attorney's fees, litigation costs, and delay;

- A conditional limitation on noneconomic damages where the defendant concedes willingness to pay economic damages and reasonable attorney's fees; and

- Limitations on the noneconomic damages components of large awards to provide increased predictability of outcome of the claims resolution process for insurer anticipated losses planning, and to facilitate early resolution of medical negligence claims.

Section 766.207, F.S., provides for voluntary binding arbitration of medical negligence claims. Upon completion of presuit investigation with preliminary reasonable grounds for a medical negligence claim intact, either party may elect to have damages determined by an arbitration panel. The opposing party may accept the offer of voluntary binding arbitration and the acceptance is a binding commitment to comply with the decision of the arbitration panel. Arbitration precludes recourse to any other remedy by the claimant against any participating defendant. Voluntary binding arbitration is undertaken with the understanding that:

- Net 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;

- Noneconomic damages shall be limited to a maximum of $250,000 per incident, and shall be calculated on a percentage basis with respect to capacity to enjoy life, so that a finding that the claimant's injuries resulted in a 50-percent reduction in his or her capacity to enjoy life would warrant an award of no more than $125,000 in noneconomic damages;

- Damages for future economic losses shall be awarded to be paid by periodic payments pursuant to s. 766.202(8), F.S., and shall be offset by future collateral source payments;

- Punitive damages shall not be awarded;

- The defendant shall be responsible for the payment of interest on all accrued damages with respect to which interest would be awarded at trial;

- The defendant shall pay the claimant's reasonable attorney's fees and costs, as determined by the arbitration panel, but in no event more than 15 percent of the award, reduced to present value;

- The defendant shall pay all of the costs of the arbitration proceeding and the fees of all the arbitrators other than the administrative law judge;

- Each defendant who submits to arbitration shall be jointly and severally liable for all damages assessed under this section;

- The defendant's obligation to pay the claimant's damages shall be for the purpose of arbitration under this section only;

- A defendant's or claimant's offer to arbitrate shall not be used in evidence or in argument during any subsequent litigation of the claim following the rejection thereof;

- The fact of making or accepting an offer to arbitrate shall not be admissible as evidence of liability in any collateral or subsequent proceeding on the claim;

- Any offer by a claimant to arbitrate must be made to each defendant against whom the claimant has made a claim;

- Any offer by a defendant to arbitrate must be made to each claimant who has joined in the notice of intent to initiate litigation;

- A defendant who rejects a claimant's offer to arbitrate shall be subject to the claim proceeding to trial without limitation on damages, and the claimant, upon proving medical negligence, shall be entitled to recover prejudgment interest and reasonable attorney's fees up to 25 percent of the award reduced to present value;

- A claimant who rejects a defendant's offer to arbitrate shall be subject to damages awardable at trial being limited to net economic damages, plus noneconomic damages not to exceed $350,000 per incident;

- The hearing shall be conducted by all of the arbitrators, but a majority may determine any question of fact and render a final decision;

- The chief arbitrator shall decide all evidentiary matters; and

- Voluntary binding arbitration does not preclude settlement at any time by mutual agreement of the parties.

Section 766.207, F.S., also specifies that the arbitration panel is composed of three arbitrators: one selected by the claimant, one selected by the defendant, and one administrative law judge furnished by the Division of Administrative Hearings who shall serve as the chief arbitrator. This section specifies how arbitrators are to be selected if there are multiple plaintiffs or multiple defendants, requires independence of arbitrators, specifies the rate of compensation for arbitrators, and authorizes the Division of Administrative Hearings to promulgate rules for voluntary binding arbitration.

Section 766.208, F.S., establishes the procedures for arbitration to allocate responsibility among multiple defendants, when there is a dispute among the defendants as to the apportionment of the damages that are awarded by the voluntary binding arbitration panel under s. 766.207, F.S. This section provides for a separate arbitration panel and binding arbitration proceeding for apportioning financial responsibility among multiple defendants.

Section 766.209, F.S., specifies the effects of failure to offer or accept voluntary binding arbitration. Voluntary binding arbitration is an alternative to jury trial and does not supersede the right of any party to a jury trial. If neither party requests or agrees to voluntary binding arbitration, the claim proceeds to trial or to any other available legal alternative. If a defendant rejects a claimant's offer to arbitrate, the claim proceeds to trial without limitation on damages, and the claimant, upon proving medical negligence, is entitled to recover prejudgment interest and reasonable attorney's fees up to 25 percent of the award reduced to present value. If a claimant rejects a defendant's offer to arbitrate, damages awardable at trial are limited to net economic damages, plus noneconomic damages not to exceed $350,000 per incident.

Section 766.21, F.S., authorizes the administrative law judge serving as chief arbitrator on an arbitration panel to dissolve the panel and request appointment of a new panel if he or she determines that agreement cannot be reached. The administrative law judge serving as chief arbitrator on a panel arbitrating the allocation of responsibility among multiple defendants is authorized to dissolve the panel and declare the proceedings concluded if he or she determines that agreement cannot be reached.

Section 766.211, F.S., requires the defendant to pay the arbitration award, including interest at the legal rate, to the claimant within 20 days after the determination of damages by the arbitration panel or submit any dispute among multiple defendants to arbitration. Starting 90 days after the award, interest at the rate of 18 percent per year begins to accrue.

Section 766.212, F.S., provides for appeal of arbitration awards and allocation of financial responsibility among multiple defendants. An appeal does not stay an arbitration award. The district court of appeal may order a stay to prevent manifest injustice. Any party to an arbitration proceeding may enforce an arbitration award or an allocation of financial responsibility by filing a petition in the circuit court for the circuit in which the arbitration took place.

Expert Witnesses in Medical Malpractice Actions

Standards of recovery in medical negligence cases are found in s. 766.102, F.S. In any action for recovery of damages based on the death or personal injury of any person in which it is alleged that such death or injury resulted from the negligence of a health care provider, the claimant has the burden of proving the alleged actions of the health care provider represented a breach of the prevailing standard of care for that health care provider (s. 766.102(1), F.S.). The prevailing professional standard of care for a given health care provider is that level of care, skill, and treatment which, in light of all relevant, surrounding circumstances, is recognized as acceptable and appropriate by reasonably prudent similar health care providers.

Section 766.104(1), F.S., provides that no action shall be filed for personal injury or wrongful death arising out of medical negligence unless the attorney filing the action has made a reasonable investigation to determine there are grounds for a good faith belief that there has been negligence in the care or treatment of the claimant. This statute provides a safe harbor for the attorney's good faith determination, as good faith may be shown to exist if the claimant or his or her counsel has received a written opinion of an expert as defined in s. 766.102, F.S., that there appears to be evidence of medical negligence. The written opinion of the expert is not subject to discovery by an opposing party to the litigation. Section 766.102(2), F.S., sets forth the qualifications of the health care provider who may testify as an expert in a medical negligence action, and who, pursuant to s. 766.104(1), F.S., may provide an opinion supporting the attorney's good faith presuit belief that there has been medical negligence.

The purpose of s. 766.102(2), F.S., is to establish a relative standard of care for various categories and classifications of health care providers for the purpose of testifying in court. Accordingly, pursuant to s. 766.102(2)(c), F.S., any health care provider may testify as an expert if he or she is a similar health care provider to the provider accused of negligence. If the expert is not a similar health care provider, he or she may still testify if the court determines the expert possesses sufficient training, experience, and knowledge as a result of practice or teaching in the specialty of the defendant, or practice or teaching in a related field of medicine, such that the expert can testify to the prevailing professional standard of care in a given field of medicine. The expert must have had active involvement in the practice or teaching of medicine within the five-year period before the incident giving rise to the claim.

Paragraphs 766.102(2)(a) and (b), F.S., define the term "similar health care provider" and classify health care providers as specialists and non-specialists. A specialist is one who is certified by the appropriate American board as a specialist, is trained and experienced as a medical specialist, or holds himself or herself out as a specialist. A non-specialist is a health care provider who meets none of the aforementioned criteria. For a specialist, a similar health care provider is one who is trained and experienced in the same specialty and is certified by the appropriate American board in the same specialty. For a non-specialist, a similar health care

provider is one who is licensed by the appropriate regulatory agency of this state, is trained and experienced in the same discipline or school of practice, and practices in the same or similar medical community. If a health care provider provides treatment or diagnosis for a condition which is not in his or her specialty, a specialist trained in the treatment or diagnosis of that condition shall be considered a similar health care provider.

A great deal of litigation has occurred as a result of attempting to interpret and apply the provisions of s. 766.102(2), F.S. The terms "medical specialty", "specialty", "specialist", and "discipline or school of practice" are not defined in the statutes. As a result, it is not uncommon for trial court judges to allow specialists to testify against non-specialists and general practitioners.

Setoff of Settlement Proceeds

Section 46.015, F.S., provides that if any person at trial shows that a plaintiff has delivered a written release or covenant not to sue to any person in partial satisfaction of the damages sued for, the court shall set off this amount from the amount of any judgment to which the plaintiff would be otherwise entitled at the time of the rendering of judgment. Section 768.041, F.S., provides that at trial, if any defendant shows the court that the plaintiff, or any person lawfully on her or his behalf, has delivered a release or covenant not to sue to any person, firm, or corporation in partial satisfaction of the damages sued for, the court shall set off this amount from the amount of any judgment to which the plaintiff would be otherwise entitled. The Florida Supreme Court has addressed whether a non-settling defendant is entitled to setoff or a reduction of damages based on payments by settling defendants in excess of their liability as apportioned by the jury. The court held that the setoff statutes apply to economic damages as found by the jury but not to noneconomic damages.[9]

Joint and Several Liability

Under the doctrine of joint and several liability, all defendants are responsible for the plaintiff's damages regardless of the extent of each defendant's fault in causing the plaintiff's damages.[10] Under the doctrine of contributory negligence, any fault on the part of the plaintiff bars recovery. Various methods of apportioning damages have been used in Florida. Under the doctrine of comparative fault, each party is responsible to the extent of its proportion of fault and the court enters a judgment in a negligence case based on each party's proportion of liability. Until recently, the doctrine of joint and several liability applied to joint tortfeasors such that the court entered a judgment with respect to the economic damages against the party holding him or her responsible for those damages for all parties until the plaintiff recovered all damages completely. However, in 1999, Florida law was amended to abolish the doctrine of joint and several liability for non-economic damages, and to limit its application to economic damages.[11] Regarding

[9] See *Wells v. Tallahassee Memorial Regional Medical Center, Inc.*, 659 So.2d 249 (Fla. 1995). See also *Gouty v. Schnepel*, 795 So.2d 959 (Fla. 2001) in which the Florida Supreme Court held the setoff statutes do not apply to reduce a non-settling defendant's payment for liability. See *D'Angelo v. Fitzmaurice*, 832 So.2d 135, (2nd DCA 2002), in which the Second District Court of Appeals extended *Gouty* and held that setoff was not appropriate when a settling party was not placed on the jury verdict form.

[10] See *Fabre v. Marin*, 623 So.2d 1182, 1184 (Fla. 1993).

[11] See ch. 99-225, L.O.F.; s. 768.81, F.S.

economic damages, it established new limitations and maximum liability amounts, which increase with a defendant's share of fault and is dependent on whether the plaintiff was at fault or not. Section 768.81, F.S., requires the court to enter judgment based on fault of the parties rather than joint and several liability in negligence cases. Section 768.81(3), F.S., provides a formula to be used by the courts to apportion damages when the plaintiff is found to be at fault.

Section 768.81(5), F.S.,[12] provides that notwithstanding any law to the contrary, in any action for damages for personal injury or wrongful death arising out of medical malpractice, whether in tort or contract, when an apportionment of damages pursuant to this subsection is attributed to a statutory teaching hospital, the court shall enter judgment against the statutory teaching hospital on the basis of such party's percentage of fault and not on the basis of the doctrine of joint and several liability. Subsection (2) of s. 766.112, F.S., also provides that a claimant's sole remedy to collect a judgment or settlement against a board of trustees of a state university in a medical malpractice action is through the legislative claim bill process as provided in s. 768.28, F.S.

Itemized Verdicts and Alternative Methods of Payment of Damage Awards

Section 768.77, F.S., currently requires the jury in a civil trial to itemize the damages it awards to the plaintiff. The jury must separately determine the amounts for economic, noneconomic, and punitive damages, if any, and separately enter those amounts on the verdict form.

Section 768.78, F.S., currently requires the trier of fact in any action for damages based on personal injury or wrongful death arising out of medical malpractice, to make an award intended to compensate the claimant for future economic losses by one of the following means: the defendant may make a lump-sum payment; or the court shall, at the request of either party, enter a judgment ordering future economic damages as itemized by the jury pursuant to s. 768.77, F.S., to be paid by periodic payments rather than lump sum. "Periodic payment" is defined to mean provision for the spreading of future economic damage payments, in whole or in part, over a period of time, as follows:

- A specific finding of the dollar amount of periodic payment which will compensate for future damages after offset by collateral sources must be made;
- The defendant must post a bond or security to assure full payment of these damages awarded. The bond must be written by a company that is rated A+ by Bests. If the defendant is unable to adequately assure full payment of the damages, all damages reduced to present value shall be paid to the claimant; and
- The provision for payment of future damages must specify the recipient or recipients of payments.

Good Samaritan Act

Section 768.13, F.S., the "Good Samaritan Act", provides immunity from civil liability to:

- Any persons, including those licensed to practice medicine, who gratuitously and in good faith render emergency care or treatment either in direct response to emergency situations

[12] An identical provision exists in s. 766.112(1), F.S.

related to and arising out of a state of emergency which has been declared pursuant to s. 252.36, F.S., or at the scene of an emergency outside of a hospital, doctor's office, or other place having proper medical equipment;

- Any hospital, any employee of such hospital working in a clinical area within the facility and providing patient care, and any person licensed to practice medicine who in good faith renders medical care or treatment necessitated by a sudden, unexpected situation or occurrence resulting in a serious medical condition demanding immediate medical attention, for which the patient enters the hospital through its emergency room or trauma center, or necessitated by a declared public health emergency. The act does not extend immunity from liability to acts of medical care or treatment *after stabilization* of the patient, unless surgery is required as a result of the emergency within a reasonable time after the patient is stabilized, in which case the immunity applies to any act or omission of medical care or treatment which occurs prior to stabilization of the patient following the surgery;

- Any person who is licensed to practice medicine, while acting as a staff member or with professional clinical privileges at a nonprofit medical facility, other than a hospital, or while performing health screening services for care and treatment provided gratuitously in such capacity; or

- Any person, including those licensed to practice veterinary medicine, who gratuitously and in good faith renders emergency care or treatment to an injured animal at the scene of an emergency on or adjacent to a roadway.

Section 768.13, F.S., establishes standards of conduct for each of these categories, in order for the immunity from liability to apply.

Sovereign Immunity

Article X, s. 13, of the State Constitution, authorized the Florida Legislature in 1868 to waive sovereign immunity by stating that, "Provision may be made by general law for bringing suit against the state as to all liabilities now existing or hereafter originating." The doctrine of sovereign immunity prohibits lawsuits in state court against a state government and its agencies and subdivisions without the government's consent. Section 768.28, F.S., provides that sovereign immunity for tort liability is waived for the state and its agencies and subdivisions. Section 768.28(5), F.S., imposes a $100,000 limit on the government's liability to a single person. For claims arising out of a single incident, the limit is $200,000. Section 768.28, F.S., outlines requirements for claimants alleging an injury by the state or its agencies. Section 11.066, F.S., requires a claimant to petition the Legislature in accordance with its rules, to seek an appropriation to enforce a judgment against the state or state agency. The exclusive remedy to enforce damage awards that exceed the recovery cap is by an act of the Legislature through the claims bill process. A claim bill is a bill that compensates an individual or entity for injuries or losses occasioned by the negligence or error of a public officer or agency.

Section 768.28(9), F.S., defines "officer, employee, or agent" to include, but not be limited to, any health care provider when providing services pursuant to s. 766.1115, F.S., any member of

the Florida Health Services Corps, as defined in s. 381.0302, F.S., who provides uncompensated care to medically indigent persons referred by DOH, and any public defender or her or his employee or agent, including among others, an assistant public defender and an investigator.

The second form of sovereign immunity potentially available to private entities under contract with the government is set forth in s. 768.28(9), F.S. It states that agents of the state or its subdivisions are not personally liable in tort; instead, the government entity is held liable for its agent's torts. The factors required to establish an agency relationship are: (1) acknowledgment by the principal that the agent will act for him; (2) the agent's acceptance of the undertaking; and (3) control by the principal over the actions of the agent.[13] The existence of an agency relationship is generally a question of fact to be resolved by the fact-finder based on the facts and circumstances of a particular case. In the event, however, that the evidence of an agency is susceptible of only one interpretation the court may decide the issue as a matter of law.[14]

General Regulatory Provisions for Health Care Practitioners

Chapter 456, F.S., provides the general regulatory provisions for health care professions within the Division of Medical Quality Assurance at DOH. Section 456.001, F.S., defines "health care practitioner" to mean any person licensed under ch. 457, F.S., (acupuncture); ch. 458, F.S., (medicine); ch. 459, F.S., (osteopathic medicine); ch. 460, F.S., (chiropractic medicine); ch. 461, F.S., (podiatric medicine); ch. 462, F.S., (naturopathic medicine); ch. 463, F.S., (optometry); ch. 464, F.S., (nursing); ch. 465, F.S., (pharmacy); ch. 466, F.S., (dentistry and dental hygiene); ch. 467, F.S., (midwifery); part I, II, III, IV, V, X, XIII, or XIV of ch. 468, F.S., (speech-language pathology and audiology, nursing home administration, occupational therapy, radiologic technology, respiratory therapy, dietetics and nutrition practice, athletic trainers, and orthotics, prosthetics, and pedorthics); ch. 478, F.S., (electrology or electrolysis); ch. 480, F.S., (massage therapy); part III or IV of ch. 483, F.S., (clinical laboratory personnel or medical physics); ch. 484, F.S., (opticianry and hearing aid specialists); ch. 486, F.S., (physical therapy); ch. 490, F.S., (psychology); and ch. 491, F.S., (psychotherapy).

Disciplinary Procedures

Section 456.073, F.S., sets forth procedures DOH must follow in order to conduct disciplinary proceedings against practitioners under its jurisdiction. The department, for the boards under its jurisdiction, must investigate all written complaints filed with it that are legally sufficient. Complaints are legally sufficient if they contain facts, which, if true, show that a licensee has violated any applicable regulations governing the licensee's profession or occupation. Even if the original complainant withdraws or otherwise indicates a desire that the complaint not be investigated or prosecuted to its completion, the department at its discretion may continue its investigation of the complaint. The department may investigate anonymous, written complaints or complaints filed by confidential informants if the complaints are legally sufficient and the department has reason to believe after a preliminary inquiry that the alleged violations are true. If the department has reasonable cause to believe that a licensee has violated any applicable regulations governing the licensee's profession, it may initiate an investigation on its own.

[13] *Goldschmidt v. Holman,* 571 So.2d 422 (Fla. 1990).
[14] *Campbell v. Osmond*, 917 F. Supp. 1574, 1583 (M.D. Fla. 1996). See also *Stoll v. Noel*, 694 So.2d 701 (Fla. 1997).

When investigations of licensees within the department's jurisdiction are determined to be complete and legally sufficient, the department is required to prepare, and submit to a probable cause panel of the appropriate board, if there is a board, an investigative report along with a recommendation of the department regarding the existence of probable cause. A board has discretion over whether to delegate the responsibility of determining probable cause to the department or to retain the responsibility to do so by appointing a probable cause panel for the board. The determination as to whether probable cause exists must be made by majority vote of a probable cause panel of the appropriate board, or by the department if there is no board or if the board has delegated the probable cause determination to the department.

The licensee who is the subject of the complaint must be notified regarding the department's investigation of alleged violations that may subject the licensee to disciplinary action. When the department investigates a complaint, it must provide the subject of the complaint or her or his attorney a copy of the complaint or document that resulted in the initiation of the investigation. Within 20 days after the service of the complaint, the subject of the complaint may submit a written response to the information contained in the complaint. The department may conduct an investigation without notification to the licensee if the act under investigation is a criminal offense. If the department's secretary or her or his designee and the chair of its probable cause panel agree, in writing, that notification to the licensee of the investigation would be detrimental to the investigation, then the department may withhold notification of the licensee.

If the licensee who is the subject of the complaint makes a written request and agrees to maintain the confidentiality of the information, the licensee may review the department's complete investigative file. The licensee may respond within 20 days of the licensee's review of the investigative file to information in the file before it is considered by the probable cause panel. Complaints and information obtained by the department during its investigations are exempt from the public records law until 10 days after probable cause has been found to exist by the probable cause panel or the department, or until the subject of the investigation waives confidentiality. If no probable cause is found to exist, the complaints and information remain confidential in perpetuity.

When the department presents its recommendations regarding the existence of probable cause to the probable cause panel of the appropriate board, the panel may find that probable cause exists or does not exist, or it may find that additional investigative information is necessary in order to make its findings regarding probable cause. Probable cause proceedings are exempt from the noticing requirements of ch. 120, F.S. After the panel convenes and receives the department's final investigative report, the panel may make additional requests for investigative information. Section 456.073(4), F.S., specifies time limits within which the probable cause panel may request additional investigative information from the department and within which the probable cause panel must make a determination regarding the existence of probable cause. Within 30 days of receiving the final investigative report, the department or the appropriate probable cause panel must make a determination regarding the existence of probable cause. The secretary of the department may grant an extension of the 15-day and 30-day time limits outlined in s. 456.073(4), F.S. If the panel does not issue a letter of guidance or find probable cause within the 30-day time limit as extended, the department must make a determination regarding the existence of probable cause within 10 days after the time limit has elapsed.

Instead of making a finding of probable cause, the probable cause panel may issue a letter of guidance to the subject of a disciplinary complaint. Letters of guidance do not constitute discipline. If the panel finds that probable cause exists, it must direct the department to file a formal administrative complaint against the licensee under the provisions of ch. 120, F.S. The department has the option of not prosecuting the complaint if it finds that probable cause has been improvidently found by the probable cause panel. In the event the department does not prosecute the complaint on the grounds that probable cause was improvidently found, it must refer the complaint back to the board that then may independently prosecute the complaint. The department must report to the appropriate board any investigation or disciplinary proceeding not before the Division of Administrative Hearings under ch. 120, F.S., or otherwise not completed within one year of the filing of the complaint. The appropriate probable cause panel then has the option to retain independent legal counsel, employ investigators, and continue the investigation, as it deems necessary.

When an administrative complaint is filed against a licensee based on an alleged disciplinary violation, the subject of the complaint is informed of her or his right to request an informal hearing if there are no disputed issues of material fact, or a formal hearing if there are disputed issues of material fact or the subject disputes the allegations of the complaint. The licensee may waive her or his rights to object to the allegations of the complaint, which allows the department to proceed with the prosecution of the case without the licensee's involvement. Once the administrative complaint has been filed, the licensee has 21 days to respond to the department. If the subject of the complaint and the department do not agree in writing that there are no disputed issues of material fact, s. 456.073(5), F.S., requires a formal hearing before a hearing officer of the Division of Administrative Hearings under ch. 120, F.S. The hearing provides a forum for the licensee to dispute the allegations of the administrative complaint. At any point before an administrative hearing is held, the licensee and the department may reach a settlement. The settlement is prepared by the prosecuting attorney and sent to the appropriate board. The board may accept, reject, or modify the settlement offer. If accepted, the board may issue a final order to dispose of the complaint. If rejected or modified by the board, the licensee and department may renegotiate a settlement or the licensee may request a formal hearing. If a hearing is held, the hearing officer makes findings of fact and conclusions of law that are placed in a recommended order. The licensee and the department's prosecuting attorney may file exceptions to the hearing officer's findings of facts. The boards resolve the exceptions to the hearing officer's findings of facts when they issue a final order for the disciplinary action.

The boards within DOH have the status of an agency for certain administrative actions, including licensee discipline. A board may issue an order imposing discipline on any licensee under its jurisdiction as authorized by the profession's practice act and the provisions of ch. 456, F.S. Typically, boards are authorized to impose the following disciplinary penalties against licensees: refusal to certify, or to certify with restrictions, an application for a license; suspension or permanent revocation of a license; restriction of practice or license; imposition of an administrative fine for each count or separate offense; issuance of a reprimand or letter of concern; placement of the licensee on probation for a specified period of time and subject to specified conditions; or corrective action.

Alternatives to Disciplinary Actions

Notwithstanding s. 456.073, F.S., the board, or department if there is no board, must adopt rules to permit the issuance of citations. The citation must clearly state that the subject may choose, in lieu of accepting the citation, to follow the standard procedures for a disciplinary action under s. 456.073, F.S. If the subject does not dispute the matter in the citation within 30 days after the citation is served, the citation becomes a final order and constitutes discipline. The penalty for a citation must be a fine or other conditions as established by rule.

Notwithstanding s. 456.073, F.S., the board or department if there is no board, must adopt rules to designate which violations of the applicable practice act are appropriate for mediation. They may designate as mediation offenses those complaints where harm caused by the licensee is economic in nature or can be remedied by the licensed health care practitioner.

Administrative Law

Except as provided in the specified exceptions in sections 120.80 and 120.81, F.S., an administrative law judge assigned by the Division of Administrative Hearings must conduct all hearings involving the substantial interests of a party affected by an agency action except for hearings before agency heads or a member thereof.[15] In disciplinary cases involving professionals licensed by DOH, formal hearings may not be conducted by the Secretary of DOH, or a board or member of a board within DOH for matters relating to the regulation of professions.[16] For disciplinary cases involving licensed health care practitioners under the Division of Medical Quality Assurance within DOH, a formal hearing before an administrative law judge from the Division of Administrative Hearings must be held pursuant to the Administrative Procedure Act (ch. 120, F.S.), if there are any disputed issues of material fact.[17] The administrative law judge must issue a recommended order pursuant to ch 120, F.S. If any party raises an issue of disputed fact during an informal hearing, the hearing must be terminated and a formal hearing pursuant to ch. 120, F.S., must be held.

When an administrative complaint is filed against a subject based on an alleged disciplinary violation, the subject of the complaint is informed of his or her right to request an informal hearing if there are no disputed issues of material fact, or a formal hearing if there are disputed issues of material fact or the subject disputes the allegations of the complaint.[18] The subject may waive her or his rights to object to the allegations of the complaint, which allows the department to proceed with the prosecution of the case without the licensee's involvement. Once the administrative complaint has been filed, the licensee has 21 days to respond to the department.

[15] See s. 120.57(1)(a), F.S.
[16] See s. 120.80(15), F.S. See also s. 120.80(4)(b), F.S., which contains a similar provision prohibiting the Secretary of the Department of Business and Professional Regulation (DBPR) or any board or member of a board within the department from conducting formal hearings for matters relating to the regulation of professions by DBPR.
[17] See s. 456.073(5), F.S.
[18] See s. 456.073(5), F.S. See also s. 120.60(5), F.S., which provides that in a proceeding, which involves the revocation, suspension, annulment, or withdrawal of any license, the agency must serve an administrative complaint and must provide the licensee an opportunity to request a hearing pursuant to ss. 120.569 and 120.57, F.S.

When an administrative complaint involving a licensed health care practitioner is referred to the Division of Administrative Hearings, the affected party is granted a de novo hearing involving disputed issues of fact to be conducted by an administrative law judge. After hearing the evidence presented in the case, the administrative law judge renders a recommended order that includes findings of fact, conclusions of law, and a recommended penalty or disposition.[19] The board or DOH, as appropriate, may adopt the recommended order, or may reject or modify the findings of fact.[20] Findings of fact in a recommended order may not be rejected or modified unless the department (board or DOH) states with particularity in its final order that the findings were not based upon competent substantial evidence or that the proceedings on which the findings are based did not comply with the essential requirements of law.[21] The department is not permitted to weigh the evidence, judge the credibility of the witnesses, or interpret the evidence to fits its ultimate conclusions.[22] The agency may not rely on its own expertise to reverse the administrative law judge's finding that a particular statute was violated.[23]

One exception under which an agency may reverse an administrative law judge is under the "deference rule." The "deference rule" recognizes that policy considerations left to the discretion of an agency may take precedence over findings of fact by an administrative law judge. The rule provides that matters that are susceptible to ordinary methods of proof, such as determining the credibility of witnesses or the weight to accord evidence, are factual matters to be determined by the hearing officer. On the other hand, matters infused with overriding policy considerations are left to agency discretion.[24]

In cases involving issues that are determinable by ordinary methods of proof through the weighing of evidence and the judging of the credibility of witnesses, courts in Florida have held that such functions are "solely the prerogative of the hearing officer as finder of fact.[25] Courts have generally held that the issue of whether an individual violated a statute by breaching the applicable standard of care is a factual issue that is susceptible to ordinary methods of proof and is an issue that is not infused with policy considerations."[26] The Third District Court of Appeal in wrestling with this issue declared that:

> [I]t is settled Florida doctrine that the rule which ascribes effect to an agency's determination of ultimate 'facts' on a subject about which it may rightfully claim expert insight, which originated in McDonald v. Department of Banking and Finance, 346 So.2d 569, 579 (Fla. 1st DCA

[19] See s. 120.57(1)(k), F.S.
[20] Boards are agencies for purposes of disciplinary action pursuant to s. 120.57, F.S.
[21] See s. 120.57(1)(l), F.S.
[22] See *Gross v. Department of Health*, 819 So.2d 997, 1001 (Fla.5th DCA 2002).
[23] *Id* .at 1001.
[24] See *Baptist Hosp., Inc. v. Department of Health & Rehabilitative Servs*., 500 So.2d 620, 623 (Fla. 1st DCA 1986) and *McDonald v. Department of Banking & Finance*, 346 So.2d 569 (Fla. 1st DCA 1977).
[25] Id. at 1003. See also, *B.B. v. Department of Health &Rehabilitative Servs.*, 542 So.2d 1362, 1364 (Fla. 3d DCA 1989) (quoting *Holmes v. Turlington*, 480 So.2d 150, 153 (Fla. 1st DCA 1985).
[26] *Id.* at 1003. The court also noted that whether a doctor deviated from the applicable standard of care is an issue of fact to be determined by the administrative judge. See also *Hoover v. Agency for Health Care Admin.*, 676 So.2d 1380 (Fla. 3d DCA 1996); *Nest v. Department of Prof'l Regulation, Bd. Of Med. Exam'rs*, 490 So.2d 987 (Fla. 1st DCA(1986); *Holmes; Johnston v. Department of Prof'l Regulation, Bd. Of Med Exam'rs*, 456 So.2d 939 (Fla. 1st DCA 1984); *Bush v. Brogan*, 725 So.2d 1237 (Fla. 2d DCA 1999).

> 1977), is not applicable to disciplinary proceedings in general, and to ones like this which are based upon an alleged breach of a broad standard of conduct in particular. In such an instance, the issue of whether the licensee's conduct was indeed in violation of a statutory standard is one of fact which not only must be established by 'conventional' proof, but as to which the prosecuting agency bears a significantly enhanced burden.[27]

The court was concerned that in disciplinary proceedings, the board has the burden of proving the applicable standard of conduct by competent substantial evidence and made a distinction between evidence which substantially supports conventional forms of regulatory action and evidence which is required to support substantially "a retrospective characterization of conduct requiring suspension or revocation of the actor's license." The court held that an agency may not rely upon its own expertise to retrospectively reverse a hearing officer's finding of no violation.[28]

A conclusion of law that is based on the application of rules of law is also issued as part of the hearing officer's order and, up until recent changes in the law, did not come to the agency with a presumption of correctness. The reviewing agency was free to disagree with the hearing officer's conclusions of law and could substitute its own. In 1999, the Legislature further narrowed an agency's authority to reject or modify a hearing officer's recommended conclusions of law by requiring that the agency state with particularity its reason for rejecting or modifying the recommended conclusion of law and by requiring that the agency find that its substituted conclusion of law is as, or more, reasonable than the rejected or modified conclusion.[29] Further the agency in its final order may reject or modify only those conclusions of law over which the agency has substantive jurisdiction.[30]

Sexual Misconduct

Pursuant to s. 456.063, F.S., sexual misconduct in the practice of a health care profession means violation of the professional relationship through which the health care practitioner uses such relationship to engage or attempt to engage the patient or client, or an immediate family member, guardian, or representative of the patient or client in, or to induce or attempt to induce such person to engage in, verbal or physical activity outside the scope of the professional practice of such health care profession. Sexual misconduct in the practice of a health care profession is prohibited. A candidate for licensure must be refused the license if the candidate has had any license revoked or surrendered based on a violation of sexual misconduct and that license has not been reinstated; or committed any act in any state, territory, or possession of the U.S. that would constitute sexual misconduct.

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[27] *Cohn v. Department of Prof'l Regulation*, 477 So.2d 1039, 1046 (Fla. 3d DCA 1985).
[28] *Id.* at 1047. See also *Heifetz v. Department of Business Regulation*, 475 So.2d 1277 (Fla. 1st DCA 1985); *Purvis v Professional Regulation*, 461 So.2d 134 (Fla. 1st DCA 1984); *Johnston v. Department of Professional Regulation*, 456 So.2d 939 (Fla. 1st DCA 1984); *Sneij v. Department of Professional Regulation*, 454 So.2d 795 (Fla. 3d DCA 1984).
[29] See Section 6, chapter 99-379, Laws of Florida.
[30] Id.

Practitioner Profiles

Section 456.039, F.S., requires each licensed physician, osteopathic physician, chiropractic physician, and podiatric physician to submit specified information which, beginning July 1, 1999, has been compiled into practitioner profiles to be made available to the public. The information must include: graduate medical education; hospitals at which the physician has privileges; the address at which the physician will primarily conduct his or her practice; specialty certification; the year the physician began practice; faculty appointments; a description of any criminal offense committed; a description of any final disciplinary action taken within the most recent 10 years; and professional liability closed claims reported to the Department of Insurance within the most recent 10 years exceeding $5,000. In addition the physician may submit: professional awards and publications; languages, other than English, used by the physician to communicate with patients; and an indication of whether the physician participates in the Medicaid program. Each person who applies for initial licensure as a medical physician, osteopathic physician, chiropractic physician, or podiatric physician must, at the time of application, and, in conjunction with the renewal of the license, submit the information required for practitioner profiles.

National Center for Patient Safety

One entity in Florida has been designated as a national center for patient safety. A partnership between the University of South Florida, Health Sciences Center and the Veteran's Health Administration has resulted in the formal designation of the University of South Florida as the State's only National Center for Patient Safety Research and Evaluation by the Federal Agency for Healthcare Research and Quality, and of the partnership as a National Patient Safety Center of Inquiry by the Veteran's Administration.

Adverse Incident Reporting

Hospitals, ambulatory surgical centers and mobile surgical facilities must be licensed under chapter 395, F.S. Chapter 395, F.S., imposes requirements on these facilities that include inspection and accreditation, and reporting of adverse incidents that result in serious patient injury. Hospitals, ambulatory surgical centers and mobile surgical facilities, under s. 395.0197(8), F.S., must report the following incidents within 15 calendar days after they occur to AHCA: death of a patient; brain or spinal damage to a patient; performance of a surgical procedure on the wrong patient; performance of a wrong-site surgical procedure; performance of a wrong surgical procedure; performance of a surgical procedure that is medically unnecessary or otherwise unrelated to the patient's diagnosis or medical condition; surgical repair of damage resulting to the patient from a planned surgical procedure where damage is not a recognized specific risk, as disclosed to the patient and documented through the informed consent process; or performance of procedures to remove unplanned foreign objects remaining in a patient following surgery.

Under s. 395.0197(8), F.S., the incident reports filed with AHCA may not be made available to the public under s. 119.07(1), F.S., or any other law providing access to public records, nor be discoverable or admissible in any civil or administrative action, except in disciplinary proceedings by DOH or the appropriate regulatory board. The incident reports may not be made

available to the public as part of the records of investigation for and prosecution in disciplinary proceedings that are made available to the public. DOH or the appropriate regulatory board must make available, upon written request by a health care professional against whom probable cause has been found, any such records which form the basis of the determination of probable cause. DOH must review each incident and determine whether it potentially involved conduct by the health care professional who is subject to disciplinary action under the provisions of s. 456.073, F.S.

Section 400.147, F.S., requires nursing homes to have an internal risk management and quality assurance program and report adverse incidents to AHCA.

Sections 458.351 and 459.026, F.S., require any medical physician, osteopathic physician, or physician assistant to notify DOH of any adverse incident that involved the physician or physician assistant which occurred on or after January 1, 2000, in any office maintained by the physician for the practice of medicine that is not licensed under chapter 395, F.S. The sections require any medical physician, osteopathic physician, or physician assistant to notify the department in writing and by certified mail of the adverse incident within 15 days after the adverse incident occurred. The notice must be postmarked within 15 days after the adverse incident occurred.

Confidentiality of Patient Records

Section 456.057, F.S., provides that medical records are confidential and, absent certain exceptions, they cannot be shared with or provided to anyone without the consent of the patient. Subsection (5) identifies the circumstances when medical records may be released without written authorization from the patient. The circumstances are as follows:

- To any person, firm, or corporation that has procured or furnished such examination or treatment with the patient's consent;
- When compulsory physical examination is made pursuant to Rule 1.360, Florida Rules of Civil Procedure, in which case copies of the medical records shall be furnished to both the defendant and the plaintiff;
- In any civil or criminal action, unless otherwise prohibited by law, upon the issuance of a subpoena from a court of competent jurisdiction and proper notice to the patient or the patient's legal representative by the party seeking such records; or
- For statistical and scientific research, provided the information is abstracted in such a way as to protect the identity of the patient or provided written permission is received from the patient or the patient's legal representative.

The Florida Supreme Court has addressed the issue of whether a health care provider, absent any of the above-referenced circumstances, can disclose confidential information contained in a patient's medical records as part of a medical malpractice action.[31] The court ruled that, pursuant to s. 455.241, F.S., (the predecessor to current s. 456.057(6), F.S.), only a health care provider who is a defendant, or reasonably expects to become a defendant, in a medical malpractice action can discuss a patient's medical condition. The court also held that the health care provider can

[31] *Acosta v. Richter*, 671 So.2d 149 (Fla. 1996).

only discuss the patient's medical condition with his or her attorney in conjunction with the defense of the action. The court determined that a defendant's attorney cannot have ex parte discussions about the patient's medical condition with any other treating health care provider.

Under s. 456.057(7), F.S., DOH may obtain patient records pursuant to a subpoena without written authorization from the patient, if the department and the probable cause panel of the appropriate board find reasonable cause to believe that a health care practitioner has excessively or inappropriately prescribed any controlled substance violating ch. 893, F.S, relating to controlled substances or any professional practice act, or that a health care practitioner has practiced his or her profession below that level of care, skill, and treatment required by law and also find that reasonable attempts were made to obtain a patient release.

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

The department may obtain patient records, billing records, insurance information, and provider contracts pursuant to a subpoena without written authorization from the patient if the department and probable cause panel of the appropriate board, if any, find reasonable cause to believe that a health care practitioner has submitted a claim, statement, or bill using a billing code that would result in payment greater in amount than would be paid using the appropriate billing code; used information derived from an automobile accident report to solicit or obtain patients personally or through an agent; solicited patients fraudulently; received a kickback; violated patient brokering provisions; presented a false or fraudulent insurance claim; or patient authorization cannot be obtained because the patient cannot be located or is deceased, incapacitated, or suspected of being a participant in the fraud or scheme; and if the subpoena is issued for specific and relevant records.

Financial Responsibility and Closed Claims

Sections 458.320 and 459.0085, F.S., require Florida-licensed allopathic and osteopathic physicians to maintain professional liability insurance or other specified financial responsibility to cover potential claims for medical malpractice as a condition of licensure, with specified exemptions. Physicians who have hospital privileges must maintain professional liability insurance or other financial responsibility to cover an amount not less than $250,000 per claim. Physicians without hospital privileges must carry sufficient insurance or other financial responsibility in coverage amounts of not less than $100,000 per claim. Physicians who do not carry professional liability insurance must provide notice to their patients. A physician is said to be "going bare" when that physician has elected not to carry professional liability insurance. Physicians who go bare must either provide notice by posting a sign which is prominently displayed in the reception area and clearly noticeable by all parties or provide a written statement to each patient. Such sign or statement must state:

> "Under Florida law, physicians are generally required to carry medical malpractice insurance or otherwise demonstrate financial responsibility to cover potential claims for

> medical malpractice. YOUR DOCTOR HAS DECIDED NOT TO CARRY MEDICAL MALPRACTICE INSURANCE. This is permitted under Florida law subject to certain conditions. Florida imposes penalties against noninsured physicians who fail to satisfy adverse judgments arising from claims of medical malpractice. This notice is provided pursuant to Florida law."

With specified exceptions, DOH must suspend on an emergency basis, any licensed allopathic or osteopathic physician who fails to satisfy a medical malpractice claim against him or her within specified time frames.

Section 627.912, F.S., requires insurers to report "closed claims" that involve any action for damage for personal injuries in the performance of professional services by a Florida-licensed medical physician, osteopathic physician, podiatric physician, dentist, hospital, crisis stabilization unit, health maintenance organization, ambulatory surgical center, or attorney to the Department of Insurance. DOH must review each closed claim involving a Florida-licensed medical physician, osteopathic physician, podiatric physician, or dentist and determine whether any of the incidents that resulted in the claim involved conduct by the licensed health care practitioner that is subject to disciplinary action.

Section 456.049, F.S., requires medical physicians, osteopathic physicians, physician assistants, podiatric physicians, and dentists to report "closed claims" for damages for personal injury that are alleged to have been caused by the negligence of the practitioner that are not covered by an insurer and reported as a closed claim under s. 627.912, F.S., to DOH. Section 456.051, F.S., specifies that "closed claims" reported under s. 456.049 and s. 627.912, F.S., to DOH are public information except for the name of the claimant or injured person. Any information that DOH possesses that relates to a bankruptcy proceeding by a medical physician, osteopathic physician, physician assistant, podiatric physician, or dentist is public information.

Discipline for Gross or Repeated Malpractice

Sections 458.331 and 459.015, F.S., provide grounds for which an allopathic or osteopathic physician may be subject to discipline by his or her board. Allopathic and osteopathic physicians may be subject to discipline for gross or repeated malpractice or the failure to practice medicine with that level of care, skill, and treatment recognized by a reasonably prudent similar physician as being acceptable under similar conditions and circumstances. "Repeated malpractice" includes, but is not limited to, three or more claims for medical malpractice within the previous 5-year period resulting in indemnities being paid in excess of $25,000. If it is reported that a physician has had three or more claims with indemnities exceeding $25,000 each within the previous 5-year period, DOH must investigate the occurrences upon which the claims were based and determine if action by the department against the physician is warranted.

Similarly, s. 461.013, F.S., provides that a podiatric physician may be subject to discipline for gross or repeated malpractice or the failure to practice podiatric medicine at a level of care, skill, and treatment which is recognized by a reasonably prudent podiatric physician as being acceptable under similar circumstances and conditions. "Repeated malpractice" includes but is not limited to, three or more claims for medical malpractice within the previous 5-year period resulting in indemnities being paid in excess of $10,000. A dentist is subject to discipline for

"dental malpractice" which includes but is not limited to, three or more claims within the previous 5-year period which resulted in indemnity being paid, or any single indemnity paid in excess of $5,000 in a judgment or settlement, as a result of negligent conduct on behalf of the dentist.

Governor's Select Task Force on Healthcare Professional Liability Insurance

In recognition of the problems with the affordability and availability of medical malpractice insurance, Governor Bush appointed the Governor's Select Task Force on Healthcare Professional Liability Insurance on August 28, 2002, to address the impact of skyrocketing liability insurance premiums on health care in Florida. The Task Force was charged with making recommendations to prevent a future rapid decline in accessibility and affordability of health care in Florida and was further charged to submit a report to the Governor, the President of the Senate, and the Speaker of the House of Representatives by January 31, 2003.

The Task Force had 10 meetings at which it received testimony and discussed five major areas: (1) health care quality; (2) physician discipline; (3) the need for tort reform; (4) alternative dispute resolution; and (5) insurance premiums and markets. The final report of the Task Force includes findings and 60 recommendations to address the medical malpractice crisis in Florida. The reports and information received by the Task Force, as well as transcripts of the meetings, were compiled into 13 volumes that accompany the main report.

III. Effect of Proposed Changes:

Section 1. Provides 14 legislative findings regarding the crisis relating to medical malpractice insurance, including:

- Florida is in the midst of a medical malpractice insurance crisis of unprecedented magnitude and that this crisis threatens the quality and availability of health care for all Florida citizens;
- 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 from the practice of medicine;
- The Governor's Select Task Force on Healthcare Professional Liability Insurance has established that a medical malpractice insurance crisis exists in Florida which can be alleviated by the adoption of comprehensive legislatively enacted reforms;
- There is an overwhelming public necessity to make high-quality health care available to the citizens of this state, to ensure that physicians continue to practice in Florida, and to ensure the availability of affordable professional liability insurance for physicians; and
- These overwhelming public necessities cannot be met unless comprehensive legislation is adopted.

Section 2. Adds a new subsection (4) to s. 46.015, F.S., to provide that at trial, arbitration or the rejection of an offer for arbitration in a medical malpractice action, if any defendant shows the court that the plaintiff, or his or her legal representative has delivered a written release or covenant not to sue to any person in partial satisfaction of the damages sued for, the court or arbitration panel shall set off this amount from the amount of any judgment or arbitration award to which the plaintiff would otherwise be entitled before entry of the final judgment. The amount

of the setoff must include all sums received by the plaintiff, including economic and noneconomic damages, costs, and attorney's fees.

Section 3. Creates s. 381.0409, F.S., contingent on the enactment of a companion public records exemption, to establish the Florida Center for Excellence in Health Care (center) which shall be responsible for performing activities and functions that are designed to improve the quality of health care delivered by health care facilities and health care practitioners. The principal goals of the center are the improvement of health care quality and patient safety.

The bill defines the terms "center," "health care practitioner," "health care facility," "health research entity," "patient safety data," and "patient safety event."

The center must, either directly or by contract:

- Analyze patient safety data for the purpose of recommending changes in practices and procedures which may be implemented by health care practitioners and health care facilities to prevent future adverse incidents;
- Collect, analyze, and evaluate patient safety data voluntarily submitted by a health care practitioner or health care facility. The center must recommend to health care practitioners and facilities any changes in practices and procedures that may be implemented for the purpose of improving patient safety and preventing patient safety events.
- Foster the development of a statewide electronic infrastructure to improve patient care and the delivery and quality of health care services by health care practitioners and facilities. The electronic infrastructure must be a secure platform for communication and the sharing of clinical and other data among providers and between providers and patients. The electronic infrastructure must include a "core" electronic medical record. Health care practitioners and health care facilities must have access to individual electronic medical records subject to consent of the individual. Health insurers must have access to the electronic medical records of their policy holders and to other data with limitations. Such access must be for the sole purpose of conducting research to identify diagnostic tests and treatments that are medically effective. Health research entities must have access to electronic medical records of individuals subject to the consent of the individual and to other data subject to other limitations. Such access must be for the sole purpose of conducting research to identify diagnostic tests and treatments that are medically effective.
- Inventory hospitals to determine the current status of implementation of computerized physician order entry systems and recommend a plan for expediting implementation statewide or, in hospitals where the center determines that implementation of such systems is not practicable, alternative methods to reduce medication errors. The center must identify in its plan any barriers to statewide implementation and must include recommendations to the Legislature of statutory changes that may be necessary to eliminate those barriers.
- Establish a simulation center for high technology intervention surgery and intensive care for use by all hospitals.
- Identify best practices and share this information with health care providers.

The center may release information contained in patient safety data to any health care practitioner or health care facility when recommending changes in practice and procedures which may be implemented by such practitioner or facility to prevent patient safety events and adverse incidents if the identity of the source of the information, and the names of persons have been removed from such information. All information related to adverse incident reports and all patient safety data received by the center may not be subject to discovery or introduction into evidence in any civil or administrative action. Individuals in attendance at meetings held for the purpose of discussing patient safety data and held to formulate recommendations to prevent future adverse incidents or patient safety events may not be permitted or required to testify in any civil or administrative action related to such events.

Employees or agents of the center are immune from liability for any lawful action taken by such individuals in advising health care practitioners or facilities when carrying out the duties of the center. There shall be no liability on the part of, and no cause of action of any nature shall arise against a health care practitioner or facility, its agents or employees when acting in reliance on any advice or information provided by the center.

The center must be a nonprofit corporation registered, incorporated, organized, and operated in compliance with ch. 617, F.S., and shall have all powers necessary to carry out the purposes of the center, including the power to receive and accept contributions of money, property, labor, or any other thing of value to be applied to its purpose. The center must be designed and operated with demonstrated expertise in health care quality data and systems analysis, health information management, systems thinking and analysis, human factors analysis, and identification of latent and active errors. The center must include systems for ensuring the confidentiality of data which are consistent with state and federal law.

The center will be governed by a 10-member board of directors appointed by the Governor to 2-year terms. The Secretary of Health and the Secretary of Health Care Administration or their respective designees shall be members of the board. The board members must serve without compensation but may be reimbursed for travel expenses pursuant to s. 112.061, F.S.

Notwithstanding any law to the contrary, the center shall be financed by requiring an assessment on various regulated individuals or entities. In each case, the assessment described below may be collected by the regulated party from the individual who is served. The assessment is applied as follows:

- Each health insurer that is issued a certificate of authority under part VI, VII, or VIII, of ch. 627, F.S., as a condition of maintaining the certificate must pay to the center an amount equal to $1 for each individual included in every insurance policy issued during the previous calendar year.
- Each health maintenance organization (HMO) issued a certificate of authority under part I, ch. 641, F.S., and each prepaid health clinic issued a certificate of authority under part II of ch. 641, F.S., as a condition of maintaining the certificate of authority must pay to the center an amount equal to $1 for each individual who was eligible to receive services pursuant to a contract with the HMO or prepaid health clinic during the previous calendar year.

- Each hospital and ambulatory surgical center licensed under ch. 395, F.S., as a condition of licensure, must pay to the center an amount equal to $1 for each individual during the previous 12 months who was an inpatient discharged by a hospital or who was a patient discharged by an ambulatory surgical center.
- Each nursing home licensed under part II, ch. 400, F.S., assisted living facility licensed under part III, ch. 400, F.S., home health agency licensed under part IV, ch. 400, F.S., hospice licensed under part VI, ch. 400, F.S., prescribed pediatric extended care center licensed under part IX, ch. 400, F.S., and health care services pool licensed under part XII, ch. 400, F.S., must pay to the center an amount equal to $1 for each individual served by each aforementioned entity during the previous 12 months.
- Each application and renewal fee for each license and each fee for certification or recertification for each person licensed or certified under ch. 401, F.S., (emergency medical services or personnel) or under ch. 404, F.S., (radiological technicians) and each person licensed as a health care practitioner under the Division of Medical Quality Assurance in the Department of Health shall be increased by the amount of $1 for each year or part thereof for which the license or certification is issued.

The payment is due on April 1 of each year and must be accompanied by a certification under oath by the chief executive officer that states the number of individuals upon which payment is based. The Department of Health must make payment to the center on April 1 of each year in the amount of the total received from the additional fee assessed on health care professional licensees during the preceding 12 months. The entity may be directed by the center to provide an independent audit of the certification within 90 days. An interest rate at the annualized rate of 18 percent is charged on any amount due that is not received by the center within 30 days after April 1. If payment is not received within 60 days after interest is charged, the center must notify the agency having regulatory jurisdiction over the entity that payment has not been received. Any entity that refuses to make the payment is subject to forfeiture of its certificate of authority or license, as appropriate.

The center must develop a business and financing plan to accomplish its objectives and may enter into affiliations with universities for any purpose. State agencies may contract with the center on a sole source basis for projects to improve the quality of program administration, such as the implementation of an electronic medical record for Medicaid program recipients. Travel and per diem paid with center funds must be in accordance with s. 112.061, F.S. The center may use state purchasing and travel contracts and the state communications system in accordance with s. 282.105(3), F.S. The center may acquire, enjoy, use and dispose of patents, copyrights, trademarks, and any licenses, royalties, and other rights or interests thereunder or therein.

The center must submit an annual report to the Governor and the presiding officers of the Legislature no later than October 1 of each year. The initial report must include any recommendations regarding revisions in the definition of adverse incidents in s. 395.0197, F.S., and the reporting of such adverse incidents by licensed facilities.

The center may establish and manage an operating fund for the fiscal management of the corporation. Upon dissolution of the corporation, any remaining cash balances of any state funds revert to the General Revenue Fund, or other state funds as provided by law. All books, records, and audits of the center shall be open to the public unless exempted by law. The center must

furnish an annual audited report to the Governor and Legislature by March 1 of each year. The center must consult with various parties, as appropriate, within the health care industry and educational institutions.

Section 4. Adds a new subsection (3) to s. 395.004, F.S., to provide that a facility licensed under ch. 395, F.S., may apply for certification of a program that reduces patient adverse incidents. The Agency for Health Care Administration in consultation with the Office of Insurance Regulation must develop criteria for such certification. Insurers are required to submit rates that reflect a discount for implementing such a program. The Office of Insurance Regulation is required to review these adjusted rates and must consider whether the implemented program is otherwise part of a risk management program offered by an insurance company or self-insurance plan providing medical malpractice coverage.

Section 5. Creates s. 395.0056, F.S., to provide that when the Agency for Health Care Administration receives, pursuant to s. 766.106, F.S., a complaint alleging medical malpractice filed against a hospital, it is to review its files to determine whether the hospital has complied with the adverse incident reporting requirements of s. 395.0197, F.S., and whether the incident that is the basis for the complaint can be the subject of a disciplinary proceeding.

Section 6. Amends s. 395.0193, F.S., relating to peer review, to add mental or physical abuse of a nurse or other staff member as grounds for discipline of a staff member or physician who delivers health care services at a hospital, ambulatory surgical center, or mobile surgical facility. This section also limits the monetary liability of a person who participated in peer review under this section or who was a subject of a peer review action to an amount that must not exceed $250,000 except when intentional fraud is involved.

Section 7. Amends s. 395.0197, F.S., to require copies of all reports of adverse incidents submitted to the Agency for Health Care Administration by hospitals and ambulatory surgical centers to be forwarded by the agency to the Florida Center for Excellence in Health Care for analysis by experts who may make recommendations regarding the prevention of such incidents. Such information shall remain confidential as otherwise provided by law. The bill further revises the requirements for the internal risk management program that every hospital, ambulatory surgical center, or mobile surgical facility must implement to: require facilities to report the name and judgments entered against each health care practitioner for which it assumes liability; require a facility to have a system by which the patient, patient's family member, or patient's designated representative is notified that the patient was the subject of an adverse incident; and require a facility at which an incident of sexual abuse occurs to offer the victim of the abuse testing for sexually transmissible diseases, if appropriate, and provide all such testing at no cost to the victim.

Section 8. Creates s. 395.1012, F.S., to require each licensed hospital, ambulatory surgical center and mobile surgical facility to adopt a patient safety plan. Any plan adopted to implement the requirements of 42 CFR 482.21 shall be deemed to comply with this requirement. Each licensed facility must appoint a patient safety officer and a patient safety committee. The officer and committee shall promote the health and safety of patients, review and evaluate the quality of patient safety measures used by the facility, and assist in the implementation of the facility safety plan.

Section 9. Amends s. 456.025, F.S., relating to the Department of Health's or board's authority to set license renewal fees for health care practitioners within the department's Division of Medical Quality Assurance, to delete provisions that limit the department's or board's authority to set license renewal fees which are no more than 10 percent greater than the fee imposed during the previous 2-year licensure period and that are no more than 10 percent greater than the actual cost to regulate a profession.

Section 10. Creates an undesignated section of law to require the Agency for Health Care Administration to conduct or contract for a study to determine what information is most feasible to provide the public to compare state-licensed hospitals on certain inpatient quality indicators developed by the federal Agency for Healthcare Research and Quality. The Agency for Health Care Administration or the study contractor must refer to hospital quality reports published in New York and Texas as a guide during the evaluation. The concepts that the study must address are specified. The Agency for Health Care Administration must consider the input of interested parties, including hospitals, physicians, consumer organizations, and patients. The agency must submit the final report to the Governor and the presiding officers of the Legislature by January 1, 2004.

Section 11. Creates s. 395.1051, F.S., to require the risk manager, or his or her designee, of each facility licensed under ch. 395, F.S., to inform each patient or personal representative of the patient of adverse incidents that result in harm to the patient. Such notice does not constitute acknowledgement or admission of liability nor can it be introduced as evidence.

Section 12. Creates s. 456.0575, F.S., to require every Florida-licensed health care practitioner to inform each patient or personal representative of the patient of adverse incidents that result in harm to the patient. Such notice does not constitute acknowledgement or admission of liability nor can it be introduced as evidence.

Section 13. Amends s. 456.026, F.S., relating to the annual report of the Department of Health's Division of Medical Quality Assurance, to require the department to publish the report to its website simultaneous with delivery of the report to the presiding officers of the Legislature. The report must be directly accessible on the department's Internet homepage highlighted by easily identifiable links. The report must also include additional statistics and relevant information detailing: the number of health care practitioners licensed by the department or otherwise authorized to provide services in Florida, if known to the department; and information on the professional liability claims and actions reported by insurers as closed claims for medical physicians, osteopathic physicians, podiatric physicians or dentists.

Section 14. Amends s. 456.039, F.S., relating to practitioner profiles, to require licensed physicians to provide to the Department of Health relevant professional qualifications to be included in that physician's profile.

Section 15. Amends s. 456.041, F.S., relating to practitioner profiles, to require the Department of Health to develop a format to compile uniformly any information submitted by certain health care practitioners.

The Department of Health must update the practitioner profile within 45 business days with information that the practitioner is required to provide and verify. Each profile must indicate whether the criminal history information included in the practitioner profile is, or is not, corroborated by a criminal history check. The department or the board having regulatory authority over the practitioner must investigate any information received and limitations under current law which narrow such investigations to "reasonable grounds to believe that the practitioner has violated any law that relates to the practitioner's practice" are deleted.

The department must provide in each practitioner profile an easy-to-read narrative description of every final disciplinary action taken against the practitioner that explains the administrative complaint and the final discipline imposed on the practitioner. The department must include a hyperlink to each final order listed in its website report of dispositions of recent disciplinary actions taken against practitioners. Professional liability claims must be reported by medical physicians and osteopathic physicians which have been incurred during the previous 10 years for any claims that exceed $100,000 and the department must include such information in the practitioner profile. The department must include a hyperlink to comparison reports of closed claims filed against a practitioner in the practitioner's profile.

The department must include in the practitioner profiles the date of any disciplinary action taken by a licensed hospital or ambulatory surgical center against a practitioner. The department must state whether the action related to professional competence and whether it related to the delivery of services to a patient.

The Department of Health would no longer have to consult with the board having jurisdiction over a practitioner to include information in the practitioner's profile that is a public record and relates to the practitioner's ability to competently practice his or her profession. The department must make a practitioner's profile available at the end of a 30-day period under which the practitioner may review and verify the factual accuracy of the contents of the profile. The practitioner is required to review and verify the accuracy of his or her profile and is made subject to a fine of up to $100 per day for a failure to verify the profile contents and to correct any factual errors in his or her profile within the 30-day period.

The department must include a statement in each profile that has not been reviewed by the practitioner stating that the practitioner has not verified the information contained in the profile. Each profile must contain an easy-to-read explanation of any disciplinary action taken and the reason that sanctions were imposed. The department may provide one link in each profile to a practitioner's professional website if the practitioner requests that such a link be included in his or her profile.

Section 16. Amends s. 456.042, F.S., to revise requirements for a practitioner to submit updates of required information within 15 days after the final activity that renders such information a fact. An updated profile is subject to the same requirements as an original profile.

Section 17. Amends s. 456.049, F.S., to revise requirements for medical physicians, osteopathic physicians, podiatric physicians, and dentists to report to the Department of Health claims that are not reported by insurers as "closed claims" under s. 627.912, F.S., to no longer require the reporting of claims resulting in no payment on behalf of the licensed practitioner. The liability

claims which must be reported under the section are limited to claims with a threshold amount equal to $50,000 or more for claims reported to the Department of Health by medical physicians, osteopathic physicians, or podiatric physicians. The threshold amount of claims reported by dentists to the Department of Health is increased to $25,000 or more. The Department of Health must forward such information to the Office of Insurance Regulation.

Section 18. Amends s. 456.051, F.S., to require the Department of Health, within 45 calendar days of its receipt, to make available as part of a practitioner's profile any report of a claim for damages filed with the department by a practitioner or his or her insurer as a closed claim or any bankruptcy proceeding involving the practitioner that the department has obtained.

Section 19. Amends s. 456.057, F.S., relating to ownership and control of patient records, to authorize the Department of Health to obtain patient records pursuant to subpoena without written authorization from the patient, if the patient refuses to cooperate, is unavailable, or fails to execute a patient release. The department's access is conditioned on the department and the probable cause panel of the appropriate board having reasonable cause to believe that a health care practitioner has committed certain specified acts.

Section 20. Adds a new subsection (4) to s. 456.063, F.S., to authorize the Department of Health and each board to adopt rules to implement the requirements for reporting allegations of sexual misconduct, including rules to determine the sufficiency of the allegations.

Section 21. Creates an undesignated section of law to provide rulemaking authority to each health care practitioner licensing board within the Department of Health to adopt rules governing the prescribing of drugs to patients via the Internet or other electronic means.

Section 22. Amends s. 456.072, F.S., to authorize health care practitioner regulatory boards or the Department of Health to determine the amount of costs related to investigation and prosecution to be assessed in disciplinary cases involving a health care practitioner after its consideration of an affidavit of itemized costs and any written objections thereto. Such costs related to the investigation and prosecution include, but are not limited to, salaries and benefits of personnel, and costs related to the time spent by an attorney and other personnel working on a case. The burden of proof in an administrative hearing under ch. 120, F.S., relating to discipline of a health care practitioner, that the Department of Health and each board must meet to prove a violation, is changed from a "clear and convincing evidence" standard to the "greater weight of the evidence" standard, which is the same burden of proof for a medical malpractice case before a court of competent jurisdiction.

Section 23. Amends s. 456.073, F.S., to provide that the Department of Health may investigate paid claims information about medical and osteopathic physicians that have been reported within the previous 10 years where the indemnity paid is greater than $50,000. The right of a licensed health care practitioner to elect a formal hearing is revised from any circumstance during a proceeding in which a party raises an issue of disputed fact during an informal hearing to affirmatively require the licensee to dispute an issue of material fact and request a formal hearing within 45 days after service of the administrative complaint.

Section 24. Amends s. 456.077, F.S., to specify that each citation issued to a licensed health care practitioner by the Department of Health for a first offense and not contested by the practitioner does not constitute discipline for a first offense.

Section 25. Amends s. 456.078, F.S., to require each health care practitioner regulatory board or the Department of Health to designate violations, including standard-of-care violations, that are appropriate for mediation. Complaints where harm caused by the licensee is economic in nature or can be remedied by the licensee must be designated as mediation offenses.

Section 26. Amends s. 458.320, F.S., relating to the financial responsibility requirements for medical physicians to require a physician to demonstrate financial responsibility as a condition of maintaining an active license. Medical physicians who chose to demonstrate financial responsibility by obtaining and maintaining professional liability or establishing an irrevocable letter of credit or escrow may not use the monies for litigation costs or attorney's fees for the defense of any medical malpractice claim. Medical physicians who perform surgery in an ambulatory surgical center are required to establish financial responsibility by one of several specified methods. If any judgments or settlement are pending at the time that physician has his license suspended, those judgments or settlements must be paid as required by this section unless otherwise mutually agreed upon by the parties. This requirement does not abrogate a judgment debtor's obligation to satisfy the entire amount of any judgment. Any physician who is not actively practicing in Florida who resumes or initiates practice in Florida must fulfill the financial responsibility requirements of this section before doing so. The requirements for disclosure are revised for medical physicians who do not carry professional liability insurance. Notwithstanding any other provision of this section, the DOH must suspend the license of any physician against whom has been entered a final judgment, arbitration award, or other order or who has entered into a settlement agreement to pay damages arising out of a claim for medical malpractice, if all appellate remedies have been exhausted and payment up to amounts required by this section has not been made within 30 days after the entering of such judgment, award, or order or agreement, until proof of payment is received by the department. This requirement does not apply to a physician who has met the financial responsibility requirements by obtaining medical malpractice insurance.

Section 27. Amends s. 459.0085, F.S., relating to the financial responsibility requirements for osteopathic physicians, to require an osteopathic physician to demonstrate financial responsibility as a condition of maintaining an active license. The requirements for disclosure are revised for medical physicians who do not carry professional liability insurance. This requirement does not apply to an osteopathic physician who has met the financial responsibility requirements by obtaining medical malpractice insurance. If any judgments or settlement are pending at the time that osteopathic physician has his license suspended, those judgments or settlements must be paid as required by this section unless otherwise mutually agreed upon by the parties. This requirement does not abrogate a judgment debtor's obligation to satisfy the entire amount of any judgment. Any osteopathic physician who is not actively practicing in Florida who resumes or initiates practice in Florida must fulfill the financial responsibility requirements of this section before doing so. Notwithstanding any other provision of this section, the DOH must suspend the license of any osteopathic physician against whom has been entered a final judgment, arbitration award, or other order or who has entered into a settlement agreement to pay damages arising out of a claim for medical malpractice, if all appellate remedies have

been exhausted and payment up to amounts required by this section has not been made within 30 days after the entering of such judgment, award, or order or agreement, until proof of payment is received by the department.

Section 28. Creates an undesignated section of law to extend immunity from civil liability to each member of, or health care professional consultant to, any committee, board, group, commission, or other entity for any act, decision, omission, or utterance done or made in the performance of his or her duties while serving as a member or consultant to such committee, board, group, commission, or other entity established and operated for purposes of quality improvement review, evaluation, and planning in a state licensed health care facility. The act, decision, omission, or utterance may not be made or done in bad faith or with malicious intent. Such entities must function primarily to review, evaluate, or make recommendations relating to:

- The duration of patient stays in health care facilities;
- The professional services furnished with respect to the medical, dental, psychological, podiatric, chiropractic, or optometric necessity for such services;
- The purpose of promoting efficient use of available health care facilities and services;
- The adequacy or quality of professional services;
- The competency and qualifications for professional staff privileges;
- The reasonableness or appropriateness of charges made by or on behalf of health care facilities; and
- Patient safety.

The committee, board, group, commission, or other entity must be established in accordance with requirements of the Joint Commission on Accreditation of Healthcare Organizations, established and duly constituted by one or more public or licensed private hospitals or behavioral health agencies, or established by a governmental agency.

Section 29. Creates an undesignated section of law to establish a privilege from discovery or introduction into evidence in any civil or administrative action for patient safety data.

The terms “patient safety data” and “patient safety organization” are defined.

A patient safety organization must promptly remove all patient-identifying information after receipt of a complete patient safety data report unless such organization is otherwise permitted by state or federal law to maintain such information. The exchange of patient safety data among health care providers or patient safety organizations which does not identify any patient shall not constitute a waiver of any privilege established under this section. Reports of patient safety data to patient safety organizations does not abrogate obligations to make reports to the Department of Health, the Agency for Health Care Administration, or other state or federal regulatory agencies. Employers are prohibited from taking retaliatory actions against an employee who in good faith makes a report of patient safety data to a patient safety organization. The patient safety privilege does not make information, documents or records otherwise available from original sources immune from discovery or use in any civil or administrative action because it was collected, analyzed, or presented to a patient safety organization. The privilege does not prevent any person who testifies before a patient safety organization or members of the organization from testifying about any matter within his or her knowledge.

Section 30. Creates an undesignated section of law to require each final settlement relating to medical malpractice to include the following statement: "The decision to settle a case may reflect the economic practicalities pertaining to the cost of litigation and is not, alone, an admission that the insured failed to meet the required standard of care applicable to the patient's treatment. The decision to settle a case may be made by the insurance company without consulting its client for input unless otherwise provided by the insurance policy."

Section 31. Creates an undesignated section of law to require the Office of Insurance Regulation to revise its closed claim form for readability at the 9th grade level. The office must compile annual statistical reports that provide data summaries of all closed claims, including the number of closed claim files pertaining to the referent health care professional or health care entity, the nature of the errant conduct, the size of payments, and the frequency and size of noneconomic damage awards. The office must develop annualized historical statistical summaries beginning with the 1976 state fiscal year and publish these reports on its website no later than the 2005 state fiscal year. Medical physicians, osteopathic physicians, podiatric physicians, dentists, and physician assistants must report to the Office of Insurance Regulation and the Department of Health any claim or action for damages for personal injury alleged to have been caused by error, omission, or negligence in the performance of such licensee's professional services or based on a claimed performance of professional services without consent if the claim was not covered by an insurer required to report under s. 627.912, F.S., and resulted in: a final judgment or settlement in any amount. Reports must be filed with the Office of Insurance Regulation no later than 60 days following the occurrence of any final judgment or settlement.
Health professional reports must include information specified in the bill and any other information that the Office of Insurance Regulation requires to analyze and evaluate the nature, causes, location, cost, and damages involved in professional liability cases.

Section 32. Amends s. 458.331, F.S., to increase the threshold amount from $25,000 to $50,000 of indemnities paid within a 5-year period for purposes of the violation of gross or repeated malpractice applicable to medical physicians. To conform, the threshold amount for medical physician closed claims that must be investigated by the Department of Health is increased from $25,000 to $50,000. Requirements for the burden of proof in the discipline of physicians and physician assistants that the Department of Health must meet to prove a violation are revised from a "clear and convincing evidence" standard to the "greater weight of the evidence" standard, when revoking or suspending the license of a medical physician or physician assistant.

Section 33. Amends s. 459.015, F.S., to increase the threshold amount from $25,000 to $50,000 of indemnities paid within a 5-year period for purposes of the violation of gross or repeated malpractice applicable to osteopathic physicians. To conform, the threshold amount for osteopathic physician closed claims that must be investigated by the Department of Health is increased from $25,000 to $50,000. Requirements for the burden of proof in the discipline of osteopathic physicians and physician assistants that the Department of Health must meet to prove a violation are revised from a "clear and convincing evidence" standard to the "greater weight of the evidence" standard, when revoking or suspending the license of an osteopathic physician or physician assistant.

Section 34. Amends s. 460.413, F.S., to change the burden of proof in the discipline of chiropractic physicians that DOH must meet to prove a violation from a "clear and convincing evidence" standard to the "greater weight of the evidence" standard, when revoking or suspending the license of a chiropractic physician.

Section 35. Creates an undesignated section to express legislative intent that the reduction of the burden of proof in medical disciplinary cases to the level of greater weight of the evidence is necessary to protect the health, safety, and welfare of medical patients in Florida. Legislative intent is declared that there is an overwhelming public necessity to protect medical patients which far overrides any purported property interest in a license to practice as a health care practitioner in Florida. Legislative intent is declared that such a license to practice as a health care professional in Florida is a privilege, not a right, and that disciplinary action relating to scope of practice issues in particular is remedial and protective, not penal, in nature. The Legislature specifically reverses case law to the contrary.

Section 36. Creates an undesignated section of law to require the Division of Administrative Hearings to designate at least two administrative law judges with certain qualifications to preside over actions involving health care practitioner discipline.

Section 37. Amends s. 461.013, F.S., to increase the threshold amount from $10,000 to $50,000 of indemnities paid within a 5-year period for purposes of the violation of gross or repeated malpractice applicable to podiatric physicians. To conform, the threshold amount for podiatric physician closed claims that must be investigated by DOH is increased from $25,000 to $50,000.

Section 38. Amends s. 466.028, F.S., to increase the threshold amount from $5,000 to $25,000 of indemnities paid within a 5-year period for purposes of defining "dental malpractice" applicable to a ground for discipline relating to being guilty of incompetence or negligence by failure to meet minimum standards of performance in the practice of dentistry.

Section 39. Amends s. 624.462, F.S., to allow 10 or more health care providers to form a commercial self-insurance fund under ss. 624.460-624.488, F.S. The definition of health care provider that is cited in s. 627.351(4)(h), F.S., includes a hospital, physician, osteopath, chiropractor, naturopath, nurse, midwife, clinical laboratory, physician assistant, physical therapist, physical therapist assistant, health maintenance organization, ambulatory surgical center, blood bank, plasma center, industrial clinic, renal dialysis facility, and other medical facilities meeting certain criteria, as well as professional associations, partnerships, corporations, joint ventures, or other associations for professional activity by health care providers.
The bill, in effect, allows 10 or more health care providers to form a commercial self-insurance fund, where today such a fund for medical malpractice could be formed only if it is formed by a not-for-profit trade association, industry association, or professional association of employers or professionals which has a constitution or bylaws, which is incorporated in Florida, and which has been organized for purposes other than that of obtaining or providing insurance and operated in good faith for a continuous period of 1 year. Otherwise, all of the current requirements for such a fund, as described in the Present Situation section of this analysis, would continue to apply.

Section 40. Amends s. 627.062, F.S., relating to rate filings for property, casualty, and surety insurance, including medical malpractice insurance. The bill provides that an insurer that makes

a medical malpractice rate filing would not be permitted to require arbitration of the rate filing after the rate has been disapproved by the Office of Insurance Regulation. More specifically, an insurer is currently allowed to require arbitration after "any action with respect to a rate filing that constitutes agency action," which would no longer be allowed for an insurer that makes a medical malpractice rate filing. Therefore, if the office disapproved a medical malpractice rate filing, the insurer would only have the options available under the Administrative Procedure Act to request a formal or informal hearing.

The bill also creates additional requirements for rate filings of medical malpractice insurers. The insurer cannot include in the base rate nor use to justify a rate or rate change:

- a portion of a judgment or settlement paid as a result of bad faith actions of the insurer;
- a portion of a judgment in which punitive damages were awarded against the insurer; or
- taxable costs or attorneys fees which relate to the assessing of damages against the insurer for bad faith actions.

Rate filing for medical malpractice insurance would also be subject to the following:

- in determining whether a rate is excessive, inadequate, or discriminatory, the Office of Insurance Regulation must consider loss experience solely for Florida or give greater credibility to Florida loss experience; and
- the insurer must apply a discount or surcharge to the rate based on the health care provider's loss experience.

Section 41. Amends s. 627.0645, F.S., to require medical malpractice insurers to make an annual base filing to the Office of Insurance Regulation and to report deviations from such base rate filings.

Section 42. Creates an undesignated section to require OPPAGA to complete a study of the eligibility requirements for a birth to be covered under the Florida Birth-Related Neurological Injury Compensation Association.

Section 43. Creates s. 627.0662, F.S., to prohibit excessive profits for medical malpractice insurers and to provide a mechanism for reviewing the gains and losses of insurance companies to determine if any insurance company has realized excessive profits. The bill provides for refunds to policyholders on a pro rata basis in the event it is determined the insurance company has realized excessive profits. In general, an insurer would be deemed to have earned excess profits if its actual underwriting profit for the previous three years is greater than the insurer's anticipated underwriting profit (as reflected in its approved rate filings) plus 5 percent of earned premiums for those 3 years.

Section 44. Amends s. 627.357, F.S., to eliminate a prohibition against creating medical malpractice self-insurance funds after October 1, 1992. An application to form a medical malpractice self-insurance fund must be filed with the Office of Insurance Regulation. The Financial Services Commission must ensure that medical malpractice self-insurance funds remain solvent and provide insurance coverage purchased by participants. The Financial Services Commission is granted rulemaking authority to implement its responsibilities over medical malpractice self-insurance trust funds.

Section 45. Amends s. 627.4147, F.S., relating to medical malpractice insurance contracts, to require the insurer or self-insurer to notify the insured no less than 90 days, rather than 60 days, prior to the effective data of cancellation or nonrenewal of a policy or contract. In addition, the insurer or self-insurer must provide 60-days notice prior to the effective date of a rate increase. Currently, under s. 627.4133, F.S., all property and casualty insurers, which includes medical malpractice insurers, must provide at least 45-days written notice of the renewal premium.

The bill deletes a prohibition against medical malpractice insurers requiring the insured to be a member in good standing of a duly recognized state or local professional society of health care providers which maintains a medical review committee.

This bill authorizes medical and osteopathic physicians, licensed under ch. 458 and 459, F.S., to purchase insurance allowing the physician input to the decision-making process to settle claim disputes.

The changes to s. 627.4147, F.S., become effective October 1, 2003.

Section 46. Creates s. 627.41491, F.S., to require the Office of Insurance Regulation to provide health care providers with a comparison of the rate in effect for each medical malpractice insurer and self-insurer and the Florida Medical Malpractice Joint Underwriting Association (FMMJUA). The comparison chart is to be made available to the public through the Internet and other commonly used means of distribution no later than July 1 of each year.

Section 47. Creates s. 627.41492, F.S., to require the Office of Insurance Regulation to prepare annually and post on the Internet a report which analyzes closed claim information and medical malpractice insurer annual and quarterly financial reports.

Section 48. Creates s. 627.41493, F.S., to require medical malpractice insurance rate rollbacks. For any coverage for medical malpractice insurance subject to ch. 627, F.S., that is issued or renewed on or after July 1, 2003, and before July 1, 2004, every insurer must reduce its charges to levels that were in effect on January 1, 2002. According to the Office of Insurance Regulation, this equates to about a 20 percent rate rollback compared to rates that are currently in effect.

For policies issued or renewed on or after July 1, 2003, and before July 1, 2004, rates and premiums that have been reduced as prescribed above may only be increased if the director of the Office of Insurance Regulation finds, after a hearing, that the rate reduced pursuant to this section would result in an inadequate rate. Any such increase must be approved by the director of the Office of Insurance Regulation prior to being used.

Section 49. Creates an undesignated section of law to provide a trigger to effect the operation of the Florida Medical Malpractice Insurance Fund. If the director of the Office of Insurance Regulation, as of July 1, 2004, determines that the rates of medical malpractice insurers with a combined market share of 50 percent or greater, as measured by net written premium in Florida for the most recent calendar year have been reduced to the January 1, 2002, level, but have not remained at that level for the year beginning July 1, 2003, or that such medical malpractice insurers have proposed increases that are greater than 15 percent in either of the next two years

beginning July 1, 2004, then the Florida Medical Malpractice Insurance Fund shall begin providing coverage.

Section 50. Creates the Florida Medical Malpractice Insurance Fund (fund), effective October 1, 2003. However, the fund would not begin offering coverage unless it is triggered pursuant to section 49. This fund is to be a primary medical malpractice insurance carrier, but is also required to offer excess coverage above specified large deductible amounts. The bill provides for findings and purpose; definitions; administration by a board of governors; approval of a plan of operation by the Office of Insurance Regulation; investment of funds; limits of coverage; the offering of excess coverage for specific underwriting provisions; factors to be addressed in the setting of premium rates by the fund, including that there should be no factor for profits and that the anticipated future investment income of the fund should be based on an average of the actual income of the fund for the prior seven years; a requirement that the State Board of Administration invest one-third of the moneys in the fund and that the Division of Treasury of the Department of Financial Services invest two-thirds of the funds; an exemption from surplus requirements, premium writing limitations, and deposit requirements to which authorized insurers are subject; a tax exemption from state corporate income and premium taxes and for the fund to seek federal tax-exempt status; an initial capitalization of $100 million derived from a loan from the Florida Birth-Related Neurological Injury Compensation Fund, with repayment commencing during the fourth year of operation; oversight by the Financial Services Commission; termination of the fund 10 years from the date the fund begins offering coverage; and reversion of remaining assets back to the state's General Revenue Fund.

Section 51. Provides that, if the Florida Medical Malpractice Insurance Fund begins offering coverage, all medical and osteopathic physicians must obtain and maintain professional liability coverage in an amount not less than $250,000 per claim and $500,000 in the aggregate from specified entities authorized to underwrite such coverage including the Florida Medical Malpractice Insurance Fund. Additionally, this section exempts physicians who are currently exempt from financial responsibility requirements under ss. 458.320(5) and 459.0085(5), F.S.

Section 52. Creates s. 627.41495, F.S., to require consumer participation in medical malpractice insurance rate review. Medical malpractice insurers, self-insurers, or risk retention groups, upon the filing of a proposed rate change that would result in an average statewide increase of 25 percent or more, must give notice to the public and to its insureds. The rate filing must be available for public inspection. If the insureds request a hearing within 30 days after the mailing of the notification of the proposed rate changes, the director of the Office of Insurance Regulation must hold a hearing within 30 days after such request. Any consumer may participate in the hearing. The Office of Insurance Regulation is authorized to adopt rules to implement these provisions.

Section 53. Creates an undesignated section of law to provide that medical malpractice insurers are to submit rate filings effective January 1, 2004, which reduce rates by a presumed factor that reflects the impact of the changes enacted by the Legislature in 2003. The Office of Insurance Regulation is to review the rate filings using generally accepted actuarial techniques and standards. Insurers are to also file along with that rate filing an alternative rate with supporting evidence when such insurer contends that the rate required under this section is excessive, inadequate, or unfairly discriminatory.

Section 54. Amends s. 627.912, F.S., to increase the threshold amount to $50,000 or more for closed claims reported to the Department of Health for medical physicians, osteopathic physicians, or podiatric physicians. The threshold amount is increased to $25,000 or more for closed claims reported to the Department of Health for dentists. The Financial Services Commission is directed to adopt rules for the submission of additional information to assist the Office of Insurance Regulation in its analysis of professional liability cases. The bill requires the imposition of a fine against an insurer that violates the closed claim reporting requirements and the maximum fine that may be imposed is increased from $1,000 per case to $10,000 per case.

Section 55. Creates s. 627.9121, F.S., to require each entity that makes payment under a policy of insurance, self-insurance, or otherwise in settlement or partial settlement of, or in satisfaction of a judgment in, a medical malpractice action or claim and that is required to report information to the National Practitioner Data Bank under 42 U.S.C. section 11131 to also report the same information to the Office of Insurance Regulation. The Office of Insurance Regulation must include such information in the data that it compiles under s. 627.912, F.S. The office must compile and review the data collected pursuant to this section and must assess an administrative fine on any entity that fails to fully comply with the requirements imposed by law.

Section 56. Amends s. 766.102, F.S., to remove language that allowed a health care provider to testify as an expert in any action even if he or she was *not* a "similar health care provider" but possessed sufficient training, experience, and knowledge as a result of practice or teaching in a specialty of the defendant or practice or teaching in a related field of medicine to be able to provide expert testimony. The term "similar health care provider" is redefined to require expert witnesses to have the same or similar *in-kind training, experience, practice, education, and certification and licensure* as the person in question prior to offering an expert opinion or testifying to the prevailing professional standard of care in medical malpractice actions whether the person is a specialist, nonspecialist, or a general practitioner.

Specifically, if the incident involves a *specialist*, the expert witness must specialize in the same or a similar specialty and must have devoted professional time during the three previous years to active clinical practice or consultation with same or similar health professionals, or to teaching in the same or a similar health profession at an accredited health profession school or residency program, or to clinical research at a program at an accredited health professional or teaching hospital in the same or a similar specialty. If the incident involves a nonspecialist, the expert witness must have devoted professional time during the three previous years to active clinical practice or consultation with the same or similar health professionals, or to teaching in an accredited residency program in the same or a similar health profession. If the incident involves a general practitioner, then the expert witness must have devoted professional time within the five preceding years to active clinical practice or consultation, to academic teaching at an accredited health professional school or residency program, or to clinical research at an accredited medical school or teaching hospital.

A physician licensed under chapter 458 or 459, F.S., can qualify as an expert witness under the law and testify to the applicable standard of care for support medical staff such as nurses, nurse practitioners, nurse midwives, and physician assistants. In medical malpractice actions against a health care or medical facility, a person can offer expert witness testimony on the appropriate

standard of care relating to administrative and other nonclinical issues if the person has substantial knowledge of such matters. If a health care provider is evaluating, treating, or diagnosing a condition not within his or her specialty, for purposes of the expert witness qualification, a specialist within that area is deemed a similar health care provider.

An expert witness is prohibited from testifying on a contingency fee basis. An attorney who proffers a person as an expert witness must certify that the expert has not been found guilty of fraud or perjury in any jurisdiction. The bill specifies that the trial court is not limited in its qualification of an expert witness to the qualifications in this section.

Section 57. Amends s. 766.106, F.S., effective October 1, 2003, and applicable to any action arising from a medical malpractice claim initiated by a notice of intent to litigate received by a potential defendant in a medical malpractice case on or after that date, to provide that with regard to insurance company bad-faith causes of action arising out of medical malpractice claims, the action must be brought pursuant to common law and not under s. 624.155, F.S. An insurer may not be held to have acted in bad faith for failure to timely pay its policy limits if it tenders its policy limits and meets reasonable conditions of settlement before the conclusion of the presuit screening period for a medical malpractice action, during an extension provided therein, during a period of 270 days thereafter, or during a 90-day period after the filing of an amended medical malpractice complaint alleging new facts previously unknown to the insurer. If a case is set for trial within 1 year from the date of filing of the claim, an insurer may not be held in bad faith if policy limits are tendered 60 days or more prior to trial. Legislative intent is expressed to encourage all insurers, insureds, and their assigns and legal representatives to act in good faith during a medical negligence action, both during the presuit period and the litigation.

Section 58. Amends s. 766.106, F.S., effective October 1, 2003, and applicable to notices of intent to litigate sent on or after that date, to revise several presuit requirements. First, a claimant's presuit notice must include: 1) a list of all known health care providers seen by the claimant subsequent to the injury giving rise to the claim of malpractice, 2) a list of all known health care providers who evaluated or treated the claimant the two previous years, and 3) copies of all medical records relied upon by the expert witness who verified the medical malpractice claim.

Additionally, any party can submit for response a maximum of 30 questions including subparts. A response is due within 20 days after receipt of the questions. The section also provides that the defendant insurer's offer of admission of liability and offer to arbitrate means that liability is admitted and arbitration will only be held on the issue of damages once the offer is accepted.

If the complaint involves a hospital, ambulatory surgical center, or mobile surgical facility, the claimant in a medical malpractice suit must file a copy of the complaint with the Agency for Health Care Administration and the agency must review the complaint to see if involves conduct by a licensed facility which may be subject to an administrative sanction.

Section 59. Amends s. 766.108, F.S., to require mandatory mediation in medical negligence actions if voluntary binding arbitration has not been agreed to by the parties. Within 120 days after suit is filed, the parties must engage in mediation in accordance with s. 44.102, F.S. The Florida Rules of Civil Procedure will apply to such mediation.

Section 60. Creates s. 766.118, F.S., that provides with respect to a cause of action for personal injury or wrongful death resulting from an occurrence of medical negligence, including voluntary binding arbitration, damages recoverable for noneconomic losses to compensate for pain and suffering, inconvenience, physical impairment, mental anguish, disfigurement, loss of capacity for enjoyment of life, and all other noneconomic damages may not exceed $500,000 per defendant, regardless of the number of claimants involved in the action subject to the limitations set forth in the section.

A trier of fact may award noneconomic damages under this section in excess of the $500,000 limit in cases where medical negligence results in certain catastrophic injuries, including death, severe and permanent brain damage, coma, paralysis, quadriplegia, paraplegia, blindness, or a permanent vegetative state except in those actions involving voluntary binding arbitration.

Section 61. Amends s. 766.202, F.S., to revise the definitions relating to medical negligence actions. The terms "economic damages" and "noneconomic damages" are redefined to provide that the claimant's recovery is limited to the extent the claimant is entitled to recover such damages under general law,[32] including the Wrongful Death Act. This may reduce the range of economic damages recoverable as the damages recoverable under the Wrongful Death Act are limited by s. 768.21, F.S. The loss of earning capacity, past and future medical expenses, past and future loss of services as elements of damages are not available under the Wrongful Death Act.

The term "medical expert" is redefined to mean someone 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 who meets the requirements of an expert witness as set forth in s. 766.102, F.S. This revision will have the effect of changing the criteria for who may provide an expert opinion as to a medical malpractice claim.

The term "periodic payment" is revised to provide that any portion of the periodic payment which is attributable to medical expenses that have not yet been incurred shall terminate upon the death of the claimant. Any outstanding medical expenses incurred prior to the death of the claimant shall be paid from that portion of the periodic payment attributable to medical expenses.

Section 62. Amends s. 766.206, F.S., effective July 1, 2003, and applicable to all causes of action accruing on or after that date, to revise the requirements for a court's review of a medical negligence claim or denial to determine if it rests on a reasonable basis. As part of proceeding under s. 766.206, F.S., the court must additionally ensure that the claimant has completed a review of the claim and has obtained a verified written medical expert opinion by an expert witness as defined in s. 766.202, F.S.

The bill requires the court, in reviewing the defendant's response, to ensure that the defendant has completed a review of the claim and has obtained a verified written medical expert opinion

[32] A law that operates universally throughout the state, uniformly upon subjects as they may exist throughout the state, or uniformly within a permissible classification is a general law. *See* City of Miami v. McGrath, 824 So.2d 143 (Fla. 2002), citing to State ex rel. Landis v. Harris, 120 Fla. 555, 163 So. 237 (Fla.1934).

by an expert witness as defined in s. 766.202, F.S. The bill revises the sanction for any defendant who is not in compliance to require the court to strike the defendant's pleading. The sanction for noncompliance by a defendant under the current law is to strike the defendant's response to the claimant's claim.

Under the bill, the court is directed to report to the Division of Medical Quality Assurance any medical expert submitting an opinion who did not meet the expert witness qualifications in s. 766.202(5), F.S. The court shall, rather than may, refuse to consider the testimony of an expert whose medical expert witness opinion attached to any notice of intent or to any response rejecting a claim has been disqualified three times.

Section 63. Amends s. 766.207, F.S., relating to voluntary binding arbitration of medical negligence claims, to provide that any damages awarded pursuant to arbitration must be awarded as provided by general law, including the Wrongful Death Act, subject to limitations.

Section 64. Adds a new subsection (4) to s. 768.041, F.S., relating to releases or covenants not to sue, to require set-offs at trial following an rejection of an offer to arbitrate in a medical malpractice action, if any defendant shows the court that the plaintiff, or his or her legal representative has delivered a written release or covenant not to sue to any person in partial satisfaction of the damages sued for. The set-off must be made from the amount of the damages set forth in the verdict and before entry of the final judgment. The amount of the setoff must include all sums received by the plaintiff, including economic and noneconomic damages, costs, and attorney's fees.

Section 65 Amends s. 768.13, F.S, the Good Samaritan Act, to revise the circumstances under which immunity from civil liability is extended to specified health care providers. Immunity from civil liability is extended to any health care practitioner who is in a hospital attending to a patient of his or her practice or for business or personal reasons unrelated to direct patient care, and who voluntarily responds to provide care or treatment to a patient with whom the practitioner has no preexisting provider-patient relationship, when such care or treatment is necessitated by a sudden or unexpected situation or by an occurrence that demands immediate medical attention, unless the care or treatment is proven to amount to conduct that is willful and wanton and would likely result in injury so as to affect the life and health of another. Such immunity does not apply to medical care or treatment unrelated to the original situation that demanded immediate medical attention. Legislative intent is expressed to encourage health care practitioners to provide necessary emergency care to all persons without fear of litigation.

The provision extending immunity to physicians acting as staff members or with clinical privileges at a nonprofit medical facility other than a hospital or while performing health screening services and providing treatment or care gratuitously is deleted.

Section 66. Amends s. 768.77, F.S., to provide that in any action for damages based on personal injury or wrongful death arising out of medical malpractice, whether in tort or contract, to which the requirements of part II, ch. 768, F.S., applies, in which the trier of fact determines that liability exists on the part of the defendant, the trier of fact shall, as part of the verdict, itemize the amounts to be awarded to the claimant in the following categories of damages:

- Amounts intended to compensate the claimant for past economic losses; and future economic losses, not reduced to present value, and the number of years or part thereof which the award is intended to cover;
- Amounts intended to compensate the claimant for past noneconomic losses and future noneconomic losses not reduced to present value, and the number or years or part thereof which the award is intended to cover; and
- Amounts awarded to the claimant for punitive damages, if applicable.

The trier of fact in any action for damages arising out of medical malpractice would as part of the verdict, itemize amounts intended for the claimant for past economic losses, future economic losses, past noneconomic losses, and future noneconomic losses.

Section 67. Amends s. 768.81, F.S., to provide that in any action for damages for personal injury or wrongful death arising out of medical malpractice, whether in contract or tort, the trier of fact shall apportion the total fault only among the claimant and all the joint tortfeasors who are parties to the action when the case is submitted to the jury for deliberation and rendition of the verdict.

Section 68. Requires the Office of Program Policy Analysis and Government Accountability and the Office of the Auditor General to conduct an audit of the Department of Health's health care practitioner disciplinary process and closed claims that are filed with the department under s. 627.912, F.S., and to submit a report to the Legislature by January 1, 2004.

Section 69. Creates s. 1004.08, F.S., to require each public school, college, and university that offers degrees in medicine, nursing, or allied health to include in the curricula applicable to such degrees material on patient safety, including patient safety improvement. Material must include, but need not be limited to, effective communication and teamwork; epidemiology of patient injuries and medical errors; medical injuries; vigilance, attention and fatigue; checklists and inspections; automation, technological, and computer support; psychological factors in human error; and reporting systems.

Section 70. Creates s. 1005.07, F.S., to require each private school, college, and university that offers degrees in medicine, nursing, or allied health to include in the curricula applicable to such degrees material on patient safety, including patient safety improvement. Material must include, but need not be limited to, effective communication and teamwork; epidemiology of patient injuries and medical errors; medical injuries; vigilance, attention and fatigue; checklists and inspections; automation, technological, and computer support; psychological factors in human error; and reporting systems.

Section 71. Creates an undesignated section of law to require the Department of Health to convene a workgroup no later than September 1, 2003, to study the current health care practitioner disciplinary process. Provides for membership of the workgroup and that the sponsoring organization is to assume the costs of its member's participation in the workgroup. The workgroup is to submit its report no later than January 1, 2004, to the Governor, the President of the Senate and the Speaker of the House of Representatives.

Section 72. Creates s. 766.1065, F.S., establishing a mandatory medical malpractice presuit production schedule. This schedule provides that within 30 days after service of the presuit notice of intent to initiate medical malpractice litigation, each party must produce medical, hospital, health care, and employment records concerning the claimant and affirmatively certify in writing that the produced records are all available records on the claimant to all other parties. Subpoenas may be issued under the Florida Rules of Civil Procedure to obtain such records. Within 60 days after service of the presuit notice of intent to initiate medical malpractice litigation, all parties must make themselves available for the taking a sworn deposition. However, a deposition taken pursuant to this section may not be used in any civil action for any purpose by any party. Within 120 days after service of the presuit notice of intent to initiate medical malpractice litigation, each party's corroborating medical expert must be made available for the taking a sworn deposition. This expert is to be the same expert to be tendered as the medical expert necessary to comply with the provisions of s. 766.203, relating to presuit investigation of medical negligence claims and defenses by prospective parties. Finally, within 150 days after service of the presuit notice of intent to initiate medical malpractice litigation, all parties must attend in-person mandatory mediation if binding arbitration under ss. 766.106 or 766.207, F.S., is not selected. If an impasse is reached in the mediation, the claimant shall make a request of the Office of Presuit Screening Administration for a hearing to be convened pursuant to s. 766.1066, F.S.

Section 73. Creates s. 766.1066, establishing the Office of Presuit Screening Administration and presuit screening panels. The Office of Presuit Screening Administration (Office) is created to provide administrative support to the panels. It is created in the Department of Health for administrative purposes but the department cannot subject the Office to its control or supervision. The Office is to develop by September 1, 2003, a database of prospective panel members. Funding of the Office for the Fiscal Year 2004-2005 is through an appropriation provided for in section 74 of this bill. Subsequent funding is derived from a service charge equal to 0.5 percent of the amount of every judgment and arbitration award made in a medical malpractice action. The Governor and Cabinet are to appoint the director of the Office and the Administration Commission is to adopt rules to implement the section.

A Presuit Screening Panel is comprised of one consumer, two board certified civil trial lawyers, and two physicians who practice in the same specialty as the defendant physician. Physician and attorney panel members are required to meet certain criteria that demonstrate the necessary level of experience and expertise. Physician and attorney panel members have a limited service requirement and may be reported for failure to attend two panel hearings. Claimants and defendants may challenge panel members and if a panel member is removed, the Office must replace the challenged panel member with one from the same category. Panel members are granted immunity from civil liability for activities done in the course of this section to the extent provided for in s. 768.28, F.S., relating to the waiver of sovereign immunity.

The director of the office shall be appointed by the Governor and the Cabinet. The office must, by September 1, 2003, develop and maintain a database of physicians, attorneys, and consumers available to serve as members of presuit screening panels.

The department and the relevant regulatory boards must assist the office in developing the database. The office must request the assistance of The Florida Bar in developing the database.

The general expenses of the office is funded from a 0.5 percent service charge assessed from the final judgment or arbitration award in each medical malpractice liability case in Florida. All parties in such malpractice actions must in equal parts pay the clerk of the circuit court the service charge when any proceeds are initially disbursed. The clerk must remit the service charges to the Department of Revenue for deposit into the Presuit Screening Administration Trust Fund. The Department of Revenue must adopt rules to administer the service charge.

Requirements are specified for persons to serve on the presuit screening panel. Panel members must receive reimbursement for their travel expenses. The composition of the panel includes:

- a physician, who shall receive credit for 20 hours of continuing medical education for such service and who must reside and practice at least 50 miles from the location where the alleged injury occurred. The physician must have had no more than two judgments for medical malpractice liability against him or here within the preceding 5 years and no more than 10 claims of medical malpractice filed against him or her within the preceding 3 years. The physician must hold an active license in Florida and have been in active practice within the 5-year period prior to selection.
- An attorney who serves on the panel should receive 20 hours of continuing legal education and credit towards pro bono requirements for such service and must reside and practice at least 50 miles from the location where the alleged injury occurred. The attorney must have had no judgments for filing a frivolous lawsuit within the preceding 5 years and must hold an active license in Florida and have held an active license in good standing to practice law for at least 5 years. The attorney must be a board-certified trial lawyer.

Section 74. Authorizes three positions and authorizes the sum of $200,000 from the General Revenue Fund to the Office of Presuit Screening Administration to implement the provisions of this bill establishing the office and providing for the presuit screening panels. The $200,000 includes $147,600 in salaries and benefits, $47,400 in expenses, and $5,000 in capital outlay funding. The appropriations shall be continued from the Presuit Screening Trust Fund of the Department of Health in subsequent years.

Section 75. Appropriates the sum of $687,786 from the Medical Quality Assurance Trust Fund to the Department of Health and authorizes seven positions in the department and appropriates $452,122 from the General Revenue fund to the Agency for Health Care Administration and authorizes five positions in the agency for the purpose of implementing the bill during the 2003-2004 fiscal year.

Section 76. Appropriates the sum of $2.15 million from the Insurance Regulatory Trust Fund in the Department of Financial Services to the Office of Insurance Regulation for the purpose of implementing this act during the fiscal year 2003-2004.

Section 77. Provides that if any law is amended by this act that was also amended by a law enacted at the 2003 Regular Session of the Legislature or in session 2003-A, such laws must be construed as if they had been enacted during the same session of the Legislature, and full effect should be given to each if that is possible.

Section 78. Provides for severability of the provisions of the act in the event that any provision of the act is held invalid.

Section 79. Provides an effective date of July 1, 2003 or upon becoming a law whichever occurs later, except as otherwise expressly provided in the bill. The provisions of the bill will apply retroactively to July 1, 2003, with respect to any action arising from a medical malpractice claim initiated by a notice of intent to litigate received by a potential defendant in a medical malpractice case on or after July 1, 2003.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

The provisions of this bill have no impact on municipalities and the counties under the requirements of Article VII, s. 18 of the Florida Constitution.

B. Public Records/Open Meetings Issues:

Committee Substitute for Senate Bill 4-B makes information contained in patient safety data, as defined in s. 381.0409, F.S., which is held by the Florida Center for Excellence in Health Care and all patient records obtained by the center and any other documents maintained by the center which identify the patient by name confidential and exempt from the Public Records Law. Any portion of a meeting held by the Florida Center for Excellence in Health Care at which such information is discussed is made exempt from the Public Meetings Law requirements. The bill specifies the conditions under which the confidential and exempt information may be disclosed.

C. Trust Funds Restrictions:

The provisions of this bill have no impact on the trust fund restrictions under the requirements of Article III, Subsection 19(f) of the Florida Constitution.

D. Other Constitutional Issues:

The bill creates s. 766.118, F.S., to impose an aggregate cap for noneconomic damages of $500,000 per defendant, regardless of the number of claimants for a claim arising out of the same medical negligence. This aggregate cap applies whether the parties go directly to trial, go to medical negligence arbitration or go to trial following failure to offer or accept arbitration. The aggregate cap may be "pierced" or waived by the trier of fact in those cases involving catastrophic injuries including death, coma, paralysis, quadriplegia, paraplegia, blindness, permanent vegetative state, or severe and permanent brain injury. The catastrophic exception however does not apply if the parties are in medical negligence arbitration or at trial subsequent to a failure to offer or accept voluntary binding arbitration under ss. 766.207-766.212, F.S.

By specifically cross-referencing the medical arbitration provisions in ss. 766.207-766.212, F.S., it is not clear how the caps currently set forth in s. 766.207, F.S., and s. 766.209, F.S. will be construed by the courts. There are a number of rules of statutory

construction that the courts may follow to avoid or resolve conflicts including construing the statutes to give them both effect by harmonizing them[33]; by providing that the new provisions are more specific than the old provisions[34]; or by providing that the new provision is the last expression of the Legislature and therefore controls.[35]
both including considering the statute as a whole to determine the legislative intent

Current law provides a cap of $250,000 in noneconomic damages per incident if parties submit to voluntary medical negligence arbitration under s. 766.207, F.S. If a claimant offers to arbitrate and the defendant refuses, there is no cap on noneconomic damages at trial. See s. 766.209, F.S. If the defendant offers to arbitrate and the claimant refuses, there is a $350,000 cap on noneconomic damages per incident..

The new provisions could be construed to override the noneconomic damages provisions in ss. 766.207 and 766.209, F.S., as follows:

A claimant in voluntary binding medical negligence arbitration could recover at least $250,000 more than they can currently under law. Such claimant's recovery would be limited by all other potential claimants as a whole for the same claim as the cap is in the aggregate. However, the claimant or the claimants as a whole could recover up to $500,000 in noneconomic damages from each defendant, provided no set-off were made for a settling defendant.

A claimant at trial for medical negligence following either party's failure to request voluntary binding arbitration could only recover $500,000 in noneconomic damage from each defendant whereas currently they are not limited under current law. Moreover, such claimant's recovery would be limited by all other potential claimants for the same claim as the cap is in the aggregate which is not the case under current law.

A claimant who rejects a defendant's offer to voluntary binding medical negligence arbitration could recover $150,000 more than they can currently under law. Moreover, if there is more than one claimant, the cap is in the aggregate and all the claimants from the same incident of medical negligence be limited to the aggregate cap against each defendant.

A claimant at trial following a defendant's refusal to a claimant's offer to voluntarily binding arbitration could not recover any more than $500,000 in noneconomic damages per defendant. Moreover, if there is more than one claimant, the cap is in the aggregate and all the claimants from the same incident of medical negligence would be limited in the aggregate to $500,000. This is in contrast to current law which does not limit a claimant's award of damages to any amount or number of claimants under this scenario.

Notably, if the new cap on noneconomic damages is construed to override the existing damages provisions in ss. 766.207-766.212, F.S., the cap does not differentiate between

[33] See *Ferguson v. State*, 377 So.2d 709 (Fla. 1979).
[34] See *Adams v. Culver*, 111 So.2d 665 (Fla. 1959).
[35] See *State v. Young*, 357 So.2d 416 (Fla. 1978).

those cases where the parties mutually agreed to voluntary binding arbitration, where the claimant refuses a defendant's offer to arbitrate, or where the defendant refuses a claimant's offer to arbitrate. Additionally, it would appear to be always in a defendant's best interest to offer voluntary binding arbitration in every medical negligence case regardless of a claimant's subsequent acceptance or refusal, particularly in those cases in which there is a catastrophic injury since the cap can not be pierced by a trier of fact under any of the arbitration provisions. In contrast, it would appear to be in a claimant's best interest to proceed directly to trial (if not settled beforehand) particularly in those cases involving catastrophic injuries.

These provisions which limit recovery of noneconomic damages for a claim regardless of the number of claimants may also implicate equal protection concerns under the Florida Constitution. In *St. Mary's Hospital, Inc. v. Phillipe*, 769 So.2d 961 (Fla. 2000) the Florida Supreme Court considered whether the "per incident" language in the voluntary arbitration statute under the Medical Malpractice Act 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. 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. 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. 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.

To the extent the bill imposes a cap on noneconomic damages, the remedy available to persons whose recovery in excess of the cap is barred by the bill, their constitutional right to access to courts may be implicated. The test for assuring the right of access to the courts was declared in *Kluger v. White* in which the Florida Supreme Court held that:

> Where a right of access to the courts for redress for a particular injury has been provided by statutory law predating the adoption of the Declaration of Rights of the Constitution of the State of Florida, or where such right has become a part of the common law of the State pursuant to Fla. Stat. s. 2.01, F.S.A., the Legislature is without power to abolish such a right without providing a reasonable alternative to protect the rights of the people of the State to redress for injuries, unless the Legislature can show an overpowering public necessity for the abolishment of such right, and no alternative method of meeting such public necessity can be shown.[36]

[36] See *Kluger v. White*, 281 So.2d 1 (1973), at 4.

V. Economic Impact and Fiscal Note:

A. Tax/Fee Issues:

Section 3 of the bill requires the assessment of a one-dollar tax on health care insurers, health maintenance organizations, prepaid health clinics, hospitals, ambulatory surgical centers, nursing homes, assisted living facilities, home health agencies, hospices, prescribed pediatric extended care centers and health care services pools for each person insured or receiving services from one of the above mentioned entities. These entities may pass on the fee to the individuals served. The bill also requires the assessment of a one-dollar tax on health care professionals licensed by the Department of Health. The amount of revenue generated is estimated below. In some cases data sources are incomplete or non-existent.

B. Private Sector Impact:

Sections 2 and 64 of the bill provide a new setoff for settlement proceeds. This new provision would allow a non-settling defendant to receive a setoff of his or her apportioned share of all damages based on any settlement amounts by settling defendants even if the non-settling defendant is held by the jury to be 100 percent at fault for the injuries to the plaintiff.

Hospitals will incur costs to report patient safety data to the Florida Center for Excellence in Health Care, to implement a patient safety plan, and to inform patients of unanticipated outcomes of care. Costs could also increase due to greater requirements for data analysis and potentially increased fines.

Funding of the Office of Presuit Screening Administration for the Fiscal Year 2004-2005 is through an appropriation provided for in section 74 of this bill. Subsequent funding is derived from a service charge equal to 0.5 percent of the amount of every judgment and arbitration award made in a medical malpractice action.

There could be an increase in risk management and patient safety information available to consumers, purchasers and payers.

The entity or individual responsible for implementing the duties and responsibilities of the Florida Center for Excellence in Health Care will incur costs. Such costs are currently indeterminate.

Private Education
Private schools, colleges, and universities offering degrees in medicine, nursing, or allied health will incur costs to include material in curricula on patient safety.

Health Care Practitioners
The bill generates revenue by the assessment of a $1 fee on the application and renewal fee for each license and for each certification or re-certification of various health care practitioners regulated by the Department of Health. The number of two-year Medical

Quality Assurance Trust Fund renewals scheduled in fiscal year 2003-2004 is 259,341 and the number of two-year renewals scheduled in fiscal year 2004-2005 is 352,822. The number of initial licenses received and approved in fiscal year 2001-2002 was 58,681 and it is assumed that the same number will be issued for fiscal year 2003-2004 and fiscal year 2004-2005. It is estimated that revenues received and transferred to the Florida Center for Excellence in Health Care would be $577,363 for fiscal year 2003-2004 and $764,325 for fiscal year 2004-2005.

The number of five-year radioactive material renewals issued annually is estimated at 284 and the number of one-year radioactive material renewals issued annually is estimated at 523.The number of one-year radon certificate renewals issued annually is estimated at 300. The number of initial applications received and approved annually is 140. Total revenues received and transferred to the Florida Center for Excellence in Health Care from the Division of Environmental Health in fiscal year 2003-2004 is estimated at $2,383 and in fiscal year 2004-2005 is estimated at $2,383.

The number of two-year renewals for emergency medical technicians and paramedics is estimated at 35,000. Renewals in 2004-2005 will generate an estimated at $70,000 from the Division of Emergency Medical Services and Community Health Resources. In addition, the number of initial applications received per year is approximately 4,500 which would generate $4,500 in revenue annually for the Florida Center for Excellence in Health Care.

Total Revenue from DOH for the Center	$584,246	fiscal year 2003-2004
	$841,208	fiscal year 2004-2005

Health Insurers

The bill requires health insurers to make a payment of $1 for each individual included in every insurance policy issued during the previous calendar year. To the extent such insurers are doing business in multiple states they may be able to obtain a credit for a retaliatory tax which would generate a loss in General Revenue funds. Under the concept of a retaliatory tax the insurers subject to the assessment or tax in the bill would receive a credit for the sum of revenue equal to that assessment**.**

According to AHCA, the 1999 Florida Health Insurance Survey reported that 62.7 percent of Floridians under the age of 65 receive health insurance through their employers and that nine percent obtain insurance through other sources. Maintaining these percentages for current population estimates would project 10,038,000 (71.7 percent of 14 million Floridians under the age of 65) beneficiaries per year. Subtracting the commercial HMO enrollees described below results in an estimated 6,818,992 currently covered enrollees. The extent of multiple coverages by an individual within a year is unknown. The number of Floridians covered by private Medicare supplement policies cannot be determined without further research. However, it could reasonably be estimated that $6 million would result from this funding source annually.

According to AHCA, there are one prepaid health clinic and twenty-six HMOs in the state of Florida. As of June 30, 2002 the Department of Financial Services listed

3,219,008 commercial subscribers and 576,056 Medicare subscribers. In March of 2003 there were 681,479 individuals in Medicaid Managed Care. Based on the foregoing, this provision would generate approximately $4,476,543 each year.

Service Providers
AHCA provided the following estimates:

Hospitals and Ambulatory Surgical Centers
There are approximately 270 hospitals in Florida, which admitted about 2.2 million inpatients in Year 2001. There are approximately 299 ambulatory surgical centers in Florida, which performed about 2.4 million procedures in the Year 2001. It is unknown how many of these inpatients were repeat admissions of the same person within a year. Hospitals and ASCs would reasonably produce an estimated $4,000,000 in funds each year.

Clinics and Centers
An additional $1.00 for persons seen in hospital outpatient clinics ($1,573,874), radiation therapy centers, cardiac catheterization centers and lithotripsy centers ($289,800), would produce an estimated total of $1,700,000 annually from clinics and centers. The extent of multiple service use by an individual within a year is unknown.

Hospice
The $1.00 increase in hospice fees based on the number of persons served (73,272) equates to an estimated $73,272 annually.

Prescribed Pediatric Extended Care
Prescribed Pediatric Extended Care Centers served an estimated 746 persons in 2000-2001, or $746. The extent of multiple service use by an individual within a year is unknown.

Nursing Homes
Nursing homes discharged an estimated 178,463 individuals and hospital skilled nursing facilities another estimated 40,000 for an estimated total of $200,000 annually. The extent of multiple service use by an individual within a year is unknown.

Assisted Living, Home Health, Services Pools
Assisted living facilities, home health agencies, and health care services pools do not collect data on admissions and discharges therefore an estimate of the total number of persons served annually cannot be made.

Responsible Entity	**Number of Individuals Served**
Insurers	6,000,000.00
HMOs	4,476,543.00

Hospitals	2,200,000.00
Ambulatory Surgical Centers	2,400,000.00
Clinics and Centers	1,700,000.00
Hospice	73,272.00
Prescribed Pediatric Extended Care	734.00
Nursing Homes	200,000.00
Assisted Living Facilities	N/A
Home Health Agencies	N/A
Health Care Services Pools	N/A
Total Estimated Revenue	17,050,549.00

C. Government Sector Impact:

OPPAGA/Auditor General
OPPAGA and the Office of the Auditor General will incur costs to jointly conduct an audit of the Department of Health's disciplinary process and the closed claims filed with the department.

Public Education
Public schools, colleges, and universities offering degrees in medicine, nursing, or allied health will incur costs to include material in curricula on patient safety.

Department of Health
The Department of Health will incur costs associated with revising the practitioner profiles to accommodate additional information; and to adopt rules regarding sexual misconduct and Internet prescribing standards.

The Department of Health has indicated that it will incur cost to implement the additional reporting, monitoring, enforcement and publishing requirements for practitioner profiles as revised under the bill. The Department of Health estimates that it will need 7 positions and incur costs for profile system maintenance and data confirmation mailings and postage totaling $687,786 for fiscal year 2003-2004 and $654,510 for fiscal year 2004-2005.

NICA
Section 50 creates the Florida Medical Malpractice Insurance Fund and provides initial capitalization by a $100 million loan from the Florida Birth-Related Neurological Injury Compensation Association (NICA). NICA reports that as of June 30, 2002, its assets totaled approximately $321 million but that its reserves for future liabilities were about $299 million, leaving a balance or surplus of about $22 million. Also, current law in s. 766.314(9), F.S., states that NICA shall not accept any new claims (with certain exceptions) if the total present value of all filed claims equals 80 percent of the funds on hand and the funds that will become available within the next 12 months. NICA

representatives further state that lending the $100 million to the state malpractice fund would impair its ability to obtain private reinsurance.

Agency for Health Care Administration

The bill provides for an appropriation of $452,122 from General Revenue funds to the Agency and five positions are authorized for the purpose of implementing this act during the 2003-2004 fiscal year.

The anticipated immediate impact on AHCA workload is estimated to require (1) Government Operations Consultant III (class code 2238, pay grade 25, pay band 010) for 1,854 hours annually to oversee the additional requirements of the bill and supervise the staff needed to handle that workload. Duties will include establishing certification requirements, promulgating rules, and directing data collection.

The collection of additional reports, provision of clinical consultation, assistance in the development and review of patient safety plans and programs, distribution of reports to the Center, and increased annual reporting and data collection requirements will require approximately 1,854 each of (1.00) Clinical Registered Nurse Consultant (class code 5312, pay grade 79, pay band 010); (2.00) Health Services and Facilities Consultants (class code 5894, pay grade 24, pay band 010); and (1.00) Administrative Secretary (class code 0108, pay grade 12, pay band 003).

AHCA Total Revenues and Expenditures:	**Amount Year 1 (FY 03-04)**	**Amount Year 2 (FY 04-05)**
Sub-Total Non-Recurring Revenues	$ 0	$ 0
Sub-Total Recurring Revenues	$ 0	$ 0
Total Revenues	**$ 0**	**$ 0**

	Amount Year 1 (FY 03-04)	**Amount Year 2 (FY 04-05)**
Sub-Total Non-Recurring Expenditures	$ 167,542	$ 0
Sub-Total Recurring Expenditures	$ 284,580	$ 284,580
Total Expenditures	**$ 452,122**	**$ 284,580**

Difference (Total Revenues minus Total Expenditures)	**Amount Year 1 (FY 03-04)**	**Amount Year 2 (FY 04-05)**
	($ 452,122)	**($284,580)**

Office of Insurance Regulation

The Office of Insurance Regulation reports that the changes related to closed claim data and related information that must be filed with the Office of Insurance Regulation will result in an estimated $1.8 million impact to reengineer and potentially re-equip the Office of Insurance Regulation to receive, accommodate, and reconcile information in their medical malpractice closed claim data base from 1976 to present. In addition, consultant staff and/or additional permanent staff will be needed to maintain and to generate required analysis of such data.

The Office of Insurance Regulation estimates an additional $350,000 will be needed to comply with the requirement for the web based medical malpractice rate comparison feature required under Section 46 of the bill.

Office of Presuit Screening Administration

The Office of Presuit Screening Administration will incur costs to implement its responsibilities to establish presuit screening panels under the bill. The bill provides an appropriation of $200,000 from the General Revenue Fund to the Office of Presuit Screening Administration and authorizes three positions to implement the provisions of this bill establishing the office and providing for the presuit screening panels. The $200,000 includes $147,600 in salaries and benefits, $47,400 in expenses, and $5,000 in capital outlay funding. The appropriations shall be continued from the Presuit Screening Trust Fund of the Department of Health in subsequent years.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Amendments:

None.