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

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

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

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

121 to the Office of Insurance Regulation; providing for
122 enforcement; amending s. 641.19, F.S.; providing that
123 health care providers providing services pursuant to
124 coverage provided under a health maintenance organization
125 contract are not employees or agents of the health
126 maintenance organization; providing exceptions; amending
127 s. 641.51, F.S.; proscribing a health maintenance
128 organization's right to control the professional judgment
129 of a physician; providing that a health maintenance
130 organization shall not be vicariously liable for the
131 medical negligence of a health care provider; providing
132 exceptions; amending s. 766.106, F.S.; requiring the
133 inclusion of additional information in presuit notices
134 provided to defendants; extending the time period for the
135 presuit screening period; providing that liability is
136 deemed admitted when an offer is made by a defendant to
137 arbitrate providing conditions for causes of action for
138 bad faith against insurers providing coverage for medical
139 negligence; specifying consequences of failure to
140 cooperate on the part of any party during the presuit
141 investigation; providing factors to be considered with
142 respect to certain claims against bad faith against an
143 insurer; revising requirements for presuit notice and
144 insurer or self-insurer response to a claim; permitting
145 written questions during informal discovery; requiring a
146 claimant to execute a medical release to authorize
147 defendants in medical negligence actions to take unsworn
148 statements from a claimant's treating physicians;
149 providing for informal discovery without notice; imposing
150 limits on such statements; creating s. 766.1065, F.S.;

151 requiring parties to provide certain information to
152 parties without request; authorizing the issuance of
153 subpoenas without case numbers; requiring that parties and
154 certain experts be made available for deposition; creating
155 s. 766.1067, F.S.; providing for mandatory mediation in
156 medical negligence causes of action; creating s. 766.118,
157 F.S.; providing a limitation on noneconomic damages which
158 can be awarded in causes of action involving medical
159 negligence; creating s. 766.2015, F.S.; providing for the
160 award of prevailing party attorney's fees and costs for
161 frivolous claims; amending s. 766.202, F.S.; redefining
162 the terms "economic damages," "medical expert,"
163 "noneconomic damages," and "periodic payment"; extending
164 the definitions of economic and noneconomic damages to
165 include any such damages recoverable under the Wrongful
166 Death Act or general law; providing requirements for
167 medical experts; providing for periodic payments for
168 future noneconomic damages; revising regulations of
169 periodic payments; amending s. 766.203, F.S.; providing
170 for discovery of opinions and statements tendered during
171 presuit investigation; amending s. 766.207, F.S.;
172 conforming provisions to the extension in the time period
173 for presuit investigation; providing for the applicability
174 of the Wrongful Death Act and general law to arbitration
175 awards; creating s. 766.213, F.S.; providing for the
176 termination of periodic payments for unincurred medical
177 expenses upon the death of the claimant; providing for the
178 payment of medical expenses incurred prior to the death of
179 the claimant; amending s. 768.041, F.S.; revising
180 requirements for setoffs against damages in medical

181 malpractice actions if there is a written release or
182 covenant not to sue; amending s. 768.77, F.S.; prescribing
183 a method for itemization of specific categories of damages
184 awarded in medical malpractice actions; amending s.
185 768.78, F.S.; correcting a cross reference; providing that
186 a defendant may elect to make lump sum payments rather
187 than periodic payments for either or both future economic
188 and noneconomic damages; authorizing the payment of
189 certain losses for a shorter period of time under certain
190 circumstances; providing for modification of periodic
191 payments or for requiring additional security by order of
192 the court under certain circumstances; amending ss.
193 766.112 and 768.81, F.S.; providing that a defendant's
194 liability for damages in medical negligence cases is
195 several only; creating s. 1004.08, F.S.; requiring patient
196 safety instruction for certain students in public schools,
197 colleges, and universities; creating s. 1004.085, F.S.;
198 requiring certain public schools to assist the Department
199 of Health in the development of information to be provided
200 to patients and their families on risks of treatment
201 options to assist in receiving informed consent; creating
202 s. 1005.07, F.S.; requiring patient safety instruction for
203 certain students in nonpublic schools, colleges, and
204 universities; creating s. 1005.075, F.S.; requiring
205 certain nonpublic schools to assist the Department of
206 Health in the development of information to be provided to
207 patients and their families on risks of treatment options
208 to assist in receiving informed consent; requiring the
209 Department of Health to study the efficacy and
210 constitutionality of medical review panels; requiring a

211 report; directing the Agency for Health Care
212 Administration to conduct or contract for a study to
213 determine what information to provide to the public
214 comparing hospitals, based on inpatient quality indicators
215 developed by the federal Agency for Healthcare Research
216 and Quality; requiring a report by the Agency for Health
217 Care Administration regarding the establishment of a
218 Patient Safety Authority; specifying elements of the
219 report; requiring the Office of Program Policy Analysis
220 and Government Accountability to study and report to the
221 Legislature on requirements for coverage by the Florida
222 Birth-Related Neurological Injury Compensation
223 Association; providing civil immunity for certain
224 participants in quality improvement processes; requiring
225 the Office of Program Policy Analysis and Government
226 Accountability and the Office of the Auditor General to
227 conduct an audit of the Department of Health's health care
228 practitioner disciplinary process and certain closed
229 claims and to report to the Legislature; creating a
230 workgroup to study the health care practitioner
231 disciplinary process; providing for workgroup membership;
232 providing that the workgroup deliver its report by January
233 1, 2004; providing restrictions on advertisements or other
234 similar public dissemination of information by or on
235 behalf of an attorney regarding issues of medical
236 malpractice; providing severability; providing legislative
237 findings and intent; amending s. 768.28, F.S.; revising
238 the definition of the term "officer, employee, or agent"
239 to include certain receiving facilities and employees or
240 agents of such facilities, providers of emergency medical

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241 services and care, and certain hospitals for purposes of
242 limitation of liability in tort under certain
243 circumstances; providing that providers of emergency
244 medical services and care are deemed agents of the
245 Department of Health for certain purposes; requiring such
246 providers to indemnify the state for certain reasonable
247 defense and indemnity costs within certain limitations;
248 specifying certain persons as providers of emergency
249 medical services and care; defining emergency medical
250 services; providing severability; providing for
251 construction of the act in pari materia with laws enacted
252 during the 2003 Regular Session or the 2003 Special
253 Session A of the Legislature; providing an effective date.
254
255 Be It Enacted by the Legislature of the State of Florida:
256
257 Section 1. Findings.--
258 (1) The Legislature finds that Florida is in the midst of
259 a medical malpractice insurance crisis of unprecedented
260 magnitude.
261 (2) The Legislature finds that this crisis threatens the
262 quality and availability of health care for all Florida
263 citizens.
264 (3) The Legislature finds that the rapidly growing
265 population and the changing demographics of Florida make it
266 imperative that students continue to choose Florida as the place
267 they will receive their medical educations and practice
268 medicine.
269 (4) The Legislature finds that Florida is among the states
270 with the highest medical malpractice insurance premiums in the

271 nation.
272 (5) The Legislature finds that the cost of medical
273 malpractice insurance has increased dramatically during the past
274 decade and both the increase and the current cost are
275 substantially higher than the national average.
276 (6) The Legislature finds that the increase in medical
277 malpractice liability insurance rates is forcing physicians to
278 practice medicine without professional liability insurance, to
279 leave Florida, to not perform high-risk procedures, or to retire
280 early from the practice of medicine.
281 (7) The Legislature finds that there are certain elements
282 of damage presently recoverable that have no monetary value,
283 except on a purely arbitrary basis, while other elements of
284 damage are either easily measured on a monetary basis or reflect
285 ultimate monetary loss.
286 (8) The Governor created the Governor's Select Task Force
287 on Healthcare Professional Liability Insurance to study and make
288 recommendations to address these problems.
289 (9) The Legislature has reviewed the findings and
290 recommendations of the Governor's Select Task Force on
291 Healthcare Professional Liability Insurance.
292 (10) The Legislature finds that the Governor's Select Task
293 Force on Healthcare Professional Liability Insurance has
294 established that a medical malpractice crisis exists in the
295 State of Florida which can be alleviated by the adoption of
296 comprehensive legislatively enacted reforms.
297 (11) The Legislature finds that making high-quality health
298 care available to the citizens of this state is an overwhelming
299 public necessity.
300 (12) The Legislature finds that ensuring that physicians

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301 continue to practice in Florida is an overwhelming public
302 necessity.
303 (13) The Legislature finds that ensuring the availability
304 of affordable professional liability insurance for physicians is
305 an overwhelming public necessity.
306 (14) The Legislature finds, based upon the findings and
307 recommendations of the Governor's Select Task Force on
308 Healthcare Professional Liability Insurance, the findings and
309 recommendations of various study groups throughout the nation,
310 and the experience of other states, that the overwhelming public
311 necessities of making quality health care available to the
312 citizens of this state, of ensuring that physicians continue to
313 practice in Florida, and of ensuring that those physicians have
314 the opportunity to purchase affordable professional liability
315 insurance cannot be met unless a cap on noneconomic damages in
316 an amount no higher than $250,000 is imposed.
317 (15) The Legislature finds that the high cost of medical
318 malpractice claims can be substantially alleviated by imposing a
319 limitation on noneconomic damages in medical malpractice
320 actions.
321 (16) The Legislature further finds that there is no
322 alternative measure of accomplishing such result without
323 imposing even greater limits upon the ability of persons to
324 recover damages for medical malpractice.
325 (17) The Legislature finds that the provisions of this act
326 are naturally and logically connected to each other and to the
327 purpose of making quality health care available to the citizens
328 of Florida.
329 (18) The Legislature finds that each of the provisions of
330 this act is necessary to alleviate the crisis relating to

331 medical malpractice insurance.
332 Section 2. Subsection (4) is added to section 46.015,
333 Florida Statutes, to read:
334 46.015 Release of parties.--
335 (4)(a) At trial pursuant to a suit filed under chapter 766
336 or pursuant to s. 766.209, if any defendant shows the court that
337 the plaintiff, or his or her legal representative, has delivered
338 a written release or covenant not to sue to any person in
339 partial satisfaction of the damages sued for, the court shall
340 setoff this amount from the total amount of the damages set
341 forth in the verdict and before entry of the final judgment.
342 (b) The amount of any set off under this subsection shall
343 include all sums received by the plaintiff, including economic
344 and noneconomic damages, costs, and attorney's fees.
345 Section 3. Subsection (7) of section 395.0191, Florida
346 Statutes, is amended to read:
347 395.0191 Staff membership and clinical privileges.--
348 (7) There shall be no monetary liability on the part of,
349 and no cause of action for injunctive relief or damages shall
350 arise against, any licensed facility, its governing board or
351 governing board members, medical staff, or disciplinary board or
352 against its agents, investigators, witnesses, or employees, or
353 against any other person, for any action arising out of or
354 related to carrying out the provisions of this section, absent
355 ~~taken in good faith and without~~ intentional fraud ~~in carrying~~
356 ~~out the provisions of this section~~.
357 Section 4. Section 395.1012, Florida Statutes, is created
358 to read:
359 395.1012 Patient safety.--
360 (1) Each licensed facility shall adopt a patient safety

361 plan. A plan adopted to implement the requirements of 42 C.F.R.
362 s. 482.21 shall be deemed to comply with this requirement.
363 (2) Each licensed facility shall appoint a patient safety
364 officer and a patient safety committee, which shall include at
365 least one person who is neither employed by nor practicing in
366 the facility, for the purpose of promoting the health and safety
367 of patients, reviewing and evaluating the quality of patient
368 safety measures used by the facility, and assisting in the
369 implementation of the facility patient safety plan.
370 Section 5. Section 395.1051, Florida Statutes, is created
371 to read:
372 395.1051 Duty to notify patients.--Every licensed facility
373 shall inform each patient, or an individual identified pursuant
374 to s. 765.401(1), in person about unanticipated outcomes of care
375 that result in serious harm to the patient. Notification of
376 outcomes of care that result in harm to the patient under this
377 section shall not constitute an acknowledgement or admission of
378 liability, nor can it be introduced as evidence in any civil
379 lawsuit.
380 Section 6. Section 415.1111, Florida Statutes, is amended
381 to read:
382 415.1111 Civil actions.--A vulnerable adult who has been
383 abused, neglected, or exploited as specified in this chapter has
384 a cause of action against any perpetrator and may recover actual
385 and punitive damages for such abuse, neglect, or exploitation.
386 The action may be brought by the vulnerable adult, or that
387 person's guardian, by a person or organization acting on behalf
388 of the vulnerable adult with the consent of that person or that
389 person's guardian, or by the personal representative of the
390 estate of a deceased victim without regard to whether the cause

391 of death resulted from the abuse, neglect, or exploitation. The
392 action may be brought in any court of competent jurisdiction to
393 enforce such action and to recover actual and punitive damages
394 for any deprivation of or infringement on the rights of a
395 vulnerable adult. A party who prevails in any such action may be
396 entitled to recover reasonable attorney's fees, costs of the
397 action, and damages. The remedies provided in this section are
398 in addition to and cumulative with other legal and
399 administrative remedies available to a vulnerable adult.
400 Notwithstanding the foregoing, any civil action for damages
401 against any licensee or entity who establishes, controls,
402 conducts, manages, or operates a facility licensed under part II
403 of chapter 400 relating to its operation of the licensed
404 facility shall be brought pursuant to s. 400.023, or against any
405 licensee or entity who establishes, controls, conducts, manages,
406 or operates a facility licensed under part III of chapter 400
407 relating to its operation of the licensed facility shall be
408 brought pursuant to s. 400.429. Such licensee or entity shall
409 not be vicariously liable for the acts or omissions of its
410 employees or agents or any other third party in an action
411 brought under this section. Notwithstanding the provisions of
412 this section, any claim that qualifies as a claim for medical
413 malpractice, as defined in s. 766.106(1)(a), against any
414 licensee or entity who establishes, controls, conducts, manages,
415 or operates a facility licensed under chapter 395 shall be
416 brought pursuant to chapter 766.
417 Section 7. Paragraph (a) of subsection (1) of section
418 456.039, Florida Statutes, is amended to read:
419 456.039 Designated health care professionals; information
420 required for licensure.--

421 (1) Each person who applies for initial licensure as a
422 physician under chapter 458, chapter 459, chapter 460, or
423 chapter 461, except a person applying for registration pursuant
424 to ss. 458.345 and 459.021, must, at the time of application,
425 and each physician who applies for license renewal under chapter
426 458, chapter 459, chapter 460, or chapter 461, except a person
427 registered pursuant to ss. 458.345 and 459.021, must, in
428 conjunction with the renewal of such license and under
429 procedures adopted by the Department of Health, and in addition
430 to any other information that may be required from the
431 applicant, furnish the following information to the Department
432 of Health:
433 (a)1. The name of each medical school that the applicant
434 has attended, with the dates of attendance and the date of
435 graduation, and a description of all graduate medical education
436 completed by the applicant, excluding any coursework taken to
437 satisfy medical licensure continuing education requirements.
438 2. The name of each hospital at which the applicant has
439 privileges.
440 3. The address at which the applicant will primarily
441 conduct his or her practice.
442 4. Any certification that the applicant has received from
443 a specialty board that is recognized by the board to which the
444 applicant is applying.
445 5. The year that the applicant began practicing medicine.
446 6. Any appointment to the faculty of a medical school
447 which the applicant currently holds and an indication as to
448 whether the applicant has had the responsibility for graduate
449 medical education within the most recent 10 years.
450 7. A description of any criminal offense of which the

451 applicant has been found guilty, regardless of whether
452 adjudication of guilt was withheld, or to which the applicant
453 has pled guilty or nolo contendere. A criminal offense committed
454 in another jurisdiction which would have been a felony or
455 misdemeanor if committed in this state must be reported. If the
456 applicant indicates that a criminal offense is under appeal and
457 submits a copy of the notice for appeal of that criminal
458 offense, the department must state that the criminal offense is
459 under appeal if the criminal offense is reported in the
460 applicant's profile. If the applicant indicates to the
461 department that a criminal offense is under appeal, the
462 applicant must, upon disposition of the appeal, submit to the
463 department a copy of the final written order of disposition.
464 8. A description of any final disciplinary action taken
465 within the previous 10 years against the applicant by the agency
466 regulating the profession that the applicant is or has been
467 licensed to practice, whether in this state or in any other
468 jurisdiction, by a specialty board that is recognized by the
469 American Board of Medical Specialties, the American Osteopathic
470 Association, or a similar national organization, or by a
471 licensed hospital, health maintenance organization, prepaid
472 health clinic, ambulatory surgical center, or nursing home.
473 Disciplinary action includes resignation from or nonrenewal of
474 medical staff membership or the restriction of privileges at a
475 licensed hospital, health maintenance organization, prepaid
476 health clinic, ambulatory surgical center, or nursing home taken
477 in lieu of or in settlement of a pending disciplinary case
478 related to competence or character. If the applicant indicates
479 that the disciplinary action is under appeal and submits a copy
480 of the document initiating an appeal of the disciplinary action,

481 the department must state that the disciplinary action is under
482 appeal if the disciplinary action is reported in the applicant's
483 profile.
484 9. Relevant professional qualifications as defined by the
485 applicable board.
486 Section 8. Section 456.041, Florida Statutes, is amended
487 to read:
488 456.041 Practitioner profile; creation.--
489 (1)(a) Beginning July 1, 1999, the Department of Health
490 shall compile the information submitted pursuant to s. 456.039
491 into a practitioner profile of the applicant submitting the
492 information, except that the Department of Health may develop a
493 format to compile uniformly any information submitted under s.
494 456.039(4)(b). Beginning July 1, 2001, the Department of Health
495 may, and beginning July 1, 2004, shall, compile the information
496 submitted pursuant to s. 456.0391 into a practitioner profile of
497 the applicant submitting the information.
498 (b) Each practitioner licensed under chapter 458 or
499 chapter 459 must report to the Department of Health and the
500 Board of Medicine or the Board of Osteopathic Medicine,
501 respectively, all final disciplinary actions, sanctions by a
502 governmental agency or a facility or entity licensed under state
503 law, and claims or actions, as provided under s. 456.051, to
504 which he or she is subjected no later than 15 calendar days
505 after such action or sanction is imposed. Failure to submit the
506 requisite information within 15 calendar days in accordance with
507 this paragraph shall subject the practitioner to discipline by
508 the Board of Medicine or the Board of Osteopathic Medicine and a
509 fine of $100 for each day that the information is not submitted
510 after the expiration of the 15-day reporting period.

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511 (c) Within 15 days after receiving a report under
512 paragraph (b), the department shall update the practitioner's
513 profile in accordance with the requirements of subsection (7).
514 (2) On the profile published under subsection (1), the
515 department shall indicate whether ~~if~~ the information provided
516 under s. 456.039(1)(a)7. or s. 456.0391(1)(a)7. is or is not
517 corroborated by a criminal history check conducted according to
518 this subsection. ~~If the information provided under s.~~
519 ~~456.039(1)(a)7. or s. 456.0391(1)(a)7. is corroborated by the~~
520 ~~criminal history check, the fact that the criminal history check~~
521 ~~was performed need not be indicated on the profile.~~ The
522 department, or the board having regulatory authority over the
523 practitioner acting on behalf of the department, shall
524 investigate any information received by the department or the
525 board when it has reasonable grounds to believe that the
526 practitioner has violated any law that relates to the
527 practitioner's practice.
528 (3) The Department of Health shall ~~may~~ include in each
529 practitioner's practitioner profile that criminal information
530 that directly relates to the practitioner's ability to
531 competently practice his or her profession. The department must
532 include in each practitioner's practitioner profile the
533 following statement: "The criminal history information, if any
534 exists, may be incomplete; federal criminal history information
535 is not available to the public." The department shall provide in
536 each practitioner profile, for every final disciplinary action
537 taken against the practitioner, a narrative description, written
538 in plain English, that explains the administrative complaint
539 filed against the practitioner and the final disciplinary action
540 imposed on the practitioner. The department shall include a

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541 hyperlink to each final order listed on its Internet website
542 report of dispositions of recent disciplinary actions taken
543 against practitioners.
544 (4) The Department of Health shall include, with respect
545 to a practitioner licensed under chapter 458 or chapter 459, a
546 statement of how the practitioner has elected to comply with the
547 financial responsibility requirements of s. 458.320 or s.
548 459.0085. The department shall include, with respect to
549 practitioners subject to s. 456.048, a statement of how the
550 practitioner has elected to comply with the financial
551 responsibility requirements of that section. The department
552 shall include, with respect to practitioners licensed under
553 chapter 458, chapter 459, or chapter 461, information relating
554 to liability actions which has been reported under s. 456.049 or
555 s. 627.912 within the previous 10 years for any paid claim of
556 $50,000 or more ~~that exceeds $5,000~~. Such claims information
557 shall be reported in the context of comparing an individual
558 practitioner's claims to the experience of other practitioners
559 within the same specialty, or profession if the practitioner is
560 not a specialist~~, to the extent such information is available to~~
561 ~~the Department of Health~~. The department shall include a
562 hyperlink to all such comparison reports in such practitioner's
563 profile on its Internet website. If information relating to a
564 liability action is included in a practitioner's practitioner
565 profile, the profile must also include the following statement:
566 "Settlement of a claim may occur for a variety of reasons that
567 do not necessarily reflect negatively on the professional
568 competence or conduct of the practitioner. A payment in
569 settlement of a medical malpractice action or claim should not
570 be construed as creating a presumption that medical malpractice

571 has occurred."
572 (5) The Department of Health shall ~~may not~~ include the
573 date of a disciplinary action taken by a licensed hospital or an
574 ambulatory surgical center, in accordance with the requirements
575 of s. 395.0193, in the practitioner profile. Any practitioner
576 disciplined under paragraph (1)(b) must report to the department
577 the date the disciplinary action was imposed. The department
578 shall state whether the action is related to professional
579 competence and whether it is related to the delivery of services
580 to a patient.
581 (6) The Department of Health may include in the
582 practitioner's practitioner profile any other information that
583 is a public record of any governmental entity and that relates
584 to a practitioner's ability to competently practice his or her
585 profession. However, the department must consult with the board
586 having regulatory authority over the practitioner before such
587 information is included in his or her profile.
588 (7) Upon the completion of a practitioner profile under
589 this section, the Department of Health shall furnish the
590 practitioner who is the subject of the profile a copy of it. The
591 practitioner has a period of 30 days in which to review the
592 profile and to correct any factual inaccuracies in it. The
593 Department of Health shall make the profile available to the
594 public at the end of the 30-day period. The department shall
595 make the profiles available to the public through the World Wide
596 Web and other commonly used means of distribution.
597 (8) The Department of Health shall provide in each profile
598 an easy-to-read explanation of any disciplinary action taken and
599 the reason the sanction or sanctions were imposed.
600 (9)~~(8)~~ Making a practitioner profile available to the

601 public under this section does not constitute agency action for
602 which a hearing under s. 120.57 may be sought.
603 Section 9. Section 456.042, Florida Statutes, is amended
604 to read:
605 456.042 Practitioner profiles; update.--A practitioner
606 must submit updates of required information within 15 days after
607 the final activity that renders such information a fact. The
608 Department of Health shall update each practitioner's
609 practitioner profile periodically. An updated profile is subject
610 to the same requirements as an original profile with respect to
611 the period within which the practitioner may review the profile
612 for the purpose of correcting factual inaccuracies.
613 Section 10. Subsection (1) of section 456.049, Florida
614 Statutes, is amended, and subsection (3) is added to said
615 section, to read:
616 456.049 Health care practitioners; reports on professional
617 liability claims and actions.--
618 (1) Any practitioner of medicine licensed pursuant to the
619 provisions of chapter 458, practitioner of osteopathic medicine
620 licensed pursuant to the provisions of chapter 459, podiatric
621 physician licensed pursuant to the provisions of chapter 461, or
622 dentist licensed pursuant to the provisions of chapter 466 shall
623 report to the department any claim or action for damages for
624 personal injury alleged to have been caused by error, omission,
625 or negligence in the performance of such licensee's professional
626 services or based on a claimed performance of professional
627 services without consent if ~~the claim was not covered by an~~
628 ~~insurer required to report under s. 627.912 and~~ the claim
629 resulted in:
630 (a) A final judgment of $50,000 or more or, with respect

631 to a dentist licensed pursuant to chapter 466, a final judgment
632 of $25,000 or more ~~in any amount~~.
633 (b) A settlement of $50,000 or more or, with respect to a
634 dentist licensed pursuant to chapter 466, a settlement of
635 $25,000 or more ~~in any amount~~.
636 (c) A final disposition not resulting in payment on behalf
637 of the licensee.
638
639 Reports shall be filed with the department no later than 60 days
640 following the occurrence of any event listed in paragraph (a),
641 paragraph (b), or paragraph (c).
642 (3) The department shall forward the information collected
643 under this section to the Office of Insurance Regulation.
644 Section 11. Section 456.051, Florida Statutes, is amended
645 to read:
646 456.051 Reports of professional liability actions;
647 bankruptcies; Department of Health's responsibility to
648 provide.--
649 (1) The report of a claim or action for damages for
650 personal injury which is required to be provided to the
651 Department of Health under s. 456.049 or s. 627.912 is public
652 information except for the name of the claimant or injured
653 person, which remains confidential as provided in ss.
654 456.049(2)(d) and 627.912(2)(e). The Department of Health
655 shall, upon request, make such report available to any person.
656 The department shall make such report available as a part of the
657 practitioner's profile within 45 calendar days after receipt.
658 (2) Any information in the possession of the Department of
659 Health which relates to a bankruptcy proceeding by a
660 practitioner of medicine licensed under chapter 458, a

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661 practitioner of osteopathic medicine licensed under chapter 459,
662 a podiatric physician licensed under chapter 461, or a dentist
663 licensed under chapter 466 is public information. The Department
664 of Health shall, upon request, make such information available
665 to any person. The department shall make such report available
666 as a part of the practitioner's profile within 45 calendar days
667 after receipt.

668 Section 12. Paragraph (a) of subsection (7) of section
669 456.057, Florida Statutes, is amended to read:

670 456.057 Ownership and control of patient records; report
671 or copies of records to be furnished.--

672 (7)(a)1. The department may obtain patient records
673 pursuant to a subpoena without written authorization from the
674 patient if the department and the probable cause panel of the
675 appropriate board, if any, find reasonable cause to believe that
676 a health care practitioner has excessively or inappropriately
677 prescribed any controlled substance specified in chapter 893 in
678 violation of this chapter or any professional practice act or
679 that a health care practitioner has practiced his or her
680 profession below that level of care, skill, and treatment
681 required as defined by this chapter or any professional practice
682 act and also find that appropriate, reasonable attempts were
683 made to obtain a patient release.

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

691 patient release.
692 3. The department may obtain patient records, billing
693 records, insurance information, provider contracts, and all
694 attachments thereto pursuant to a subpoena without written
695 authorization from the patient if the department and probable
696 cause panel of the appropriate board, if any, find reasonable
697 cause to believe that a health care practitioner has submitted a
698 claim, statement, or bill using a billing code that would result
699 in payment greater in amount than would be paid using a billing
700 code that accurately describes the services performed, requested
701 payment for services that were not performed by that health care
702 practitioner, used information derived from a written report of
703 an automobile accident generated pursuant to chapter 316 to
704 solicit or obtain patients personally or through an agent
705 regardless of whether the information is derived directly from
706 the report or a summary of that report or from another person,
707 solicited patients fraudulently, received a kickback as defined
708 in s. 456.054, violated the patient brokering provisions of s.
709 817.505, or presented or caused to be presented a false or
710 fraudulent insurance claim within the meaning of s.
711 817.234(1)(a), and also find that, within the meaning of s.
712 817.234(1)(a), patient authorization cannot be obtained because
713 the patient cannot be located or is deceased, incapacitated, or
714 suspected of being a participant in the fraud or scheme, and if
715 the subpoena is issued for specific and relevant records.
716 4. Notwithstanding subparagraphs 1.-3., when the
717 department investigates a professional liability claim or
718 undertakes action pursuant to s. 456.049 or s. 627.912, the
719 department may obtain patient records pursuant to a subpoena
720 without written authorization from the patient if the patient

721 refuses to cooperate or attempts to obtain a patient release and
722 failure to obtain the patient records would be detrimental to
723 the investigation.
724 Section 13. Subsection (4) is added to section 456.063,
725 Florida Statutes, to read:
726 456.063 Sexual misconduct; disqualification for license,
727 certificate, or registration.--
728 (4) Each board, or the department if there is no board,
729 may adopt rules to implement the requirements for reporting
730 allegations of sexual misconduct, including rules to determine
731 the sufficiency of the allegations.
732 Section 14. Subsection (4) of section 456.072, Florida
733 Statutes, is amended to read:
734 456.072 Grounds for discipline; penalties; enforcement.--
735 (4) In any ~~addition to any other discipline imposed~~
736 ~~through~~ final order, or citation, entered on or after July 1,
737 2001, that imposes a penalty or other form of discipline
738 pursuant to this section or ~~discipline imposed through final~~
739 ~~order, or citation, entered on or after July 1, 2001,~~ for a
740 violation of any practice act, the board, or the department when
741 there is no board, shall assess costs related to the
742 investigation and prosecution of the case, including costs
743 associated with an attorney's time. The amount of costs to be
744 assessed shall be determined by the board, or the department
745 when there is no board, following its consideration of an
746 affidavit of itemized costs and any written objections thereto.
747 In any case in which ~~where the board or the department imposes~~ a
748 fine or assessment of costs imposed by the board or department
749 ~~and the fine or assessment~~ is not paid within a reasonable time,
750 such reasonable time to be prescribed in the rules of the board,

751 or the department when there is no board, or in the order
752 assessing such fines or costs, the department or the Department
753 of Legal Affairs may contract for the collection of, or bring a
754 civil action to recover, the fine or assessment.
755 Section 15. Subsection (5) of section 456.073, Florida
756 Statutes, is amended to read:
757 456.073 Disciplinary proceedings.--Disciplinary
758 proceedings for each board shall be within the jurisdiction of
759 the department.
760 (5)(a) A formal hearing before an administrative law judge
761 from the Division of Administrative Hearings shall be held
762 pursuant to chapter 120 if there are any disputed issues of
763 material fact. The administrative law judge shall issue a
764 recommended order pursuant to chapter 120. If any party raises
765 an issue of disputed fact during an informal hearing, the
766 hearing shall be terminated and a formal hearing pursuant to
767 chapter 120 shall be held.
768 (b) Notwithstanding s. 120.569(2), the department shall
769 notify the Division of Administrative Hearings within 45 days
770 after receipt of a petition or request for a hearing that the
771 department has determined requires a formal hearing before an
772 administrative law judge.
773 Section 16. Subsections (1) and (2) of section 456.077,
774 Florida Statutes, are amended to read:
775 456.077 Authority to issue citations.--
776 (1) Notwithstanding s. 456.073, the board, or the
777 department if there is no board, shall adopt rules to permit the
778 issuance of citations. The citation shall be issued to the
779 subject and shall contain the subject's name and address, the
780 subject's license number if applicable, a brief factual

781 statement, the sections of the law allegedly violated, and the
782 penalty imposed. The citation must clearly state that the
783 subject may choose, in lieu of accepting the citation, to follow
784 the procedure under s. 456.073. If the subject disputes the
785 matter in the citation, the procedures set forth in s. 456.073
786 must be followed. However, if the subject does not dispute the
787 matter in the citation with the department within 30 days after
788 the citation is served, the citation becomes a public final
789 order and does not constitute ~~constitutes~~ discipline for a first
790 offense, but does constitute discipline for a second or
791 subsequent offense. The penalty shall be a fine or other
792 conditions as established by rule.
793 (2) The board, or the department if there is no board,
794 shall adopt rules designating violations for which a citation
795 may be issued. Such rules shall designate as citation violations
796 those violations for which there is no substantial threat to the
797 public health, safety, and welfare or no violation of standard
798 of care involving injury to a patient. Violations for which a
799 citation may be issued shall include violations of continuing
800 education requirements; failure to timely pay required fees and
801 fines; failure to comply with the requirements of ss. 381.026
802 and 381.0261 regarding the dissemination of information
803 regarding patient rights; failure to comply with advertising
804 requirements; failure to timely update practitioner profile and
805 credentialing files; failure to display signs, licenses, and
806 permits; failure to have required reference books available; and
807 all other violations that do not pose a direct and serious
808 threat to the health and safety of the patient or involve a
809 violation of standard of care that has resulted in injury to a
810 patient.

811 Section 17. Subsections (1) and (2) of section 456.078,
812 Florida Statutes, are amended to read:
813 456.078 Mediation.--
814 (1) Notwithstanding the provisions of s. 456.073, the
815 board, or the department when there is no board, shall adopt
816 rules to designate which violations of the applicable
817 professional practice act are appropriate for mediation. The
818 board, or the department when there is no board, shall ~~may~~
819 designate as mediation offenses those complaints where harm
820 caused by the licensee is economic in nature, except any act or
821 omission involving intentional misconduct, ~~or~~ can be remedied by
822 the licensee, is not a standard of care violation involving any
823 type of injury to a patient, or does not result in an adverse
824 incident. For the purposes of this section, an "adverse
825 incident" means an event that results in:
826 (a) The death of a patient;
827 (b) Brain or spinal damage to a patient;
828 (c) The performance of a surgical procedure on the wrong
829 patient;
830 (d) The performance of a wrong-site surgical procedure;
831 (e) The performance of a surgical procedure that is
832 medically unnecessary or otherwise unrelated to the patient's
833 diagnosis or medical condition;
834 (f) The surgical repair of damage to a patient resulting
835 from a planned surgical procedure, which damage is not a
836 recognized specific risk as disclosed to the patient and
837 documented through the informed-consent process;
838 (g) The performance of a procedure to remove unplanned
839 foreign objects remaining from a surgical procedure; or
840 (h) The performance of any other surgical procedure that

841 breached the standard of care.
842 (2) After the department determines a complaint is legally
843 sufficient and the alleged violations are defined as mediation
844 offenses, the department or any agent of the department may
845 conduct informal mediation to resolve the complaint. If the
846 complainant and the subject of the complaint agree to a
847 resolution of a complaint within 14 days after contact by the
848 mediator, the mediator shall notify the department of the terms
849 of the resolution. The department or board shall take no further
850 action unless the complainant and the subject each fail to
851 record with the department an acknowledgment of satisfaction of
852 the terms of mediation within 60 days of the mediator's
853 notification to the department. A successful mediation shall not
854 constitute discipline. In the event the complainant and subject
855 fail to reach settlement terms or to record the required
856 acknowledgment, the department shall process the complaint
857 according to the provisions of s. 456.073.
858 Section 18. Section 456.085, Florida Statutes, is created
859 to read:
860 456.085 Duty to notify patients.--Every physician licensed
861 under chapter 458 or chapter 459 shall inform each patient, or
862 an individual identified pursuant to s. 765.401(1), in person
863 about unanticipated outcomes of care that result in serious harm
864 to the patient. Notification of outcomes of care that result in
865 harm to the patient under this section shall not constitute an
866 acknowledgement or admission of liability, nor can it be
867 introduced as evidence in any civil lawsuit.
868 Section 19. Present subsection (8) of section 458.320,
869 Florida Statutes, is renumbered as subsection (9), and a new
870 subsection (8) is added to said section, to read:

871 458.320 Financial responsibility.--
872 (8) Notwithstanding any other provision of this section,
873 the department shall suspend the license of any physician
874 against whom has been entered a final judgment, arbitration
875 award, or other order or who has entered into a settlement
876 agreement to pay damages arising out of a claim for medical
877 malpractice, if all appellate remedies have been exhausted and
878 payment up to the amounts required by this section has not been
879 made within 30 days after the entering of such judgment, award,
880 or order or agreement, until proof of payment is received by the
881 department or a payment schedule has been agreed upon by the
882 physician and the claimant and presented to the department. This
883 subsection does not apply to a physician who has met the
884 financial responsibility requirements in paragraphs (1)(b) and
885 (2)(b).
886 Section 20. Paragraph (t) of subsection (1) and subsection
887 (6) of section 458.331, Florida Statutes, are amended to read:
888 458.331 Grounds for disciplinary action; action by the
889 board and department.--
890 (1) The following acts constitute grounds for denial of a
891 license or disciplinary action, as specified in s. 456.072(2):
892 (t) Gross or repeated malpractice or the failure to
893 practice medicine with that level of care, skill, and treatment
894 which is recognized by a reasonably prudent similar physician as
895 being acceptable under similar conditions and circumstances. The
896 board shall give great weight to the provisions of s. 766.102
897 when enforcing this paragraph. As used in this paragraph,
898 "repeated malpractice" includes, but is not limited to, three or
899 more claims for medical malpractice within the previous 5-year
900 period resulting in indemnities being paid in excess of $50,000

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901 ~~$25,000~~ each to the claimant in a judgment or settlement and
902 which incidents involved negligent conduct by the physician. As
903 used in this paragraph, "gross malpractice" or "the failure to
904 practice medicine with that level of care, skill, and treatment
905 which is recognized by a reasonably prudent similar physician as
906 being acceptable under similar conditions and circumstances,"
907 shall not be construed so as to require more than one instance,
908 event, or act. Nothing in this paragraph shall be construed to
909 require that a physician be incompetent to practice medicine in
910 order to be disciplined pursuant to this paragraph.
911 (6) Upon the department's receipt from an insurer or self-
912 insurer of a report of a closed claim against a physician
913 pursuant to s. 627.912 or from a health care practitioner of a
914 report pursuant to s. 456.049, or upon the receipt from a
915 claimant of a presuit notice against a physician pursuant to s.
916 766.106, the department shall review each report and determine
917 whether it potentially involved conduct by a licensee that is
918 subject to disciplinary action, in which case the provisions of
919 s. 456.073 shall apply. However, if it is reported that a
920 physician has had three or more claims with indemnities
921 exceeding <u>$50,000</u> ~~$25,000~~ each within the previous 5-year
922 period, the department shall investigate the occurrences upon
923 which the claims were based and determine if action by the
924 department against the physician is warranted.
925 Section 21. Section 458.3311, Florida Statutes, is created
926 to read:
927 <u>458.3311 Emergency procedures for disciplinary</u>
928 <u>action.--Notwithstanding any other provision of law to the</u>
929 <u>contrary:</u>
930 <u>(1) Each physician must report to the Department of Health</u>

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931 any judgment for medical negligence levied against the
932 physician. The physician must make the report no later than 15
933 days after the exhaustion of the last opportunity for any party
934 to appeal the judgment or request a rehearing.
935 (2) No later than 30 days after a physician has, within a
936 60-month period, made three reports as required by subsection
937 (1), the Department of Health shall initiate an emergency
938 investigation and the Board of Medicine shall conduct an
939 emergency probable cause hearing to determine whether the
940 physician should be disciplined for a violation of s.
941 458.331(1)(t) or any other relevant provision of law.
942 Section 22. Present subsection (9) of section 459.0085,
943 Florida Statutes, is renumbered as subsection (10), and a new
944 subsection (9) is added to said section, to read:
945 459.0085 Financial responsibility.--
946 (9) Notwithstanding any other provision of this section,
947 the department shall suspend the license of any osteopathic
948 physician against whom has been entered a final judgment,
949 arbitration award, or other order or who has entered into a
950 settlement agreement to pay damages arising out of a claim for
951 medical malpractice, if all appellate remedies have been
952 exhausted and payment up to the amounts required by this section
953 has not been made within 30 days after the entering of such
954 judgment, award, or order or agreement, until proof of payment
955 is received by the department or a payment schedule has been
956 agreed upon by the osteopathic physician and the claimant and
957 presented to the department. This subsection does not apply to
958 an osteopathic physician who has met the financial
959 responsibility requirements in paragraphs (1)(b) and (2)(b).
960 Section 23. Paragraph (x) of subsection (1) and subsection

961 (6) of section 459.015, Florida Statutes, are amended to read:
962 459.015 Grounds for disciplinary action; action by the
963 board and department.--
964 (1) The following acts constitute grounds for denial of a
965 license or disciplinary action, as specified in s. 456.072(2):
966 (x) Gross or repeated malpractice or the failure to
967 practice osteopathic medicine with that level of care, skill,
968 and treatment which is recognized by a reasonably prudent
969 similar osteopathic physician as being acceptable under similar
970 conditions and circumstances. The board shall give great weight
971 to the provisions of s. 766.102 when enforcing this paragraph.
972 As used in this paragraph, "repeated malpractice" includes, but
973 is not limited to, three or more claims for medical malpractice
974 within the previous 5-year period resulting in indemnities being
975 paid in excess of $50,000 ~~$25,000~~ each to the claimant in a
976 judgment or settlement and which incidents involved negligent
977 conduct by the osteopathic physician. As used in this paragraph,
978 "gross malpractice" or "the failure to practice osteopathic
979 medicine with that level of care, skill, and treatment which is
980 recognized by a reasonably prudent similar osteopathic physician
981 as being acceptable under similar conditions and circumstances"
982 shall not be construed so as to require more than one instance,
983 event, or act. Nothing in this paragraph shall be construed to
984 require that an osteopathic physician be incompetent to practice
985 osteopathic medicine in order to be disciplined pursuant to this
986 paragraph. A recommended order by an administrative law judge or
987 a final order of the board finding a violation under this
988 paragraph shall specify whether the licensee was found to have
989 committed "gross malpractice," "repeated malpractice," or
990 "failure to practice osteopathic medicine with that level of

991 care, skill, and treatment which is recognized as being
992 acceptable under similar conditions and circumstances," or any
993 combination thereof, and any publication by the board shall so
994 specify.
995 (6) Upon the department's receipt from an insurer or self-
996 insurer of a report of a closed claim against an osteopathic
997 physician pursuant to s. 627.912 or from a health care
998 practitioner of a report pursuant to s. 456.049, or upon the
999 receipt from a claimant of a presuit notice against an
1000 osteopathic physician pursuant to s. 766.106, the department
1001 shall review each report and determine whether it potentially
1002 involved conduct by a licensee that is subject to disciplinary
1003 action, in which case the provisions of s. 456.073 shall apply.
1004 However, if it is reported that an osteopathic physician has had
1005 three or more claims with indemnities exceeding $50,000 ~~$25,000~~
1006 each within the previous 5-year period, the department shall
1007 investigate the occurrences upon which the claims were based and
1008 determine if action by the department against the osteopathic
1009 physician is warranted.
1010 Section 24. Section 459.0151, Florida Statutes, is created
1011 to read:
1012 459.0151 Emergency procedures for disciplinary
1013 action.--Notwithstanding any other provision of law to the
1014 contrary:
1015 (1) Each osteopathic physician must report to the
1016 Department of Health any judgment for medical negligence levied
1017 against the physician. The osteopathic physician must make the
1018 report no later than 15 days after the exhaustion of the last
1019 opportunity for any party to appeal the judgment or request a
1020 rehearing.

1021 (2) No later than 30 days after an osteopathic physician
1022 has, within a 60-month period, made three reports as required by
1023 subsection (1), the Department of Health shall initiate an
1024 emergency investigation and the Board of Osteopathic Medicine
1025 shall conduct an emergency probable cause hearing to determine
1026 whether the physician should be disciplined for a violation of
1027 s. 459.015(1)(x) or any other relevant provision of law.
1028 Section 25. Paragraph (s) of subsection (1) and paragraph
1029 (a) of subsection (5) of section 461.013, Florida Statutes, are
1030 amended to read:
1031 461.013 Grounds for disciplinary action; action by the
1032 board; investigations by department.--
1033 (1) The following acts constitute grounds for denial of a
1034 license or disciplinary action, as specified in s. 456.072(2):
1035 (s) Gross or repeated malpractice or the failure to
1036 practice podiatric medicine at a level of care, skill, and
1037 treatment which is recognized by a reasonably prudent podiatric
1038 physician as being acceptable under similar conditions and
1039 circumstances. The board shall give great weight to the
1040 standards for malpractice in s. 766.102 in interpreting this
1041 section. As used in this paragraph, "repeated malpractice"
1042 includes, but is not limited to, three or more claims for
1043 medical malpractice within the previous 5-year period resulting
1044 in indemnities being paid in excess of $50,000 ~~$10,000~~ each to
1045 the claimant in a judgment or settlement and which incidents
1046 involved negligent conduct by the podiatric physicians. As used
1047 in this paragraph, "gross malpractice" or "the failure to
1048 practice podiatric medicine with the level of care, skill, and
1049 treatment which is recognized by a reasonably prudent similar
1050 podiatric physician as being acceptable under similar conditions

1051 and circumstances" shall not be construed so as to require more
1052 than one instance, event, or act.
1053 (5)(a) Upon the department's receipt from an insurer or
1054 self-insurer of a report of a closed claim against a podiatric
1055 physician pursuant to s. 627.912, or upon the receipt from a
1056 claimant of a presuit notice against a podiatric physician
1057 pursuant to s. 766.106, the department shall review each report
1058 and determine whether it potentially involved conduct by a
1059 licensee that is subject to disciplinary action, in which case
1060 the provisions of s. 456.073 shall apply. However, if it is
1061 reported that a podiatric physician has had three or more claims
1062 with indemnities exceeding $50,000 ~~$25,000~~ each within the
1063 previous 5-year period, the department shall investigate the
1064 occurrences upon which the claims were based and determine if
1065 action by the department against the podiatric physician is
1066 warranted.
1067 Section 26. Subsection (2) of section 624.462, Florida
1068 Statutes, is amended to read:
1069 624.462 Commercial self-insurance funds.--
1070 (2) As used in ss. 624.460-624.488, "commercial self-
1071 insurance fund" or "fund" means a group of members, operating
1072 individually and collectively through a trust or corporation,
1073 that must be:
1074 (a) Established by:
1075 1. A not-for-profit trade association, industry
1076 association, or professional association of employers or
1077 professionals which has a constitution or bylaws, which is
1078 incorporated under the laws of this state, and which has been
1079 organized for purposes other than that of obtaining or providing
1080 insurance and operated in good faith for a continuous period of

1081 1 year;
1082 2. A self-insurance trust fund organized pursuant to s.
1083 627.357 and maintained in good faith for a continuous period of
1084 1 year for purposes other than that of obtaining or providing
1085 insurance pursuant to this section. Each member of a commercial
1086 self-insurance trust fund established pursuant to this
1087 subsection must maintain membership in the self-insurance trust
1088 fund organized pursuant to s. 627.357; ~~or~~
1089 3. A group of 10 or more health care providers, as defined
1090 in s. 627.351(4)(h); or
1091 4.~~3.~~ A not-for-profit group comprised of no less than 10
1092 condominium associations as defined in s. 718.103(2), which is
1093 incorporated under the laws of this state, which restricts its
1094 membership to condominium associations only, and which has been
1095 organized and maintained in good faith for a continuous period
1096 of 1 year for purposes other than that of obtaining or providing
1097 insurance.
1098 (b)1. In the case of funds established pursuant to
1099 subparagraph (a)2. or subparagraph (a)4.~~3.~~, operated pursuant to
1100 a trust agreement by a board of trustees which shall have
1101 complete fiscal control over the fund and which shall be
1102 responsible for all operations of the fund. The majority of the
1103 trustees shall be owners, partners, officers, directors, or
1104 employees of one or more members of the fund. The trustees
1105 shall have the authority to approve applications of members for
1106 participation in the fund and to contract with an authorized
1107 administrator or servicing company to administer the day-to-day
1108 affairs of the fund.
1109 2. In the case of funds established pursuant to
1110 subparagraph (a)1. or subparagraph (a)3., operated pursuant to a

1111 trust agreement by a board of trustees or as a corporation by a
1112 board of directors which board shall:
1113 a. Be responsible to members of the fund or beneficiaries
1114 of the trust or policyholders of the corporation;
1115 b. Appoint independent certified public accountants, legal
1116 counsel, actuaries, and investment advisers as needed;
1117 c. Approve payment of dividends to members;
1118 d. Approve changes in corporate structure; and
1119 e. Have the authority to contract with an administrator
1120 authorized under s. 626.88 to administer the day-to-day affairs
1121 of the fund including, but not limited to, marketing,
1122 underwriting, billing, collection, claims administration, safety
1123 and loss prevention, reinsurance, policy issuance, accounting,
1124 regulatory reporting, and general administration. The fees or
1125 compensation for services under such contract shall be
1126 comparable to the costs for similar services incurred by
1127 insurers writing the same lines of insurance, or where available
1128 such expenses as filed by boards, bureaus, and associations
1129 designated by insurers to file such data. A majority of the
1130 trustees or directors shall be owners, partners, officers,
1131 directors, or employees of one or more members of the fund.
1132 Section 27. Subsections (7), (8), and (9) are added to
1133 section 627.062, Florida Statutes, to read:
1134 627.062 Rate standards.--
1135 (7)(a) The provisions of this subsection apply only with
1136 respect to rates for medical malpractice insurance and shall
1137 control to the extent of any conflict with other provisions of
1138 this section.
1139 (b) Any portion of a judgment entered or settlement paid
1140 as a result of a statutory or common-law badfaith action and any

1141 portion of a judgment entered which awards punitive damages
1142 against an insurer may not be included in the insurer's rate
1143 base and shall not be used to justify a rate or rate change. Any
1144 common-law badfaith action identified as such and any portion of
1145 a settlement entered as a result of a statutory or portion of a
1146 settlement wherein an insurer agrees to pay specific punitive
1147 damages may not be used to justify a rate or rate change. The
1148 portion of the taxable costs and attorney's fees which is
1149 identified as being related to the bad faith and punitive
1150 damages in these judgments and settlements may not be included
1151 in the insurer's rate base and may not be utilized to justify a
1152 rate or rate change.
1153 (c) Upon reviewing a rate filing and determining whether
1154 the rate is excessive, inadequate, or unfairly discriminatory,
1155 the Office of Insurance Regulation shall consider, in accordance
1156 with generally accepted and reasonable actuarial techniques,
1157 past and present prospective loss experience, either using loss
1158 experience solely for this state or giving greater credibility
1159 to this state's loss data.
1160 (d) Rates shall be deemed excessive if, among other
1161 standards established by this section, the rate structure
1162 provides for replenishment of reserves or surpluses from
1163 premiums when the replenishment is attributable to investment
1164 losses.
1165 (e) The insurer must apply a discount or surcharge based
1166 on the health care provider's loss experience or shall establish
1167 an alternative method giving due consideration to the provider's
1168 loss experience. The insurer must include in the filing a copy
1169 of the surcharge or discount schedule or a description of the
1170 alternative method used and must provide a copy of such schedule

1171 or description, as approved by the office, to policyholders at
1172 the time of renewal and to prospective policyholders at the time
1173 of application for coverage.
1174 (8) Each insurer writing professional liability insurance
1175 coverage for medical negligence must make a rate filing under
1176 this section with the Office of Insurance Regulation at least
1177 once each calendar year.
1178 (9)(a) Medical malpractice insurance companies shall
1179 submit a rate filing effective January 1, 2004, to the Office of
1180 Insurance Regulation no earlier than 30 days, but no later than
1181 120 days, after the date upon which this act becomes law which
1182 reduces rates by a presumed factor that reflects the impact the
1183 changes contained in all medical malpractice legislation enacted
1184 by the Florida Legislature in 2003 will have on such rates, as
1185 determined by the Office of Insurance Regulation. In determining
1186 the presumed factor, the office shall use generally accepted
1187 actuarial techniques and standards provided in this section in
1188 determining the expected impact on losses, expenses, and
1189 investment income of the insurer. Inclusion in the presumed
1190 factor of the expected impact of such legislation shall be held
1191 in abeyance during the review of such measure's validity in any
1192 proceeding by a court of competent jurisdiction.
1193 (b) Any insurer or rating organization that contends that
1194 the rate provided for in subsection (1) is excessive,
1195 inadequate, or unfairly discriminatory shall separately state in
1196 its filing the rate it contends is appropriate and shall state
1197 with specificity the factors or data that it contends should be
1198 considered in order to produce such appropriate rate. The
1199 insurer or rating organization shall be permitted to use all of
1200 the generally accepted actuarial techniques provided in this

1201 section in making any filing pursuant to this subsection. The
1202 Office of Insurance Regulation shall review each such exception
1203 and approve or disapprove it prior to use. It shall be the
1204 insurer's burden to actuarially justify any deviations from the
1205 rates filed under subsection (1). Each insurer or rating
1206 organization shall include in the filing the expected impact of
1207 all malpractice legislation enacted by the Florida Legislature
1208 in 2003 on losses, expenses, and rates. If any provision of this
1209 act is held invalid by a court of competent jurisdiction, the
1210 department shall permit an adjustment of all rates filed under
1211 this section to reflect the impact of such holding on such rates
1212 so as to ensure that the rates are not excessive, inadequate, or
1213 unfairly discriminatory.
1214 Section 28. Section 627.0662, Florida Statutes, is created
1215 to read:
1216 627.0662 Excessive profits for medical liability insurance
1217 prohibited.--
1218 (1) As used in this section:
1219 (a) "Medical liability insurance" means insurance that is
1220 written on a professional liability insurance policy issued to a
1221 health care practitioner or on a liability insurance policy
1222 covering medical malpractice claims issued to a health care
1223 facility.
1224 (b) "Medical liability insurer" means any insurance
1225 company or group of insurance companies writing medical
1226 liability insurance in this state and does not include any self-
1227 insurance fund or other nonprofit entity writing such insurance.
1228 (2) Each medical liability insurer shall file with the
1229 Office of Insurance Regulation, prior to July 1 of each year on
1230 forms prescribed by the office, the following data for medical

1231 liability insurance business in this state. The data shall
1232 include both voluntary and joint underwriting association
1233 business, as follows:
1234 (a) Calendar-year earned premium.
1235 (b) Accident-year incurred losses and loss adjustment
1236 expenses.
1237 (c) The administrative and selling expenses incurred in
1238 this state or allocated to this state for the calendar year.
1239 (d) Policyholder dividends incurred during the applicable
1240 calendar year.
1241 (3)(a) Excessive profit has been realized if there has
1242 been an underwriting gain for the 3 most recent calendar-
1243 accident years combined which is greater than the anticipated
1244 underwriting profit plus 5 percent of earned premiums for those
1245 calendar-accident years.
1246 (b) As used in this subsection with respect to any 3-year
1247 period, "anticipated underwriting profit" means the sum of the
1248 dollar amounts obtained by multiplying, for each rate filing of
1249 the insurer group in effect during such period, the earned
1250 premiums applicable to such rate filing during such period by
1251 the percentage factor included in such rate filing for profit
1252 and contingencies, such percentage factor having been determined
1253 with due recognition to investment income from funds generated
1254 by business in this state. Separate calculations need not be
1255 made for consecutive rate filings containing the same percentage
1256 factor for profits and contingencies.
1257 (4) Each medical liability insurer shall also file a
1258 schedule of medical liability insurance loss in this state and
1259 loss adjustment experience for each of the 3 most recent
1260 accident years. The incurred losses and loss adjustment expenses

1261 shall be valued as of March 31 of the year following the close
1262 of the accident year, developed to an ultimate basis, and at two
1263 12-month intervals thereafter, each developed to an ultimate
1264 basis, to the extent that a total of three evaluations is
1265 provided for each accident year. The first year to be so
1266 reported shall be accident year 2004, such that the reporting of
1267 3 accident years will not take place until accident years 2005
1268 and 2006 have become available.
1269 (5) Each insurer group's underwriting gain or loss for
1270 each calendar-accident year shall be computed as follows: the
1271 sum of the accident-year incurred losses and loss adjustment
1272 expenses as of March 31 of the following year, developed to an
1273 ultimate basis, plus the administrative and selling expenses
1274 incurred in the calendar year, plus policyholder dividends
1275 applicable to the calendar year, shall be subtracted from the
1276 calendar-year earned premium to determine the underwriting gain
1277 or loss.
1278 (6) For the 3 most recent calendar-accident years, the
1279 underwriting gain or loss shall be compared to the anticipated
1280 underwriting profit.
1281 (7) If the medical liability insurer has realized an
1282 excessive profit, the office shall order a return of the
1283 excessive amounts to policyholders after affording the insurer
1284 an opportunity for hearing and otherwise complying with the
1285 requirements of chapter 120. Such excessive amounts shall be
1286 refunded to policyholders in all instances unless the insurer
1287 affirmatively demonstrates to the office that the refund of the
1288 excessive amounts will render the insurer or a member of the
1289 insurer group financially impaired or will render it insolvent.
1290 (8) The excessive amount shall be refunded to

1291 policyholders on a pro rata basis in relation to the final
1292 compilation year earned premiums to the voluntary medical
1293 liability insurance policyholders of record of the insurer group
1294 on December 31 of the final compilation year.
1295 (9) Any return of excessive profits to policyholders under
1296 this section shall be provided in the form of a cash refund or a
1297 credit towards the future purchase of insurance.
1298 (10)(a) Cash refunds to policyholders may be rounded to
1299 the nearest dollar.
1300 (b) Data in required reports to the office may be rounded
1301 to the nearest dollar.
1302 (c) Rounding, if elected by the insurer group, shall be
1303 applied consistently.
1304 (11)(a) Refunds to policyholders shall be completed as
1305 follows:
1306 1. If the insurer elects to make a cash refund, the refund
1307 shall be completed within 60 days after entry of a final order
1308 determining that excessive profits have been realized; or
1309 2. If the insurer elects to make refunds in the form of a
1310 credit to renewal policies, such credits shall be applied to
1311 policy renewal premium notices which are forwarded to insureds
1312 more than 60 calendar days after entry of a final order
1313 determining that excessive profits have been realized. If an
1314 insurer has made this election but an insured thereafter cancels
1315 his or her policy or otherwise allows the policy to terminate,
1316 the insurer group shall make a cash refund not later than 60
1317 days after termination of such coverage.
1318 (b) Upon completion of the renewal credits or refund
1319 payments, the insurer shall immediately certify to the office
1320 that the refunds have been made.

1321 (12) Any refund or renewal credit made pursuant to this
1322 section shall be treated as a policyholder dividend applicable
1323 to the year in which it is incurred, for purposes of reporting
1324 under this section for subsequent years.
1325 Section 29. Subsection (10) of section 627.357, Florida
1326 Statutes, is amended to read:
1327 627.357 Medical malpractice self-insurance.--
1328 (10)(a) An application to form a self-insurance fund under
1329 this section must be filed with the Office of Insurance
1330 Regulation.
1331 (b) The Office of Insurance Regulation must ensure that
1332 self-insurance funds remain solvent and provide insurance
1333 coverage purchased by participants. The Financial Services
1334 Commission may adopt rules pursuant to ss. 120.536(1) and 120.54
1335 to implement this subsection ~~A self-insurance fund may not be~~
1336 ~~formed under this section after October 1, 1992~~.
1337 Section 30. Section 627.3575, Florida Statutes, is created
1338 to read:
1339 627.3575 Health Care Professional Liability Insurance
1340 Facility.--
1341 (1) FACILITY CREATED; PURPOSE; STATUS.--There is created
1342 the Health Care Professional Liability Insurance Facility. The
1343 facility is intended to meet ongoing availability and
1344 affordability problems relating to liability insurance for
1345 health care professionals by providing an affordable, self-
1346 supporting source of professional liability insurance coverage
1347 with a high deductible for those professionals who are willing
1348 and able to self-insure for smaller losses. The facility shall
1349 operate on a not-for-profit basis. The facility is self-funding
1350 and is intended to serve a public purpose but is not a state

1351 agency or program, and no activity of the facility shall create
1352 any state liability.
1353 (2) GOVERNANCE; POWERS.--
1354 (a) The facility shall operate under a seven-member board
1355 of governors consisting of the Secretary of Health, three
1356 members appointed by the Governor, and three members appointed
1357 by the Chief Financial Officer. The board shall be chaired by
1358 the Secretary of Health. The secretary shall serve by virtue of
1359 his or her office, and the other members of the board shall
1360 serve terms concurrent with the term of office of the official
1361 who appointed them. Any vacancy on the board shall be filled in
1362 the same manner as the original appointment. Members serve at
1363 the pleasure of the official who appointed them. Members are not
1364 eligible for compensation for their service on the board, but
1365 the facility may reimburse them for per diem and travel expenses
1366 at the same levels as are provided in s. 112.061 for state
1367 employees.
1368 (b) The facility shall have such powers as are necessary
1369 to operate as an insurer, including the power to:
1370 1. Sue and be sued.
1371 2. Hire such employees and retain such consultants,
1372 attorneys, actuaries, and other professionals as it deems
1373 appropriate.
1374 3. Contract with such service providers as it deems
1375 appropriate.
1376 4. Maintain offices appropriate to the conduct of its
1377 business.
1378 5. Take such other actions as are necessary or appropriate
1379 in fulfillment of its responsibilities under this section.
1380 (3) COVERAGE PROVIDED.--The facility shall provide

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1381 liability insurance coverage for health care professionals. The
1382 facility shall allow policyholders to select only from policies
1383 with deductibles of $25,000 per claim, $50,000 per claim, and
1384 $100,000 per claim and with coverage limits of $250,000 per
1385 claim and $750,000 annual aggregate and $1 million per claim and
1386 $3 million annual aggregate. To the greatest extent possible,
1387 the terms and conditions of the policies shall be consistent
1388 with terms and conditions commonly used by professional
1389 liability insurers.
1390 (4) ELIGIBILITY; TERMINATION.--
1391 (a) Any health care professional is eligible for coverage
1392 provided by the facility if the professional at all times
1393 maintains either:
1394 1. An escrow account consisting of cash or assets eligible
1395 for deposit under s. 625.52 in an amount equal to the deductible
1396 amount of the policy; or
1397 2. An unexpired, irrevocable letter of credit, established
1398 pursuant to chapter 675, in an amount not less than the
1399 deductible amount of the policy. The letter of credit shall be
1400 payable to the health care professional as beneficiary upon
1401 presentment of a final judgment indicating liability and
1402 awarding damages to be paid by the physician or upon presentment
1403 of a settlement agreement signed by all parties to such
1404 agreement when such final judgment or settlement is a result of
1405 a claim arising out of the rendering of, or the failure to
1406 render, medical care and services. Such letter of credit shall
1407 be nonassignable and nontransferable. Such letter of credit
1408 shall be issued by any bank or savings association organized and
1409 existing under the laws of this state or any bank or savings
1410 association organized under the laws of the United States that

1411 has its principal place of business in this state or has a
1412 branch office which is authorized under the laws of this state
1413 or of the United States to receive deposits in this state.
1414 (b) The eligibility of a health care professional for
1415 coverage terminates upon:
1416 1. The failure of the professional to comply with
1417 paragraph (a);
1418 2. The failure of the professional to timely pay premiums
1419 or assessments; or
1420 3. The commission of any act of fraud in connection with
1421 the policy, as determined by the board of governors.
1422 (c) The board of governors, in its discretion, may
1423 reinstate the eligibility of a health care professional whose
1424 eligibility has terminated pursuant to paragraph (b) upon
1425 determining that the professional has come back into compliance
1426 with paragraph (a) or has paid the overdue premiums or
1427 assessments. Eligibility may be reinstated in the case of fraud
1428 only if the board determines that its initial determination of
1429 fraud was in error.
1430 (5) PREMIUMS; ASSESSMENTS.--
1431 (a) The facility shall charge the actuarially indicated
1432 rate for the coverage provided plus a component for debt service
1433 and shall retain the services of consulting actuaries to prepare
1434 its rate filings. The facility shall not provide dividends to
1435 policyholders, and, to the extent that premiums are more than
1436 the amount required to cover claims and expenses, such excess
1437 shall be retained by the facility for payment of future claims.
1438 In the event of dissolution of the facility, any amounts not
1439 required as a reserve for outstanding claims shall be
1440 transferred to the policyholders of record as of the last day of

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1441 operation.

1442 (b) In the event that the premiums for a particular year,
1443 together with any investment income or reinsurance recoveries
1444 attributable to that year, are insufficient to pay losses
1445 arising out of claims accruing in that year, the facility shall
1446 levy assessments against all of the persons who were its
1447 policyholders in that year in a uniform percentage of premium.
1448 Each policyholder's assessment shall be such percentage of the
1449 premium that policyholder paid for coverage for the year to
1450 which the insufficiency is attributable.

1451 (c) The policyholder is personally liable for any
1452 assessment. The failure to timely pay an assessment is grounds
1453 for suspension or revocation of the policyholder's professional
1454 license by the appropriate licensing entity.

1455 (6) REGULATION; APPLICABILITY OF OTHER STATUTES.--

1456 (a) The facility shall operate pursuant to a plan of
1457 operation approved by order of the Office of Insurance
1458 Regulation of the Financial Services Commission. The board of
1459 governors may at any time adopt amendments to the plan of
1460 operation and submit the amendments to the Office of Insurance
1461 Regulation for approval.

1462 (b) The facility is subject to regulation by the Office of
1463 Insurance Regulation of the Financial Services Commission in the
1464 same manner as other insurers, except that, in recognition of
1465 the fact that its ability to levy assessments against its own
1466 policyholders is a substitute for the protections ordinarily
1467 afforded by such statutory requirements, the facility is exempt
1468 from statutory requirements relating to surplus as to
1469 policyholders.

1470 (c) The facility is not subject to part II of chapter 631,

1471 relating to the Florida Insurance Guaranty Association.
1472 (d) The Financial Service Commission may adopt rules to
1473 provide for the regulation of the facility consistent with the
1474 provisions of this section.
1475 (7) STARTUP PROVISIONS.--
1476 (a) It is the intent of the Legislature that the facility
1477 begin providing coverage no later than January 1, 2004.
1478 (b) The Governor and the Chief Financial Officer shall
1479 make their appointments to the board of governors of the
1480 facility no later than August 1, 2003. Until the board is
1481 appointed, the Secretary of Health may perform ministerial acts
1482 on behalf of the facility as chair of the board of governors.
1483 (c) Until the facility is able to hire permanent staff and
1484 enter into contracts for professional services, the office of
1485 the Secretary of Health shall provide support services to the
1486 facility.
1487 (d) In order to provide startup funds for the facility,
1488 the board of governors may incur debt or enter into agreements
1489 for lines of credit, provided that the sole source of funds for
1490 repayment of any debt is future premium revenues of the
1491 facility. The amount of such debt or lines of credit may not
1492 exceed $10 million.
1493 Section 31. Paragraph (c) of subsection (1) of section
1494 627.4147, Florida Statutes, is amended, and paragraph (d) is
1495 added to said subsection, to read:
1496 627.4147 Medical malpractice insurance contracts.--
1497 (1) In addition to any other requirements imposed by law,
1498 each self-insurance policy as authorized under s. 627.357 or
1499 insurance policy providing coverage for claims arising out of
1500 the rendering of, or the failure to render, medical care or

1501 services, including those of the Florida Medical Malpractice
1502 Joint Underwriting Association, shall include:
1503 (c)1. If the insurer is not leaving the state, a clause
1504 requiring the insurer or self-insurer to notify the insured no
1505 less than 60 days prior to the effective date of cancellation of
1506 the policy or contract and, in the event of a determination by
1507 the insurer or self-insurer not to renew the policy or contract,
1508 to notify the insured no less than 60 days prior to the end of
1509 the policy or contract period. If cancellation or nonrenewal is
1510 due to nonpayment or loss of license, 10 days' notice is
1511 required.
1512 2. If the insurer is leaving the state, a clause requiring
1513 the insurer or self-insurer to notify the insured no less than
1514 90 days prior to the effective date of cancellation of the
1515 policy or contract and, in the event of a determination by the
1516 insurer or self-insurer not to renew the policy or contract, to
1517 notify the insured no less than 90 days prior to the end of the
1518 policy or contract period. If cancellation or nonrenewal is due
1519 to nonpayment or loss of license, 10 days' notice is required.
1520 (d) A clause requiring the insurer or self-insurer to
1521 notify the insured no less than 60 days prior to the effective
1522 date of a rate increase. The provisions of s. 627.4133 shall
1523 apply to such notice and to the failure of the insurer to
1524 provide such notice to the extent not in conflict with this
1525 section.
1526 Section 32. Subsections (1) and (4) and paragraph (n) of
1527 subsection (2) of section 627.912, Florida Statutes, are amended
1528 to read:
1529 627.912 Professional liability claims and actions; reports
1530 by insurers.--

1531 (1)(a) Each self-insurer authorized under s. 627.357 and
1532 each insurer or joint underwriting association providing
1533 professional liability insurance to a practitioner of medicine
1534 licensed under chapter 458, to a practitioner of osteopathic
1535 medicine licensed under chapter 459, to a podiatric physician
1536 licensed under chapter 461, to a dentist licensed under chapter
1537 466, to a hospital licensed under chapter 395, to a crisis
1538 stabilization unit licensed under part IV of chapter 394, to a
1539 health maintenance organization certificated under part I of
1540 chapter 641, to clinics included in chapter 390, to an
1541 ambulatory surgical center as defined in s. 395.002, or to a
1542 member of The Florida Bar shall report in duplicate to the
1543 Department of Insurance any claim or action for damages for
1544 personal injuries claimed to have been caused by error,
1545 omission, or negligence in the performance of such insured's
1546 professional services or based on a claimed performance of
1547 professional services without consent, if the claim resulted in:
1548 1.(a) A final judgment in any amount.
1549 2.(b) A settlement in any amount.
1550
1551 Reports shall be filed with the department.
1552 (b) In addition to the requirements of paragraph (a), if
1553 the insured party is licensed under chapter 395, chapter 458,
1554 chapter 459, chapter 461, or chapter 466, the insurer shall
1555 report in duplicate to the Office of Insurance Regulation any
1556 other disposition of the claim, including, but not limited to, a
1557 dismissal. If the insured is licensed under chapter 458, chapter
1558 459, or chapter 461, any claim that resulted in a final judgment
1559 or settlement in the amount of $50,000 or more shall be reported
1560 to the Department of Health no later than 30 days following the

1561 occurrence of that event. If the insured is licensed under
1562 chapter 466, any claim that resulted in a final judgment or
1563 settlement in the amount of $25,000 or more shall be reported to
1564 the Department of Health no later than 30 days following the
1565 occurrence of that event and, if the insured party is licensed
1566 under chapter 458, chapter 459, chapter 461, or chapter 466,
1567 with the Department of Health, no later than 30 days following
1568 the occurrence of any event listed in paragraph (a) or paragraph
1569 (b). The Department of Health shall review each report and
1570 determine whether any of the incidents that resulted in the
1571 claim potentially involved conduct by the licensee that is
1572 subject to disciplinary action, in which case the provisions of
1573 s. 456.073 shall apply. The Department of Health, as part of the
1574 annual report required by s. 456.026, shall publish annual
1575 statistics, without identifying licensees, on the reports it
1576 receives, including final action taken on such reports by the
1577 Department of Health or the appropriate regulatory board.
1578 (2) The reports required by subsection (1) shall contain:
1579 (n) Any other information required by the department to
1580 analyze and evaluate the nature, causes, location, cost, and
1581 damages involved in professional liability cases. The Financial
1582 Services Commission shall adopt by rule requirements for
1583 additional information to assist the Office of Insurance
1584 Regulation in its analysis and evaluation of the nature, causes,
1585 location, cost, and damages involved in professional liability
1586 cases reported by insurers under this section.
1587 (4) There shall be no liability on the part of, and no
1588 cause of action of any nature shall arise against, any insurer
1589 reporting hereunder or its agents or employees or the department
1590 or its employees for any action taken by them under this

1591 section. The department may impose a fine of $250 per day per
1592 case, but not to exceed a total of $10,000 ~~$1,000~~ per case,
1593 against an insurer that violates the requirements of this
1594 section. This subsection applies to claims accruing on or after
1595 October 1, 1997.
1596 Section 33. Section 627.9121, Florida Statutes, is created
1597 to read:
1598 627.9121 Required reporting of claims; penalties.--Each
1599 entity that makes payment under a policy of insurance, self-
1600 insurance, or otherwise in settlement, partial settlement, or
1601 satisfaction of a judgment in a medical malpractice action or
1602 claim that is required to report information to the National
1603 Practitioner Data Bank under 42 U.S.C. s. 11131 must also report
1604 the same information to the Office of Insurance Regulation. The
1605 office shall include such information in the data that it
1606 compiles under s. 627.912. The office must compile and review
1607 the data collected pursuant to this section and must assess an
1608 administrative fine on any entity that fails to fully comply
1609 with such reporting requirements.
1610 Section 34. Subsections (12), (13), and (18) of section
1611 641.19, Florida Statutes, are amended to read:
1612 641.19 Definitions.--As used in this part, the term:
1613 (12) "Health maintenance contract" means any contract
1614 entered into by a health maintenance organization with a
1615 subscriber or group of subscribers to provide coverage for
1616 comprehensive health care services in exchange for a prepaid per
1617 capita or prepaid aggregate fixed sum.
1618 (13) "Health maintenance organization" means any
1619 organization authorized under this part which:
1620 (a) Provides, through arrangements with other persons,

1621 emergency care, inpatient hospital services, physician care
1622 including care provided by physicians licensed under chapters
1623 458, 459, 460, and 461, ambulatory diagnostic treatment, and
1624 preventive health care services.~~;~~
1625 (b) Provides, either directly or through arrangements with
1626 other persons, health care services to persons enrolled with
1627 such organization, on a prepaid per capita or prepaid aggregate
1628 fixed-sum basis.~~;~~
1629 (c) Provides, either directly or through arrangements with
1630 other persons, comprehensive health care services which
1631 subscribers are entitled to receive pursuant to a contract.~~;~~
1632 (d) Provides physician services, by physicians licensed
1633 under chapters 458, 459, 460, and 461, directly through
1634 physicians who are either employees or partners of such
1635 organization or under arrangements with a physician or any group
1636 of physicians.~~; and~~
1637 (e) If offering services through a managed care system,
1638 then the managed care system must be a system in which a primary
1639 physician licensed under chapter 458 or chapter 459 and chapters
1640 460 and 461 is designated for each subscriber upon request of a
1641 subscriber requesting service by a physician licensed under any
1642 of those chapters, and is responsible for coordinating the
1643 health care of the subscriber of the respectively requested
1644 service and for referring the subscriber to other providers of
1645 the same discipline when necessary. Each female subscriber may
1646 select as her primary physician an obstetrician/gynecologist who
1647 has agreed to serve as a primary physician and is in the health
1648 maintenance organization's provider network.
1649 (f) Except in cases in which the health care provider is
1650 an employee of the health maintenance organization, the fact

1651 that the health maintenance organization arranges for the
1652 provision of health care services under this chapter does not
1653 create an actual agency, apparent agency, or employer-employee
1654 relationship between the health care provider and the health
1655 maintenance organization for purposes of vicarious liability for
1656 the medical negligence of the health care provider.
1657 (18) "Subscriber" means an entity or individual who has
1658 contracted, or on whose behalf a contract has been entered into,
1659 with a health maintenance organization for health care coverage
1660 ~~services~~ or other persons who also receive health care coverage
1661 ~~services~~ as a result of the contract.
1662 Section 35. Subsection (3) of section 641.51, Florida
1663 Statutes, is amended to read:
1664 641.51 Quality assurance program; second medical opinion
1665 requirement.--
1666 (3) The health maintenance organization shall not have the
1667 right to control the professional judgment of a physician
1668 licensed under chapter 458, chapter 459, chapter 460, or chapter
1669 461 concerning the proper course of treatment of a subscriber
1670 ~~shall not be subject to modification by the organization or its~~
1671 ~~board of directors, officers, or administrators, unless the~~
1672 ~~course of treatment prescribed is inconsistent with the~~
1673 ~~prevailing standards of medical practice in the community~~.
1674 However, this subsection shall not be considered to restrict a
1675 utilization management program established by an organization or
1676 to affect an organization's decision as to payment for covered
1677 services. Except in cases in which the health care provider is
1678 an employee of the health maintenance organization, the health
1679 maintenance organization shall not be vicariously liable for the
1680 medical negligence of the health care provider, whether such

1681 claim is alleged under a theory of actual agency, apparent
1682 agency, or employer-employee relationship.
1683 Section 36. Subsections (2), (3), (4), and (7) of section
1684 766.106, Florida Statutes, are amended, and subsections (13),
1685 (14), (15), and (16) are added to said section, to read:
1686 766.106 Notice before filing action for medical
1687 malpractice; presuit screening period; offers for admission of
1688 liability and for arbitration; informal discovery; review.--
1689 (2)(a) After completion of presuit investigation pursuant
1690 to s. 766.203 and prior to filing a claim for medical
1691 malpractice, a claimant shall notify each prospective defendant
1692 by certified mail, return receipt requested, of intent to
1693 initiate litigation for medical malpractice. Notice to each
1694 prospective defendant must include, if available, a list of all
1695 known health care providers seen by the claimant for the
1696 injuries complained of subsequent to the alleged act of
1697 malpractice, a list of all known health care providers during
1698 the 2-year period prior to the alleged act of malpractice who
1699 treated or evaluated the claimant, and copies of all of the
1700 medical records relied upon by the expert in signing the
1701 affidavit. The requirement of providing the list of known health
1702 care providers may not serve as grounds for imposing sanctions
1703 for failure to provide presuit discovery.
1704 (b) Following the initiation of a suit alleging medical
1705 malpractice with a court of competent jurisdiction, and service
1706 of the complaint upon a defendant, the claimant shall provide a
1707 copy of the complaint to the Department of Health. The
1708 requirement of providing the complaint to the Department of
1709 Health does not impair the claimant's legal rights or ability to
1710 seek relief for his or her claim. The Department of Health shall

1711 review each incident and determine whether it involved conduct
1712 by a licensee which is potentially subject to disciplinary
1713 action, in which case the provisions of s. 456.073 apply.
1714 (3)(a) No suit may be filed for a period of 180 ~~90~~ days
1715 after notice is mailed to any prospective defendant. During the
1716 180-day ~~90-day~~ period, the prospective defendant's insurer or
1717 self-insurer shall conduct a review to determine the liability
1718 of the defendant. Each insurer or self-insurer shall have a
1719 procedure for the prompt investigation, review, and evaluation
1720 of claims during the 180-day ~~90-day~~ period. This procedure shall
1721 include one or more of the following:
1722 1. Internal review by a duly qualified claims adjuster;
1723 2. Creation of a panel comprised of an attorney
1724 knowledgeable in the prosecution or defense of medical
1725 malpractice actions, a health care provider trained in the same
1726 or similar medical specialty as the prospective defendant, and a
1727 duly qualified claims adjuster;
1728 3. A contractual agreement with a state or local
1729 professional society of health care providers, which maintains a
1730 medical review committee;
1731 4. Any other similar procedure which fairly and promptly
1732 evaluates the pending claim.
1733
1734 Each insurer or self-insurer shall investigate the claim in good
1735 faith, and both the claimant and prospective defendant shall
1736 cooperate with the insurer in good faith. If the insurer
1737 requires, a claimant shall appear before a pretrial screening
1738 panel or before a medical review committee and shall submit to a
1739 physical examination, if required. Unreasonable failure of any
1740 party to comply with this section justifies dismissal of claims

1741 or defenses. There shall be no civil liability for participation
1742 in a pretrial screening procedure if done without intentional
1743 fraud.
1744 (b) At or before the end of the 180 ~~90~~ days, the insurer
1745 or self-insurer shall provide the claimant with a response:
1746 1. Rejecting the claim;
1747 2. Making a settlement offer; or
1748 3. Making an offer to arbitrate, in which case liability
1749 is deemed admitted and arbitration will be held only ~~of~~
1750 ~~admission of liability and for arbitration~~ on the issue of
1751 damages. This offer may be made contingent upon a limit of
1752 general damages.
1753 (c) The response shall be delivered to the claimant if not
1754 represented by counsel or to the claimant's attorney, by
1755 certified mail, return receipt requested. Failure of the
1756 prospective defendant or insurer or self-insurer to reply to the
1757 notice within 180 ~~90~~ days after receipt shall be deemed a final
1758 rejection of the claim for purposes of this section.
1759 (d) Within 30 days after ~~of~~ receipt of a response by a
1760 prospective defendant, insurer, or self-insurer to a claimant
1761 represented by an attorney, the attorney shall advise the
1762 claimant in writing of the response, including:
1763 1. The exact nature of the response under paragraph (b).
1764 2. The exact terms of any settlement offer, or admission
1765 of liability and offer of arbitration on damages.
1766 3. The legal and financial consequences of acceptance or
1767 rejection of any settlement offer, or admission of liability,
1768 including the provisions of this section.
1769 4. An evaluation of the time and likelihood of ultimate
1770 success at trial on the merits of the claimant's action.

1771 5. An estimation of the costs and attorney's fees of
1772 proceeding through trial.
1773 (4) The notice of intent to initiate litigation shall be
1774 served within the time limits set forth in s. 95.11. However,
1775 during the 180-day ~~90-day~~ period, the statute of limitations is
1776 tolled as to all potential defendants. Upon stipulation by the
1777 parties, the 180-day ~~90-day~~ period may be extended and the
1778 statute of limitations is tolled during any such extension. Upon
1779 receiving notice of termination of negotiations in an extended
1780 period, the claimant shall have 60 days or the remainder of the
1781 period of the statute of limitations, whichever is greater,
1782 within which to file suit.
1783 (7) Informal discovery may be used by a party to obtain
1784 unsworn statements, the production of documents or things, and
1785 physical and mental examinations, as follows:
1786 (a) *Unsworn statements.*--Any party may require other
1787 parties to appear for the taking of an unsworn statement. Such
1788 statements may be used only for the purpose of presuit screening
1789 and are not discoverable or admissible in any civil action for
1790 any purpose by any party. A party desiring to take the unsworn
1791 statement of any party must give reasonable notice in writing to
1792 all parties. The notice must state the time and place for taking
1793 the statement and the name and address of the party to be
1794 examined. Unless otherwise impractical, the examination of any
1795 party must be done at the same time by all other parties. Any
1796 party may be represented by counsel at the taking of an unsworn
1797 statement. An unsworn statement may be recorded electronically,
1798 stenographically, or on videotape. The taking of unsworn
1799 statements is subject to the provisions of the Florida Rules of
1800 Civil Procedure and may be terminated for abuses.

1801 (b) *Documents or things.*--Any party may request discovery
1802 of documents or things. The documents or things must be
1803 produced, at the expense of the requesting party, within 20 days
1804 after the date of receipt of the request. A party is required to
1805 produce discoverable documents or things within that party's
1806 possession or control.
1807 (c) *Physical and mental examinations.*--A prospective
1808 defendant may require an injured prospective claimant to appear
1809 for examination by an appropriate health care provider. The
1810 defendant shall give reasonable notice in writing to all parties
1811 as to the time and place for examination. Unless otherwise
1812 impractical, a prospective claimant is required to submit to
1813 only one examination on behalf of all potential defendants. The
1814 practicality of a single examination must be determined by the
1815 nature of the potential claimant's condition, as it relates to
1816 the liability of each potential defendant. Such examination
1817 report is available to the parties and their attorneys upon
1818 payment of the reasonable cost of reproduction and may be used
1819 only for the purpose of presuit screening. Otherwise, such
1820 examination report is confidential and exempt from the
1821 provisions of s. 119.07(1) and s. 24(a), Art. I of the State
1822 Constitution.
1823 (d) Written questions.--Any party may request answers to
1824 written questions, the number of which may not exceed 30,
1825 including subparts. A response must be made within 20 days after
1826 receipt of the questions.
1827 (e) Informal discovery.--It is the intent of the
1828 Legislature that informal discovery may be conducted pursuant to
1829 this subsection by any party without notice to any other party,
1830 except that such informal discovery shall not infringe upon or

1831 violate such other party's physician-patient, attorney-client,
1832 psychotherapist-patient, or other such privilege of
1833 confidentiality as provided by law.
1834 (13) In matters relating to professional liability
1835 insurance coverage for medical negligence, an insurer shall not
1836 be held in bad faith for failure to timely pay its policy limits
1837 if it tenders its policy limits and meets all other conditions
1838 of settlement prior to the conclusion of the presuit screening
1839 period provided for in this section.
1840 (14) Failure to cooperate on the part of any party during
1841 the presuit investigation may be grounds to strike any claim
1842 made, or defense raised, by such party in suit.
1843 (15) In all matters relating to professional liability
1844 insurance coverage for medical negligence, and in determining
1845 whether the insurer acted fairly and honestly towards its
1846 insured with due regard for her or his interest during the
1847 presuit process or after a complaint has been filed, the
1848 following factors shall be considered, together with all other
1849 relevant facts and circumstances:
1850 (a) The insurer's willingness to negotiate with the
1851 claimant;
1852 (b) The insurer's consideration of the advice of its
1853 defense counsel;
1854 (c) The insurer's proper investigation of the claim;
1855 (d) Whether the insurer informed the insured of the offer
1856 to settle within the limits of coverage, the right to retain
1857 personal counsel, and risk of litigation;
1858 (e) Whether the insured denied liability or requested that
1859 the case be defended; and
1860 (f) Whether the claimant imposed any condition, other than

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1861 the tender of the policy limits, on the settlement of the claim.
1862 (16) The claimant must execute a medical information
1863 release that allows a defendant or his or her legal
1864 representative to obtain unsworn statements of the claimant's
1865 treating physicians, which statements must be limited to those
1866 areas that are potentially relevant to the claim of personal
1867 injury or wrongful death.
1868 Section 37. Section 766.1065, Florida Statutes, is created
1869 to read:
1870 766.1065 Mandatory staging of presuit investigation and
1871 mandatory mediation.--
1872 (1) Within 30 days after service of the presuit notice of
1873 intent to initiate medical malpractice litigation, each party
1874 shall voluntarily produce to all other parties, without being
1875 requested, any and all medical, hospital, health care, and
1876 employment records concerning the claimant in the disclosing
1877 party's possession, custody, or control, and the disclosing
1878 party shall affirmatively certify in writing that the records
1879 produced include all records in that party's possession,
1880 custody, or control or that the disclosing party has no medical,
1881 hospital, health care, or employment records concerning the
1882 claimant.
1883 (a) Subpoenas may be issued according to the Florida Rules
1884 of Civil Procedure as though suit had been filed for the limited
1885 purpose of obtaining copies of medical, hospital, health care,
1886 and employment records of the claimant. The party shall indicate
1887 on the subpoena that it is being issued in accordance with the
1888 presuit procedures of this section and shall not be required to
1889 include a case number.
1890 (b) Nothing in this section shall limit the ability of any

1891 party to use any other available form of presuit discovery
1892 available under this chapter or the Florida Rules of Civil
1893 Procedure.
1894 (2) Within 60 days after service of the presuit notice of
1895 intent to initiate medical malpractice litigation, all parties
1896 must be made available for a sworn deposition. Such deposition
1897 may not be used in a civil suit for medical negligence.
1898 (3) Within 120 days after service of the presuit notice of
1899 intent to initiate medical malpractice litigation, each party's
1900 corroborating expert, who will otherwise be tendered as the
1901 expert complying with the affidavit provisions set forth in s.
1902 766.203, must be made available for a sworn deposition.
1903 (a) The expenses associated with the expert's time and
1904 travel in preparing for and attending such deposition shall be
1905 the responsibility of the party retaining such expert.
1906 (b) An expert shall be deemed available for deposition if
1907 suitable accommodations can be made for appearance of said
1908 expert via real-time video technology.
1909 Section 38. Section 766.1067, Florida Statutes, is created
1910 to read:
1911 766.1067 Mandatory mediation after suit is filed.--Within
1912 120 days after suit being filed, unless such period is extended
1913 by mutual agreement of all parties, all parties shall attend in-
1914 person mandatory mediation in accordance with s. 44.102 if
1915 binding arbitration under s. 766.106 or s. 766.207 has not been
1916 agreed to by the parties. The Florida Rules of Civil Procedure
1917 shall apply to mediation held pursuant to this section.
1918 Section 39. Section 766.118, Florida Statutes, is created
1919 to read:
1920 766.118 Determination of noneconomic damages.--With

1921 respect to a cause of action for personal injury or wrongful
1922 death resulting from an occurrence of medical negligence,
1923 including actions pursuant to s. 766.209, damages recoverable
1924 for noneconomic losses to compensate for pain and suffering,
1925 inconvenience, physical impairment, mental anguish,
1926 disfigurement, loss of capacity for enjoyment of life, and all
1927 other noneconomic damages shall not exceed $250,000, regardless
1928 of the number of claimants or defendants involved in the action.
1929 Section 40. Section 766.2015, Florida Statutes, is created
1930 to read:
1931 766.2015 Frivolous claims.--
1932 (1) In any civil litigation resulting from a medical
1933 malpractice claim, the prevailing party, after judgment in the
1934 trial court and exhaustion of all appeals, if any, may receive
1935 his or her reasonable attorney’s fees and costs from the
1936 nonprevailing party if the court finds that there was a complete
1937 absence of a justiciable issue of either law or fact raised by
1938 the losing party or if the court finds bad faith on the part of
1939 the losing party.
1940 (2) The attorney for the prevailing party shall submit to
1941 the trial judge who presided over the civil case a sworn
1942 affidavit of his or her time spent on the case and the costs
1943 incurred by the prevailing party for all the motions, hearings,
1944 and appeals.
1945 (3) The trial judge may award the prevailing party the sum
1946 of reasonable costs incurred in the action plus a reasonable
1947 attorney's fee for the hours actually spent on the case as sworn
1948 to in an affidavit.
1949 (4) Any award of attorney’s fees or costs shall become a
1950 part of the judgment and shall be subject to execution as

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1951 provided by law.

1952 Section 41. Subsections (3), (5), (7), and (8) of section
1953 766.202, Florida Statutes, are amended to read:

1954 766.202 Definitions; ss. 766.201-766.212.--As used in ss.
1955 766.201-766.212, the term:

1956 (3) "Economic damages" means financial losses that ~~which~~
1957 would not have occurred but for the injury giving rise to the
1958 cause of action, including, but not limited to, past and future
1959 medical expenses and 80 percent of wage loss and loss of earning
1960 capacity, to the extent the claimant is entitled to recover such
1961 damages under general law, including the Wrongful Death Act.

1962 (5) "Medical expert" means a person familiar with the
1963 evaluation, diagnosis, or treatment of the medical condition at
1964 issue who:

1965 (a) Is duly and regularly engaged in the practice of his
1966 or her profession, ~~who~~ holds a health care professional degree
1967 from a university or college, and has had special professional
1968 training and experience; or

1969 (b) Has ~~one possessed of~~ special health care knowledge or
1970 skill about the subject upon which he or she is called to
1971 testify or provide an opinion.

1972

1973 Such expert shall certify that he or she has similar credentials
1974 and expertise in the area of the defendant's particular practice
1975 or specialty, if the defendant is a specialist.

1976 (7) "Noneconomic damages" means nonfinancial losses which
1977 would not have occurred but for the injury giving rise to the
1978 cause of action, including pain and suffering, inconvenience,
1979 physical impairment, mental anguish, disfigurement, loss of
1980 capacity for enjoyment of life, and other nonfinancial losses,

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1981 to the extent the claimant is entitled to recover such damages
1982 under general law, including the Wrongful Death Act.
1983 (8) "Periodic payment" means provision for the structuring
1984 of future economic and future noneconomic damages payments, in
1985 whole or in part, over a period of time, as follows:
1986 (a) A specific finding must be made of the dollar amount
1987 of periodic payments which will compensate for these future
1988 damages after offset for collateral sources and after having
1989 been reduced to present value ~~shall be made~~. A periodic payment
1990 must be structured to last as long as the claimant lives ~~The~~
1991 ~~total dollar amount of the periodic payments shall equal the~~
1992 ~~dollar amount of all such future damages before any reduction to~~
1993 ~~present value~~.
1994 (b) A defendant that elects to make periodic payments of
1995 either or both future economic and future noneconomic losses may
1996 contractually obligate a company that is authorized to do
1997 business in this state and rated by A.M. Best Company as "A+" or
1998 higher to make those periodic payments on its behalf. Upon a
1999 joint petition by the defendant and the company that is
2000 contractually obligated to make the periodic payments, the court
2001 shall discharge the defendant from any further obligations to
2002 the claimant for those future economic and future noneconomic
2003 damages that are to be paid by that company by periodic
2004 payments.
2005 (c) A bond or security may not be required of any
2006 defendant or company that is obligated to make periodic payments
2007 pursuant to this section; however, if, upon petition by a
2008 claimant who is receiving periodic payments pursuant to this
2009 section, the court finds that there is substantial, competent
2010 evidence that the defendant that is responsible for the periodic

2011 payments cannot adequately ensure full and continuous payments
2012 thereof or that the company that is obligated to make the
2013 payments has been rated by A.M. Best Company as "B+" or lower,
2014 and that doing so is in the best interest of the claimant, the
2015 court may require the defendant or the company that is obligated
2016 to make the periodic payments to provide such additional
2017 financial security as the court determines to be reasonable
2018 under the circumstances.
2019 (d) The provision for the periodic payments must specify
2020 the recipient or recipients of the payments, the address to
2021 which the payments are to be delivered, and the amount and
2022 intervals of the payments; however, in any one year, any payment
2023 or payments may not exceed the amount intended by the trier of
2024 fact to be awarded each year, offset for collateral sources. A
2025 periodic payment may not be accelerated, deferred, increased, or
2026 decreased, except by court order based upon the mutual consent
2027 and agreement of the claimant, the defendant, whether or not
2028 discharged, and the company that is obligated to make the
2029 periodic payments, if any; nor may the claimant sell, mortgage,
2030 encumber, or anticipate the periodic payments or any part
2031 thereof, by assignment or otherwise. ~~The defendant shall be~~
2032 ~~required to post a bond or security or otherwise to assure full~~
2033 ~~payment of these damages awarded. A bond is not adequate unless~~
2034 ~~it is written by a company authorized to do business in this~~
2035 ~~state and is rated A+ by Best's. If the defendant is unable to~~
2036 ~~adequately assure full payment of the damages, all damages,~~
2037 ~~reduced to present value, shall be paid to the claimant in a~~
2038 ~~lump sum. No bond may be canceled or be subject to cancellation~~
2039 ~~unless at least 60 days' advance written notice is filed with~~
2040 ~~the court and the claimant. Upon termination of periodic~~

2041 ~~payments, the security, or so much as remains, shall be returned~~
2042 ~~to the defendant.~~
2043 ~~(c) The provision for payment of future damages by~~
2044 ~~periodic payments shall specify the recipient or recipients of~~
2045 ~~the payments, the dollar amounts of the payments, the interval~~
2046 ~~between payments, and the number of payments or the period of~~
2047 ~~time over which payments shall be made.~~
2048 Section 42. Subsections (2) and (3) of section 766.203,
2049 Florida Statutes, are amended to read:
2050 766.203 Presuit investigation of medical negligence claims
2051 and defenses by prospective parties.--
2052 (2) Prior to issuing notification of intent to initiate
2053 medical malpractice litigation pursuant to s. 766.106, the
2054 claimant shall conduct an investigation to ascertain that there
2055 are reasonable grounds to believe that:
2056 (a) Any named defendant in the litigation was negligent in
2057 the care or treatment of the claimant; and
2058 (b) Such negligence resulted in injury to the claimant.
2059
2060 Corroboration of reasonable grounds to initiate medical
2061 negligence litigation shall be provided by the claimant's
2062 submission of a verified written medical expert opinion from a
2063 medical expert as defined in s. 766.202(5), at the time the
2064 notice of intent to initiate litigation is mailed, which
2065 statement shall corroborate reasonable grounds to support the
2066 claim of medical negligence. <u>This opinion and statement are</u>
2067 <u>subject to discovery.</u>
2068 (3) Prior to issuing its response to the claimant's notice
2069 of intent to initiate litigation, during the time period for
2070 response authorized pursuant to s. 766.106, the defendant or the

2071 defendant's insurer or self-insurer shall conduct an
2072 investigation to ascertain whether there are reasonable grounds
2073 to believe that:
2074 (a) The defendant was negligent in the care or treatment
2075 of the claimant; and
2076 (b) Such negligence resulted in injury to the claimant.
2077
2078 Corroboration of lack of reasonable grounds for medical
2079 negligence litigation shall be provided with any response
2080 rejecting the claim by the defendant's submission of a verified
2081 written medical expert opinion from a medical expert as defined
2082 in s. 766.202(5), at the time the response rejecting the claim
2083 is mailed, which statement shall corroborate reasonable grounds
2084 for lack of negligent injury sufficient to support the response
2085 denying negligent injury. This opinion and statement are subject
2086 to discovery.
2087 Section 43. Subsections (2), (3), and (7) of section
2088 766.207, Florida Statutes, are amended to read:
2089 766.207 Voluntary binding arbitration of medical
2090 negligence claims.--
2091 (2) Upon the completion of presuit investigation with
2092 preliminary reasonable grounds for a medical negligence claim
2093 intact, the parties may elect to have damages determined by an
2094 arbitration panel. Such election may be initiated by either
2095 party by serving a request for voluntary binding arbitration of
2096 damages within 180 ~~90~~ days after service of the claimant's
2097 notice of intent to initiate litigation upon the defendant. The
2098 evidentiary standards for voluntary binding arbitration of
2099 medical negligence claims shall be as provided in ss.
2100 120.569(2)(g) and 120.57(1)(c).

2101 (3) Upon receipt of a party's request for such
2102 arbitration, the opposing party may accept the offer of
2103 voluntary binding arbitration within 30 days. However, in no
2104 event shall the defendant be required to respond to the request
2105 for arbitration sooner than 180 ~~90~~ days after service of the
2106 notice of intent to initiate litigation under s. 766.106. Such
2107 acceptance within the time period provided by this subsection
2108 shall be a binding commitment to comply with the decision of the
2109 arbitration panel. The liability of any insurer shall be subject
2110 to any applicable insurance policy limits.
2111 (7) Arbitration pursuant to this section shall preclude
2112 recourse to any other remedy by the claimant against any
2113 participating defendant, and shall be undertaken with the
2114 understanding that damages shall be awarded as provided by
2115 general law, including the Wrongful Death Act, subject to the
2116 following limitations:
2117 (a) Net economic damages shall be awardable, including,
2118 but not limited to, past and future medical expenses and 80
2119 percent of wage loss and loss of earning capacity, offset by any
2120 collateral source payments.
2121 (b) Noneconomic damages shall be limited to a maximum of
2122 $250,000 per incident, and shall be calculated on a percentage
2123 basis with respect to capacity to enjoy life, so that a finding
2124 that the claimant's injuries resulted in a 50-percent reduction
2125 in his or her capacity to enjoy life would warrant an award of
2126 not more than $125,000 noneconomic damages.
2127 (c) Damages for future economic losses shall be awarded to
2128 be paid by periodic payments pursuant to s. 766.202(8) and shall
2129 be offset by future collateral source payments.
2130 (d) Punitive damages shall not be awarded.

2131 (e) The defendant shall be responsible for the payment of
2132 interest on all accrued damages with respect to which interest
2133 would be awarded at trial.
2134 (f) The defendant shall pay the claimant's reasonable
2135 attorney's fees and costs, as determined by the arbitration
2136 panel, but in no event more than 15 percent of the award,
2137 reduced to present value.
2138 (g) The defendant shall pay all the costs of the
2139 arbitration proceeding and the fees of all the arbitrators other
2140 than the administrative law judge.
2141 (h) Each defendant who submits to arbitration under this
2142 section shall be jointly and severally liable for all damages
2143 assessed pursuant to this section.
2144 (i) The defendant's obligation to pay the claimant's
2145 damages shall be for the purpose of arbitration under this
2146 section only. A defendant's or claimant's offer to arbitrate
2147 shall not be used in evidence or in argument during any
2148 subsequent litigation of the claim following the rejection
2149 thereof.
2150 (j) The fact of making or accepting an offer to arbitrate
2151 shall not be admissible as evidence of liability in any
2152 collateral or subsequent proceeding on the claim.
2153 (k) Any offer by a claimant to arbitrate must be made to
2154 each defendant against whom the claimant has made a claim. Any
2155 offer by a defendant to arbitrate must be made to each claimant
2156 who has joined in the notice of intent to initiate litigation,
2157 as provided in s. 766.106. A defendant who rejects a claimant's
2158 offer to arbitrate shall be subject to the provisions of s.
2159 766.209(3). A claimant who rejects a defendant's offer to
2160 arbitrate shall be subject to the provisions of s. 766.209(4).

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2161 (l) The hearing shall be conducted by all of the
2162 arbitrators, but a majority may determine any question of fact
2163 and render a final decision. The chief arbitrator shall decide
2164 all evidentiary matters.
2165
2166 The provisions of this subsection shall not preclude settlement
2167 at any time by mutual agreement of the parties.
2168 Section 44. Section 766.213, Florida Statutes, is created
2169 to read:
2170 766.213 Periodic payment of damages upon death of
2171 claimant.--Any portion of a periodic payment made pursuant to a
2172 settlement or jury award or pursuant to mediation or arbitration
2173 which is attributable to medical expenses that have not yet been
2174 incurred shall terminate upon the death of the claimant. Any
2175 outstanding medical expenses incurred prior to the death of the
2176 claimant shall be paid from that portion of the periodic payment
2177 attributable to medical expenses.
2178 Section 45. Subsection (4) is added to section 768.041,
2179 Florida Statutes, to read:
2180 768.041 Release or covenant not to sue.--
2181 (4)(a) At trial pursuant to a suit filed under chapter
2182 766, or at trial pursuant to s. 766.209, if any defendant shows
2183 the court that the plaintiff, or his or her legal
2184 representative, has delivered a written release or covenant not
2185 to sue to any person in partial satisfaction of the damages sued
2186 for, the court shall set off this amount from the total amount
2187 of the damages set forth in the verdict and before entry of the
2188 final judgment.
2189 (b) The amount of the setoff pursuant to this subsection
2190 shall include all sums received by the plaintiff, including

2191 economic and noneconomic damages, costs, and attorney's fees.
2192 Section 46. Section 768.77, Florida Statutes, is amended
2193 to read:
2194 768.77 Itemized verdict.--
2195 (1) Except as provided in subsection (2), in any action to
2196 which this part applies in which the trier of fact determines
2197 that liability exists on the part of the defendant, the trier of
2198 fact shall, as a part of the verdict, itemize the amounts to be
2199 awarded to the claimant into the following categories of
2200 damages:
2201 (a)~~(1)~~ Amounts intended to compensate the claimant for
2202 economic losses;
2203 (b)~~(2)~~ Amounts intended to compensate the claimant for
2204 noneconomic losses; and
2205 (c)~~(3)~~ Amounts awarded to the claimant for punitive
2206 damages, if applicable.
2207 (2) In any action for damages based on personal injury or
2208 wrongful death arising out of medical malpractice, whether in
2209 tort or contract, to which this part applies in which the trier
2210 of fact determines that liability exists on the part of the
2211 defendant, the trier of fact shall, as a part of the verdict,
2212 itemize the amounts to be awarded to the claimant into the
2213 following categories of damages:
2214 (a) Amounts intended to compensate the claimant for:
2215 1. Past economic losses; and
2216 2. Future economic losses, not reduced to present value,
2217 and the number of years or part thereof which the award is
2218 intended to cover;
2219 (b) Amounts intended to compensate the claimant for:
2220 1. Past noneconomic losses; and

2221 2. Future noneconomic losses and the number of years or
2222 part thereof which the award is intended to cover; and
2223 (c) Amounts awarded to the claimant for punitive damages,
2224 if applicable.
2225 Section 47. Subsection (2) and paragraph (a) of subsection
2226 (1) of section 768.78, Florida Statutes, is amended to read:
2227 768.78 Alternative methods of payment of damage awards.--
2228 (1)(a) In any action to which this part applies in which
2229 the court determines that an award to compensate the claimant
2230 includes future economic losses which exceed $250,000, payment
2231 of amounts intended to compensate the claimant for these losses
2232 shall be made by one of the following means, unless an
2233 alternative method of payment of damages is provided in this
2234 section:
2235 1. The defendant may make a lump-sum payment for all
2236 damages so assessed, with future economic losses and expenses
2237 reduced to present value; or
2238 2. Subject to the provisions of this subsection, the court
2239 shall, at the request of either party, unless the court
2240 determines that manifest injustice would result to any party,
2241 enter a judgment ordering future economic damages, as itemized
2242 pursuant to s. 768.77(1)(a), in excess of $250,000 to be paid in
2243 whole or in part by periodic payments rather than by a lump-sum
2244 payment.
2245 (2)(a) In any action for damages based on personal injury
2246 or wrongful death arising out of medical malpractice, whether in
2247 tort or contract, in which the trier of fact makes an award to
2248 compensate the claimant for future economic or future
2249 noneconomic losses, payment of amounts intended to compensate
2250 the claimant for these future losses shall be made by one of the

2251 following means:

2252 1. The defendant may elect to make a lump-sum payment for
2253 either or both the ~~all damages so assessed, with~~ future economic
2254 and future noneconomic losses after offset for collateral
2255 sources and after having been ~~and expenses~~ reduced to present
2256 value by the court based upon competent, substantial evidence
2257 presented to it by the parties; or

2258 2. The defendant, if determined by the court to be
2259 financially capable or adequately insured, may elect to use
2260 periodic payments to satisfy in whole or in part the assessed
2261 future economic and future noneconomic losses awarded by the
2262 trier of fact after offset for collateral sources for so long as
2263 the claimant lives or the condition for which the award was made
2264 persists, whichever period may be shorter, but without regard
2265 for the number of years awarded by the trier of fact. The court
2266 shall review and, unless clearly unresponsive to the future
2267 needs of the claimant, approve the amounts and schedule of the
2268 periodic payments proposed by the defendant.

2269 (b) A defendant that elects to make periodic payments of
2270 either or both future economic and future noneconomic losses may
2271 contractually obligate a company that is authorized to do
2272 business in this state and rated by A.M. Best Company as "A+" or
2273 higher to make those periodic payments on its behalf. Upon a
2274 joint petition by the defendant and the company that is
2275 contractually obligated to make the periodic payments, the court
2276 shall discharge the defendant from any further obligations to
2277 the claimant for those future economic and future noneconomic
2278 damages that are to be paid by that company by periodic
2279 payments.

2280 (c) Upon notice of a defendant's election to make periodic

2281 payments pursuant hereto, the claimant may request that the
2282 court modify the periodic payments to reasonably provide for
2283 attorney's fees; however, a court may not make any such
2284 modification that would increase the amount the defendant would
2285 have been obligated to pay had no such adjustment been made.
2286 (d) A bond or security may not be required of any
2287 defendant or company that is obligated to make periodic payments
2288 pursuant to this section; however, if, upon petition by a
2289 claimant who is receiving periodic payments pursuant to this
2290 section, the court finds that there is substantial, competent
2291 evidence that the defendant that is responsible for the periodic
2292 payments cannot adequately ensure full and continuous payments
2293 thereof or that the company that is obligated to make the
2294 payments has been rated by A.M. Best Company as "B+" or lower,
2295 and that doing so is in the best interest of the claimant, the
2296 court may require the defendant or the company that is obligated
2297 to make the periodic payments to provide such additional
2298 financial security as the court determines to be reasonable
2299 under the circumstances.
2300 (e) The provision for the periodic payments must specify
2301 the recipient or recipients of the payments, the address to
2302 which the payments are to be delivered, and the amount and
2303 intervals of the payments; however, in any one year, any payment
2304 or payments may not exceed the amount intended by the trier of
2305 fact to be awarded each year, offset for collateral sources. A
2306 periodic payment may not be accelerated, deferred, increased, or
2307 decreased, except by court order based upon the mutual consent
2308 and agreement of the claimant, the defendant, whether or not
2309 discharged, and the company that is obligated to make the
2310 periodic payments, if any; nor may the claimant sell, mortgage,

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2311 encumber, or anticipate the periodic payments or any part
2312 thereof, by assignment or otherwise.
2313 (f) For purposes of this section, the term "periodic
2314 payment" means the payment of money or delivery of other
2315 property to the claimant at regular intervals.
2316 (g) It is the intent of the Legislature to authorize and
2317 encourage the payment of awards for future economic and future
2318 noneconomic losses by periodic payments to meet the continuing
2319 needs of the patient while eliminating the misdirection of such
2320 funds for purposes not intended by the trier of fact ~~court~~
2321 ~~shall, at the request of either party, enter a judgment ordering~~
2322 ~~future economic damages, as itemized pursuant to s. 768.77, to~~
2323 ~~be paid by periodic payments rather than lump sum~~.
2324 ~~(b) For purposes of this subsection, "periodic payment"~~
2325 ~~means provision for the spreading of future economic damage~~
2326 ~~payments, in whole or in part, over a period of time, as~~
2327 ~~follows:~~
2328 ~~1. A specific finding of the dollar amount of periodic~~
2329 ~~payments which will compensate for these future damages after~~
2330 ~~offset for collateral sources shall be made. The total dollar~~
2331 ~~amount of the periodic payments shall equal the dollar amount of~~
2332 ~~all such future damages before any reduction to present value.~~
2333 ~~2. The defendant shall be required to post a bond or~~
2334 ~~security or otherwise to assure full payment of these damages~~
2335 ~~awarded. A bond is not adequate unless it is written by a~~
2336 ~~company authorized to do business in this state and is rated A+~~
2337 ~~by Best's. If the defendant is unable to adequately assure full~~
2338 ~~payment of the damages, all damages, reduced to present value,~~
2339 ~~shall be paid to the claimant in a lump sum. No bond may be~~
2340 ~~canceled or be subject to cancellation unless at least 60 days'~~

2341 ~~advance written notice is filed with the court and the claimant.~~
2342 ~~Upon termination of periodic payments, the security, or so much~~
2343 ~~as remains, shall be returned to the defendant.~~
2344 ~~3. The provision for payment of future damages by periodic~~
2345 ~~payments shall specify the recipient or recipients of the~~
2346 ~~payments, the dollar amounts of the payments, the interval~~
2347 ~~between payments, and the number of payments or the period of~~
2348 ~~time over which payments shall be made.~~
2349 Section 48. Subsection (1) of section 766.112, Florida
2350 Statutes, is amended to read:
2351 766.112 Comparative fault.--
2352 (1) Notwithstanding <u>any provision of</u> ~~anything in~~ law to
2353 the contrary, in an action for damages for personal injury or
2354 wrongful death arising out of medical malpractice, whether in
2355 contract or tort, ~~when an apportionment of damages pursuant to~~
2356 ~~this section is attributed to a teaching hospital as defined in~~
2357 ~~s. 408.07,~~ the court shall enter judgment ~~against the teaching~~
2358 ~~hospital~~ on the basis of <u>each</u> ~~such~~ party's percentage of fault
2359 and not on the basis of the doctrine of joint and several
2360 liability.
2361 Section 49. Subsection (5) of section 768.81, Florida
2362 Statutes, is amended to read:
2363 768.81 Comparative fault.--
2364 (5) Notwithstanding <u>any provision of</u> ~~anything in~~ law to
2365 the contrary, in an action for damages for personal injury or
2366 wrongful death arising out of medical malpractice, whether in
2367 contract or tort, ~~when an apportionment of damages pursuant to~~
2368 ~~this section is attributed to a teaching hospital as defined in~~
2369 ~~s. 408.07,~~ the court shall enter judgment ~~against the teaching~~
2370 ~~hospital~~ on the basis of <u>each</u> ~~such~~ party's percentage of fault

2371 and not on the basis of the doctrine of joint and several
2372 liability.
2373 Section 50. Section 1004.08, Florida Statutes, is created
2374 to read:
2375 1004.08 Patient safety instructional requirements.--Every
2376 public school, college, and university that offers degrees in
2377 medicine, nursing, and allied health shall include in the
2378 curricula applicable to such degrees material on patient safety,
2379 including patient safety improvement. Materials shall include,
2380 but need not be limited to, effective communication and
2381 teamwork; epidemiology of patient injuries and medical errors;
2382 vigilance, attention, and fatigue; checklists and inspections;
2383 automation and technological and computer support; psychological
2384 factors in human error; and reporting systems.
2385 Section 51. Section 1004.085, Florida Statutes, is created
2386 to read:
2387 1004.085 Informed consent standardization project.--Every
2388 public school, college, and university that offers degrees in
2389 medicine, nursing, and allied health shall work with the
2390 Department of Health to develop bilingual, multimedia methods
2391 for communicating the risks of treatment options for medical
2392 procedures. Such materials shall be provided to patients and
2393 their families in an effort to educate them and to obtain the
2394 informed consent to prescribe a treatment procedure. The
2395 department shall develop a list of treatment procedures based on
2396 significance of risk and frequency of performance.
2397 Section 52. Section 1005.07, Florida Statutes, is created
2398 to read:
2399 1005.07 Patient safety instructional requirements.--Every
2400 nonpublic school, college, and university that offers degrees in

2401 medicine, nursing, and allied health shall include in the
2402 curricula applicable to such degrees material on patient safety,
2403 including patient safety improvement. Materials shall include,
2404 but need not be limited to, effective communication and
2405 teamwork; epidemiology of patient injuries and medical errors;
2406 vigilance, attention, and fatigue; checklists and inspections;
2407 automation and technological and computer support; psychological
2408 factors in human error; and reporting systems.
2409 Section 53. Section 1005.075, Florida Statutes, is created
2410 to read:
2411 1005.075 Informed consent standardization project.--Every
2412 nonpublic school, college, and university that offers degrees in
2413 medicine, nursing, and allied health shall work with the
2414 Department of Health to develop bilingual, multimedia methods
2415 for communicating the risks of treatment options for medical
2416 procedures. Such materials shall be provided to patients and
2417 their families in an effort to educate them and to obtain the
2418 informed consent to prescribe a treatment procedure. The
2419 department shall develop a list of treatment procedures based on
2420 significance of risk and frequency of performance.
2421 Section 54. (1) The Department of Health shall study and
2422 report to the Legislature as to whether medical review panels
2423 should be included as part of the presuit process in medical
2424 malpractice litigation. Medical review panels review a medical
2425 malpractice case during the presuit process and make judgments
2426 on the merits of the case based on established standards of care
2427 with the intent of reducing the number of frivolous claims. The
2428 panel's report could be used as admissible evidence at trial or
2429 for other purposes. The department's report should address:
2430 (a) Historical use of medical review panels and similar

2431 pretrial programs in this state, including the mediation panels
2432 created by chapter 75-9, Laws of Florida.
2433 (b) Constitutional issues relating to the use of medical
2434 review panels.
2435 (c) The use of medical review panels or similar programs
2436 in other states.
2437 (d) Whether medical review panels or similar panels should
2438 be created for use during the presuit process.
2439 (e) Other recommendations and information that the
2440 department deems appropriate.
2441 (f) In submitting its report with respect to (a)-(c), the
2442 Department should identify at a minimum:
2443 1. The percentage of medical malpractice claims submitted
2444 to the panels during the time period the panels were in
2445 existence.
2446 2. The percentage of claims that were settled while the
2447 panels were in existence and the percentage of claims that were
2448 settled in the 3 years prior to the establishment of such panels
2449 or, for each panel which no longer exists, 3 years after the
2450 dissolution of such panels.
2451 3. In those state where panels have been discontinued,
2452 whether additional safeguards have been implemented to avoid the
2453 filing of frivolous lawsuits and what those additional
2454 safeguards are.
2455 4. How the rates for medical malpractice insurance in
2456 states utilizing such panels compares with the rates in states
2457 not utilizing such panels.
2458 5. Whether, and to what extent, a finding by a panel is
2459 subject to review and the burden of proof required to overcome a
2460 finding by the panel.

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2461 (2) If the department finds that medical review panels or
2462 a similar structure should be created in this state, it shall
2463 include draft legislation to implement its recommendations in
2464 its report.
2465 (3) The department shall submit its report to the Speaker
2466 of the House of Representatives and the President of the Senate
2467 no later than December 31, 2003.
2468 Section 55. (1) The Agency for Health Care Administration
2469 shall conduct or contract for a study to determine what
2470 information is most feasible to provide to the public comparing
2471 state-licensed hospitals on certain inpatient quality indicators
2472 developed by the federal Agency for Healthcare Research and
2473 Quality. Such indicators shall be designed to identify
2474 information about specific procedures performed in hospitals for
2475 which there is strong evidence of a link to quality of care. The
2476 Agency for Health Care Administration or the study contractor
2477 shall refer to the hospital quality reports published in New
2478 York and Texas as guides during the evaluation.
2479 (2) The following concepts shall be specifically addressed
2480 in the study report:
2481 (a) Whether hospital discharge data about services can be
2482 translated into understandable and meaningful information for
2483 the public.
2484 (b) Whether the following measures are useful consumer
2485 guides relating to care provided in state-licensed hospitals:
2486 1. Inpatient mortality for medical conditions;
2487 2. Inpatient mortality for procedures;
2488 3. Utilization of procedures for which there are questions
2489 of overuse, underuse, or misuse; and
2490 4. Volume of procedures for which there is evidence that a

2491 higher volume of procedures is associated with lower mortality.
2492 (c) Whether there are quality indicators that are
2493 particularly useful relative to the state's unique demographics.
2494 (d) Whether all hospitals should be included in the
2495 comparison.
2496 (e) The criteria for comparison.
2497 (f) Whether comparisons are best within metropolitan
2498 statistical areas or some other geographic configuration.
2499 (g) Identification of several Internet websites on which
2500 such a report should be published to achieve the broadest
2501 dissemination of the information.
2502 (3) The Agency for Health Care Administration shall
2503 consider the input of all interested parties, including
2504 hospitals, physicians, consumer organizations, and patients, and
2505 submit the final report to the Governor and the presiding
2506 officers of the Legislature by January 1, 2004.
2507 Section 56. Comprehensive study and report on the creation
2508 of a Patient Safety Authority.--
2509 (1) The Agency for Health Care Administration, in
2510 consultation with the Department of Health, is directed to study
2511 the need for, and the implementation requirements of,
2512 establishing a Patient Safety Authority. The authority would be
2513 responsible for performing activities and functions designed to
2514 improve patient safety and the quality of care delivered by
2515 health care facilities and health care practitioners.
2516 (2) In undertaking its study, the agency shall examine and
2517 evaluate a Patient Safety Authority that would, either directly
2518 or by contract:
2519 (a) Analyze information concerning adverse incidents
2520 reported to the Agency for Health Care Administration pursuant

2521 to s. 395.0197, Florida Statutes, for the purpose of
2522 recommending changes in practices and procedures that may be
2523 implemented by health care practitioners and health care
2524 facilities to prevent future adverse incidents.
2525 (b) Collect, analyze, and evaluate patient safety data
2526 submitted voluntarily by a health care practitioner or health
2527 care facility. The authority would communicate to health care
2528 practitioners and health care facilities changes in practices
2529 and procedures that may be implemented for the purpose of
2530 improving patient safety and preventing future patient safety
2531 events from resulting in serious injury or death. At a minimum,
2532 the authority would:
2533 1. Be designed and operated by an individual or entity
2534 with demonstrated expertise in health care quality data and
2535 systems analysis, health information management, systems
2536 thinking and analysis, human factors analysis, and
2537 identification of latent and active errors.
2538 2. Include procedures for ensuring its confidentiality,
2539 timeliness, and independence.
2540 (c) Foster the development of a statewide electronic
2541 infrastructure, which would be implemented in phases over a
2542 multiyear period, that is designed to improve patient care and
2543 the delivery and quality of health care services by health care
2544 facilities and practitioners. The electronic infrastructure
2545 would be a secure platform for communication and the sharing of
2546 clinical and other data, such as business data, among providers
2547 and between patients and providers. The electronic
2548 infrastructure would include a core electronic medical record.
2549 Health care providers would have access to individual electronic
2550 medical records, subject to the consent of the individual. The

2551 right, if any, of other entities, including health insurers and
2552 researchers, to access the records would need further
2553 examination and evaluation by the agency.
2554 (d)1. As a statewide goal of reducing the occurrence of
2555 medication error, inventory hospitals to determine the current
2556 status of implementation of computerized physician medication
2557 ordering systems, barcode point of care systems, or other
2558 technological patient safety implementation, and recommend a
2559 plan for expediting implementation statewide or, in hospitals
2560 where the agency determines that implementation of such systems
2561 is not practicable, alternative methods to reduce medication
2562 errors. The agency shall identify in its plan any barriers to
2563 statewide implementation and shall include recommendations to
2564 the Legislature of statutory changes that may be necessary to
2565 eliminate those barriers. The agency will review newly developed
2566 plans for compliance with statewide initiatives and to determine
2567 both the commitment of the health care facility staff and the
2568 capability of the facility to successfully coordinate and
2569 implement these plans, especially from a technological
2570 perspective.
2571 2. "Medication error" is any preventable event that may
2572 cause or lead to inappropriate medication use or patient harm
2573 while the medication is in the control of the health care
2574 professional, patient, or consumer. Such events may be related
2575 to professional practice, health care products, health care
2576 procedures, and health care systems, each of which may include
2577 the prescribing of medications and order communications; product
2578 labeling; product packaging; the nomenclature, compounding,
2579 dispensing, distribution, administration, and use of
2580 medications; and education and monitoring related thereto.

2581 (e) Implement paragraphs (c) and (d) as a demonstration
2582 project for Medicaid recipients.
2583 (f) Identify best practices and share this information
2584 with health care providers.
2585 (g) Engage in other activities that improve health care
2586 quality, improve the diagnosis and treatment of diseases and
2587 medical conditions, increase the efficiency of the delivery of
2588 health care services, increase administrative efficiency, and
2589 increase access to quality health care services.
2590 (3) The agency shall also consider ways in which a Patient
2591 Safety Authority would be able to facilitate the development of
2592 no-fault demonstration projects as means to reduce and prevent
2593 medical errors and promote patient safety.
2594 (4) The agency shall seek information and advice from and
2595 consult with hospitals, physicians, other health care providers,
2596 attorneys, consumers, and individuals involved with and
2597 knowledgeable about patient safety and quality-of-care
2598 initiatives.
2599 (5) In evaluating the need for, and the operation of, a
2600 Patient Safety Authority, the agency shall determine the costs
2601 of implementing and administering an authority and suggest
2602 funding sources and mechanisms.
2603 (6) The agency shall complete its study and issue a report
2604 to the Legislature by February 1, 2004. In its report, the
2605 agency shall include specific findings, recommendations, and
2606 proposed legislation.
2607 Section 57. The Office of Program Policy Analysis and
2608 Government Accountability shall complete a study of the
2609 eligibility requirements for a birth to be covered under the
2610 Florida Birth-Related Neurological Injury Compensation

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2611 Association and submit a report to the Legislature by January 1,
2612 2004, recommending whether the statutory criteria for a claim to
2613 qualify for referral to the Florida Birth-Related Neurological
2614 Injury Compensation Association under s. 766.302, Florida
2615 Statutes, should be modified.
2616 Section 58. Civil immunity for members of or consultants
2617 to certain boards, committees, or other entities.--
2618 (1) Each member of, or health care professional consultant
2619 to, any committee, board, group, commission, or other entity
2620 shall be immune from civil liability for any act, decision,
2621 omission, or utterance done or made in performance of his or her
2622 duties while serving as a member of or consultant to such
2623 committee, board, group, commission, or other entity established
2624 and operated for purposes of quality improvement review,
2625 evaluation, and planning in a state-licensed health care
2626 facility. Such entities must function primarily to review,
2627 evaluate, or make recommendations relating to:
2628 (a) The duration of patient stays in health care
2629 facilities;
2630 (b) The professional services furnished with respect to
2631 the medical, dental, psychological, podiatric, chiropractic, or
2632 optometric necessity for such services;
2633 (c) The purpose of promoting the most efficient use of
2634 available health care facilities and services;
2635 (d) The adequacy or quality of professional services;
2636 (e) The competency and qualifications for professional
2637 staff privileges;
2638 (f) The reasonableness or appropriateness of charges made
2639 by or on behalf of health care facilities; or
2640 (g) Patient safety, including entering into contracts with

2641 patient safety organizations.

2642 (2) Such committee, board, group, commission, or other
2643 entity must be established in accordance with state law or in
2644 accordance with requirements of the Joint Commission on
2645 Accreditation of Healthcare Organizations, established and duly
2646 constituted by one or more public or licensed private hospitals
2647 or behavioral health agencies, or established by a governmental
2648 agency. To be protected by this section, the act, decision,
2649 omission, or utterance may not be made or done in bad faith or
2650 with malicious intent.

2651 Section 59. The Office of Program Policy Analysis and
2652 Government Accountability and the Office of the Auditor General
2653 must jointly conduct an audit of the Department of Health's
2654 health care practitioner disciplinary process and closed claims
2655 that are filed with the department under section 627.912,
2656 Florida Statutes. The Office of Program Policy Analysis and
2657 Government Accountability and the Office of the Auditor General
2658 shall submit a report to the Legislature by January 1, 2005.

2659 Section 60. No later than September 1, 2003, the
2660 Department of Health shall convene a workgroup to study the
2661 current healthcare practitioner disciplinary process. The
2662 workgroup shall include a representative of the Administrative
2663 Law section of The Florida Bar, a representative of the Health
2664 Law section of The Florida Bar, a representative of the Florida
2665 Medical Association, a representative of the Florida Osteopathic
2666 Medical Association, a representative of the Florida Dental
2667 Association, a member of the Florida Board of Medicine who has
2668 served on the probable cause panel, a member of the Board of
2669 Osteopathic Medicine who has served on the probable cause panel,
2670 and a member of the Board of Dentistry who has served on the

2671 probable cause panel. The workgroup shall also include one
2672 consumer member of the Board of Medicine. The Department of
2673 Health shall present the findings and recommendations to the
2674 Governor, the President of the Senate, and the Speaker of the
2675 House of Representatives no later than January 1, 2004. The
2676 sponsoring organizations shall assume the costs of their
2677 representatives.
2678 Section 61. In any advertisement or other similar public
2679 dissemination of information by or on behalf of an attorney
2680 regarding issues of medical malpractice, the attorney may not
2681 solicit any person to institute legal action or suggest that
2682 legal action be brought and shall be limited to providing a
2683 description of the areas of practice of the attorney, the
2684 attorney's address or business location, and a method for
2685 contacting the attorney.
2686 Section 62. (1) The Legislature finds and declares it to
2687 be of vital importance that emergency services and care be
2688 provided by hospitals, physicians, and emergency medical
2689 services providers to every person in need of such care. The
2690 Legislature finds that providers of emergency medical services
2691 and care are critical elements in responding to disaster and
2692 emergency situations that might affect our local communities,
2693 state, and country. The Legislature recognizes the importance of
2694 maintaining a viable system of providing for the emergency
2695 medical needs of residents of this state and visitors to this
2696 state. The Legislature and the Federal Government have required
2697 such providers of emergency medical services and care to provide
2698 emergency services and care to all persons who present
2699 themselves to hospitals seeking such care. The Legislature has
2700 further mandated that prehospital emergency medical treatment or

2701 transport may not be denied by emergency medical services
2702 providers to persons who have or are likely to have an emergency
2703 medical condition. Such governmental requirements have imposed a
2704 unilateral obligation for providers of emergency medical
2705 services and care to provide services to all persons seeking
2706 emergency care without ensuring payment or other consideration
2707 for provision of such care. The Legislature also recognizes that
2708 providers of emergency medical services and care provide a
2709 significant amount of uncompensated emergency medical care in
2710 furtherance of such governmental interest. A significant
2711 proportion of the residents of this state who are uninsured or
2712 are Medicaid or Medicare recipients are unable to access needed
2713 health care because health care providers fear the increased
2714 risk of medical malpractice liability. Such patients, in order
2715 to obtain medical care, are frequently forced to seek care
2716 through providers of emergency medical services and care.
2717 Providers of emergency medical services and care in this state
2718 have reported significant problems with both the availability
2719 and affordability of professional liability coverage. Medical
2720 malpractice liability insurance premiums have increased
2721 dramatically and a number of insurers have ceased providing
2722 medical malpractice coverage for emergency medical services and
2723 care in this state. This results in a functional unavailability
2724 of malpractice coverage for some providers of emergency medical
2725 services and care. The Legislature further finds that certain
2726 specialist physicians have resigned from serving on hospital
2727 staffs or have otherwise declined to provide on-call coverage to
2728 hospital emergency departments due to increased medical
2729 malpractice liability exposure created by treating such
2730 emergency department patients. It is the intent of the

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2731 Legislature that hospitals, emergency medical services
2732 providers, and physicians be able to ensure that patients who
2733 might need emergency medical services treatment or
2734 transportation or who present themselves to hospitals for
2735 emergency medical services and care have access to such needed
2736 services.
2737 (2) The Legislature finds that access to quality,
2738 affordable health care for all Floridians is a necessary goal
2739 for this state and that teaching hospitals play an essential
2740 role in providing access to comprehensive health care services.
2741 The Legislature finds that access to quality health care at
2742 teaching hospitals is enhanced when teaching hospitals affiliate
2743 and coordinate their common endeavors with medical schools.
2744 These affiliations have proved to be an integral part of the
2745 delivery of more efficient and economical health care services
2746 to patients of teaching hospitals by offering quality graduate
2747 medical education programs to resident physicians who provide
2748 patient services at teaching hospitals and clinics owned by such
2749 hospitals. These affiliations ensure continued access to quality
2750 comprehensive health care services for Floridians and,
2751 therefore, should be encouraged in order to maintain and expand
2752 such services. The Legislature finds that when teaching
2753 hospitals affiliate or enter into contracts with medical schools
2754 to provide comprehensive health care services to patients of
2755 teaching hospitals, teaching hospitals greatly increase their
2756 exposure to claims arising out of alleged medical malpractice
2757 and other allegedly negligent acts because some teaching
2758 hospital employees and agents do not have the same level of
2759 protection against liability claims as colleges and universities
2760 with medical schools and their employees providing the same

2761 patient services to the same teaching hospital patients. The
2762 Legislature finds that the high cost of litigation, unequal
2763 liability exposure, and increased medical malpractice insurance
2764 premiums have adversely impacted the ability of some teaching
2765 hospitals to permit their employees to provide patient services
2766 to patients of teaching hospitals. This finding is consistent
2767 with the report issued in April 2002 by the American Medical
2768 Association declaring Florida to be one of 12 states in the
2769 midst of a medical liability insurance crisis. The crisis in the
2770 availability and affordability of medical malpractice insurance
2771 is a contributing factor in the reduction of access to quality
2772 health care in this state and has declined significantly. If no
2773 corrective action is taken, this health care crisis will lead to
2774 a continued reduction of patient services in teaching hospitals.
2775 The Legislature finds that the state's 6 teaching hospitals
2776 provide 70 percent of the state's graduate medical education as
2777 reported in the 2001-2002 Report on Graduate Medical Education
2778 in Florida: Findings and Recommendations and that the teaching
2779 hospitals ensure the state's future medical manpower. The
2780 Legislature finds that the public is better served and will
2781 benefit from corrective action to address the foregoing
2782 concerns. It is imperative that the legislature further the
2783 public benefit by conferring sovereign immunity upon teaching
2784 hospitals and their employees and agents when teaching hospitals
2785 elect to be agents of the Department of Health as providers of
2786 the state's graduate medical education. It is also the intent of
2787 the Legislature that employees of teaching hospitals providing
2788 patient services to patients of a teaching hospital be immune
2789 from lawsuits in the same manner and to the same extent as
2790 employees and agents of the state, its agencies and political

2791 subdivisions, and further, that they shall not be held
2792 personally liable in tort or named as a party defendant in an
2793 action while performing patient services except as provided in
2794 s. 768.28(9)(a).
2795 Section 63. Paragraph (b) of subsection (9) of section
2796 768.28, Florida Statutes, is amended to read:
2797 768.28 Waiver of sovereign immunity in tort actions;
2798 recovery limits; limitation on attorney fees; statute of
2799 limitations; exclusions; indemnification; risk management
2800 programs.--
2801 (9)
2802 (b) As used in this subsection, the term:
2803 1. "Employee" includes any volunteer firefighter.
2804 2. "Officer, employee, or agent" includes, but is not
2805 limited to:,
2806 a. Any receiving facility designated under chapter 394 and
2807 any persons operating as employees or agents of the receiving
2808 facility when providing emergency treatment to a person who
2809 presented himself or herself for examination and treatment in
2810 accordance with chapter 394.
2811 b. Any health care provider when providing services
2812 pursuant to s. 766.1115, any member of the Florida Health
2813 Services Corps, as defined in s. 381.0302, who provides
2814 uncompensated care to medically indigent persons referred by the
2815 Department of Health, and any public defender or her or his
2816 employee or agent, including, among others, an assistant public
2817 defender and an investigator.
2818 c. Any provider of emergency medical services and care
2819 acting pursuant to obligations imposed by s. 395.1041, s.
2820 395.401, or s. 401.45. Except for persons or entities that are

2821 otherwise covered under this section, providers of emergency
2822 medical services and care shall be considered agents of the
2823 Department of Health and shall indemnify the state for the
2824 reasonable costs of defense and indemnity payments, if any, up
2825 to the liability limits set forth in this chapter. For purposes
2826 of this sub-subparagraph:
2827 (I) The term "provider of emergency medical services and
2828 care" means all persons and entities covered under or providing
2829 services pursuant to obligations imposed by s. 395.1041, s.
2830 395.401, or s. 401.45, including, but not limited to:
2831 (A) An emergency medical services provider licensed under
2832 part III of chapter 401 and persons operating as employees or
2833 agents of such provider or an emergency medical technician or
2834 paramedic certified under part III of chapter 401.
2835 (B) A hospital licensed under chapter 395 and persons
2836 operating as employees or agents of such hospital.
2837 (C) A physician licensed under chapter 458, chapter 459,
2838 chapter 460, or chapter 461 or a dentist licensed under chapter
2839 466.
2840 (D) A physician assistant licensed under chapter 458 or
2841 chapter 459.
2842 (E) A registered nurse, nurse midwife, licensed practical
2843 nurse, or advanced registered nurse practitioner licensed or
2844 registered under part I of chapter 464.
2845 (F) A midwife licensed under chapter 467.
2846 (G) A health care professional association and employees
2847 or agents of the association or a corporate medical group and
2848 employees or agents of such group.
2849 (H) Any student or medical resident who is enrolled in an
2850 accredited program or licensed program that prepares the student

2851 for licensure or certification in any one of the professions
2852 listed in sub-sub-sub-subparagraphs (C)-(G), the program that
2853 prepares the student for licensure or certification, and the
2854 entity responsible for the training of the student or medical
2855 resident.
2856 (I) Any other person or entity that provides services
2857 pursuant to obligations imposed by s. 395.1041, s. 395.401, or
2858 s. 401.45.
2859 (II) The term "emergency medical services" means ambulance
2860 assessment, treatment, or transport services provided pursuant
2861 to obligations imposed by s. 395.1041 or s. 401.45; all
2862 screening, examination, and evaluation performed by a physician,
2863 hospital, or other person or entity acting pursuant to
2864 obligations imposed by s. 395.1041 or s. 395.401; and any care,
2865 treatment, surgery, or other medical services provided, as
2866 outpatient or inpatient, to relieve or eliminate an emergency
2867 medical condition, including all medical services to eliminate
2868 the likelihood that the emergency medical condition will
2869 deteriorate or recur without further medical attention within a
2870 reasonable period of time.
2871 d. Any hospital which is either:
2872 (I) A teaching hospital, as defined in s. 408.07;
2873 (II) A hospital participating under the provisions of s.
2874 381.0403; or
2875 (III) A hospital designated as a family practice teaching
2876 hospital under the provisions of s. 395.806:
2877
2878 and any employee or agent of such hospital who provides patient
2879 services to patients at the hospital facility or at a clinic or
2880 other facility owned and operated by the hospital, which

2881 hospital elects to be considered as an agent of the Department
2882 of Health and indemnifies the state for the reasonable costs of
2883 defense and indemnity payments, if any, up to the liability
2884 limits set forth in this chapter.
2885 Section 64. If any provision of this act or the
2886 application thereof to any person or circumstance is held
2887 invalid, the invalidity does not affect other provisions or
2888 applications of the act which can be given effect without the
2889 invalid provision or application, and to this end the provisions
2890 of this act are declared severable.
2891 Section 65. If any law amended by this act was also
2892 amended by a law enacted at the 2003 Regular Session of the
2893 Legislature or at the 2003 Special Session A of the Legislature,
2894 such laws shall be construed as if they had been enacted at the
2895 same session of the Legislature, and full effect shall be given
2896 to each if possible.
2897 Section 66. This act shall take effect upon becoming a law
2898 and shall apply to any cause of action accruing under chapter
2899 766, Florida Statutes, after that date, unless otherwise
2900 provided herein.
2901