A bill to be entitled

An act relating to medical incidents; providing legislative findings; creating s. 395.0056, F.S.; requiring the Agency for Health Care Administration to review complaints submitted if the defendant is a hospital; amending s. 395.0191, F.S.; deleting a requirement that persons act in good faith to avoid liability or discipline for their actions regarding the awarding of staff membership or clinical privileges; amending s. 395.0197, F.S., relating to internal risk management programs; requiring a system for notifying patients that they are the subject of an adverse incident; requiring that an appropriately trained person give notice; requiring licensed facilities to annually report certain information about health care practitioners for whom they assume liability; requiring the Agency for Health Care Administration and the Department of Health to annually publish statistics about licensed facilities that assume liability for health care practitioners; repealing the requirement that licensed facilities notify the agency within 1 business day of the occurrence of certain adverse incidents; repealing s. 395.0198, F.S., which provides a public records exemption for adverse incident notifications; creating s. 395.1012, F.S.; requiring facilities to adopt a patient safety plan; providing requirements for a patient safety

plan; requiring facilities to appoint a patient safety officer and a patient safety committee and providing duties for the patient safety officer and committee; creating s. 395.1051, F.S.; requiring certain facilities to notify patients about adverse incidents under specified conditions; creating s. 456.0575, F.S.; requiring licensed health care practitioners to notify patients about adverse incidents under certain conditions; providing civil immunity for certain participants in quality improvement processes; defining the terms "patient safety data" and "patient safety organization"; providing for use of patient safety data by a patient safety organization; providing limitations on use of patient safety data; providing for protection of patient-identifying information; providing for determination of whether the privilege applies as asserted; providing that an employer may not take retaliatory action against an employee who makes a good-faith report concerning patient safety data; amending s. 456.013, F.S.; requiring, as a condition of licensure and license renewal, that physicians and physician assistants complete continuing education relating to misdiagnosed conditions as part of a continuing education course on prevention of medical errors; amending s. 456.025, F.S.; eliminating certain restrictions on the setting of licensure renewal fees for health care

practitioners; amending s. 456.039, F.S.; revising requirements for the information furnished to the Department of Health for licensure purposes; amending s. 456.041, F.S., relating to practitioner profiles; requiring the Department of Health to compile certain specified information in a practitioner profile; establishing a timeframe within which certain health care practitioners must report specified information; providing for disciplinary action and a fine for untimely submissions; deleting provisions that provide that a profile need not indicate whether a criminal history check was performed to corroborate information in the profile; authorizing the department or regulatory board to investigate any information received; requiring the department to provide an easy-to-read narrative explanation concerning final disciplinary action taken against a practitioner; requiring a hyperlink to each final order on the department's website which provides information about disciplinary actions; requiring the department to provide a hyperlink to certain comparison reports pertaining to claims experience; requiring the department to include the date that a reported disciplinary action was taken by a licensed facility and a characterization of the practitioner's conduct that resulted in the action; deleting provisions requiring the

department to consult with a regulatory board before including certain information in a health care practitioner's profile; providing a penalty for failure to comply with the timeframe for verifying and correcting a practitioner profile; requiring the department to add a statement to a practitioner profile when the profile information has not been verified by the practitioner; requiring the department to provide, in the practitioner profile, an explanation of disciplinary action taken and the reason for sanctions imposed; requiring the department to include a hyperlink to a practitioner's website when requested; providing that practitioners licensed under ch. 458 or ch. 459, F.S., shall have claim information concerning an indemnity payment greater than a specified amount posted in the practitioner profile; amending s. 456.042, F.S.; providing for the update of practitioner profiles; designating a timeframe within which a practitioner must submit new information to update his or her profile; amending s. 456.049, F.S., relating to practitioner reports on professional liability claims and actions; revising requirements for a practitioner to report claims or actions for medical malpractice; amending s. 456.051, F.S.; establishing the responsibility of the Department of Health to provide reports of professional liability actions and

bankruptcies; requiring the department to include such reports in a practitioner's profile within a specified period; amending s. 456.057, F.S.; allowing the department to obtain patient records by subpoena without the patient's written authorization, in specified circumstances; amending s. 456.072, F.S.; providing for determining the amount of any costs to be assessed in a disciplinary proceeding; amending s. 456.073, F.S.; authorizing the Department of Health to investigate certain paid claims made on behalf of practitioners licensed under ch. 458 or ch. 459, F.S.; amending procedures for certain disciplinary proceedings; providing a deadline for raising issues of material fact; providing a deadline relating to notice of receipt of a request for a formal hearing; excepting gross or repeated malpractice and standard-of-care violations from the 6-year limitation on investigation or filing of an administrative complaint; amending s. 456.077, F.S.; providing a presumption related to an undisputed citation; revising requirements under which the Department of Health may issue citations as an alternative to disciplinary procedures against certain licensed health care practitioners; amending s. 456.078, F.S.; revising standards for determining which violations of the applicable professional practice act are appropriate for mediation; amending s. 458.320,

F.S., relating to financial responsibility requirements for medical physicians; requiring maintenance of financial responsibility as a condition of licensure of medical physicians; providing for payment of any outstanding judgments or settlements pending at the time a physician is suspended by the Department of Health; requiring the department to suspend the license of a medical physician who has not paid, up to the amounts required by any applicable financial responsibility provision, any outstanding judgment, arbitration award, other order, or settlement; amending s. 459.0085, F.S., relating to financial responsibility requirements for osteopathic physicians; requiring maintenance of financial responsibility as a condition of licensure of osteopathic physicians; providing for payment of any outstanding judgments or settlements pending at the time an osteopathic physician is suspended by the Department of Health; requiring that the department suspend the license of an osteopathic physician who has not paid, up to the amounts required by any applicable financial responsibility provision, any outstanding judgment, arbitration award, other order, or settlement; amending s. 458.331, F.S., relating to grounds for disciplinary action against a physician; redefining the term "repeated malpractice"; revising the minimum amount of a claim against

a licensee which will trigger a departmental investigation; requiring that administrative orders issued by an administrative law judge or board for certain practice violations by physicians specify certain information; creating s. 458.3311, F.S.; establishing emergency procedures for disciplinary actions; amending s. 459.015, F.S., relating to grounds for disciplinary action against an osteopathic physician; redefining the term "repeated malpractice"; amending conditions that necessitate a departmental investigation of an osteopathic physician; revising the minimum amount of a claim against a licensee which will trigger a departmental investigation; creating s. 459.0151, F.S.; establishing emergency procedures for disciplinary actions; amending s. 461.013, F.S., relating to grounds for disciplinary action against a podiatric physician; redefining the term "repeated malpractice"; amending the minimum amount of a claim against such a physician which will trigger a departmental investigation; requiring that administrative orders issued by an administrative law judge or board for certain practice violations by physicians specify certain information; creating s. 461.0131, F.S.; establishing emergency procedures for disciplinary actions; amending s. 466.028, F.S., relating to grounds for disciplinary action against a dentist or a dental hygienist;

redefining the term "dental malpractice"; revising the minimum amount of a claim against a dentist which will trigger a departmental investigation; requiring that the Division of Administrative Hearings designate administrative law judges who have special qualifications for hearings involving certain health care practitioners; creating ss. 1004.08 and 1005.07, F.S.; requiring schools, colleges, and universities to include material on patient safety in their curricula if the institution awards specified degrees; directing the Agency for Health Care Administration to conduct or contract for a study to determine what information to provide to the public comparing hospitals, based on inpatient quality indicators developed by the federal Agency for Healthcare Research and Quality; requiring the Agency for Health Care Administration to conduct a study on patient safety; requiring a report and submission of findings to the Legislature; requiring the Office of Program Policy Analysis and Government Accountability and the Office of the Auditor General to conduct an audit of the health care practitioner disciplinary process and closed claims and report to the Legislature; creating a workgroup to study the health care practitioner disciplinary process; providing for workgroup membership; providing that the workgroup deliver its report by January 1,

2004; amending s. 624.462, F.S.; authorizing health care providers to form a commercial self-insurance fund; amending s. 627.062, F.S.; prohibiting the submission of medical malpractice insurance rate filings to arbitration; providing additional requirements for medical malpractice insurance rate filings; providing that portions of judgments and settlements entered against a medical malpractice insurer for bad-faith actions or for punitive damages against the insurer, as well as related taxable costs and attorney's fees, may not be included in an insurer's base rate; providing for review of rate filings by the Office of Insurance Regulation for excessive, inadequate, or unfairly discriminatory rates; requiring insurers to apply a discount based on the health care provider's loss experience; requiring the Office of Insurance Regulation to calculate a presumed factor that reflects the impact of medical malpractice legislation on rates; requiring insurers to make a rate filing reflecting such presumed factor; allowing for deviations; requiring that rates remain in effect until new rate filings are approved; requiring that the Office of Program Policy Analysis and Government Accountability study the feasibility of authorizing the Office of the Public Counsel to represent the public in medical malpractice rate hearings; amending s.

627.357, F.S.; providing guidelines for the formation and regulation of certain self-insurance funds; amending s. 627.4147, F.S.; revising certain notification criteria for medical and osteopathic physicians; requiring prior notification of a rate increase; creating s. 627.41495, F.S.; providing for notice to policyholders of certain medical malpractice rate filings; amending s. 627.912, F.S.; revising requirements for the medical malpractice closed claim reports that must be filed with the Office of Insurance Regulation; applying such requirements to additional persons and entities; providing for access by the Department of Health to such reports; providing for the imposition of a fine or disciplinary action for failing to report; requiring that reports obtain additional information; authorizing the Financial Services Commission to adopt rules; requiring that the Office of Insurance Regulation prepare summaries of closed claim reports of prior years and prepare an annual report and analysis of closed claim and insurer financial reports; amending s. 641.19, F.S.; revising definitions; providing that health care providers providing services pursuant to coverage provided under a health maintenance organization contract are not employees or agents of the health maintenance organization; providing exceptions; amending s.

641.51, F.S.; proscribing a health maintenance organization's right to control the professional judgment of a physician; providing that a health maintenance organization shall not be vicariously liable for the medical negligence of a health care provider; providing exceptions; amending s. 766.102, F.S; revising requirements for health care providers who offer corroborating medical expert opinion and expert testimony in medical negligence actions; prohibiting contingency fees for an expert witness; requiring certification that an expert witness not previously have been found guilty of fraud or perjury; amending s. 766.106, F.S.; specifying sanctions for failure to cooperate with presuit investigations; requiring the execution of medical release to allow taking of unsworn statements from claimant's treating physicians; imposing limits on use of such statements; deleting provisions relating to voluntary arbitration in conflict with s. 766.207, F.S.; revising requirements for presuit notice and for an insurer's or self-insurer's response to a claim; requiring that a claimant provide the Agency for Health Care Administration with a copy of the complaint alleging medical negligence against licensed facilities; requiring that the agency review such complaints for licensure noncompliance; permitting written questions during informal discovery; amending s. 766.108,

F.S.; providing for mandatory mediation; amending ss. 766.1115, 766.112, 766.113, 766.201, 766.303, 768.21, F.S.; revising references to "medical malpractice" to "medical negligence"; amending s. 766.113, F.S.; requiring that a specific statement be included in all medical negligence settlement agreements; creating s. 766.118, F.S.; limiting noneconomic damages in medical negligence actions; providing legislative findings and intent regarding provision of emergency medical services and care; creating s. 766.1185, F.S.; providing that an action for bad faith may not be brought against a medical malpractice insurer if such insurer offers to pay policy limits and meets other specified conditions of settlement within a specified time period; providing for factors to be considered in determining whether a medical malpractice insurer has acted in bad faith; providing for the delivery of a copy of an amended witness list to the insurer of a defendant health care provider; providing a limitation on the amount of damages which may be awarded to certain third parties in actions alleging bad faith by a medical malpractice insurer; amending s. 766.202, F.S.; redefining the terms "economic damages," "medical expert," and "noneconomic damages"; defining the term "health care provider"; creating s. 766.2021, F.S.; providing a limitation on damages against

insurers, prepaid limited health service organizations, health maintenance organizations, or prepaid health clinics for medical negligence of contracted health care providers; requiring actions against such entities to be brought pursuant to ch. 766, F.S.; amending s. 766.203, F.S.; providing for discovery of presuit medical expert opinion; amending s. 766.206, F.S.; providing for dismissal of a claim under certain circumstances; requiring the court to make certain reports concerning a medical expert who fails to meet qualifications; amending s. 766.207, F.S.; providing for the applicability of the Wrongful Death Act and general law to arbitration awards; amending s. 766.209, F.S.; revising applicable damages available in voluntary binding arbitration relating to claims of medical negligence; creating s. 768.0981, F.S.; providing a limitation on damages arising from vicarious liability for insurers, prepaid limited health service organizations, health maintenance organizations, and prepaid health clinics for actions of a health care provider; amending s. 768.13, F.S.; revising guidelines for immunity from liability under the "Good Samaritan Act"; amending s. 768.28, F.S.; providing that health care practitioners furnishing medical services to student athletes for intercollegiate athletics under specified circumstances will be

considered agents of a state university board of trustees; amending s. 768.77, F.S.; prescribing a method for itemization of specific categories of damages awarded in medical malpractice actions; preserving sovereign immunity and the abrogation of certain joint and several liability; amending s. 1006.20, F.S.; requiring completion of a uniform participation physical evaluation and history form incorporating recommendations of the American Heart Association; deleting revisions to procedures for students' physical examinations; requiring the Department of Health to study the efficacy and constitutionality of medical review panels; requiring a report; amending s. 391.025, F.S.; adding infants receiving compensation awards as eligible for Children's Medical Services health services; amending s. 391.029, F.S.; providing financial eligibility criteria for Children's Medical Services; amending s. 766.304, F.S.; limiting the use of civil actions when claimants accept awards from the Florida Birth-Related Neurological Injury Compensation Plan; amending s. 766.305, F.S.; deleting a requirement for provision of certain information in a petition filed with the Florida Birth-Related Neurological Injury Compensation Plan; providing for service of copies of such petition to certain participants; requiring that a claimant provide

the Florida Birth-Related Neurological Injury Compensation Association with certain information within 10 days after filing such petition; amending s. 766.309, F.S.; allowing for claims against the association to be bifurcated; amending s. 766.31, F.S.; providing for a death benefit for an infant in the amount of $10,000; limiting liability of the claimant for expenses and attorney's fees; amending s. 766.314, F.S.; revising obsolete terms; providing procedures by which hospitals in certain counties may pay the annual fees for participating physicians and nurse midwives; providing for annually assessing participating physicians; requiring that the Office of Program Policy Analysis and Government Accountability study and report to the Legislature on requirements for coverage by the Florida Birth-Related Neurological Injury Compensation Association; providing appropriations and authorizing positions; providing for construction of the act in pari materia with laws enacted during the 2003 Regular Session or a 2003 special session of the Legislature; providing for severability; providing effective dates.

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

Section 1. Findings.--

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(15) The Legislature finds that the high cost of medical malpractice claims can be substantially alleviated by

imposing a limitation on noneconomic damages in medical malpractice actions.

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

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

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

Section 2. Section 395.0056, Florida Statutes, is created to read:

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

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

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

Section 3. Subsection (7) of section 395.0191, Florida Statutes, is amended to read:

395.0191 Staff membership and clinical privileges.--

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

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

Section 4. Subsections (1), (3), (7), (8), (9), (10), (11), (12), (13), (14), and (15) of section 395.0197, Florida Statutes, are amended to read:

395.0197 Internal risk management program.--

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

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

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

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

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

b. At least 1 hour of such education and training annually for all personnel of the licensed facility working in clinical areas and providing patient care, except those persons licensed as health care practitioners who are required

to complete continuing education coursework pursuant to chapter 456 or the respective practice act.

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

a. Live visual observation;

b. Electronic observation; or

c. Any other reasonable measure taken to ensure patient protection and privacy.

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

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

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

(d) A system for informing a patient or an individual identified pursuant to s. 765.401(1) that the patient was the subject of an adverse incident, as defined in subsection (5). Such notice shall be given by an appropriately trained person designated by the licensed facility as soon as practicable to allow the patient an opportunity to minimize damage or injury.

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

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

~~(7) The licensed facility shall notify the agency no later than 1 business day after the risk manager or his or her~~

~~designee has received a report pursuant to paragraph (1)(d) and can determine within 1 business day that any of the following adverse incidents has occurred, whether occurring in the licensed facility or arising from health care prior to admission in the licensed facility:~~

~~(a) The death of a patient;~~

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

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

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

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

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

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

(a) The death of a patient;

(b) Brain or spinal damage to a patient;

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

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

(e) The performance of a wrong surgical procedure;

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

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

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

The agency may grant extensions to this reporting requirement for more than 15 days upon justification submitted in writing by the facility administrator to the agency. The agency may require an additional, final report. These reports shall not be available to the public pursuant to s. 119.07(1) or any other law providing access to public records, nor be discoverable or admissible in any civil or administrative action, except in disciplinary proceedings by the agency or the appropriate regulatory board, nor shall they be available to the public as part of the record of investigation for and prosecution in disciplinary proceedings made available to the public by the agency or the appropriate regulatory board. However, the agency or the appropriate regulatory board shall make available, upon written request by a health care professional against whom probable cause has been found, any such records which form the basis of the determination of probable cause. The agency may investigate, as it deems appropriate, any such incident and prescribe measures that must or may be taken in response to the incident. The agency shall review each incident and determine whether it

potentially involved conduct by the health care professional who is subject to disciplinary action, in which case the provisions of s. 456.073 shall apply.

(8)~~(9)~~ The agency shall publish on the agency's website, no less than quarterly, a summary and trend analysis of adverse incident reports received pursuant to this section, which shall not include information that would identify the patient, the reporting facility, or the health care practitioners involved. The agency shall publish on the agency's website an annual summary and trend analysis of all adverse incident reports and malpractice claims information provided by facilities in their annual reports, which shall not include information that would identify the patient, the reporting facility, or the practitioners involved. The purpose of the publication of the summary and trend analysis is to promote the rapid dissemination of information relating to adverse incidents and malpractice claims to assist in avoidance of similar incidents and reduce morbidity and mortality.

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

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

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

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

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

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

(a) Notify the local police; and

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

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

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

(12)~~(13)~~ In addition to any penalty imposed pursuant to this section, the agency shall require a written plan of

correction from the facility. For a single incident or series of isolated incidents that are nonwillful violations of the reporting requirements of this section, the agency shall first seek to obtain corrective action by the facility. If the correction is not demonstrated within the timeframe established by the agency or if there is a pattern of nonwillful violations of this section, the agency may impose an administrative fine, not to exceed $5,000 for any violation of the reporting requirements of this section. The administrative fine for repeated nonwillful violations shall not exceed $10,000 for any violation. The administrative fine for each intentional and willful violation may not exceed $25,000 per violation, per day. The fine for an intentional and willful violation of this section may not exceed $250,000. In determining the amount of fine to be levied, the agency shall be guided by s. 395.1065(2)(b). ~~This subsection does not apply to the notice requirements under subsection (7).~~

(13)~~(14)~~ The agency shall have access to all licensed facility records necessary to carry out the provisions of this section. The records obtained by the agency under subsection (6), subsection(7)~~(8)~~, or subsection(9)~~(10)~~are not available to the public under s. 119.07(1), nor shall they be discoverable or admissible in any civil or administrative action, except in disciplinary proceedings by the agency or the appropriate regulatory board, nor shall records obtained pursuant to s. 456.071 be available to the public as part of the record of investigation for and prosecution in disciplinary proceedings made available to the public by the agency or the appropriate regulatory board. However, the agency or the appropriate regulatory board shall make available, upon written request by a health care professional

against whom probable cause has been found, any such records which form the basis of the determination of probable cause, except that, with respect to medical review committee records, s. 766.101 controls.

(14)~~(15)~~ The meetings of the committees and governing board of a licensed facility held solely for the purpose of achieving the objectives of risk management as provided by this section shall not be open to the public under the provisions of chapter 286. The records of such meetings are confidential and exempt from s. 119.07(1), except as provided in subsection(13)~~(14)~~.

Section 5. Section 395.0198, Florida Statutes, is repealed.

Section 6. Section 395.1012, Florida Statutes, is created to read:

395.1012 Patient safety.--

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

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

Section 7. Section 395.1051, Florida Statutes, is created to read:

395.1051 Duty to notify patients.--An appropriately trained person designated by each licensed facility shall inform each patient, or an individual identified pursuant to s. 765.401(1), in person about adverse incidents that result in serious harm to the patient. Notification of outcomes of care that result in harm to the patient under this section shall not constitute an acknowledgement or admission of liability, nor can it be introduced as evidence.

Section 8. Section 456.0575, Florida Statutes, is created to read:

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

Section 9. Civil immunity for members of or consultants to certain boards, committees, or other entities.--

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

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

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

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

(d) The adequacy or quality of professional services;

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

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

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

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

Section 10. Patient safety data privilege.--

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

(a) "Patient safety data" means reports made to patient safety organizations, including all health care data, interviews, memoranda, analyses, root cause analyses, products of quality assurance or quality improvement processes, corrective action plans, or information collected or created by a health care facility licensed under chapter 395, Florida

Statutes, or a health care practitioner as defined in section 456.001(4), Florida Statutes, as a result of an occurrence related to the provision of health care services which exacerbates an existing medical condition or could result in injury, illness, or death.

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

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

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

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

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

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

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

Section 11. Subsection (7) of section 456.013, Florida Statutes, is amended to read:

456.013 Department; general licensing provisions.--

(7) The boards, or the department when there is no board, shall require the completion of a 2-hour course relating to prevention of medical errors as part of the licensure and renewal process. The 2-hour course shall count towards the total number of continuing education hours required for the profession. The course shall be approved by the board or department, as appropriate, and shall include a study of root-cause analysis, error reduction and prevention, and patient safety. In addition, the course approved by the Board of Medicine and the Board of Osteopathic Medicine shall include information relating to the five most misdiagnosed conditions during the previous biennium, as determined by the board.If the course is being offered by a facility licensed

pursuant to chapter 395 for its employees, the board may approve up to 1 hour of the 2-hour course to be specifically related to error reduction and prevention methods used in that facility.

Section 12. Subsection (1) of section 456.025, Florida Statutes, is amended to read:

456.025 Fees; receipts; disposition.--

(1) It is the intent of the Legislature that all costs of regulating health care professions and practitioners shall be borne solely by licensees and licensure applicants. It is also the intent of the Legislature that fees should be reasonable and not serve as a barrier to licensure. Moreover, it is the intent of the Legislature that the department operate as efficiently as possible and regularly report to the Legislature additional methods to streamline operational costs. Therefore, the boards in consultation with the department, or the department if there is no board, shall, by rule, set renewal fees which:

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

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

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

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

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

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

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

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

Section 13. Paragraph (a) of subsection (1) of section 456.039, Florida Statutes, is amended to read:

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

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

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

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

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

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

5. The year that the applicant began practicing medicine.

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

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

8. A description of any final disciplinary action taken within the previous 10 years against the applicant by the agency regulating the profession that the applicant is or has been licensed to practice, whether in this state or in any other jurisdiction, by a specialty board that is recognized by the American Board of Medical Specialties, the American Osteopathic Association, or a similar national organization,

or by a licensed hospital, health maintenance organization, prepaid health clinic, ambulatory surgical center, or nursing home. Disciplinary action includes resignation from or nonrenewal of medical staff membership or the restriction of privileges at a licensed hospital, health maintenance organization, prepaid health clinic, ambulatory surgical center, or nursing home taken in lieu of or in settlement of a pending disciplinary case related to competence or character. If the applicant indicates that the disciplinary action is under appeal and submits a copy of the document initiating an appeal of the disciplinary action, the department must state that the disciplinary action is under appeal if the disciplinary action is reported in the applicant's profile.

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

Section 14. Section 456.041, Florida Statutes, is amended to read:

456.041 Practitioner profile; creation.--

(1)(a) ~~Beginning July 1, 1999,~~The Department of Health shall compile the information submitted pursuant to s. 456.039 into a practitioner profile of the applicant submitting the information, except that the Department of Health shall ~~may~~ develop a format to compile uniformly any information submitted under s. 456.039(4)(b). Beginning July 1, 2001, the Department of Health may compile the information submitted pursuant to s. 456.0391 into a practitioner profile of the applicant submitting the information.

(b) Within 30 calendar days after receiving an update of information required for the practitioner's profile, the department shall update the practitioner's profile in accordance with the requirements of subsection (7).

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

(3) The Department of Health shall ~~may~~ include in each practitioner's practitioner profile that criminal information that directly relates to the practitioner's ability to competently practice his or her profession. The department must include in each practitioner's practitioner profile the following statement: "The criminal history information, if any exists, may be incomplete; federal criminal history information is not available to the public." The department shall provide in each practitioner profile, for every final disciplinary action taken against the practitioner, an easy-to-read narrative description that explains the administrative complaint filed against the practitioner and the final disciplinary action imposed on the practitioner. The department shall include a hyperlink to each final order listed in its website report of dispositions of recent disciplinary actions taken against practitioners.

(4) The Department of Health shall include, with respect to a practitioner licensed under chapter 458 or chapter 459, a statement of how the practitioner has elected to comply with the financial responsibility requirements of s. 458.320 or s. 459.0085. The department shall include, with respect to practitioners subject to s. 456.048, a statement of how the practitioner has elected to comply with the financial responsibility requirements of that section. The department shall include, with respect to practitioners licensed under ~~chapter 458, chapter 459, or~~ chapter 461, information relating to liability actions which has been reported under s. 456.049 or s. 627.912 within the previous 10 years for any paid claim that exceeds $5,000. The department shall include, with respect to practitioners licensed under chapter 458 or chapter 459, information relating to liability actions which has been reported under ss. 456.049 and 627.912 within the previous 10 years for any paid claim that exceeds $100,000.Such claims information shall be reported in the context of comparing an individual practitioner's claims to the experience of other practitioners within the same specialty, or profession if the practitioner is not a specialist~~, to the extent such information is available to the Department of Health~~. The department must provide a hyperlink in such practitioner's profile to all such comparison reports.If information relating to a liability action is included in a practitioner's practitioner profile, the profile must also include the following statement: "Settlement of a claim may occur for a variety of reasons that do not necessarily reflect negatively on the professional competence or conduct of the practitioner. A payment in settlement of a medical malpractice action or

claim should not be construed as creating a presumption that medical malpractice has occurred."

(5) The Department of Health shall ~~may not~~ include the date of a hospital or ambulatory surgical center disciplinary action taken by a licensed hospital or an ambulatory surgical center, in accordance with the requirements of s. 395.0193, in the practitioner profile. The department shall state whether the action related to professional competence and whether it related to the delivery of services to a patient.

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

(7) Upon the completion of a practitioner profile under this section, the Department of Health shall furnish the practitioner who is the subject of the profile a copy of it for review and verification. The practitioner has a period of 30 days in which to review and verify the contents of the profile and to correct any factual inaccuracies in it. The Department of Health shall make the profile available to the public at the end of the 30-day period regardless of whether the practitioner has provided verification of the profile content. A practitioner shall be subject to a fine of up to $100 per day for failure to verify the profile contents and to correct any factual errors in his or her profile within the 30-day period.The department shall make the profiles available to the public through the World Wide Web and other commonly used means of distribution. The department must

include the following statement, in boldface type, in each profile that has not been reviewed by the practitioner to which it applies: "The practitioner has not verified the information contained in this profile."

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

(9) The Department of Health may provide one link in each profile to a practitioner's professional website if the practitioner requests that such a link be included in his or her profile.

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

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

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

Section 16. Section 456.049, Florida Statutes, is amended to read:

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

~~(1)~~ Any practitioner of medicine licensed pursuant to the provisions of chapter 458, practitioner of osteopathic

medicine licensed pursuant to the provisions of chapter 459, podiatric physician licensed pursuant to the provisions of chapter 461, or dentist licensed pursuant to the provisions of chapter 466 shall report to the Office of Insurance Regulation ~~department~~ any claim or action for damages for personal injury alleged to have been caused by error, omission, or negligence in the performance of such licensee's professional services or based on a claimed performance of professional services without consent pursuant to ~~if the claim was not covered by an insurer required to report under~~ s. 627.912.~~and the claim resulted in:~~

~~(a) A final judgment in any amount.~~

~~(b) A settlement in any amount.~~

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

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

~~(2) Reports shall contain:~~

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

~~(b) The date of the occurrence which created the claim.~~

~~(c) The date the claim was reported to the licensee.~~

~~(d) The name and address of the injured person. This information is confidential and exempt from s. 119.07(1) and shall not be disclosed by the department without the injured person's consent. This information may be used by the department for purposes of identifying multiple or duplicate claims arising out of the same occurrence.~~

~~(e) The date of suit, if filed.~~

~~(f) The injured person's age and sex.~~

~~(g) The total number and names of all defendants involved in the claim.~~

~~(h) The date and amount of judgment or settlement, if any, including the itemization of the verdict, together with a copy of the settlement or judgment.~~

~~(i) In the case of a settlement, such information as the department may require with regard to the injured person's incurred and anticipated medical expense, wage loss, and other expenses.~~

~~(j) The loss adjustment expense paid to defense counsel, and all other allocated loss adjustment expense paid.~~

~~(k) The date and reason for final disposition, if no judgment or settlement.~~

~~(l) A summary of the occurrence which created the claim, which shall include:~~

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

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

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

~~4. The operation or the diagnostic or treatment procedure causing the injury.~~

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

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

~~(m) Any other information required by the department to analyze and evaluate the nature, causes, location, cost, and damages involved in professional liability cases.~~

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

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

(1) The report of a claim or action for damages for personal injury which is required to be provided to the Department of Health under s. 456.049 or s. 627.912 is public information except for the name of the claimant or injured person, which remains confidential as provided in ss. 456.049(2)(d) and 627.912(2)(e). The Department of Health shall, upon request, make such report available to any person. The department shall make such report available as a part of the practitioner's profile within 30 calendar days after receipt.

(2) Any information in the possession of the Department of Health which relates to a bankruptcy proceeding by a practitioner of medicine licensed under chapter 458, a practitioner of osteopathic medicine licensed under chapter 459, a podiatric physician licensed under chapter 461, or a dentist licensed under chapter 466 is public information. The Department of Health shall, upon request, make such information available to any person. The department shall make such report available as a part of the practitioner's profile within 30 calendar days after receipt.

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

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

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

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

3. The department may obtain patient records, billing records, insurance information, provider contracts, and all attachments thereto pursuant to a subpoena without written authorization from the patient if the department and probable cause panel of the appropriate board, if any, find reasonable cause to believe that a health care practitioner has submitted a claim, statement, or bill using a billing code that would result in payment greater in amount than would be paid using a billing code that accurately describes the services performed,

requested payment for services that were not performed by that health care practitioner, used information derived from a written report of an automobile accident generated pursuant to chapter 316 to solicit or obtain patients personally or through an agent regardless of whether the information is derived directly from the report or a summary of that report or from another person, solicited patients fraudulently, received a kickback as defined in s. 456.054, violated the patient brokering provisions of s. 817.505, or presented or caused to be presented a false or fraudulent insurance claim within the meaning of s. 817.234(1)(a), and also find that, within the meaning of s. 817.234(1)(a), patient authorization cannot be obtained because the patient cannot be located or is deceased, incapacitated, or suspected of being a participant in the fraud or scheme, and if the subpoena is issued for specific and relevant records.

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

Section 19. Subsection (4) of section 456.072, Florida Statutes, as amended by section 6 of chapter 2003-411, Laws of Florida, is amended to read:

456.072 Grounds for discipline; penalties; enforcement.--

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

2001, pursuant to this section or discipline imposed through final order, or citation, entered on or after July 1, 2001, for a violation of any practice act, the board, or the department when there is no board, shall assess costs related to the investigation and prosecution of the case. Such costs related to the investigation and prosecution include, but are not limited to, salaries and benefits of personnel, costs related to the time spent by the attorney and other personnel working on the case, and any other expenses incurred by the department for the case. The board, or the department when there in no board, shall determine the amount of costs to be assessed after its consideration of an affidavit of itemized costs and any written objections thereto.In any case where the board or the department imposes a fine or assessment and the fine or assessment is not paid within a reasonable time, such reasonable time to be prescribed in the rules of the board, or the department when there is no board, or in the order assessing such fines or costs, the department or the Department of Legal Affairs may contract for the collection of, or bring a civil action to recover, the fine or assessment.

Section 20. Subsections (1) and (5) of section 456.073, Florida Statutes, as amended by section 1 of chapter 2003-27, Laws of Florida, are amended to read:

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

(1) The department, for the boards under its jurisdiction, shall cause to be investigated any complaint that is filed before it if the complaint is in writing, signed by the complainant, and legally sufficient. A complaint filed

by a state prisoner against a health care practitioner employed by or otherwise providing health care services within a facility of the Department of Corrections is not legally sufficient unless there is a showing that the prisoner complainant has exhausted all available administrative remedies within the state correctional system before filing the complaint. However, if the Department of Health determines after a preliminary inquiry of a state prisoner's complaint that the practitioner may present a serious threat to the health and safety of any individual who is not a state prisoner, the Department of Health may determine legal sufficiency and proceed with discipline. The Department of Health shall be notified within 15 days after the Department of Corrections disciplines or allows a health care practitioner to resign for an offense related to the practice of his or her profession. A complaint is legally sufficient if it contains ultimate facts that show that a violation of this chapter, of any of the practice acts relating to the professions regulated by the department, or of any rule adopted by the department or a regulatory board in the department has occurred. In order to determine legal sufficiency, the department may require supporting information or documentation. The department may investigate, and the department or the appropriate board may take appropriate final action on, a complaint even though the original complainant withdraws it or otherwise indicates a desire not to cause the complaint to be investigated or prosecuted to completion. The department may investigate an anonymous complaint if the complaint is in writing and is legally sufficient, if the alleged violation of law or rules is substantial, and if the department has reason to believe, after preliminary inquiry,

that the violations alleged in the complaint are true. The department may investigate a complaint made by a confidential informant if the complaint is legally sufficient, if the alleged violation of law or rule is substantial, and if the department has reason to believe, after preliminary inquiry, that the allegations of the complainant are true. The department may initiate an investigation if it has reasonable cause to believe that a licensee or a group of licensees has violated a Florida statute, a rule of the department, or a rule of a board. Notwithstanding subsection (13), the department may investigate information filed pursuant to s. 456.041(4) relating to liability actions with respect to practitioners licensed under chapter 458 or chapter 459 which have been reported under s. 456.049 or s. 627.912 within the previous 6 years for any paid claim that exceeds $50,000. Except as provided in ss. 458.331(9), 459.015(9), 460.413(5), and 461.013(6), when an investigation of any subject is undertaken, the department shall promptly furnish to the subject or the subject's attorney a copy of the complaint or document that resulted in the initiation of the investigation. The subject may submit a written response to the information contained in such complaint or document within 20 days after service to the subject of the complaint or document. The subject's written response shall be considered by the probable cause panel. The right to respond does not prohibit the issuance of a summary emergency order if necessary to protect the public. However, if the secretary, or the secretary's designee, and the chair of the respective board or the chair of its probable cause panel agree in writing that such notification would be detrimental to the investigation, the department may withhold notification. The department may

conduct an investigation without notification to any subject if the act under investigation is a criminal offense.

(5) A formal hearing before an administrative law judge from the Division of Administrative Hearings shall be held pursuant to chapter 120 if there are any disputed issues of material fact. The determination of whether or not a licensee has violated the laws and rules regulating the profession, including a determination of the reasonable standard of care, is a conclusion of law to be determined by the board, or department when there is no board, and is not a finding of fact to be determined by an administrative law judge.The administrative law judge shall issue a recommended order pursuant to chapter 120. Notwithstanding s. 120.569(2), the department shall notify the division within 45 days after receipt of a petition or request for a formal hearing.~~If any party raises an issue of disputed fact during an informal hearing, the hearing shall be terminated and a formal hearing pursuant to chapter 120 shall be held.~~

Section 21. Subsections (1) and (2) of section 456.077, Florida Statutes, are amended to read:

456.077 Authority to issue citations.--

(1) Notwithstanding s. 456.073, the board, or the department if there is no board, shall adopt rules to permit the issuance of citations. The citation shall be issued to the subject and shall contain the subject's name and address, the subject's license number if applicable, a brief factual statement, the sections of the law allegedly violated, and the penalty imposed. The citation must clearly state that the subject may choose, in lieu of accepting the citation, to follow the procedure under s. 456.073. If the subject disputes the matter in the citation, the procedures set forth in s.

456.073 must be followed. However, if the subject does not dispute the matter in the citation with the department within 30 days after the citation is served, the citation becomes a public final order and does not constitute ~~constitutes~~ discipline for a first offense, but does constitute discipline for a second or subsequent offense. The penalty shall be a fine or other conditions as established by rule.

(2) The board, or the department if there is no board, shall adopt rules designating violations for which a citation may be issued. Such rules shall designate as citation violations those violations for which there is no substantial threat to the public health, safety, and welfare or no violation of standard of care involving injury to a patient. Violations for which a citation may be issued shall include violations of continuing education requirements; failure to timely pay required fees and fines; failure to comply with the requirements of ss. 381.026 and 381.0261 regarding the dissemination of information regarding patient rights; failure to comply with advertising requirements; failure to timely update practitioner profile and credentialing files; failure to display signs, licenses, and permits; failure to have required reference books available; and all other violations that do not pose a direct and serious threat to the health and safety of the patient or involve a violation of standard of care that has resulted in injury to a patient.

Section 22. Section 456.078, Florida Statutes, is amended to read:

456.078 Mediation.--

(1) Notwithstanding the provisions of s. 456.073, the board, or the department when there is no board, shall adopt rules to designate which violations of the applicable

professional practice act are appropriate for mediation. The board, or the department when there is no board, shall ~~may~~ designate as mediation offenses those complaints where harm caused by the licensee:

(a) Is economic in nature except any act or omission involving intentional misconduct;~~or~~

(b) Can be remedied by the licensee;~~.~~

(c) Is not a standard of care violation involving any type of injury to a patient; or

(d) Does not result in an adverse incident.

(2) For the purposes of this section, an "adverse incident" means an event that results in:

(a) The death of a patient;

(b) Brain or spinal damage to a patient;

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

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

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

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

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

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

(3)~~(2)~~ After the department determines a complaint is legally sufficient and the alleged violations are defined as

mediation offenses, the department or any agent of the department may conduct informal mediation to resolve the complaint. If the complainant and the subject of the complaint agree to a resolution of a complaint within 14 days after contact by the mediator, the mediator shall notify the department of the terms of the resolution. The department or board shall take no further action unless the complainant and the subject each fail to record with the department an acknowledgment of satisfaction of the terms of mediation within 60 days of the mediator's notification to the department. A successful mediation shall not constitute discipline.In the event the complainant and subject fail to reach settlement terms or to record the required acknowledgment, the department shall process the complaint according to the provisions of s. 456.073.

(4)~~(3)~~ Conduct or statements made during mediation are inadmissible in any proceeding pursuant to s. 456.073. Further, any information relating to the mediation of a case shall be subject to the confidentiality provisions of s. 456.073.

(5)~~(4)~~ No licensee shall go through the mediation process more than three times without approval of the department. The department may consider the subject and dates of the earlier complaints in rendering its decision. Such decision shall not be considered a final agency action for purposes of chapter 120.

(6)~~(5)~~ Any board created on or after January 1, 1995, shall have 6 months to adopt rules designating which violations are appropriate for mediation, after which time the department shall have exclusive authority to adopt rules

pursuant to this section. A board shall have continuing authority to amend its rules adopted pursuant to this section.

Section 23. Effective upon this act becoming a law and applying to claims accruing on or after that date, section 458.320, Florida Statutes, is amended to read:

458.320 Financial responsibility.--

(1) As a condition of licensing and maintaining an active license, and prior to the issuance or renewal of an active license or reactivation of an inactive license for the practice of medicine, an applicant must ~~shall~~ by one of the following methods demonstrate to the satisfaction of the board and the department financial responsibility to pay claims and costs ancillary thereto arising out of the rendering of, or the failure to render, medical care or services:

(a) Establishing and maintaining an escrow account consisting of cash or assets eligible for deposit in accordance with s. 625.52 in the per claim amounts specified in paragraph (b). The required escrow amount set forth in this paragraph may not be used for litigation costs or attorney's fees for the defense of any medical malpractice claim.

(b) Obtaining and maintaining professional liability coverage in an amount not less than $100,000 per claim, with a minimum annual aggregate of not less than $300,000, from an authorized insurer as defined under s. 624.09, from a surplus lines insurer as defined under s. 626.914(2), from a risk retention group as defined under s. 627.942, from the Joint Underwriting Association established under s. 627.351(4), or through a plan of self-insurance as provided in s. 627.357. The required coverage amount set forth in this paragraph may not be used for litigation costs or attorney's fees for the defense of any medical malpractice claim.

(c) Obtaining and maintaining an unexpired, irrevocable letter of credit, established pursuant to chapter 675, in an amount not less than $100,000 per claim, with a minimum aggregate availability of credit of not less than $300,000. The letter of credit must ~~shall~~ be payable to the physician as beneficiary upon presentment of a final judgment indicating liability and awarding damages to be paid by the physician or upon presentment of a settlement agreement signed by all parties to such agreement when such final judgment or settlement is a result of a claim arising out of the rendering of, or the failure to render, medical care and services. The letter of credit may not be used for litigation costs or attorney's fees for the defense of any medical malpractice claim. The ~~Such~~ letter of credit must ~~shall~~ be nonassignable and nontransferable. Such letter of credit must ~~shall~~ be issued by any bank or savings association organized and existing under the laws of this state or any bank or savings association organized under the laws of the United States which ~~that~~ has its principal place of business in this state or has a branch office that ~~which~~ is authorized under the laws of this state or of the United States to receive deposits in this state.

(2) Physicians who perform surgery in an ambulatory surgical center licensed under chapter 395 and, as a continuing condition of hospital staff privileges, physicians who have ~~with~~ staff privileges must ~~shall~~ also ~~be required to~~ establish financial responsibility by one of the following methods:

(a) Establishing and maintaining an escrow account consisting of cash or assets eligible for deposit in accordance with s. 625.52 in the per claim amounts specified

in paragraph (b). The required escrow amount set forth in this paragraph may not be used for litigation costs or attorney's fees for the defense of any medical malpractice claim.

(b) Obtaining and maintaining professional liability coverage in an amount not less than $250,000 per claim, with a minimum annual aggregate of not less than $750,000 from an authorized insurer as defined under s. 624.09, from a surplus lines insurer as defined under s. 626.914(2), from a risk retention group as defined under s. 627.942, from the Joint Underwriting Association established under s. 627.351(4), through a plan of self-insurance as provided in s. 627.357, or through a plan of self-insurance which meets the conditions specified for satisfying financial responsibility in s. 766.110. The required coverage amount set forth in this paragraph may not be used for litigation costs or attorney's fees for the defense of any medical malpractice claim.

(c) Obtaining and maintaining an unexpired irrevocable letter of credit, established pursuant to chapter 675, in an amount not less than $250,000 per claim, with a minimum aggregate availability of credit of not less than $750,000. The letter of credit must ~~shall~~ be payable to the physician as beneficiary upon presentment of a final judgment indicating liability and awarding damages to be paid by the physician or upon presentment of a settlement agreement signed by all parties to such agreement when such final judgment or settlement is a result of a claim arising out of the rendering of, or the failure to render, medical care and services. The letter of credit may not be used for litigation costs or attorney's fees for the defense of any medical malpractice claim. The ~~Such~~ letter of credit must ~~shall~~ be nonassignable and nontransferable. The ~~Such~~ letter of credit must ~~shall~~ be

issued by any bank or savings association organized and existing under the laws of this state or any bank or savings association organized under the laws of the United States which ~~that~~ has its principal place of business in this state or has a branch office that ~~which~~ is authorized under the laws of this state or of the United States to receive deposits in this state.

This subsection shall be inclusive of the coverage in subsection (1).

(3)(a) ~~The financial responsibility requirements of subsections (1) and (2) shall apply to claims for incidents that occur on or after January 1, 1987, or the initial date of licensure in this state, whichever is later.~~

~~(b)~~ Meeting the financial responsibility requirements of this section or the criteria for any exemption from such requirements must ~~shall~~ be established at the time of issuance or renewal of a license ~~on or after January 1, 1987~~.

(b)~~(c)~~ Any person may, at any time, submit to the department a request for an advisory opinion regarding such person's qualifications for exemption.

(4)(a) Each insurer, self-insurer, risk retention group, or Joint Underwriting Association must ~~shall~~ promptly notify the department of cancellation or nonrenewal of insurance required by this section. Unless the physician demonstrates that he or she is otherwise in compliance with the requirements of this section, the department shall suspend the license of the physician pursuant to ss. 120.569 and 120.57 and notify all health care facilities licensed under chapter 395 of such action. Any suspension under this subsection remains ~~shall remain~~ in effect until the physician

demonstrates compliance with the requirements of this section. If any judgments or settlements are pending at the time of suspension, those judgments or settlements must be paid in accordance with this section unless otherwise mutually agreed to in writing by the parties. This paragraph does not abrogate a judgment debtor's obligation to satisfy the entire amount of any judgment~~, except that a license suspended under paragraph (5)(g) shall not be reinstated until the physician demonstrates compliance with the requirements of that provision~~.

(b) If financial responsibility requirements are met by maintaining an escrow account or letter of credit as provided in this section, upon the entry of an adverse final judgment arising from a medical malpractice arbitration award, from a claim of medical malpractice either in contract or tort, or from noncompliance with the terms of a settlement agreement arising from a claim of medical malpractice either in contract or tort, the licensee shall pay the entire amount of the judgment together with all accrued interest, or the amount maintained in the escrow account or provided in the letter of credit as required by this section, whichever is less, within 60 days after the date such judgment became final and subject to execution, unless otherwise mutually agreed to in writing by the parties. If timely payment is not made by the physician, the department shall suspend the license of the physician pursuant to procedures set forth in subparagraphs (5)(g)3., 4., and 5. Nothing in this paragraph shall abrogate a judgment debtor's obligation to satisfy the entire amount of any judgment.

(5) The requirements of subsections (1), (2), and (3) do ~~shall~~ not apply to:

(a) Any person licensed under this chapter who practices medicine exclusively as an officer, employee, or agent of the Federal Government or of the state or its agencies or its subdivisions. For the purposes of this subsection, an agent of the state, its agencies, or its subdivisions is a person who is eligible for coverage under any self-insurance or insurance program authorized by the provisions of s. 768.28(15).

(b) Any person whose license has become inactive under this chapter and who is not practicing medicine in this state. Any person applying for reactivation of a license must show either that such licensee maintained tail insurance coverage which provided liability coverage for incidents that occurred on or after January 1, 1987, or the initial date of licensure in this state, whichever is later, and incidents that occurred before the date on which the license became inactive; or such licensee must submit an affidavit stating that such licensee has no unsatisfied medical malpractice judgments or settlements at the time of application for reactivation.

(c) Any person holding a limited license pursuant to s. 458.317 and practicing under the scope of such limited license.

(d) Any person licensed or certified under this chapter who practices only in conjunction with his or her teaching duties at an accredited medical school or in its main teaching hospitals. Such person may engage in the practice of medicine to the extent that such practice is incidental to and a necessary part of duties in connection with the teaching position in the medical school.

(e) Any person holding an active license under this chapter who is not practicing medicine in this state. If such

person initiates or resumes any practice of medicine in this state, he or she must notify the department of such activity and fulfill the financial responsibility requirements of this section before resuming the practice of medicine in this state.

(f) Any person holding an active license under this chapter who meets all of the following criteria:

1. The licensee has held an active license to practice in this state or another state or some combination thereof for more than 15 years.

2. The licensee has either retired from the practice of medicine or maintains a part-time practice of no more than 1,000 patient contact hours per year.

3. The licensee has had no more than two claims for medical malpractice resulting in an indemnity exceeding $25,000 within the previous 5-year period.

4. The licensee has not been convicted of, or pled guilty or nolo contendere to, any criminal violation specified in this chapter or the medical practice act of any other state.

5. The licensee has not been subject within the last 10 years of practice to license revocation or suspension for any period of time; probation for a period of 3 years or longer; or a fine of $500 or more for a violation of this chapter or the medical practice act of another jurisdiction. The regulatory agency's acceptance of a physician's relinquishment of a license, stipulation, consent order, or other settlement, offered in response to or in anticipation of the filing of administrative charges against the physician's license, constitutes ~~shall be construed as~~ action against the physician's license for the purposes of this paragraph.

6. The licensee has submitted a form supplying necessary information as required by the department and an affidavit affirming compliance with ~~the provisions of~~ this paragraph.

7. The licensee must ~~shall~~ submit biennially to the department certification stating compliance with the provisions of this paragraph. The licensee must ~~shall~~, upon request, demonstrate to the department information verifying compliance with this paragraph.

A licensee who meets the requirements of this paragraph must ~~shall be required either to~~ post notice in the form of a sign prominently displayed in the reception area and clearly noticeable by all patients or provide a written statement to any person to whom medical services are being provided. The ~~Such~~ sign or statement must read as follows ~~shall state~~ that: "Under Florida law, physicians are generally required to carry medical malpractice insurance or otherwise demonstrate financial responsibility to cover potential claims for medical malpractice. However, certain part-time physicians who meet state requirements are exempt from the financial responsibility law. YOUR DOCTOR MEETS THESE REQUIREMENTS AND HAS DECIDED NOT TO CARRY MEDICAL MALPRACTICE INSURANCE. This notice is provided pursuant to Florida law."

(g) Any person holding an active license under this chapter who agrees to meet all of the following criteria:

1. Upon the entry of an adverse final judgment arising from a medical malpractice arbitration award, from a claim of medical malpractice either in contract or tort, or from noncompliance with the terms of a settlement agreement arising from a claim of medical malpractice either in contract or

tort, the licensee shall pay the judgment creditor the lesser of the entire amount of the judgment with all accrued interest or either $100,000, if the physician is licensed pursuant to this chapter but does not maintain hospital staff privileges, or $250,000, if the physician is licensed pursuant to this chapter and maintains hospital staff privileges, within 60 days after the date such judgment became final and subject to execution, unless otherwise mutually agreed to in writing by the parties. Such adverse final judgment shall include any cross-claim, counterclaim, or claim for indemnity or contribution arising from the claim of medical malpractice. Upon notification of the existence of an unsatisfied judgment or payment pursuant to this subparagraph, the department shall notify the licensee by certified mail that he or she shall be subject to disciplinary action unless, within 30 days from the date of mailing, he or she either:

a. Shows proof that the unsatisfied judgment has been paid in the amount specified in this subparagraph; or

b. Furnishes the department with a copy of a timely filed notice of appeal and either:

(I) A copy of a supersedeas bond properly posted in the amount required by law; or

(II) An order from a court of competent jurisdiction staying execution on the final judgment pending disposition of the appeal.

2. The Department of Health shall issue an emergency order suspending the license of any licensee who, after 30 days following receipt of a notice from the Department of Health, has failed to: satisfy a medical malpractice claim against him or her; furnish the Department of Health a copy of a timely filed notice of appeal; furnish the Department of

Health a copy of a supersedeas bond properly posted in the amount required by law; or furnish the Department of Health an order from a court of competent jurisdiction staying execution on the final judgment pending disposition of the appeal.

3. Upon the next meeting of the probable cause panel of the board following 30 days after the date of mailing the notice of disciplinary action to the licensee, the panel shall make a determination of whether probable cause exists to take disciplinary action against the licensee pursuant to subparagraph 1.

4. If the board determines that the factual requirements of subparagraph 1. are met, it shall take disciplinary action as it deems appropriate against the licensee. Such disciplinary action shall include, at a minimum, probation of the license with the restriction that the licensee must make payments to the judgment creditor on a schedule determined by the board to be reasonable and within the financial capability of the physician. Notwithstanding any other disciplinary penalty imposed, the disciplinary penalty may include suspension of the license for a period not to exceed 5 years. In the event that an agreement to satisfy a judgment has been met, the board shall remove any restriction on the license.

5. The licensee has completed a form supplying necessary information as required by the department.

A licensee who meets the requirements of this paragraph shall be required either to post notice in the form of a sign prominently displayed in the reception area and clearly noticeable by all patients or to provide a written statement to any person to whom medical services are being provided.

Such sign or statement shall state: "Under Florida law, physicians are generally required to carry medical malpractice insurance or otherwise demonstrate financial responsibility to cover potential claims for medical malpractice. YOUR DOCTOR HAS DECIDED NOT TO CARRY MEDICAL MALPRACTICE INSURANCE. This is permitted under Florida law subject to certain conditions. Florida law imposes penalties against noninsured physicians who fail to satisfy adverse judgments arising from claims of medical malpractice. This notice is provided pursuant to Florida law."

(6) Any deceptive, untrue, or fraudulent representation by the licensee with respect to any provision of this section shall result in permanent disqualification from any exemption to mandated financial responsibility as provided in this section and shall constitute grounds for disciplinary action under s. 458.331.

(7) Any licensee who relies on any exemption from the financial responsibility requirement shall notify the department, in writing, of any change of circumstance regarding his or her qualifications for such exemption and shall demonstrate that he or she is in compliance with the requirements of this section.

(8) Notwithstanding any other provision of this section, the department shall suspend the license of any physician against whom has been entered a final judgment, arbitration award, or other order or who has entered into a settlement agreement to pay damages arising out of a claim for medical malpractice, if all appellate remedies have been exhausted and payment up to the amounts required by this section has not been made within 30 days after the entering of such judgment, award, or order or agreement, until proof of

payment is received by the department or a payment schedule has been agreed upon by the physician and the claimant and presented to the department. This subsection does not apply to a physician who has met the financial responsibility requirements in paragraphs (1)(b) and (2)(b).

(9)~~(8)~~ The board shall adopt rules to implement the provisions of this section.

Section 24. Effective upon this act becoming a law and applying to claims accruing on or after that date, section 459.0085, Florida Statutes, is amended to read:

459.0085 Financial responsibility.--

(1) As a condition of licensing and maintaining an active license, and prior to the issuance or renewal of an active license or reactivation of an inactive license for the practice of osteopathic medicine, an applicant must ~~shall~~ by one of the following methods demonstrate to the satisfaction of the board and the department financial responsibility to pay claims and costs ancillary thereto arising out of the rendering of, or the failure to render, medical care or services:

(a) Establishing and maintaining an escrow account consisting of cash or assets eligible for deposit in accordance with s. 625.52 in the per-claim amounts specified in paragraph (b). The required escrow amount set forth in this paragraph may not be used for litigation costs or attorney's fees for the defense of any medical malpractice claim.

(b) Obtaining and maintaining professional liability coverage in an amount not less than $100,000 per claim, with a minimum annual aggregate of not less than $300,000, from an authorized insurer as defined under s. 624.09, from a surplus lines insurer as defined under s. 626.914(2), from a risk

retention group as defined under s. 627.942, from the Joint Underwriting Association established under s. 627.351(4), or through a plan of self-insurance as provided in s. 627.357. The required coverage amount set forth in this paragraph may not be used for litigation costs or attorney's fees for the defense of any medical malpractice claim.

(c) Obtaining and maintaining an unexpired, irrevocable letter of credit, established pursuant to chapter 675, in an amount not less than $100,000 per claim, with a minimum aggregate availability of credit of not less than $300,000. The letter of credit must ~~shall~~ be payable to the osteopathic physician as beneficiary upon presentment of a final judgment indicating liability and awarding damages to be paid by the osteopathic physician or upon presentment of a settlement agreement signed by all parties to such agreement when such final judgment or settlement is a result of a claim arising out of the rendering of, or the failure to render, medical care and services. The letter of credit may not be used for litigation costs or attorney's fees for the defense of any medical malpractice claim. The ~~Such~~ letter of credit must ~~shall~~ be nonassignable and nontransferable. Such letter of credit must ~~shall~~ be issued by any bank or savings association organized and existing under the laws of this state or any bank or savings association organized under the laws of the United States which ~~that~~ has its principal place of business in this state or has a branch office that ~~which~~ is authorized under the laws of this state or of the United States to receive deposits in this state.

(2) Osteopathic physicians who perform surgery in an ambulatory surgical center licensed under chapter 395 and, as a continuing condition of hospital staff privileges,

osteopathic physicians who have ~~with~~ staff privileges must ~~shall~~ also ~~be required to~~ establish financial responsibility by one of the following methods:

(a) Establishing and maintaining an escrow account consisting of cash or assets eligible for deposit in accordance with s. 625.52 in the per-claim amounts specified in paragraph (b). The required escrow amount set forth in this paragraph may not be used for litigation costs or attorney's fees for the defense of any medical malpractice claim.

(b) Obtaining and maintaining professional liability coverage in an amount not less than $250,000 per claim, with a minimum annual aggregate of not less than $750,000 from an authorized insurer as defined under s. 624.09, from a surplus lines insurer as defined under s. 626.914(2), from a risk retention group as defined under s. 627.942, from the Joint Underwriting Association established under s. 627.351(4), through a plan of self-insurance as provided in s. 627.357, or through a plan of self-insurance that ~~which~~ meets the conditions specified for satisfying financial responsibility in s. 766.110. The required coverage amount set forth in this paragraph may not be used for litigation costs or attorney's fees for the defense of any medical malpractice claim.

(c) Obtaining and maintaining an unexpired, irrevocable letter of credit, established pursuant to chapter 675, in an amount not less than $250,000 per claim, with a minimum aggregate availability of credit of not less than $750,000. The letter of credit must ~~shall~~ be payable to the osteopathic physician as beneficiary upon presentment of a final judgment indicating liability and awarding damages to be paid by the osteopathic physician or upon presentment of a settlement agreement signed by all parties to such agreement

when such final judgment or settlement is a result of a claim arising out of the rendering of, or the failure to render, medical care and services. The letter of credit may not be used for litigation costs or attorney's fees for the defense of any medical malpractice claim. The ~~Such~~ letter of credit must ~~shall~~ be nonassignable and nontransferable. The ~~Such~~ letter of credit must ~~shall~~ be issued by any bank or savings association organized and existing under the laws of this state or any bank or savings association organized under the laws of the United States which ~~that~~ has its principal place of business in this state or has a branch office that ~~which~~ is authorized under the laws of this state or of the United States to receive deposits in this state.

This subsection shall be inclusive of the coverage in subsection (1).

(3)(a) ~~The financial responsibility requirements of subsections (1) and (2) shall apply to claims for incidents that occur on or after January 1, 1987, or the initial date of licensure in this state, whichever is later.~~

~~(b)~~ Meeting the financial responsibility requirements of this section or the criteria for any exemption from such requirements must ~~shall~~ be established at the time of issuance or renewal of a license ~~on or after January 1, 1987~~.

(b)~~(c)~~ Any person may, at any time, submit to the department a request for an advisory opinion regarding such person's qualifications for exemption.

(4)(a) Each insurer, self-insurer, risk retention group, or joint underwriting association must ~~shall~~ promptly notify the department of cancellation or nonrenewal of insurance required by this section. Unless the osteopathic

physician demonstrates that he or she is otherwise in compliance with the requirements of this section, the department shall suspend the license of the osteopathic physician pursuant to ss. 120.569 and 120.57 and notify all health care facilities licensed under chapter 395, part IV of chapter 394, or part I of chapter 641 of such action. Any suspension under this subsection remains ~~shall remain~~ in effect until the osteopathic physician demonstrates compliance with the requirements of this section. If any judgments or settlements are pending at the time of suspension, those judgments or settlements must be paid in accordance with this section unless otherwise mutually agreed to in writing by the parties. This paragraph does not abrogate a judgment debtor's obligation to satisfy the entire amount of any judgment ~~except that a license suspended under paragraph (5)(g) shall not be reinstated until the osteopathic physician demonstrates compliance with the requirements of that provision~~.

(b) If financial responsibility requirements are met by maintaining an escrow account or letter of credit as provided in this section, upon the entry of an adverse final judgment arising from a medical malpractice arbitration award, from a claim of medical malpractice either in contract or tort, or from noncompliance with the terms of a settlement agreement arising from a claim of medical malpractice either in contract or tort, the licensee shall pay the entire amount of the judgment together with all accrued interest or the amount maintained in the escrow account or provided in the letter of credit as required by this section, whichever is less, within 60 days after the date such judgment became final and subject to execution, unless otherwise mutually agreed to in writing by the parties. If timely payment is not made by

the osteopathic physician, the department shall suspend the license of the osteopathic physician pursuant to procedures set forth in subparagraphs (5)(g)3., 4., and 5. Nothing in this paragraph shall abrogate a judgment debtor's obligation to satisfy the entire amount of any judgment.

(5) The requirements of subsections (1), (2), and (3) do ~~shall~~ not apply to:

(a) Any person licensed under this chapter who practices medicine exclusively as an officer, employee, or agent of the Federal Government or of the state or its agencies or its subdivisions. For the purposes of this subsection, an agent of the state, its agencies, or its subdivisions is a person who is eligible for coverage under any self-insurance or insurance program authorized by the provisions of s. 768.28(15).

(b) Any person whose license has become inactive under this chapter and who is not practicing medicine in this state. Any person applying for reactivation of a license must show either that such licensee maintained tail insurance coverage that ~~which~~ provided liability coverage for incidents that occurred on or after January 1, 1987, or the initial date of licensure in this state, whichever is later, and incidents that occurred before the date on which the license became inactive; or such licensee must submit an affidavit stating that such licensee has no unsatisfied medical malpractice judgments or settlements at the time of application for reactivation.

(c) Any person holding a limited license pursuant to s. 459.0075 and practicing under the scope of such limited license.

(d) Any person licensed or certified under this chapter who practices only in conjunction with his or her teaching duties at a college of osteopathic medicine. Such person may engage in the practice of osteopathic medicine to the extent that such practice is incidental to and a necessary part of duties in connection with the teaching position in the college of osteopathic medicine.

(e) Any person holding an active license under this chapter who is not practicing osteopathic medicine in this state. If such person initiates or resumes any practice of osteopathic medicine in this state, he or she must notify the department of such activity and fulfill the financial responsibility requirements of this section before resuming the practice of osteopathic medicine in this state.

(f) Any person holding an active license under this chapter who meets all of the following criteria:

1. The licensee has held an active license to practice in this state or another state or some combination thereof for more than 15 years.

2. The licensee has either retired from the practice of osteopathic medicine or maintains a part-time practice of osteopathic medicine of no more than 1,000 patient contact hours per year.

3. The licensee has had no more than two claims for medical malpractice resulting in an indemnity exceeding $25,000 within the previous 5-year period.

4. The licensee has not been convicted of, or pled guilty or nolo contendere to, any criminal violation specified in this chapter or the practice act of any other state.

5. The licensee has not been subject within the last 10 years of practice to license revocation or suspension for

any period of time, probation for a period of 3 years or longer, or a fine of $500 or more for a violation of this chapter or the medical practice act of another jurisdiction. The regulatory agency's acceptance of an osteopathic physician's relinquishment of a license, stipulation, consent order, or other settlement, offered in response to or in anticipation of the filing of administrative charges against the osteopathic physician's license, constitutes ~~shall be construed as~~ action against the physician's license for the purposes of this paragraph.

6. The licensee has submitted a form supplying necessary information as required by the department and an affidavit affirming compliance with ~~the provisions of~~ this paragraph.

7. The licensee must ~~shall~~ submit biennially to the department a certification stating compliance with ~~the provisions of~~ this paragraph. The licensee must ~~shall~~, upon request, demonstrate to the department information verifying compliance with this paragraph.

A licensee who meets the requirements of this paragraph must ~~shall be required either to~~ post notice in the form of a sign prominently displayed in the reception area and clearly noticeable by all patients or ~~to~~ provide a written statement to any person to whom medical services are being provided. The ~~Such~~ sign or statement must read as follows ~~shall state that~~: "Under Florida law, osteopathic physicians are generally required to carry medical malpractice insurance or otherwise demonstrate financial responsibility to cover potential claims for medical malpractice. However, certain part-time osteopathic physicians who meet state requirements are exempt

from the financial responsibility law. YOUR OSTEOPATHIC PHYSICIAN MEETS THESE REQUIREMENTS AND HAS DECIDED NOT TO CARRY MEDICAL MALPRACTICE INSURANCE. This notice is provided pursuant to Florida law."

(g) Any person holding an active license under this chapter who agrees to meet all of the following criteria.

1. Upon the entry of an adverse final judgment arising from a medical malpractice arbitration award, from a claim of medical malpractice either in contract or tort, or from noncompliance with the terms of a settlement agreement arising from a claim of medical malpractice either in contract or tort, the licensee shall pay the judgment creditor the lesser of the entire amount of the judgment with all accrued interest or either $100,000, if the osteopathic physician is licensed pursuant to this chapter but does not maintain hospital staff privileges, or $250,000, if the osteopathic physician is licensed pursuant to this chapter and maintains hospital staff privileges, within 60 days after the date such judgment became final and subject to execution, unless otherwise mutually agreed to in writing by the parties. Such adverse final judgment shall include any cross-claim, counterclaim, or claim for indemnity or contribution arising from the claim of medical malpractice. Upon notification of the existence of an unsatisfied judgment or payment pursuant to this subparagraph, the department shall notify the licensee by certified mail that he or she shall be subject to disciplinary action unless, within 30 days from the date of mailing, the licensee either:

a. Shows proof that the unsatisfied judgment has been paid in the amount specified in this subparagraph; or

b. Furnishes the department with a copy of a timely filed notice of appeal and either:

(I) A copy of a supersedeas bond properly posted in the amount required by law; or

(II) An order from a court of competent jurisdiction staying execution on the final judgment, pending disposition of the appeal.

2. The Department of Health shall issue an emergency order suspending the license of any licensee who, after 30 days following receipt of a notice from the Department of Health, has failed to: satisfy a medical malpractice claim against him or her; furnish the Department of Health a copy of a timely filed notice of appeal; furnish the Department of Health a copy of a supersedeas bond properly posted in the amount required by law; or furnish the Department of Health an order from a court of competent jurisdiction staying execution on the final judgment pending disposition of the appeal.

3. Upon the next meeting of the probable cause panel of the board following 30 days after the date of mailing the notice of disciplinary action to the licensee, the panel shall make a determination of whether probable cause exists to take disciplinary action against the licensee pursuant to subparagraph 1.

4. If the board determines that the factual requirements of subparagraph 1. are met, it shall take disciplinary action as it deems appropriate against the licensee. Such disciplinary action shall include, at a minimum, probation of the license with the restriction that the licensee must make payments to the judgment creditor on a schedule determined by the board to be reasonable and within the financial capability of the osteopathic physician. Notwithstanding any other disciplinary penalty imposed, the disciplinary penalty may include suspension of the license for

a period not to exceed 5 years. In the event that an agreement to satisfy a judgment has been met, the board shall remove any restriction on the license.

5. The licensee has completed a form supplying necessary information as required by the department.

A licensee who meets the requirements of this paragraph shall be required either to post notice in the form of a sign prominently displayed in the reception area and clearly noticeable by all patients or to provide a written statement to any person to whom medical services are being provided. Such sign or statement shall state: "Under Florida law, osteopathic physicians are generally required to carry medical malpractice insurance or otherwise demonstrate financial responsibility to cover potential claims for medical malpractice. YOUR OSTEOPATHIC PHYSICIAN HAS DECIDED NOT TO CARRY MEDICAL MALPRACTICE INSURANCE. This is permitted under Florida law subject to certain conditions. Florida law imposes strict penalties against noninsured osteopathic physicians who fail to satisfy adverse judgments arising from claims of medical malpractice. This notice is provided pursuant to Florida law."

(6) Any deceptive, untrue, or fraudulent representation by the licensee with respect to any provision of this section shall result in permanent disqualification from any exemption to mandated financial responsibility as provided in this section and shall constitute grounds for disciplinary action under s. 459.015.

(7) Any licensee who relies on any exemption from the financial responsibility requirement shall notify the department in writing of any change of circumstance regarding

his or her qualifications for such exemption and shall demonstrate that he or she is in compliance with the requirements of this section.

(8) If a physician is either a resident physician, assistant resident physician, or intern in an approved postgraduate training program, as defined by the board's rules, and is supervised by a physician who is participating in the Florida Birth-Related Neurological Injury Compensation Plan, such resident physician, assistant resident physician, or intern is deemed to be a participating physician without the payment of the assessment set forth in s. 766.314(4).

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

(10)~~(9)~~ The board shall adopt rules to implement the provisions of this section.

Section 25. Paragraph (t) of subsection (1) and subsection (6) of section 458.331, Florida Statutes, are amended to read:

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

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

(t) Gross or repeated malpractice or the failure to practice medicine with that level of care, skill, and treatment which is recognized by a reasonably prudent similar physician as being acceptable under similar conditions and circumstances. The board shall give great weight to the provisions of s. 766.102 when enforcing this paragraph. As used in this paragraph, "repeated malpractice" includes, but is not limited to, three or more claims for medical malpractice within the previous 5-year period resulting in indemnities being paid in excess of$50,000~~$25,000~~ each to the claimant in a judgment or settlement and which incidents involved negligent conduct by the physician. As used in this paragraph, "gross malpractice" or "the failure to practice medicine with that level of care, skill, and treatment which is recognized by a reasonably prudent similar physician as being acceptable under similar conditions and circumstances," shall not be construed so as to require more than one instance, event, or act. Nothing in this paragraph shall be construed to require that a physician be incompetent to practice medicine in order to be disciplined pursuant to this paragraph. A recommended order by an administrative law judge or a final order of the board finding a violation under this paragraph shall specify whether the licensee was found to have committed "gross malpractice," "repeated malpractice," or "failure to practice medicine with that level of care, skill, and treatment which is recognized as being acceptable under

similar conditions and circumstances," or any combination thereof, and any publication by the board must so specify.

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

Section 26. Section 458.3311, Florida Statutes, is created to read:

458.3311 Emergency procedures for disciplinary action.--Notwithstanding any other provision of law to the contrary, no later than 30 days after a third report of a professional liability claim against a licensed physician has been submitted, within a 60-month period, as required by ss. 456.049 and 627.912, the Department of Health shall initiate an emergency investigation and the Board of Medicine shall conduct an emergency probable cause hearing to determine whether the physician should be disciplined for a violation of s. 458.331(1)(t) or any other relevant provision of law.

Section 27. Paragraph (x) of subsection (1) and subsection (6) of section 459.015, Florida Statutes, are amended to read:

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

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

(x) Gross or repeated malpractice or the failure to practice osteopathic medicine with that level of care, skill, and treatment which is recognized by a reasonably prudent similar osteopathic physician as being acceptable under similar conditions and circumstances. The board shall give great weight to the provisions of s. 766.102 when enforcing this paragraph. As used in this paragraph, "repeated malpractice" includes, but is not limited to, three or more claims for medical malpractice within the previous 5-year period resulting in indemnities being paid in excess of $50,000~~$25,000~~ each to the claimant in a judgment or settlement and which incidents involved negligent conduct by the osteopathic physician. As used in this paragraph, "gross malpractice" or "the failure to practice osteopathic medicine with that level of care, skill, and treatment which is recognized by a reasonably prudent similar osteopathic physician as being acceptable under similar conditions and circumstances" shall not be construed so as to require more than one instance, event, or act. Nothing in this paragraph shall be construed to require that an osteopathic physician be incompetent to practice osteopathic medicine in order to be disciplined pursuant to this paragraph. A recommended order by an administrative law judge or a final order of the board finding a violation under this paragraph shall specify whether the licensee was found to have committed "gross malpractice," "repeated malpractice," or "failure to practice osteopathic

medicine with that level of care, skill, and treatment which is recognized as being acceptable under similar conditions and circumstances," or any combination thereof, and any publication by the board shall so specify.

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

Section 28. Section 459.0151, Florida Statutes, is created to read:

459.0151 Emergency procedures for disciplinary action.--Notwithstanding any other provision of law to the contrary, no later than 30 days after a third report of a professional liability claim against a licensed osteopathic physician has been submitted, within a 60-month period, as required by ss. 456.049 and 627.912, the Department of Health shall initiate an emergency investigation and the Board of Osteopathic Medicine shall conduct an emergency probable cause hearing to determine whether the physician should be

disciplined for a violation of s. 459.015(1)(x) or any other relevant provision of law.

Section 29. Paragraph (s) of subsection (1) and paragraph (a) of subsection (5) of section 461.013, Florida Statutes, are amended to read:

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

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

(s) Gross or repeated malpractice or the failure to practice podiatric medicine at a level of care, skill, and treatment which is recognized by a reasonably prudent podiatric physician as being acceptable under similar conditions and circumstances. The board shall give great weight to the standards for malpractice in s. 766.102 in interpreting this section. As used in this paragraph, "repeated malpractice" includes, but is not limited to, three or more claims for medical malpractice within the previous 5-year period resulting in indemnities being paid in excess of $50,000~~$10,000~~ each to the claimant in a judgment or settlement and which incidents involved negligent conduct by the podiatric physicians. As used in this paragraph, "gross malpractice" or "the failure to practice podiatric medicine with the level of care, skill, and treatment which is recognized by a reasonably prudent similar podiatric physician as being acceptable under similar conditions and circumstances" shall not be construed so as to require more than one instance, event, or act. A recommended order by an administrative law judge or a final order of the board finding a violation under this paragraph shall specify whether the

licensee was found to have committed "gross malpractice," "repeated malpractice," or "failure to practice podiatric medicine with that level of care, skill, and treatment which is recognized as being acceptable under similar conditions and circumstances," or any combination thereof, and any publication by the board must so specify.

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

Section 30. Section 461.0131, Florida Statutes, is created to read:

461.0131 Emergency procedures for disciplinary action.--Notwithstanding any other provision of law to the contrary, no later than 30 days after a third report of a professional liability claim against a licensed podiatric physician has been submitted, within a 60-month period, as required by ss. 456.049 and 627.912, the Department of Health shall initiate an emergency investigation and the Board of Podiatric Medicine shall conduct an emergency probable cause hearing to determine whether the physician should be

disciplined for a violation of s. 461.013(1)(s) or any other relevant provision of law.

Section 31. Paragraph (x) of subsection (1) of section 466.028, Florida Statutes, is amended to read:

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

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

(x) Being guilty of incompetence or negligence by failing to meet the minimum standards of performance in diagnosis and treatment when measured against generally prevailing peer performance, including, but not limited to, the undertaking of diagnosis and treatment for which the dentist is not qualified by training or experience or being guilty of dental malpractice. For purposes of this paragraph, it shall be legally presumed that a dentist is not guilty of incompetence or negligence by declining to treat an individual if, in the dentist's professional judgment, the dentist or a member of her or his clinical staff is not qualified by training and experience, or the dentist's treatment facility is not clinically satisfactory or properly equipped to treat the unique characteristics and health status of the dental patient, provided the dentist refers the patient to a qualified dentist or facility for appropriate treatment. As used in this paragraph, "dental malpractice" includes, but is not limited to, three or more claims within the previous 5-year period which resulted in indemnity being paid, or any single indemnity paid in excess of $25,000 ~~$5,000~~ in a judgment or settlement, as a result of negligent conduct on the part of the dentist.

Section 32. The Division of Administrative Hearings shall designate at least two administrative law judges who shall specifically preside over actions involving the Department of Health or boards within the Department of Health. Each designated administrative law judge must be a member of The Florida Bar in good standing and must have legal, managerial, or clinical experience in issues related to health care or have attained board certification in health care law from The Florida Bar.

Section 33. Section 1004.08, Florida Statutes, is created to read:

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

Section 34. Section 1005.07, Florida Statutes, is created to read:

1005.07 Patient safety instructional requirements.--Each private school, college, and university that offers degrees in medicine, nursing, and allied health shall include in the curricula applicable to such degrees material on patient safety, including patient safety improvement. Materials shall include, but need not be limited to, effective communication and teamwork; epidemiology of

patient injuries and medical errors; medical injuries; vigilance, attention, and fatigue; checklists and inspections; automation, technological, and computer support; psychological factors in human error; and reporting systems.

Section 35. (1) The Agency for Health Care Administration shall conduct or contract for a study to determine what information is most feasible to provide to the public comparing state-licensed hospitals on certain inpatient quality indicators developed by the federal Agency for Healthcare Research and Quality. Such indicators shall be designed to identify information about specific procedures performed in hospitals for which there is strong evidence of a link to quality of care. The Agency for Health Care Administration or the study contractor shall refer to the hospital quality reports published in New York and Texas as guides during the evaluation.

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

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

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

1. Inpatient mortality for medical conditions;

2. Inpatient mortality for procedures;

3. Utilization of procedures for which there are questions of overuse, underuse, or misuse; and

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

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

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

(e) The criteria for comparison.

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

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

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

Section 36. Comprehensive study and report on the establishment of a Patient Safety Authority.--

(1) The Agency for Health Care Administration, in consultation with the Department of Health and existing patient safety centers in the state universities, is directed to study the implementation requirements of establishing a statewide Patient Safety Authority. The authority would be responsible for performing activities and functions designed to improve patient safety and the quality of care delivered by health care facilities and health care practitioners.

(2) In undertaking the study, the agency shall examine and evaluate a Patient Safety Authority that would, either directly, by contract, or through a consortium of university-based patient safety centers:

(a) Analyze patient safety data and quality and patient safety indicators, including information concerning adverse incidents reported to the Agency for Health Care Administration pursuant to section 395.0197, Florida Statutes, for the purpose of recommending changes in practices and procedures which may be implemented by health care practitioners and health care facilities to improve health care quality and prevent future adverse incidents.

(b) Collect, analyze, and evaluate patient safety data submitted voluntarily by a health care practitioner or health care facility. The authority would communicate to health care practitioners and health care facilities changes in practices and procedures which may be implemented for the purpose of improving patient safety and preventing future patient safety events from resulting in serious injury or death.

(c) Foster the development of a statewide electronic infrastructure that may be implemented in phases over a multiyear period and that is designed to improve patient care and the delivery and quality of health care services by health care facilities and practitioners. The electronic infrastructure shall be a secure platform for communication and the sharing of clinical and other data, such as business data, among providers and between patients and providers. The electronic infrastructure would include a core electronic medical record. Health care providers shall have access to individual electronic medical records, subject to the consent of the individual. The right, if any, of other entities, including health insurers and researchers, to access the records must be examined and evaluated by the agency.

(d) As a statewide goal of reducing the occurrence of medication errors, inventory hospitals to determine the

current status of implementation of computerized physician order entry systems, barcode point of care systems, or other technological patient safety systems and recommend a plan for expediting implementation statewide or, in hospitals where the agency determines that implementation of such systems is not practicable, alternative methods to reduce medication errors. The agency shall identify in its plan any barriers to statewide implementation and shall include recommendations to the Legislature of statutory changes that may be necessary to eliminate those barriers.

(e) Identify best practices and share this information with health care providers.

(f) Assess the patient safety culture at volunteering hospitals and recommend methods to improve the working environment as it relates to patient safety at these hospitals.

(g) Develop core competencies in patient safety that can be incorporated into the curriculums in Florida's schools of medicine, nursing, and allied health.

(h) Provide continuing medical education regarding patient safety to practicing physicians, nurses, and other health care providers.

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

(3) The agency shall also consider ways in which a Patient Safety Authority could facilitate the development of

no-fault demonstration projects as a means of reducing and preventing medical errors and promoting patient safety.

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

(5) In evaluating the operation of a Patient Safety Authority, the agency shall determine the costs of implementing and administering an authority and suggest funding sources and mechanisms. At a minimum, the entity should:

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

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

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

Section 37. The Office of Program Policy Analysis and Government Accountability and the Office of the Auditor General must jointly conduct an audit of the Department of Health's health care practitioner disciplinary process and closed claims that are filed with the department under section 627.912, Florida Statutes. The Office of Program Policy Analysis and Government Accountability and the Office of the

Auditor General shall submit a report to the Legislature by January 1, 2005.

Section 38. No later than September 1, 2003, the Department of Health shall convene a workgroup to study the current healthcare practitioner disciplinary process. The workgroup shall include a representative of the Administrative Law section of The Florida Bar, a representative of the Health Law section of The Florida Bar, a representative of the Florida Medical Association, a representative of the Florida Osteopathic Medical Association, a representative of the Florida Dental Association, a member of the Florida Board of Medicine who has served on the probable cause panel, a member of the Board of Osteopathic Medicine who has served on the probable cause panel, and a member of the Board of Dentistry who has served on the probable cause panel. The workgroup shall also include one consumer member of the Board of Medicine. The Department of Health shall present the findings and recommendations to the Governor, the President of the Senate, and the Speaker of the House of Representatives no later than January 1, 2004. Each sponsoring organization shall assume the costs of its representative.

Section 39. Subsections (2) and (3) of section 624.462, Florida Statutes, are amended to read:

624.462 Commercial self-insurance funds.--

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

(a) Established by:

1. A not-for-profit trade association, industry association, or professional association of employers or

professionals which has a constitution or bylaws, which is incorporated under the laws of this state, and which has been organized for purposes other than that of obtaining or providing insurance and operated in good faith for a continuous period of 1 year;

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

3. A group of 10 or more health care providers, as defined in s. 627.351(4)(h), for purposes of providing medical malpractice coverage; or

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

(b)1. In the case of funds established pursuant to subparagraph (a)2. or subparagraph (a)4.~~subparagraph (a)3.~~, operated pursuant to a trust agreement by a board of trustees which shall have complete fiscal control over the fund and which shall be responsible for all operations of the fund. The majority of the trustees shall be owners, partners, officers, directors, or employees of one or more members of the fund. The trustees shall have the authority to approve applications of members for participation in the fund and to

contract with an authorized administrator or servicing company to administer the day-to-day affairs of the fund.

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

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

b. Appoint independent certified public accountants, legal counsel, actuaries, and investment advisers as needed;

c. Approve payment of dividends to members;

d. Approve changes in corporate structure; and

e. Have the authority to contract with an administrator authorized under s. 626.88 to administer the day-to-day affairs of the fund including, but not limited to, marketing, underwriting, billing, collection, claims administration, safety and loss prevention, reinsurance, policy issuance, accounting, regulatory reporting, and general administration. The fees or compensation for services under such contract shall be comparable to the costs for similar services incurred by insurers writing the same lines of insurance, or where available such expenses as filed by boards, bureaus, and associations designated by insurers to file such data. A majority of the trustees or directors shall be owners, partners, officers, directors, or employees of one or more members of the fund.

(3) Each member of a commercial self-insurance trust fund established pursuant to this section, except a fund established pursuant to subparagraph (2)(a)3., must maintain membership in the association or self-insurance trust fund

established under s. 627.357. Membership in a not-for-profit trade association, industry association, or professional association of employers or professionals for the purpose of obtaining or providing insurance shall be in accordance with the constitution or bylaws of the association, and the dues, fees, or other costs of membership shall not be different for members obtaining insurance from the commercial self-insurance fund. The association shall not be liable for any actions of the fund nor shall it have any responsibility for establishing or enforcing any policy of the commercial self-insurance fund. Fees, services, and other aspects of the relationship between the association and the fund shall be subject to contractual agreement.

Section 40. Paragraph (a) of subsection (6) of section 627.062, Florida Statutes, as amended by section 1064 of chapter 2003-261, Laws of Florida, is amended, and subsections (7) and (8) are added to that section, to read:

627.062 Rate standards.--

(6)(a) After any action with respect to a rate filing that constitutes agency action for purposes of the Administrative Procedure Act, except for a rate filing for medical malpractice, an insurer may, in lieu of demanding a hearing under s. 120.57, require arbitration of the rate filing. Arbitration shall be conducted by a board of arbitrators consisting of an arbitrator selected by the department, an arbitrator selected by the insurer, and an arbitrator selected jointly by the other two arbitrators. Each arbitrator must be certified by the American Arbitration Association. A decision is valid only upon the affirmative vote of at least two of the arbitrators. No arbitrator may be an employee of any insurance regulator or regulatory body or

of any insurer, regardless of whether or not the employing insurer does business in this state. The department and the insurer must treat the decision of the arbitrators as the final approval of a rate filing. Costs of arbitration shall be paid by the insurer.

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

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

(c) Upon reviewing a rate filing and determining whether the rate is excessive, inadequate, or unfairly discriminatory, the office shall consider, in accordance with generally accepted and reasonable actuarial techniques, past and present prospective loss experience, either using loss experience solely for this state or giving greater credibility

to this state's loss data after applying actuarially sound methods of assigning credibility to such data.

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

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

(f) Each medical malpractice insurer must make a rate filing under this section, sworn to by at least two executive officers of the insurer, at least once each calendar year.

(8)(a)1. No later than 60 days after the effective date of medical malpractice legislation enacted during the 2003 Special Session D of the Florida Legislature, the office shall calculate a presumed factor that reflects the impact that the changes contained in such legislation will have on rates for medical malpractice insurance and shall issue a notice informing all insurers writing medical malpractice coverage of such presumed factor. In determining the presumed factor, the office shall use generally accepted actuarial techniques and standards provided in this section in determining the expected impact on losses, expenses, and

investment income of the insurer. To the extent that the operation of a provision of medical malpractice legislation enacted during the 2003 Special Session D of the Florida Legislature is stayed pending a constitutional challenge, the impact of that provision shall not be included in the calculation of a presumed factor under this subparagraph.

2. No later than 60 days after the office issues its notice of the presumed rate change factor under subparagraph 1., each insurer writing medical malpractice coverage in this state shall submit to the office a rate filing for medical malpractice insurance, which will take effect no later than January 1, 2004, and apply retroactively to policies issued or renewed on or after the effective date of medical malpractice legislation enacted during the 2003 Special Session D of the Florida Legislature. Except as authorized under paragraph (b), the filing shall reflect an overall rate reduction at least as great as the presumed factor determined under subparagraph 1. With respect to policies issued on or after the effective date of such legislation and prior to the effective date of the rate filing required by this subsection, the office shall order the insurer to make a refund of the amount that was charged in excess of the rate that is approved.

(b) Any insurer or rating organization that contends that the rate provided for in paragraph (a) is excessive, inadequate, or unfairly discriminatory shall separately state in its filing the rate it contends is appropriate and shall state with specificity the factors or data that it contends should be considered in order to produce such appropriate rate. The insurer or rating organization shall be permitted to use all of the generally accepted actuarial techniques provided in this section in making any filing pursuant to this

subsection. The office shall review each such exception and approve or disapprove it prior to use. It shall be the insurer's burden to actuarially justify any deviations from the rates required to be filed under paragraph (a). The insurer making a filing under this paragraph shall include in the filing the expected impact of medical malpractice legislation enacted during the 2003 Special Session D of the Florida Legislature on losses, expenses, and rates.

(c) If any provision of medical malpractice legislation enacted during the 2003 Special Session D of the Florida Legislature is held invalid by a court of competent jurisdiction, the office shall permit an adjustment of all medical malpractice rates filed under this section to reflect the impact of such holding on such rates so as to ensure that the rates are not excessive, inadequate, or unfairly discriminatory.

(d) Rates approved on or before July 1, 2003, for medical malpractice insurance shall remain in effect until the effective date of a new rate filing approved under this subsection.

(e) The calculation and notice by the office of the presumed factor pursuant to paragraph (a) is not an order or rule that is subject to chapter 120. If the office enters into a contract with an independent consultant to assist the office in calculating the presumed factor, such contract shall not be subject to the competitive solicitation requirements of s. 287.057.

Section 41. The Office of Program Policy Analysis and Government Accountability shall study the feasibility and merits of authorizing the Public Counsel to examine insurance rate filings for medical malpractice submitted to the Office

of Insurance Regulation, to make recommendations to the office regarding such rate filings, and to represent the public in any hearing related to such rate filings. The study must include an evaluation of the effectiveness of the current authority of the Office of the Insurance Consumer Advocate to perform such functions and comparable functions exercised in other states.

Section 42. Subsections (6) and (10) of section 627.357, Florida Statutes, as amended by section 1107 of chapter 2003-261, Laws of Florida, are amended to read:

627.357 Medical malpractice self-insurance.--

(6) The commission shall adopt rules to implement this section, including rules that ensure that a trust fund remains solvent and maintains a sufficient reserve to cover contingent liabilities under subsection (7) in the event of its dissolution.

~~(10) A self-insurance fund may not be formed under this section after October 1, 1992.~~

Section 43. Effective October 1, 2003, section 627.4147, Florida Statutes, is amended to read:

627.4147 Medical malpractice insurance contracts.--

(1) In addition to any other requirements imposed by law, each self-insurance policy as authorized under s. 627.357 or s. 624.462 or insurance policy providing coverage for claims arising out of the rendering of, or the failure to render, medical care or services, including those of the Florida Medical Malpractice Joint Underwriting Association, shall include:

(a) A clause requiring the insured to cooperate fully in the review process prescribed under s. 766.106 if a notice

of intent to file a claim for medical malpractice is made against the insured.

(b)1. Except as provided in subparagraph 2., a clause authorizing the insurer or self-insurer to determine, to make, and to conclude, without the permission of the insured, any offer of admission of liability and for arbitration pursuant to s. 766.106, settlement offer, or offer of judgment, if the offer is within the policy limits. It is against public policy for any insurance or self-insurance policy to contain a clause giving the insured the exclusive right to veto any offer for admission of liability and for arbitration made pursuant to s. 766.106, settlement offer, or offer of judgment, when such offer is within the policy limits. However, any offer of admission of liability, settlement offer, or offer of judgment made by an insurer or self-insurer shall be made in good faith and in the best interests of the insured.

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

b. If the policy contains a clause stating the insured does not have the exclusive right to veto any offer or admission of liability and for arbitration made pursuant to s. 766.106, settlement offer or offer of judgment, the insurer or self-insurer shall provide to the insured or the insured's legal representative by certified mail, return receipt requested, a copy of the final offer of admission of liability and for arbitration made pursuant to s. 766.106, settlement offer or offer of judgment and at the same time such offer is provided to the claimant. A copy of any final agreement reached between the insurer and claimant shall also be provided to the insurer or his or her legal representative by certified mail, return receipt requested not more than 10 days after affecting such agreement.

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

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

(2) Each insurer covered by this section may require the insured to be a member in good standing, i.e., not subject to expulsion or suspension, of a duly recognized state or

local professional society of health care providers which maintains a medical review committee. No professional society shall expel or suspend a member solely because he or she participates in a health maintenance organization licensed under part I of chapter 641.

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

Section 44. Section 627.41495, Florida Statutes, is created to read:

627.41495 Public notice of medical malpractice rate filings.--

(1) Upon the filing of a proposed rate change by a medical malpractice insurer or self-insurance fund, which filing would result in an average statewide increase of 25 percent or more, pursuant to standards determined by the office, the insurer or self-insurance fund shall mail notice of such filing to each of its policyholders or members.

(2) The rate filing shall be available for public inspection.

Section 45. Section 627.912, Florida Statutes, as amended by section 1226 of chapter 2003-261, Laws of Florida, is amended to read:

627.912 Professional liability claims and actions; reports by insurers and health care providers; annual report by office.--

(1)(a) Each self-insurer authorized under s. 627.357 and each commercial self-insurance fund authorized under s. 624.462, authorized insurer, surplus lines insurer, risk retention group, and ~~or~~ joint underwriting association providing professional liability insurance to a practitioner of medicine licensed under chapter 458, to a practitioner of

osteopathic medicine licensed under chapter 459, to a podiatric physician licensed under chapter 461, to a dentist licensed under chapter 466, to a hospital licensed under chapter 395, to a crisis stabilization unit licensed under part IV of chapter 394, to a health maintenance organization certificated under part I of chapter 641, to clinics included in chapter 390, or to an ambulatory surgical center as defined in s. 395.002, and each insurer providing professional liability insurance ~~or~~ to a member of The Florida Bar shall report ~~in duplicate~~ to the office any claim or action for damages for personal injuries claimed to have been caused by error, omission, or negligence in the performance of such insured's professional services or based on a claimed performance of professional services without consent, if the claim resulted in:

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

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

3. A final disposition of a medical malpractice claim resulting in no indemnity payment on behalf of the insured.

(b) Each health care practitioner and health care facility listed in paragraph (a) must report any claim or action for damages as described in paragraph (a), if the claim is not otherwise required to be reported by an insurer or other insuring entity.

Reports under this subsection shall be filed with the office ~~and, if the insured party is licensed under chapter 458, chapter 459, chapter 461, or chapter 466, with the Department of Health,~~no later than 30 days following the occurrence of any event listed in paragraph (a) ~~or paragraph (b)~~. ~~The Department of Health shall review each report and determine~~

~~whether any of the incidents that resulted in the claim potentially involved conduct by the licensee that is subject to disciplinary action, in which case the provisions of s. 456.073 shall apply. The Department of Health, as part of the annual report required by s. 456.026, shall publish annual statistics, without identifying licensees, on the reports it receives, including final action taken on such reports by the Department of Health or the appropriate regulatory board.~~

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

(a) The name, address, health care provider professional license number, and specialty coverage of the insured.

(b) The insured's policy number.

(c) The date of the occurrence which created the claim.

(d) The date the claim was reported to the insurer or self-insurer.

(e) The name and address of the injured person. This information is confidential and exempt from the provisions of s. 119.07(1), and must not be disclosed by the office without the injured person's consent, except for disclosure by the office to the Department of Health. This information may be used by the office for purposes of identifying multiple or duplicate claims arising out of the same occurrence.

(f) The date of suit, if filed.

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

(h) The total number, ~~and~~ names, and health care provider professional license numbers of all defendants involved in the claim.

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

(j) In the case of a settlement, such information as the office may require with regard to the injured person's incurred and anticipated medical expense, wage loss, and other expenses.

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

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

(m) A summary of the occurrence which created the claim, which shall include:

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

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

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

4. The operation, diagnostic, or treatment procedure causing the injury.

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

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

(n) Any other information required by the commission, by rule,~~office~~ to assist the office in its analysis and evaluation of ~~analyze and evaluate~~ the nature, causes, location, cost, and damages involved in professional liability cases.

(3) ~~Upon request by the Department of Health,~~The office shall provide the Department of Health with electronic access to all ~~any~~ information received under this section related to persons licensed under chapter 458, chapter 459, chapter 461, or chapter 466. The Department of Health shall review each report and determine whether any of the incidents that resulted in the claim potentially involved conduct by the licensee that is subject to disciplinary action, in which case the provisions of s. 456.073 shall apply.~~For purposes of safety management, the office shall annually provide the Department of Health with copies of the reports in cases resulting in an indemnity being paid to the claimants.~~

(4) There shall be no liability on the part of, and no cause of action of any nature shall arise against, any person or entity ~~insurer~~ reporting hereunder or its agents or employees or the office or its employees for any action taken by them under this section. The office shall ~~may~~ impose a fine of $250 per day per case, but not to exceed a total of $10,000~~$1,000~~ per case, against an insurer, commercial self-insurance fund, medical malpractice self-insurance fund, or risk retention group that violates the requirements of this section, except that the office may impose a fine of $250 per day per case, not to exceed a total of $1,000 per case, against an insurer providing professional liability insurance to a member of The Florida Bar, which insurer violates the provisions of this section. If a healthcare practitioner or health care facility violates the requirements of this section, it shall be considered a violation of the chapter or act under which the practitioner or facility is licensed and shall be grounds for a fine or disciplinary action as such

other violations of the chapter or act.~~This subsection applies to claims accruing on or after October 1, 1997.~~

(5) Any self-insurance program established under s. 1004.24 shall report ~~in duplicate~~ to the office any claim or action for damages for personal injuries claimed to have been caused by error, omission, or negligence in the performance of professional services provided by the state university board of trustees through an employee or agent of the state university board of trustees, including practitioners of medicine licensed under chapter 458, practitioners of osteopathic medicine licensed under chapter 459, podiatric physicians licensed under chapter 461, and dentists licensed under chapter 466, or based on a claimed performance of professional services without consent if the claim resulted in a final judgment in any amount, or a settlement in any amount. The reports required by this subsection shall contain the information required by subsection (3) and the name, address, and specialty of the employee or agent of the state university board of trustees whose performance or professional services is alleged in the claim or action to have caused personal injury.

(6)(a) The office shall prepare statistical summaries of the closed claims reports for medical malpractice filed pursuant to this section, for each year that such reports have been filed, and make such summaries and closed claim reports available on the Internet by July 1, 2005.

(b) The office shall prepare an annual report by October 1 of each year, beginning in 2004, which shall be available on the Internet, which summarizes and analyzes the closed claim reports for medical malpractice filed pursuant to this section and the annual financial reports filed by

insurers writing medical malpractice insurance in this state. The report must include an analysis of closed claim reports of prior years, in order to show trends in the frequency and amount of claims payments, the itemization of economic and noneconomic damages, the nature of the errant conduct, and such other information as the office determines is illustrative of the trends in closed claims. The report must also analyze the state of the medical malpractice insurance market in Florida, including an analysis of the financial reports of those insurers with a combined market share of at least 80 percent of the net written premium in the state for medical malpractice for the prior calendar year, including a loss ratio analysis for medical malpractice written in Florida and a profitability analysis of each such insurer. The report shall compare the ratios for medical malpractice in Florida compared to other states, based on financial reports filed with the National Association of Insurance Commissioners and such other information as the office deems relevant.

(c) The annual report shall also include a summary of the rate filings for medical malpractice which have been approved by the office for the prior calendar year, including an analysis of the trend of direct and incurred losses as compared to prior years.

(7) The commission may adopt rules requiring persons and entities required to report pursuant to this section to also report data related to the frequency and severity of open claims for the reporting period, amounts reserved for incurred claims, changes in reserves from the previous reporting period, and other information considered relevant to the ability of the office to monitor losses and claims development in the Florida medical malpractice insurance market.

Section 46. Subsections (11), (12), and (17) of section 641.19, Florida Statutes, as amended by section 1555 of chapter 2003-261, Laws of Florida, are amended to read:

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

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

(12) "Health maintenance organization" means any organization authorized under this part which:

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

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

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

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

(e) If offering services through a managed care system, has ~~then the managed care system must be~~ a system in which a primary physician licensed under chapter 458, ~~or~~

chapter 459, chapter ~~and chapters~~ 460, or chapter ~~and~~ 461 is designated for each subscriber upon request of a subscriber requesting service by a physician licensed under any of those chapters, and is responsible for coordinating the health care of the subscriber of the respectively requested service and for referring the subscriber to other providers of the same discipline when necessary. Each female subscriber may select as her primary physician an obstetrician/gynecologist who has agreed to serve as a primary physician and is in the health maintenance organization's provider network.

Except in cases in which the health care provider is an employee of the health maintenance organization, the fact that the health maintenance organization arranges for the provision of health care services under this chapter does not create an actual agency, apparent agency, or employer-employee relationship between the health care provider and the health maintenance organization for purposes of vicarious liability for the medical negligence of the health care provider.

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

Section 47. Subsection (3) of section 641.51, Florida Statutes, is amended to read:

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

(3) The health maintenance organization shall not have the right to control the professional judgment of a physician licensed under chapter 458, chapter 459, chapter 460, or

chapter 461 concerning the proper course of treatment of a subscriber ~~shall not be subject to modification by the organization or its board of directors, officers, or administrators, unless the course of treatment prescribed is inconsistent with the prevailing standards of medical practice in the community~~. However, this subsection shall not be considered to restrict a utilization management program established by an organization or to affect an organization's decision as to payment for covered services. Except in cases in which the health care provider is an employee of the health maintenance organization, the health maintenance organization shall not be vicariously liable for the medical negligence of the health care provider, whether such claim is alleged under a theory of actual agency, apparent agency, or employer-employee relationship.

Section 48. Section 766.102, Florida Statutes, is amended to read:

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

(1) In any action for recovery of damages based on the death or personal injury of any person in which it is alleged that such death or injury resulted from the negligence of a health care provider as defined in s. 766.202(4)~~s. 768.50(2)(b)~~, the claimant shall have the burden of proving by the greater weight of evidence that the alleged actions of the health care provider represented a breach of the prevailing professional standard of care for that health care provider. The prevailing professional standard of care for a given health care provider shall be that level of care, skill, and treatment which, in light of all relevant surrounding

circumstances, is recognized as acceptable and appropriate by reasonably prudent similar health care providers.

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

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

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

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

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

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

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

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

~~(c) The purpose of this subsection is to establish a relative standard of care for various categories and~~

~~classifications of health care providers. Any health care provider may testify as an expert in any action if he or she:~~

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

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

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

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

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

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

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

(a) If the health care provider against whom or on whose behalf the testimony is offered is a specialist, the expert witness must:

1. Specialize in the same specialty as the health care provider against whom or on whose behalf the testimony is offered; or specialize in a similar specialty that includes the evaluation, diagnosis, or treatment of the medical

condition that is the subject of the claim and have prior experience treating similar patients; and

2. Have devoted professional time during the 3 years immediately preceding the date of the occurrence that is the basis for the action to:

a. The active clinical practice of, or consulting with respect to, the same or similar specialty that includes the evaluation, diagnosis, or treatment of the medical condition that is the subject of the claim and have prior experience treating similar patients;

b. Instruction of students in an accredited health professional school or accredited residency or clinical research program in the same or similar specialty; or

c. A clinical research program that is affiliated with an accredited health professional school or accredited residency or clinical research program in the same or similar speciality.

(b) If the health care provider against whom or on whose behalf the testimony is offered is a general practitioner, the expert witness must have devoted professional time during the 5 years immediately preceding the date of the occurrence that is the basis for the action to:

1. The active clinical practice or consultation as a general practitioner;

2. The instruction of students in an accredited health professional school or accredited residency program in the general practice of medicine; or

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

(c) If the health care provider against whom or on whose behalf the testimony is offered is a health care provider other than a specialist or a general practitioner, the expert witness must have devoted professional time during the 3 years immediately preceding the date of the occurrence that is the basis for the action to:

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

2. The instruction of students in an accredited health professional school or accredited residency program in the same or similar health profession in which the health care provider against whom or on whose behalf the testimony is offered; or

3. A clinical research program that is affiliated with an accredited medical school or teaching hospital and that is in the same or similar health profession as the health care provider against whom or on whose behalf the testimony is offered.

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

(7) Notwithstanding subsection (5), in a medical negligence action against a hospital, a health care facility,

or medical facility, a person may give expert testimony on the appropriate standard of care as to administrative and other nonclinical issues if the person has substantial knowledge, by virtue of his or her training and experience, concerning the standard of care among hospitals, health care facilities, or medical facilities of the same type as the hospital, health care facility, or medical facility whose acts or omissions are the subject of the testimony and which are located in the same or similar communities at the time of the alleged act giving rise to the cause of action.

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

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

(b) For the purposes of this subsection:

1. The term "emergency medical services" means those medical services required for the immediate diagnosis and treatment of medical conditions which, if not immediately

diagnosed and treated, could lead to serious physical or mental disability or death.

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

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

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

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

Section 49. Section 766.106, Florida Statutes, is amended to read:

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

(1) DEFINITIONS.--As used in this section, the term:

(a) "Claim for medical negligence ~~malpractice~~" or "claim for medical malpractice"means a claim, arising out of the rendering of, or the failure to render, medical care or services.

(b) "Self-insurer" means any self-insurer authorized under s. 627.357 or any uninsured prospective defendant.

(c) "Insurer" includes the Joint Underwriting Association.

(2) PRESUIT NOTICE.--

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

(b) Following the initiation of a suit alleging medical negligence ~~malpractice~~ with a court of competent jurisdiction, and service of the complaint upon a defendant, the claimant shall provide a copy of the complaint to the Department of Health and, if the complaint involves a facility licensed under chapter 395, the Agency for Health Care Administration. The requirement of providing the complaint to the Department of Health or the Agency for Health Care Administration does not impair the claimant's legal rights or ability to seek relief for his or her claim. The Department of Health or the Agency for Health Care Administration shall review each incident that is the subject of the complaint and determine whether it involved conduct by a licensee which is potentially subject to disciplinary action, in which case, for

a licensed health care practitioner,the provisions of s. 456.073 apply and, for a licensed facility, the provisions of part I of chapter 395 apply.

(3) PRESUIT INVESTIGATION BY PROSPECTIVE DEFENDANT.--

(a) No suit may be filed for a period of 90 days after notice is mailed to any prospective defendant. During the 90-day period, the prospective defendant or the defendant's insurer or self-insurer shall conduct a review as provided in s. 766.203(3)to determine the liability of the defendant. Each insurer or self-insurer shall have a procedure for the prompt investigation, review, and evaluation of claims during the 90-day period. This procedure shall include one or more of the following:

1. Internal review by a duly qualified claims adjuster;

2. Creation of a panel comprised of an attorney knowledgeable in the prosecution or defense of medical negligence ~~malpractice~~ actions, a health care provider trained in the same or similar medical specialty as the prospective defendant, and a duly qualified claims adjuster;

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

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

Each insurer or self-insurer shall investigate the claim in good faith, and both the claimant and prospective defendant shall cooperate with the insurer in good faith. If the insurer requires, a claimant shall appear before a pretrial screening panel or before a medical review committee and shall

submit to a physical examination, if required. Unreasonable failure of any party to comply with this section justifies dismissal of claims or defenses. There shall be no civil liability for participation in a pretrial screening procedure if done without intentional fraud.

(b) At or before the end of the 90 days, the prospective defendant or the prospective defendant's insurer or self-insurer shall provide the claimant with a response:

1. Rejecting the claim;

2. Making a settlement offer; or

3. Making an offer to arbitrate in which liability is deemed admitted and arbitration will be held only ~~of admission of liability and for arbitration~~ on the issue of damages. This offer may be made contingent upon a limit of general damages.

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

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

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

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

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

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

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

(4) SERVICE OF PRESUIT NOTICE AND TOLLING.--The notice of intent to initiate litigation shall be served within the time limits set forth in s. 95.11. However, during the 90-day period, the statute of limitations is tolled as to all potential defendants. Upon stipulation by the parties, the 90-day period may be extended and the statute of limitations is tolled during any such extension. Upon receiving notice of termination of negotiations in an extended period, the claimant shall have 60 days or the remainder of the period of the statute of limitations, whichever is greater, within which to file suit.

(5) DISCOVERY AND ADMISSIBILITY.--No statement, discussion, written document, report, or other work product generated by the presuit screening process is discoverable or admissible in any civil action for any purpose by the opposing party. All participants, including, but not limited to, physicians, investigators, witnesses, and employees or associates of the defendant, are immune from civil liability arising from participation in the presuit screening process.

(6) INFORMAL DISCOVERY.--

(a) Upon receipt by a prospective defendant of a notice of claim, the parties shall make discoverable information available without formal discovery. Failure to do so is grounds for dismissal of claims or defenses ultimately asserted.

(b)~~(7)~~ Informal discovery may be used by a party to obtain unsworn statements, the production of documents or things, and physical and mental examinations, as follows:

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

2.~~(b)~~ Documents or things.--Any party may request discovery of documents or things. The documents or things must be produced, at the expense of the requesting party, within 20 days after the date of receipt of the request. A party is required to produce discoverable documents or things within that party's possession or control. Medical records shall be produced as provided in s.766.204.

3.~~(c)~~ Physical and mental examinations.--A prospective defendant may require an injured ~~prospective~~ claimant to appear for examination by an appropriate health care provider. The prospective defendant shall give reasonable notice in writing to all parties as to the time and place for

examination. Unless otherwise impractical, a ~~prospective~~ claimant is required to submit to only one examination on behalf of all potential defendants. The practicality of a single examination must be determined by the nature of the ~~potential~~ claimant's condition, as it relates to the liability of each prospective ~~potential~~ defendant. Such examination report is available to the parties and their attorneys upon payment of the reasonable cost of reproduction and may be used only for the purpose of presuit screening. Otherwise, such examination report is confidential and exempt from the provisions of s. 119.07(1) and s. 24(a), Art. I of the State Constitution.

4. Written questions.--Any party may request answers to written questions, the number of which may not exceed 30, including subparts. A response must be made within 20 days after receipt of the questions.

5. Medical information release.--The claimant must execute a medical information release that allows a prospective defendant or his or her legal representative to take unsworn statements of the claimant's treating physicians. The statements must be limited to those areas that are potentially relevant to the claim of personal injury or wrongful death. Subject to the procedural requirements of subparagraph 1., a prospective defendant may take unsworn statements from a claimant's treating physicians. Reasonable notice and opportunity to be heard must be given to the claimant or the claimant's legal representative. The claimant or claimant's legal representative has the right to attend the taking of such unsworn statements.

(c)~~(8)~~ Each request for and notice concerning informal presuit discovery pursuant to this section must be in writing,

and a copy thereof must be sent to all parties. Such a request or notice must bear a certificate of service identifying the name and address of the person to whom the request or notice is served, the date of the request or notice, and the manner of service thereof.

(d)~~(9)~~ Copies of any documents produced in response to the request of any party must be served upon all other parties. The party serving the documents or his or her attorney shall identify, in a notice accompanying the documents, the name and address of the parties to whom the documents were served, the date of service, the manner of service, and the identity of the document served.

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

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

~~(a) If rejected, the offer to admit liability and for arbitration on damages is not admissible in any subsequent litigation. Upon rejection of the offer to admit liability and for arbitration, the claimant has 60 days or the remainder~~

~~of the period of the statute of limitations, whichever period is greater, in which to file suit.~~

~~(b) If the offer to admit liability and for arbitration on damages is accepted, the parties have 30 days from the date of acceptance to settle the amount of damages. If the parties have not reached agreement after 30 days, they shall proceed to binding arbitration to determine the amount of damages as follows:~~

~~1. Each party shall identify his or her arbitrator to the opposing party not later than 35 days after the date of acceptance.~~

~~2. The two arbitrators shall, within 1 week after they are notified of their appointment, agree upon a third arbitrator. If they cannot agree on a third arbitrator, selection of the third arbitrator shall be in accordance with chapter 682.~~

~~3. Not later than 30 days after the selection of a third arbitrator, the parties shall file written arguments with each arbitrator and with each other indicating total damages.~~

~~4. Unless otherwise determined by the arbitration panel, within 10 days after the receipt of such arguments, unless the parties have agreed to a settlement, there shall be a 1-day hearing, at which formal rules of evidence and the rules of civil procedure shall not apply, during which each party shall present evidence as to damages. Each party shall identify the total dollar amount which he or she feels should be awarded.~~

~~5. No later than 2 weeks after the hearing, the arbitrators shall notify the parties of their determination of~~

~~the total award. The court shall have jurisdiction to enforce any award or agreement for periodic payment of future damages.~~

~~(11) If there is more than one prospective defendant, the claimant shall provide the notice of claim and follow the procedures in this section for each defendant. If an offer to admit liability and for arbitration is accepted, the procedures shall be initiated separately for each defendant, unless multiple offers are made by more than one prospective defendant and are accepted and the parties agree to consolidated arbitration. Any agreement for consolidated arbitration shall be filed with the court. No offer by any prospective defendant to admit liability and for arbitration is admissible in any civil action.~~

~~(12) To the extent not inconsistent with this part, the provisions of chapter 682, the Florida Arbitration Code, shall be applicable to such proceedings.~~

Section 50. Section 766.108, Florida Statutes, is amended to read:

766.108 Mandatory mediation and mandatory settlement conference in medical negligence ~~malpractice~~ actions.--

(1) Within 120 days after the suit is filed, unless such period is extended by mutual agreement of all parties, all parties shall attend in-person mandatory mediation in accordance with s. 44.102 if binding arbitration under s. 766.207 has not been agreed to by the parties. The Florida Rules of Civil Procedure shall apply to mediation held pursuant to this section.

(2)(a)~~(1)~~ In any action for damages based on personal injury or wrongful death arising out of medical malpractice, whether in tort or contract, the court shall require a

settlement conference at least 3 weeks before the date set for trial.

(b)~~(2)~~ Attorneys who will conduct the trial, parties, and persons with authority to settle shall attend the settlement conference held before the court unless excused by the court for good cause.

Section 51. Subsection (2) of section 766.1115, Florida Statutes, as amended by section 1900 of chapter 2003-261, Laws of Florida, is amended to read:

766.1115 Health care providers; creation of agency relationship with governmental contractors.--

(2) FINDINGS AND INTENT.--The Legislature finds that a significant proportion of the residents of this state who are uninsured or Medicaid recipients are unable to access needed health care because health care providers fear the increased risk of medical negligence ~~malpractice~~ liability. It is the intent of the Legislature that access to medical care for indigent residents be improved by providing governmental protection to health care providers who offer free quality medical services to underserved populations of the state. Therefore, it is the intent of the Legislature to ensure that health care professionals who contract to provide such services as agents of the state are provided sovereign immunity.

Section 52. Section 766.112, Florida Statutes, is amended to read:

766.112 Comparative fault.--

(1) Notwithstanding anything in law to the contrary, in an action for damages for personal injury or wrongful death arising out of medical negligence ~~malpractice~~, whether in contract or tort, when an apportionment of damages pursuant to

this section is attributed to a teaching hospital as defined in s. 408.07, the court shall enter judgment against the teaching hospital on the basis of such party's percentage of fault and not on the basis of the doctrine of joint and several liability.

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

Section 53. Section 766.113, Florida Statutes, is amended to read:

766.113 Settlement agreements; prohibition on restricting disclosure to Division of Medical Quality Assurance.--

(1) Each final settlement agreement relating to medical negligence shall include the following statement: "The decision to settle a case may reflect the economic practicalities pertaining to the cost of litigation and is not, alone, an admission that the insured failed to meet the required standard of care applicable to the patient's treatment. The decision to settle a case may be made by the insurance company without consulting its client for input, unless otherwise provided by the insurance policy."

(2) A settlement agreement involving a claim for medical negligence ~~malpractice~~ shall not prohibit any party to the agreement from discussing with or reporting to the Division of Medical Quality Assurance the events giving rise to the claim.

Section 54. Section 766.118, Florida Statutes, is created to read:

766.118 Determination of noneconomic damages.--

(1) DEFINITIONS.--As used in this section, the term:

(a) "Catastrophic injury" means a permanent impairment constituted by:

1. Spinal cord injury involving severe paralysis of an arm, a leg, or the trunk;

2. Amputation of an arm, a hand, a foot, or a leg involving the effective loss of use of that appendage;

3. Severe brain or closed-head injury as evidenced by:

a. Severe sensory or motor disturbances;

b. Severe communication disturbances;

c. Severe complex integrated disturbances of cerebral function;

d. Severe episodic neurological disorders; or

e. Other severe brain and closed-head injury conditions at least as severe in nature as any condition provided in sub-subparagraphs a.-d.;

4. Second-degree or third-degree burns of 25 percent or more of the total body surface or third-degree burns of 5 percent or more to the face and hands;

5. Blindness, defined as a complete and total loss of vision; or

6. Loss of reproductive organs which results in an inability to procreate.

(b) "Noneconomic damages" means noneconomic damages as defined in s. 766.202(8).

(c) "Practitioner" means any person licensed under chapter 458, chapter 459, chapter 460, chapter 461, chapter 462, chapter 463, chapter 466, chapter 467, or chapter 486 or certified under s. 464.012. "Practitioner" also means any association, corporation, firm, partnership, or other business entity under which such practitioner practices or any employee of such practitioner or entity acting in the scope of his or her employment. For the purpose of determining the limitations on noneconomic damages set forth in this section, the term "practitioner" includes any person or entity for whom a practitioner is vicariously liable and any person or entity whose liability is based solely on such person or entity being vicariously liable for the actions of a practitioner.

(2) LIMITATION ON NONECONOMIC DAMAGES FOR NEGLIGENCE OF PRACTITIONERS.--

(a) With respect to a cause of action for personal injury or wrongful death arising from medical negligence of practitioners, regardless of the number of such practitioner defendants, noneconomic damages shall not exceed $500,000 per claimant. No practitioner shall be liable for more than $500,000 in noneconomic damages, regardless of the number of claimants.

(b) Notwithstanding paragraph (a), if the negligence resulted in a permanent vegetative state or death, the total noneconomic damages recoverable from all practitioners, regardless of the number of claimants, under this paragraph shall not exceed $1 million. In cases that do not involve death or permanent vegetative state, the patient injured by

medical negligence may recover noneconomic damages not to exceed $1 million if:

1. The trial court determines that a manifest injustice would occur unless increased noneconomic damages are awarded, based on a finding that because of the special circumstances of the case, the noneconomic harm sustained by the injured patient was particularly severe; and

2. The trier of fact determines that the defendant's negligence caused a catastrophic injury to the patient.

(c) The total noneconomic damages recoverable by all claimants from all practitioner defendants under this subsection shall not exceed $1 million in the aggregate.

(3) LIMITATION ON NONECONOMIC DAMAGES FOR NEGLIGENCE OF NONPRACTITIONER DEFENDANTS.--

(a) With respect to a cause of action for personal injury or wrongful death arising from medical negligence of nonpractitioners, regardless of the number of such nonpractitioner defendants, noneconomic damages shall not exceed $750,000 per claimant.

(b) Notwithstanding paragraph (a), if the negligence resulted in a permanent vegetative state or death, the total noneconomic damages recoverable by such claimant from all nonpractitioner defendants under this paragraph shall not exceed $1.5 million. The patient injured by medical negligence of a nonpractitioner defendant may recover noneconomic damages not to exceed $1.5 million if:

1. The trial court determines that a manifest injustice would occur unless increased noneconomic damages are awarded, based on a finding that because of the special circumstances of the case, the noneconomic harm sustained by the injured patient was particularly severe; and

2. The trier of fact determines that the defendant's negligence caused a catastrophic injury to the patient.

(c) Nonpractitioner defendants are subject to the cap on noneconomic damages provided in this subsection regardless of the theory of liability, including vicarious liability.

(d) The total noneconomic damages recoverable by all claimants from all nonpractitioner defendants under this subsection shall not exceed $1.5 million in the aggregate.

(4) LIMITATION ON NONECONOMIC DAMAGES FOR NEGLIGENCE OF PRACTITIONERS PROVIDING EMERGENCY SERVICES AND CARE.--Notwithstanding subsections (2) and (3), with respect to a cause of action for personal injury or wrongful death arising from medical negligence of practitioners providing emergency services and care, as defined in s. 395.002(10), or providing services as provided in s. 401.265, or providing services pursuant to obligations imposed by 42 U.S.C. s. 1395dd to persons with whom the practitioner does not have a then-existing health care patient-practitioner relationship for that medical condition:

(a) Regardless of the number of such practitioner defendants, noneconomic damages shall not exceed $150,000 per claimant.

(b) Notwithstanding paragraph (a), the total noneconomic damages recoverable by all claimants from all such practitioners shall not exceed $300,000.

The limitation provided by this subsection applies only to noneconomic damages awarded as a result of any act or omission of providing medical care or treatment, including diagnosis that occurs prior to the time the patient is stabilized and is capable of receiving medical treatment as a nonemergency

patient, unless surgery is required as a result of the emergency within a reasonable time after the patient is stabilized, in which case the limitation provided by this subsection applies to any act or omission of providing medical care or treatment which occurs prior to the stabilization of the patient following the surgery.

(5) LIMITATION ON NONECONOMIC DAMAGES FOR NEGLIGENCE OF NONPRACTITIONER DEFENDANTS PROVIDING EMERGENCY SERVICES AND CARE.--Notwithstanding subsections (2) and (3), with respect to a cause of action for personal injury or wrongful death arising from medical negligence of defendants other than practitioners providing emergency services and care pursuant to obligations imposed by ss. 395.1041 or 401.45, or obligations imposed by 42 U.S.C. s. 1395dd to persons with whom the practitioner does not have a then-existing health care patient-practitioner relationship for that medical condition:

(a) Regardless of the number of such nonpractitioner defendants, noneconomic damages shall not exceed $750,000 per claimant.

(b) Notwithstanding paragraph (a), the total noneconomic damages recoverable by all claimants from all such nonpractitioner defendants shall not exceed $1.5 million.

(c) Nonpractitioner defendants may receive a full setoff for payments made by practitioner defendants.

The limitation provided by this subsection applies only to noneconomic damages awarded as a result of any act or omission of providing medical care or treatment, including diagnosis that occurs prior to the time the patient is stabilized and is capable of receiving medical treatment as a nonemergency

patient, unless surgery is required as a result of the emergency within a reasonable time after the patient is stabilized, in which case the limitation provided by this subsection applies to any act or omission of providing medical care or treatment which occurs prior to the stabilization of the patient following the surgery.

(6) SETOFF.--In any case in which the jury verdict for noneconomic damages exceeds the limits established by this section, the trial court shall reduce the award for noneconomic damages within the same category of defendants in accordance with this section after making any reduction for comparative fault as required by s. 768.81 but before application of a setoff in accordance with ss. 46.015 and 768.041. In the event of a prior settlement or settlements involving one or more defendants subject to the limitations of the same subsection applicable to a defendant remaining at trial, the court shall make such reductions within the same category of defendants as are necessary to ensure that the total amount of noneconomic damages recovered by the claimant does not exceed the aggregate limit established by the applicable subsection. This subsection is not intended to change current law relating to the setoff of economic damages.

(7) ACTIONS GOVERNED BY SOVEREIGN IMMUNITY LAW.--This section shall not apply to actions governed by s. 768.28.

Section 55. The Legislature finds and declares it to be of vital importance that emergency services and care be provided by hospitals, physicians, and emergency medical services providers to every person in need of such care. The Legislature finds that providers of emergency medical services and care are critical elements in responding to disaster and emergency situations that might affect our local communities,

state, and country. The Legislature recognizes the importance of maintaining a viable system of providing for the emergency medical needs of residents of this state and visitors to this state. The Legislature and the Federal Government have required such providers of emergency medical services and care to provide emergency services and care to all persons who present themselves to hospitals seeking such care. The Legislature has further mandated that prehospital emergency medical treatment or transport may not be denied by emergency medical services providers to persons who have or are likely to have an emergency medical condition. Such governmental requirements have imposed a unilateral obligation for providers of emergency medical services and care to provide services to all persons seeking emergency care without ensuring payment or other consideration for provision of such care. The Legislature also recognizes that providers of emergency medical services and care provide a significant amount of uncompensated emergency medical care in furtherance of such governmental interest. A significant proportion of the residents of this state who are uninsured or are Medicaid or Medicare recipients are unable to access needed health care because health care providers fear the increased risk of medical malpractice liability. Such patients, in order to obtain medical care, are frequently forced to seek care through providers of emergency medical services and care. Providers of emergency medical services and care in this state have reported significant problems with both the availability and affordability of professional liability coverage. Medical malpractice liability insurance premiums have increased dramatically and a number of insurers have ceased providing medical malpractice coverage for emergency medical services

and care in this state. This results in a functional unavailability of malpractice coverage for some providers of emergency medical services and care. The Legislature further finds that certain specialist physicians have resigned from serving on hospital staffs or have otherwise declined to provide on-call coverage to hospital emergency departments due to increased medical malpractice liability exposure created by treating such emergency department patients. It is the intent of the Legislature that hospitals, emergency medical services providers, and physicians be able to ensure that patients who might need emergency medical services treatment or transportation or who present themselves to hospitals for emergency medical services and care have access to such needed services.

Section 56. Section 766.1185, Florida Statutes, is created to read:

766.1185 Bad faith actions.--In all actions for bad faith against a medical malpractice insurer relating to professional liability insurance coverage for medical negligence, and in determining whether the insurer could and should have settled the claim within the policy limits had it acted fairly and honestly towards its insured with due regard for her or his interest, whether under statute or common law:

(1)(a) An insurer shall not be held in bad faith for failure to pay its policy limits if it tenders its policy limits and meets other reasonable conditions of settlement by the earlier of either:

1. The 210th day after service of the complaint in the medical negligence action upon the insured. The time period specified in this subparagraph shall be extended by an additional 60 days if the court in the bad-faith action finds

that, at any time during such period and after the 150th day after service of the complaint, the claimant provided new information previously unavailable to the insurer relating to the identity or testimony of any material witnesses or the identity of any additional claimants or defendants, if such disclosure materially alters the risk to the insured of an excess judgment; or

2. The 60th day after the conclusion of all of the following:

a. Deposition of all claimants named in the complaint or amended complaint.

b. Deposition of all defendants named in the complaint or amended complaint, including, in the case of a corporate defendant, deposition of a designated representative.

c. Deposition of all of the claimants' expert witnesses.

d. The initial disclosure of witnesses and production of documents.

e. Mediation as provided in s. 766.108.

(b) Either party may request that the court enter an order finding that the other party has unnecessarily or inappropriately delayed any of the events specified in subparagraph (a)2. If the court finds that the claimant was responsible for such unnecessary or inappropriate delay, subparagraph (a)1. shall not apply to the insurer's tendering of policy limits. If the court finds that the defendant or insurer was responsible for such unnecessary or inappropriate delay, subparagraph (a)2. shall not apply to the insurer's tendering of policy limits.

(c) If any party to an action alleging medical negligence amends its witness list after service of the

complaint in such action, that party shall provide a copy of the amended witness list to the insurer of the defendant health care provider.

(d) The fact that the insurer did not tender policy limits during the time periods specified in this paragraph is not presumptive evidence that the insurer acted in bad faith.

(2) When subsection (1) does not apply, the trier of fact, in determining whether an insurer has acted in bad faith, shall consider:

(a) The insurer's willingness to negotiate with the claimant in anticipation of settlement.

(b) The propriety of the insurer's methods of investigating and evaluating the claim.

(c) Whether the insurer timely informed the insured of an offer to settle within the limits of coverage, the right to retain personal counsel, and the risk of litigation.

(d) Whether the insured denied liability or requested that the case be defended after the insurer fully advised the insured as to the facts and risks.

(e) Whether the claimant imposed any condition, other than the tender of the policy limits, on the settlement of the claim.

(f) Whether the claimant provided relevant information to the insurer on a timely basis.

(g) Whether and when other defendants in the case settled or were dismissed from the case.

(h) Whether there were multiple claimants seeking, in the aggregate, compensation in excess of policy limits from the defendant or the defendant's insurer.

(i) Whether the insured misrepresented material facts to the insurer or made material omissions of fact to the insurer.

(j) In addition to the foregoing the court shall allow consideration of such additional factors as the court determines to be relevant.

(3) The provisions of s. 624.155 shall be applicable in all cases brought pursuant to that section unless specifically controlled by this section.

(4) An insurer that tenders policy limits shall be entitled to a release of its insured if the claimant accepts the tender.

Section 57. Paragraphs (c) and (d) of subsection (1) of section 766.201, Florida Statutes, are amended to read:

766.201 Legislative findings and intent.--

(1) The Legislature makes the following findings:

(c) The average cost of a medical negligence ~~malpractice~~ claim has escalated in the past decade to the point where it has become imperative to control such cost in the interests of the public need for quality medical services.

(d) The high cost of medical negligence ~~malpractice~~ claims in the state can be substantially alleviated by requiring early determination of the merit of claims, by providing for early arbitration of claims, thereby reducing delay and attorney's fees, and by imposing reasonable limitations on damages, while preserving the right of either party to have its case heard by a jury.

Section 58. Section 766.202, Florida Statutes, is amended to read:

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

(1) "Claimant" means any person who has a cause of action for damages based on personal injury or wrongful death arising from medical negligence.

(2) "Collateral sources" means any payments made to the claimant, or made on his or her behalf, by or pursuant to:

(a) The United States Social Security Act; any federal, state, or local income disability act; or any other public programs providing medical expenses, disability payments, or other similar benefits, except as prohibited by federal law.

(b) Any health, sickness, or income disability insurance; automobile accident insurance that provides health benefits or income disability coverage; and any other similar insurance benefits, except life insurance benefits available to the claimant, whether purchased by him or her or provided by others.

(c) Any contract or agreement of any group, organization, partnership, or corporation to provide, pay for, or reimburse the costs of hospital, medical, dental, or other health care services.

(d) Any contractual or voluntary wage continuation plan provided by employers or by any other system intended to provide wages during a period of disability.

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

(4) "Health care provider" means any hospital, ambulatory surgical center, or mobile surgical facility as defined and licensed under chapter 395; a birth center licensed under chapter 383; any person licensed under chapter 458, chapter 459, chapter 460, chapter 461, chapter 462, chapter 463, part I of chapter 464, chapter 466, chapter 467 or chapter 486; a clinical lab licensed under chapter 483; a health maintenance organization certificated under part I of chapter 641; a blood bank; a plasma center; an industrial clinic; a renal dialysis facility; or a professional association partnership, corporation, joint venture, or other association for professional activity by health care providers.

(5)~~(4)~~ "Investigation" means that an attorney has reviewed the case against each and every potential defendant and has consulted with a medical expert and has obtained a written opinion from said expert.

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

(7)~~(6)~~ "Medical negligence" means medical malpractice, whether grounded in tort or in contract.

(8)~~(7)~~ "Noneconomic damages" means nonfinancial losses that ~~which~~ would not have occurred but for the injury giving rise to the cause of action, including pain and suffering, inconvenience, physical impairment, mental anguish,

disfigurement, loss of capacity for enjoyment of life, and other nonfinancial losses to the extent the claimant is entitled to recover such damages under general law, including the Wrongful Death Act.

(9)~~(8)~~ "Periodic payment" means provision for the structuring of future economic damages payments, in whole or in part, over a period of time, as follows:

(a) A specific finding of the dollar amount of periodic payments which will compensate for these future damages after offset for collateral sources shall be made. The total dollar amount of the periodic payments shall equal the dollar amount of all such future damages before any reduction to present value.

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

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

Section 59. Section 766.2021, Florida Statutes, is created to read:

766.2021 Limitation on damages against insurers, prepaid limited health service organizations, health maintenance organizations, or prepaid health clinics.--An entity licensed or certified under chapter 624, chapter 636, or chapter 641 shall not be liable for the medical negligence of a health care provider with whom the licensed or certified entity has entered into a contract in any amount greater than the amount of damages that may be imposed by law directly upon the health care provider, and any suits against such entity shall be subject to all provisions and requirements of evidence in this chapter and other requirements imposed by law in connection with suits against health care providers for medical negligence.

Section 60. Section 766.203, Florida Statutes, is amended to read:

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

(1) Application of presuit investigation.--Presuit investigation of medical negligence claims and defenses pursuant to this section and ss. 766.204-766.206 shall apply to all medical negligence~~, including dental negligence,~~ claims and defenses. This shall include:

(a) Rights of action under s. 768.19 and defenses thereto.

(b) Rights of action involving the state or its agencies or subdivisions, or the officers, employees, or agents thereof, pursuant to s. 768.28 and defenses thereto.

(2) Presuit investigation by claimant.--Prior to issuing notification of intent to initiate medical negligence

~~malpractice~~ litigation pursuant to s. 766.106, the claimant shall conduct an investigation to ascertain that there are reasonable grounds to believe that:

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

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

Corroboration of reasonable grounds to initiate medical negligence litigation shall be provided by the claimant's submission of a verified written medical expert opinion from a medical expert as defined in s. 766.202(5), at the time the notice of intent to initiate litigation is mailed, which statement shall corroborate reasonable grounds to support the claim of medical negligence.

(3) Presuit investigation by prospective defendant.--Prior to issuing its response to the claimant's notice of intent to initiate litigation, during the time period for response authorized pursuant to s. 766.106, the prospective defendant or the defendant's insurer or self-insurer shall conduct an investigation as provided in s. 766.106(3)to ascertain whether there are reasonable grounds to believe that:

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

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

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

verified written medical expert opinion from a medical expert as defined in s. 766.202(5), at the time the response rejecting the claim is mailed, which statement shall corroborate reasonable grounds for lack of negligent injury sufficient to support the response denying negligent injury.

(4) Presuit medical expert opinion.--The medical expert opinions required by this section are subject to discovery. The opinions shall specify whether any previous opinion by the same medical expert has been disqualified and if so the name of the court and the case number in which the ruling was issued.

Section 61. Section 766.206, Florida Statutes, is amended to read:

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

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

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

reasonable attorney's fees and costs of the defendant or the defendant's insurer.

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

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

(5)(a) If the court finds that the corroborating written medical expert opinion attached to any notice of claim

or intent or to any response rejecting a claim lacked reasonable investigation or that the medical expert submitting the opinion did not meet the expert witness qualifications as set forth in s. 766.202(5), the court shall report the medical expert issuing such corroborating opinion to the Division of Medical Quality Assurance or its designee. If such medical expert is not a resident of the state, the division shall forward such report to the disciplining authority of that medical expert.

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

Section 62. Subsection (7) of section 766.207, Florida Statutes, is amended to read:

766.207 Voluntary binding arbitration of medical negligence claims.--

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

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

(b) Noneconomic damages shall be limited to a maximum of $250,000 per incident, and shall be calculated on a percentage basis with respect to capacity to enjoy life, so that a finding that the claimant's injuries resulted in a

50-percent reduction in his or her capacity to enjoy life would warrant an award of not more than $125,000 noneconomic damages.

(c) Damages for future economic losses shall be awarded to be paid by periodic payments pursuant to s. 766.202(9)~~s. 766.202(8)~~and shall be offset by future collateral source payments.

(d) Punitive damages shall not be awarded.

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

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

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

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

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

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

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

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

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

Section 63. Paragraph (a) of subsection (3) of section 766.209, Florida Statutes, is amended to read:

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

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

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

Section 64. Section 768.0981, Florida Statutes, is created to read:

768.0981 Limitation on actions against insurers, prepaid limited health service organizations, health maintenance organizations, or prepaid health clinics.--An entity licensed or certified under chapter 624, chapter 636, or chapter 641 shall not be liable for the medical negligence of a health care provider with whom the licensed or certified entity has entered into a contract, other than an employee of such licensed or certified entity, unless the licensed or certified entity expressly directs or exercises actual control over the specific conduct that caused injury.

Section 65. Subsection (2) of section 768.13, Florida Statutes, is amended to read:

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

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

(b)1. Any health care provider, including a hospital licensed under chapter 395, providing emergency services pursuant to obligations imposed by 42 U.S.C. s. 1395dd, s.

395.401, s. 395.1041, or s. 401.45 ~~any employee of such hospital working in a clinical area within the facility and providing patient care, and any person licensed to practice medicine who in good faith renders medical care or treatment necessitated by a sudden, unexpected situation or occurrence resulting in a serious medical condition demanding immediate medical attention, for which the patient enters the hospital through its emergency room or trauma center, or necessitated by a public health emergency declared pursuant to s. 381.00315~~ shall not be held liable for any civil damages as a result of such medical care or treatment unless such damages result from providing, or failing to provide, medical care or treatment under circumstances demonstrating a reckless disregard for the consequences so as to affect the life or health of another.

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

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

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

3. For purposes of this paragraph, "reckless disregard" as it applies to a given health care provider rendering emergency medical services shall be such conduct that ~~which~~ a health care provider knew or should have known,

at the time such services were rendered, created an unreasonable risk of injury so as to affect the life or health of another, and such risk was substantially greater than that which is necessary to make the conduct negligent.~~would be likely to result in injury so as to affect the life or health of another, taking into account the following to the extent they may be present;~~

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

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

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

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

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

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

(c)1. Any health care practitioner as defined in s. 456.001(4) who is in a hospital attending to a patient of his or her practice or for business or personal reasons unrelated to direct patient care, and who voluntarily responds to provide care or treatment to a patient with whom at that time

the practitioner does not have a then-existing health care patient-practitioner relationship, and when such care or treatment is necessitated by a sudden or unexpected situation or by an occurrence that demands immediate medical attention, shall not be held liable for any civil damages as a result of any act or omission relative to that care or treatment, unless that care or treatment is proven to amount to conduct that is willful and wanton and would likely result in injury so as to affect the life or health of another.

2. The immunity provided by this paragraph does not apply to damages as a result of any act or omission of providing medical care or treatment unrelated to the original situation that demanded immediate medical attention.

3. For purposes of this paragraph, the Legislature's intent is to encourage health care practitioners to provide necessary emergency care to all persons without fear of litigation as described in this paragraph.

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

Section 66. Subsection (8) of section 768.21, Florida Statutes, is amended to read:

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

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

Section 67. Present subsections (12) through (19) of section 768.28, Florida Statutes, as amended by section 9 of chapter 2003-159, Laws of Florida, by section 1903 of chapter 2003-261, Laws of Florida, and by section 1 of chapter 2003-290, Laws of Florida, are renumbered as subsections (13) through (20), respectively, and a new subsection (12) is added to that section to read:

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

(12)(a) A health care practitioner, as defined in s. 456.001(4), who has contractually agreed to act as an agent of a state university board of trustees to provide medical services to a student-athlete for participation in or as a result of intercollegiate athletics, to include team practices, training, and competitions, shall be considered an agent of the respective state university board of trustees, for the purposes of this section, while acting within the scope of and pursuant to guidelines established in that contract. The contracts shall provide for the indemnification

of the state by the agent for any liabilities incurred up to the limits set out in this chapter.

(b) This subsection shall not be construed as designating persons providing contracted health care services to athletes as employees or agents of a state university board of trustees for the purposes of chapter 440.

Section 68. Section 768.77, Florida Statutes, is amended to read:

768.77 Itemized verdict.--

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

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

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

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

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

(a) Amounts intended to compensate the claimant for:

1. Past economic losses; and

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

(b) Amounts intended to compensate the claimant for:

1. Past noneconomic losses; and

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

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

Section 69. Nothing in this act constitutes a waiver of sovereign immunity under section 768.28, Florida Statutes, or contravenes the abrogation of joint and several liability contained in section 766.112, Florida Statutes.

Section 70. Paragraph (c) of subsection (2) of section 1006.20, Florida Statutes, as amended by section 2 of chapter 2003-129, Laws of Florida, is amended to read:

1006.20 Athletics in public K-12 schools.--

(2) ADOPTION OF BYLAWS.--

(c) The organization shall adopt bylaws that require all students participating in interscholastic athletic competition or who are candidates for an interscholastic athletic team to satisfactorily pass a medical evaluation each year prior to participating in interscholastic athletic competition or engaging in any practice, tryout, workout, or other physical activity associated with the student's candidacy for an interscholastic athletic team. Such medical evaluation can only be administered by a practitioner licensed under the provisions of chapter 458, chapter 459, chapter 460, or s. 464.012, and in good standing with the practitioner's regulatory board. The bylaws shall establish requirements for eliciting a student's medical history and performing the

medical evaluation required under this paragraph, which shall include a physical assessment of the student's physical capabilities to participate in interscholastic athletic competition as contained in a uniform preparticipation physical evaluation and history form. The evaluation form shall incorporate the recommendations of the American Heart Association for participation cardiovascular screening and shall provide a place for the signature of the practitioner performing the evaluation with an attestation that each examination procedure listed on the form was performed by the practitioner or by someone under the direct supervision of the practitioner. The form shall also contain a place for the practitioner to indicate if a referral to another practitioner was made in lieu of completion of a certain examination procedure. The form shall provide a place for the practitioner to whom the student was referred to complete the remaining sections and attest to that portion of the examination. The preparticipation physical evaluation form shall advise students to complete a cardiovascular assessment and shall include information concerning alternative cardiovascular evaluation and diagnostic tests. ~~Practitioners administering medical evaluations pursuant to this subsection must, at a minimum, solicit all information required by, and perform a physical assessment according to, the uniform preparticipation form referred to in this paragraph and must certify, based on the information provided and the physical assessment, that the student is physically capable of participating in interscholastic athletic competition. If the practitioner determines that there are any abnormal findings in the cardiovascular system, the student may not participate until a further cardiovascular assessment, which may include an EKG,~~

~~is performed which indicates that the student is physically capable of participating in interscholastic athletic competition.~~Results of such medical evaluation must be provided to the school. No student shall be eligible to participate in any interscholastic athletic competition or engage in any practice, tryout, workout, or other physical activity associated with the student's candidacy for an interscholastic athletic team until the results of the medical evaluation ~~clearing the student for participation~~ has been received and approved by the school.

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

(a) The department's report should address:

1. Historical use of medical review panels and similar pretrial programs in this state, including the mediation panels created by chapter 75-9, Laws of Florida.

2. Constitutional issues relating to the use of medical review panels.

3. The use of medical review panels or similar programs in other states.

4. Whether medical review panels or similar panels should be created for use during the presuit process.

5. Other recommendations and information that the department deems appropriate.

(b) In submitting its report with respect to subparagraphs (a)1.-3., the department should identify at a minimum:

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

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

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

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

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

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

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

Section 72. Subsection (1) of section 391.025, Florida Statutes, as amended by section 409 of chapter 2003-261, Laws of Florida, is amended to read:

391.025 Applicability and scope.--

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

(a)1. Enrolled in the Medicaid program;

2.~~(b)~~ Enrolled in the Florida Kidcare program; and

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

(b) Infants who receive an award of compensation under s. 766.31(1).

Section 73. Paragraph (f) is added to subsection (2) of section 391.029, Florida Statutes, to read:

391.029 Program eligibility.--

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

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

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

Section 74. Subsection (2) of section 766.303, Florida Statutes, is amended to read:

766.303 Florida Birth-Related Neurological Injury Compensation Plan; exclusiveness of remedy.--

(2) The rights and remedies granted by this plan on account of a birth-related neurological injury shall exclude all other rights and remedies of such infant, her or his personal representative, parents, dependents, and next of kin, at common law or otherwise, against any person or entity directly involved with the labor, delivery, or immediate postdelivery resuscitation during which such injury occurs, arising out of or related to a medical negligence ~~malpractice~~ claim with respect to such injury; except that a civil action shall not be foreclosed where there is clear and convincing evidence of bad faith or malicious purpose or willful and wanton disregard of human rights, safety, or property, provided that such suit is filed prior to and in lieu of payment of an award under ss. 766.301-766.316. Such suit shall be filed before the award of the division becomes conclusive and binding as provided for in s. 766.311.

Section 75. Section 766.304, Florida Statutes, is amended to read:

766.304 Administrative law judge to determine claims.--The administrative law judge shall hear and determine all claims filed pursuant to ss. 766.301-766.316 and shall exercise the full power and authority granted to her or him in chapter 120, as necessary, to carry out the purposes of such sections. The administrative law judge has exclusive jurisdiction to determine whether a claim filed under this act is compensable. No civil action may be brought until the determinations under s. 766.309 have been made by the administrative law judge. If the administrative law judge determines that the claimant is entitled to compensation from

the association, or if the claimant accepts an award issued under s. 766.31, no civil action may be brought or continued in violation of the exclusiveness of remedy provisions of s. 766.303. If it is determined that a claim filed under this act is not compensable, neither the doctrine of collateral estoppel nor res judicata shall prohibit the claimant from pursuing any and all civil remedies available under common law and statutory law. The findings of fact and conclusions of law of the administrative law judge shall not be admissible in any subsequent proceeding; however, the sworn testimony of any person and the exhibits introduced into evidence in the administrative case are admissible as impeachment in any subsequent civil action only against a party to the administrative proceeding, subject to the Rules of Evidence. An award ~~action~~ may not be made or paid ~~brought~~ under ss. 766.301-766.316 if the claimant recovers under a settlement or a final judgment is entered in a civil action. The division may adopt rules to promote the efficient administration of, and to minimize the cost associated with, the prosecution of claims.

Section 76. Subsections (1) and (2) of section 766.305, Florida Statutes, are amended, present subsections (3), (4), (5), and (6) of that section are redesignated as subsections (4), (5), (6), and (7), respectively, and a new subsection (3) is added to that section to read:

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

(1) All claims filed for compensation under the plan shall commence by the claimant filing with the division a petition seeking compensation. Such petition shall include the following information:

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

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

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

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

(e) The time and place the injury occurred.

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

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

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

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

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

(2) The claimant shall furnish the division with as many copies of the petition as required for service upon the association, any physician and hospital named in the petition, and the Division of Medical Quality Assurance, along with a

$15 filing fee payable to the Division of Administrative Hearings. Upon receipt of the petition, the division shall immediately serve the association, by service upon the agent designated to accept service on behalf of the association, by registered or certified mail, and shall mail copies of the petition, by registered or certified mail, to any physician, health care provider, and hospital named in the petition, and shall furnish a copy by regular mail to the Division of Medical Quality Assurance, and the Agency for Health Care Administration.

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

(a) All available relevant medical records relating to the birth-related neurological injury and a list identifying any unavailable records known to the claimant and the reasons for the records' unavailability.

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

(c) Documentation of expenses and services incurred to date which identifies any payment made for such expenses and services and the payor.

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

The information required by (a)-(d) shall remain confidential and exempt under the provisions of s. 766.315(5)(b).

Section 77. Subsection (4) is added to section 766.309, Florida Statutes, to read:

766.309 Determination of claims; presumption; findings of administrative law judge binding on participants.--

(4) If it is in the interest of judicial economy or if requested to by the claimant, the administrative law judge may bifurcate the proceeding addressing compensability and notice pursuant to s. 766.316 first, and addressing an award pursuant to s. 766.31, if any, in a separate proceeding. The administrative law judge may issue a final order on compensability and notice which is subject to appeal under s. 766.311, prior to issuance of an award pursuant to s. 766.31.

Section 78. Subsection (1) of section 766.31, Florida Statutes, is amended to read:

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

(1) Upon determining that an infant has sustained a birth-related neurological injury and that obstetrical services were delivered by a participating physician at the birth, the administrative law judge shall make an award providing compensation for the following items relative to such injury:

(a) Actual expenses for medically necessary and reasonable medical and hospital, habilitative and training, family residential or custodial care, professional residential, and custodial care and service, for medically necessary drugs, special equipment, and facilities, and for related travel. However, such expenses shall not include:

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

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

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

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

Expenses included under this paragraph shall be limited to reasonable charges prevailing in the same community for similar treatment of injured persons when such treatment is paid for by the injured person.

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

2. Death benefit for the infant in an amount of $10,000 ~~Payment for funeral expenses not to exceed $1,500~~.

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

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

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

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

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

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

6. The contingency or certainty of a fee.

Should there be a final determination of compensability, and the claimants accept an award under this section, the claimants shall not be liable for any expenses, including attorney's fees, incurred in connection with the filing of a claim under ss. 766.301-766.316 other than those expenses awarded under this section.

Section 79. Paragraph (a) and paragraph (c) of subsection (4) of section 766.314, Florida Statutes, as amended by section 4 of chapter 2003-258, Laws of Florida, and by section 1901 of chapter 2003-261, Laws of Florida, are amended, paragraph (d) is added to that subsection, and

paragraph (a) of subsection (5) of that section is amended to read:

766.314 Assessments; plan of operation.--

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

(a) On or before October 1, 1988, each hospital licensed under chapter 395 shall pay an initial assessment of $50 per infant delivered in the hospital during the prior calendar year, as reported to the Agency for Health Care Administration; provided, however, that a hospital owned or operated by the state or a county, special taxing district, or other political subdivision of the state shall not be required to pay the initial assessment or any assessment required by subsection (5). The term "infant delivered" includes live births and not stillbirths, but the term does not include infants delivered by employees or agents of the board of trustees of a state university ~~Board of Regents~~ or those born in a teaching hospital as defined in s. 408.07. The initial assessment and any assessment imposed pursuant to subsection (5) may not include any infant born to a charity patient (as defined by rule of the Agency for Health Care Administration) or born to a patient for whom the hospital receives Medicaid reimbursement, if the sum of the annual charges for charity patients plus the annual Medicaid contractuals of the hospital exceeds 10 percent of the total annual gross operating revenues of the hospital. The hospital is responsible for documenting, to the satisfaction of the association, the exclusion of any birth from the computation of the assessment. Upon demonstration of financial need by a hospital, the

association may provide for installment payments of assessments.

(c) On or before December 1, 1988, each physician licensed pursuant to chapter 458 or chapter 459 who wishes to participate in the Florida Birth-Related Neurological Injury Compensation Plan and who otherwise qualifies as a participating physician under ss. 766.301-766.316 shall pay an initial assessment of $5,000. However, if the physician is either a resident physician, assistant resident physician, or intern in an approved postgraduate training program, as defined by the Board of Medicine or the Board of Osteopathic Medicine by rule, and is supervised in accordance with program requirements established by the Accreditation Council for Graduate Medical Education or the American Osteopathic Association by a physician who is participating in the plan, such resident physician, assistant resident physician, or intern is deemed to be a participating physician without the payment of the assessment. Participating physicians also include any employee of the board of trustees of a state university ~~Board of Regents~~ who has paid the assessment required by this paragraph and paragraph (5)(a), and any certified nurse midwife supervised by such employee. Participating physicians include any certified nurse midwife who has paid 50 percent of the physician assessment required by this paragraph and paragraph (5)(a) and who is supervised by a participating physician who has paid the assessment required by this paragraph and paragraph (5)(a). Supervision for nurse midwives shall require that the supervising physician will be easily available and have a prearranged plan of treatment for specified patient problems which the supervised certified nurse midwife may carry out in the

absence of any complicating features. Any physician who elects to participate in such plan on or after January 1, 1989, who was not a participating physician at the time of such election to participate and who otherwise qualifies as a participating physician under ss. 766.301-766.316 shall pay an additional initial assessment equal to the most recent assessment made pursuant to this paragraph, paragraph (5)(a), or paragraph (7)(b).

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

(5)(a) Beginning January 1, 1990, the persons and entities listed in paragraphs (4)(b) and (c), except those persons or entities who are specifically excluded from said provisions, as of the date determined in accordance with the plan of operation, taking into account persons licensed

subsequent to the payment of the initial assessment, shall pay an annual assessment in the amount equal to the initial assessments provided in paragraphs (4)(b) and (c). If payment of the annual assessment by a physician is received by the association by January 31 of any calendar year, the physician shall qualify as a participating physician for that entire calendar year. If the payment is received after January 31 of any calendar year, the physician shall qualify as a participating physician for that calendar year only from the date the payment was received by the association.On January 1, 1991, and on each January 1 thereafter, the association shall determine the amount of additional assessments necessary pursuant to subsection (7), in the manner required by the plan of operation, subject to any increase determined to be necessary by the Department of Insurance pursuant to paragraph (7)(b). On July 1, 1991, and on each July 1 thereafter, the persons and entities listed in paragraphs (4)(b) and (c), except those persons or entities who are specifically excluded from said provisions, shall pay the additional assessments which were determined on January 1. Beginning January 1, 1990, the entities listed in paragraph (4)(a), including those licensed on or after October 1, 1988, shall pay an annual assessment of $50 per infant delivered during the prior calendar year. The additional assessments which were determined on January 1, 1991, pursuant to the provisions of subsection (7) shall not be due and payable by the entities listed in paragraph (4)(a) until July 1.

Section 80. The Office of Program Policy Analysis and Government Accountability shall complete a study of the eligibility requirements for a birth to be covered under the Florida Birth-Related Neurological Injury Compensation

Association and submit a report to the Legislature by January 1, 2004, recommending whether or not the statutory criteria for a claim to qualify for referral to the Florida Birth-Related Neurological Injury Compensation Association under section 766.302, Florida Statutes, should be modified.

Section 81. The sum of $687,786 is appropriated from the Medical Quality Assurance Trust Fund to the Department of Health, and seven positions are authorized, for the purpose of implementing this act during the 2003-2004 fiscal year. The sum of $1,629,994 is appropriated from the Health Care Trust Fund to the Agency for Health Care Administration, and 11 positions are authorized, for the purpose of implementing this act during the 2003-2004 fiscal year.

Section 82. The sum of $1,450,000 is appropriated to the Insurance Regulatory Trust Fund in the Department of Financial Services to the Office of Insurance Regulation for the purpose of implementing this act during the 2003-2004 fiscal year.

Section 83. The sum of $850,000 in nonrecurring general revenue funds is appropriated to the Agency for Health Care Administration for the purpose of implementing patient safety initiatives during the 2003-2004 fiscal year.

Section 84. If any law that is amended by this act was also amended by a law enacted at the 2003 Regular Session or a 2003 special session of the Legislature, such laws shall be construed as if they had been enacted during the same session of the Legislature, and full effect should be given to each if that is possible.

Section 85. If any provision of this act or its application to any person or circumstance is held invalid, the invalidity does not affect other provisions or applications of

the act which can be given effect without the invalid provision or application, and to this end the provisions of this act are severable.

Section 86. It is the intent of the Legislature to apply the provisions of this act to prior medical incidents, to the extent such application is not prohibited by the State Constitution or Federal Constitution, except that the changes to chapter 766, Florida Statutes, shall apply only to any medical incident for which a notice of intent to initiate litigation is mailed on or after the effective date of this act.

Section 87. Except as otherwise expressly provided in this act, this act shall take effect September 15, 2003.