By the Committee on Banking and Insurance; and Senator Baker

597-04112-09 20092252c1

A bill to be entitled

An act relating to professional liability claims; amending s. 627.912, F.S.; revising requirements for reporting professional liability claims and actions; providing definitions; specifying events for which certain reports are required; requiring certain absence of claims submission reports to be filed under certain circumstances; providing requirements for treatment of reopened claims; providing an effective date.

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

Section 1. Subsection (1) of section 627.912, Florida Statutes, 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 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 to a member of The Florida Bar shall report to the office as set forth in paragraph (c) any written 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 final judgment in any amount.~~

~~2. 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) For purposes of this section, the term "claim" means the receipt of a notice of intent to initiate litigation, a summons and complaint, or a written demand from a person or his or her legal representative stating an intention to pursue an action for damages against a person described in paragraph (a).

(c) The duty to report specified in paragraph (a) arises upon the occurrence of the first of:

1. The entry of any judgment against any provider identified in paragraph (a) for which all appeals as a matter of right have been exhausted or for which the time period for filing such an appeal has expired;

2. The execution of an agreement between a provider identified in paragraph (a) or an entity required to report under that paragraph and a claimant to settle damages purported to arise from the provision of professional services, which agreement includes the payment of at least $1; however, if any applicable law requires any such agreement to be approved by the

court, the duty arises when the agreement is approved;

3. The final payment of any indemnity money by any of the entities required to report under paragraph (a) on behalf of any provider identified in that paragraph for damages purported to arise from professional services rendered; or

4. The final disposition of a claim for which no indemnity payment was made on behalf of the insured but for which loss adjustment expenses were paid in excess of $5,000. As used in this subparagraph, the term "final disposition" means the insurer has brought down all reserves and closed its file.

(d) After any calendar year in which no claim or action for damages was closed, the entity shall file a no claim submission report. Such report shall be filed with the office no later than April 1 of each calendar year for the immediately preceding calendar year. If a reporting entity submits such a report for a particular calendar year and subsequently discovers that its report was submitted in error, the reporting entity shall promptly notify the office of the error and take steps as directed by the office to make the needed corrections.

(e) If a claim is initially opened and then closed, and is subsequently reopened, the reopened claim shall be treated as a new claim and reported after the occurrence of the first of any event listed in paragraph (c).

(f) ~~(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.

(g) Reports under this subsection shall be filed with the

office no later than 30 days following the occurrence of the first of any event listed in paragraph (c) ~~(a)~~.

Section 2. This act shall take effect July 1, 2009.