- Contains revised findings relating to necessity to address identified medical malpractice liability situation. Changes relate to findings #6 and 9 in SB 2C.

  Requires plaintiffs to provide AHCA with copies of complaints against facilities, to review; AHCA to cross-check complaints to see if hospital filed adverse incident report and if conduct is disciplinable. The State needs more information and AHCA gets to cross check against the complaint to see if hospital filed an adverse incident report.

  Broadens immunity for hospitals and staff who take disciplinary actions against medical staff. Gives greater immunity. Encourages staff discipline.

  Repeals 24 hour reporting requirement to AHCA. AHCA does nothing with this document now. It is duplicative. This reduces bureaucracy.

  Repeals public records exemption for 24 hour adverse incident reports that are repealed by Sec. 4. If we get rid of 4 above, we don't need exemption.

  Each health facility required to have system to ensure patient safety, including a patient safety officer and patient safety committee to review facility safety measures and implement the facility patient safety plans. Increases patient safety and improves paitient outcomes.

  Patients must be notified in person if harmed. Do not require hospital risk managers to do notification. (Currently that isn't required, ie., a patient with a sponge left in need not be told, in person.)

  Provides civil immunity for participants in facility boards and committees that review professional and institutional quality of care and patient safety. This enhances hospital peer review without fear of retribution.

  Establishes patient safety data privilege and protects data from discovery and introduction as evidence. Allows for data to be collected and kept.

  Requires misdiagnosed conditions to be part of existing required 2-hour continuing education in patient safety for physicians and physician assistants. Doctors will be taught every two years in CME classes what current misdiagnosis problems exist.

  Removes limitation of no more than 10% licensure fee increase for practitioners. Boards could now increase fees to cover actual costs.

  Applicants for initial licensure or renewal of licensure must submit information re: "relevant professional qualifications" to DOH. Without good data, future "crisis" will not have information that we needed and couldn't get. Also, provides more information to patients about their doctor.

- Expands reporting requirements for physician profiles on Internet.

--Requires DOH to update profiles within 30 days
--Requires reporting on profiles of MDs DOs of claims exceeding $100K within last 10 years.
(Retains existing $5K requirement for Podiatrists.)
--Requires practitioners to submit updates to profile within 15 days.
--Requires claims and bankruptcy info to be part of physician profile within 30 days after receipt.

This enhances practitioner profiles so patients have more information for choices.

- Requires MDs, DOs & Podiatrists to report info on claims exceeding $50K & Dentists to report claims exceeding $25 to DOH. This increase reflects inflationary charges. It also focuses attention on the most serious cases.

  Higher threshold of $50K for initiating disciplinary investigations of repeated malpractice by MD's, Osteopaths & Podiatrists, with $25K threshold for Dentists. See #14 above.

  Allows DOH to subpoena patient records to facilitate handling of disciplinary cases. If patient is uncooperative and won't release records, department can subpoena for information.

  Attorney costs included in penalty assessments (including costs associated with attorney's time). Boards can access full costs of prosecution against respondent.

  Provides additional time to resolve cases before they are referred to administrative hearings. Changes from 15 to 45 days to allow 30 more days for settlement.

  Authorizes DOH to investigate liability info within 6 years if claims exceeded $50K. Grants additional authority to department to investigate closed claims.

  First offense citations are not required to be reported to national databases. Excludes adverse incidents from citation. Issuing a citation does not become a reportable event to national database.

  Similar to HB 63B, 1st Eng., but does not specifically exclude adverse incidents. Allows board to establish standards of care violations that can be mediated. Encourages mediation of disciplinary cases.

- Requires DOH to suspend license of MDs and DOs who fail to pay judgment or settlement within 30 days

--Requires escrow funds not be used for litigation costs (see Insurance provisions, below).

- License of bare doctor is suspended if they don't pay the judgement or work out a payment schedule. Can't use "self insurance" funds to pay attorney costs.

  Requires each final settlement to include statement that it is not an admission of failure to meet standard of care. Facilitates "no contest" settlements without admission of guilt.

Requires Admin Law Judge or Board to state whether physician committed gross or repeated malpractice. Gives instructions to administrative law judges.

Creates emergency disciplinary procedures for gross or repeated malpractice by MD's and Osteopaths--and for Podiatrists. Allows for emergency procedures against doctors for a quick suspension.

Requires Div. of Administrative Hearings to designate at least 2 Administrative Law Judges with health care experience to preside over disciplinary actions. Assures DOAH has properly informed judges.

College and university health care programs to include training in patient safety. The more training, hopefully, the less incidents.

Study by AHCA of information relevant to consumers for choosing hospitals. Replaces the hospital "report card."

Requires study by Agency for Health Care Administration of options to implement a Patient Safety Authority. Allows for a study on "Center of Excellence" authority and need.

Foster development of statewide electronic infrastructure to share data. Creates study of closed claim data.

Requires AHCA to inventory hospitals regarding implementation of computerized physician medication ordering systems and defines “medication error.” Implementation would provide a check & balance on hospital pharmacies.

Allows a group of 10 or more health care providers to form a commercial self insurance fund.

Invites self insurance funds for those capable. This should create competition.

Provides for annual rate filings. Need to justify rates every year.

Requires rate filing effective 1/1/2004 with rate adjustments using presumptive factor determined by OIR; insurer may file deviations from presumptive rate change but has burden of justifying deviation, which is subject to prior approval of OIR. Everyone has to do a new rate filing considering changes made in this bill.

Deletes allowance for medical malpractice insurer to submit a rate filing to arbitration.

Precludes bad faith and punitive damage losses in rate base. Provides for medical malpractice rating standards re: excessive rates and requires discounts or surcharges based on providers' loss experience. Prevents bad faith judgments and punitive damage

awards in this rate base. They were bad business decisions by the company - not the insureds.

Deletes current statutory prohibition on creation of self insurance trust funds. --Provides for regulation by OIR. (See #32)

Coverage amount to demonstrate financial responsibility can not be used for defense costs of claim. Insurance coverage requires purchase for prior years of service. Can't use escrow to pay lawyers (See #22)

- Requires study by OPPAGA re: modifying NICA (Neurological Injury Compensation Act) eligibility.

--Also provides changes in NICA regarding applicability, eligibility, procedure, administration, expenses and assessments. Potentially increases OB's use of NICA system, if warranted.

- Requires insurers to provide 90-days (instead of current 60-days) notice of a cancellation or non-renewal for any reason. Provides 30 additional days for insured to get new insurance.

  Requires insurer to notify policyholder 60 days prior to effective date of a rate increase.

  Requires advanced warning to insureds of a pending rate increase.

- Allows insurance contracts to permit MD's and DO's to veto any settlement offer within policy limits. Repeals s. 627.4147(1)(b), thereby allowing physicians to make decision, rather than insurers, as to whether case should be tried.

--Prohibits settlement outside policy limits without physician's permission. Provides for two types of policies including a "Doctor take Control" policy.

- Freezes rates and premiums at July 1, 2003 rates until new filing occurs as required by the bill. Replaces our rate roll back. If anyone wants to improve roll back language, we're amenable.

  Study feasibility of allowing public counsel to review rate filings. Consider what other states are using and doing.

- Requires reporting of additional closed claims information, including dismissals. Current data doesn't include dismissals. Now it would. Allows Department of Health electronic access to OIR.

--Requires reporting to OIR & removes reporting to DOH
--Requires OIR to provide DOH electronic access to all information.

- Requires OIR to annually publish an analysis of closed claim data and financial reports of med mal insurers. People have the right to know.

  Requires Financial Services Commission to adopt rules to analyze and evaluate claim data.

  Someone needs to decide what we need and what form we need it in.

  Requires and increases the fine for insurers who violate the requirements for reporting of professional liability claims. Insurance companies could be penalized under the provision for lack of proper reporting.

  Information reported to the National Practitioners Data Bank must also be reported to OIR for review. Enhances available data

  Maintains third party causes of action and allows insureds to assign a cause of action, contains factors for consideration in determining bad faith, contains time-driven (90+210) and information-driven avenues, and prohibits unnecessary and inappropriate delays by both parties. If plaintiff wants to move faster he can prohibit either side from "tricking" the process

  Specifies that a claim for medical malpractice involving a vulnerable adult must be brought under chapter 766 (medical malpractice statute), in lieu of ch. 415. Rep. Dudley felt strongly about this issue and we're giving it to him. (see exhibit B attached).

  Provides that an HMO shall not be liable for any tortious action of a health care provider with whom the licensed entity has entered into a contract unless the HMO directed or actually controlled the specific conduct that caused the injury. Speaker Byrd seemed to want this. We have some reservations but, if he wants it, we're prepared to give it to him.

- Requires presuit notice to include list of health care providers and medical records used by a corroborating medical expert.

--Provides for written questions during presuit discovery.
--Provides additional sanctions for failing to comply with the presuit process.
--Provides increased presuit discovery.
--Provides for presuit mediation.
--Repeals 766.106 relating to arbitration. This will eliminate any "frivolous" lawsuits in conjunction with bad faith.

- Provides for discovery of opinion and affidavit of presuit expert. Gets more information out sooner to the defense.
- Provides for presuit screening panels.

--Panel includes 3 physicians and 1 attorney who serves as facilitator.
--Provides for mandatory staging of presuit investigatory activities. (as suggested by President of American Medical Association to the President of the Florida Senate)

- Expert must have similar credentials; If the defendant is a specialist, the expert must have devoted time within the last 3 years to clinical practice, teaching, or research, or within the last 5 years if defendant is a general practitioner.

--The trial court may qualify or disqualify the expert for other non-statutory reasons.
--Changes definition of "health care provider" to increase the number of entities captured under ch. 766. Reduces probability of "hired guns" and enhances predictable testimony.

- Clarifies that defendant must notify claimant prior to interviewing a treating physician and
  allow parties or their representatives to be present. Allows for non-subpoenaed testimony but
  all parties need to be alerted to the event.

  Requires in-person mediation within 120 days after filing of suit; allows extensions. This corresponds with track 2 of bad faith.

- 1. Caps-- Non-emergency situation defendants separated into 3 categories

Category 1 = physicians and health care practitioners (non ER)Category 2 = hospitals, facilities, hospices

Category 3 = managed care entities, clinics, labs, critical stabilization units (CSU's)

- Category 1: noneconomic damages cannot exceed $500,000

Aggregate defendants within category
Multiple claimants, but regardless of number, total cap for all claimants is $1 million
Pierceable under very narrow circumstances (multiple prong test)(See exhibit D attached) ceiling if the cap is pierced and multiple claimants = $1 million (in total!) setoffs within category. (see exhibit E attached).

- Category 2: noneconomic damages cannot exceed $750,000 (all is same as above, except numbers)

  aggregate defendants within category
  multiple claimants, but regardless of number, total cap for all claimants is $1.5 million
  pierceable under very narrow circumstances (multiple prong test)
  ceiling if the cap is pierced and multiple claimants = $1.5 million s
  etoffs within category

- Category 3: noneconomic damages cannot exceed $750,000 (all is same, except numbers) aggregate defendants within category

    multiple claimants, but regardless of number, total cap for all claimants is $1.5 million
    pierceable under very narrow circumstances (multiple prong test)
    ceiling if the cap is pierced and multiple claimants = $1.5 million set offs within category

2. Emergency Care-- Caps applicable to emergency medical care provided to a patient with whom the health care practitioner has not provided medical care or treatment to recently for the same or similar medical condition, includes on-call specialists and consulting practitioners pre-stabilization

Practitioners: noneconomic damages cannot exceed $250,000 aggregate practitioner defendants - $250,000 is max collectively for all doctors multiple claimants, but regardless of number, total cap for all claimants is $1 million not pierceable at all full setoffs - Hospitals get to deduct doctor payment from their award.

Facility: noneconomic damages cannot exceed $750,000 aggregate facility defendants = can't get more than $750,000 multiple claimants, but regardless of number, total cap for all claimants is $1 million not pierceable - for any reason full setoffs

Amends definitions section to clarify that damages recoverable in med mal arbitration are limited by the Wrongful Death Act. Necessary because of St. Mary's decision.

Removes unlimited recovery of damages provision from medical malpractice arbitration in cases where defendant refuses to arbitrate. Clarification language. Damages can't go beyond cap limit.

Provides for itemized verdicts in medical malpractice cases. Necessary to implement the setoff provisions. Juries must differentiate between economic and non-economic damages.

Preserves sovereign immunity and the abrogation of certain joint and several liability in section 766.112. Those that have sovereign immunity now, will still have it.

Expands civil immunity to providers of emergency assistance unrelated to their practices. This is King's "code blue" fix. If you give aid to someone you don't know or treat, you can't be sued if an emergency, does not limit emergency care to the E.R.

Revises requirements for the Florida High School Activities Association by-laws for participation in interscholastic athletics to require that an evaluation and history form incorporate recommendations of the American Heart Association for participation in cardiovascular screening. Deletes a requirement for the physician to certify that the

student meets the minimum standards established by the association. Encourages free or reduced cost physicals for athletic participants.

Appropriates: 7 positions and $454,766 to DOH to fund presuit office, 7 positions and $687,786 for practitioner regulation, and 5 positions and $452,122 for facility regulation. If presuit panel stays, we need this.

Reenacts certain provisions to conform cross-references. Self-explanatory.

Provides severability of provisions of bill if any found invalid. Self explanatory.

Provides for interpretation of the act with laws enacted during the regular session. Safeguards whatever we did in Regular Session.

September 1, 2003, except as otherwise provided. Substantive changes to affect only new causes of action accuring (injuries) on or after the effective date of the act. Procedural changes to take effect September 1 for all new notices of intent to litigate served. This is still an "open" issue. Procedural aspects go into effect immediately.