SENATE STAFF ANALYSIS AND ECONOMIC IMPACT STATEMENT

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

Prepared By: Health Care Committee

BILL: PCS/SB 1916

SPONSOR: Health Care Committee and Senator Saunders

SUBJECT: Medical Malpractice Insurance

DATE: April 11, 2005 REVISED:

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Munroe	Wilson	HE	**Pre-meeting**
2.			BI	
3.			JU	
4.			HA	
5.				
6.				

I. Summary:

The bill establishes a medical malpractice liability system, identified as an "enterprise plan for patient protection and provider liability" for hospitals that meet specific criteria. The criteria identified in the bill limit the system to statutory teaching hospitals and hospitals owned by a university that maintains an accredited medical school. The system would permit these facilities to assume liability for physicians that provide services in those facilities, and exempt those physicians from the financial responsibility required as a condition of licensure and licensure renewal. The bill requires the Agency for Health Care Administration (AHCA) to adopt administrative rules to govern the process to be used by these facilities to be designated as a certified patient safety facility. AHCA would be required to designate these facilities by issuance of an administrative order that confirms the facility to be in compliance with specified criteria in the bill. AHCA must confirm compliance through on-site examinations of facilities. The certified patient safety facilities would be required to establish internal patient safety measures and submit annual reports to the AHCA. AHCA must aggregate those reports and submit an annual report to the Legislature.

Seven hospitals may be affected by the provisions of this bill. Those hospitals are Shands Teaching Hospital, Jackson Memorial Hospital, Mt. Sinai Medical Center, Shands Jacksonville Medical Center, Tampa General Hospital, Orlando Regional Medical Center, and H. Lee Moffit Cancer Hospital. These hospitals are identified as statutory teaching hospitals for Medicaid reimbursement purposes under s. 408.07, F.S.

This bill amends sections 381.0271, 395.0197, 458.320, 459.0085, 766.110, 766.316, and 768.28, Florida Statutes.

This bill creates ss. 627.41485, 766.401, 766.402, 766.403, 766.404, 766.405, 766.406, 766.407, 766.408, 766.409, and 766.410, F.S., and five undesignated sections of law.

II. Present Situation:

State-supported Medical Schools, the University of Miami, and Jackson Memorial Hospital

Jackson Memorial Hospital is an accredited, public, tertiary-care hospital located in Miami. It is the major teaching facility for the University of Miami School of Medicine. With 1,567 licensed beds, Jackson Memorial Hospital's many roles in South Florida include being the only full-service provider for the indigent and medically indigent of Miami-Dade County, a regional referral center, and a magnet for medical research and innovation. Based on the number of admissions to a single facility, Jackson Memorial is one of the nation's busiest hospitals. Jackson Memorial Hospital's trauma facilities form the only adult and pediatric Level 1 Trauma Center in South Florida. This center serves as a regional trauma center resource, one of the busiest such providers in the nation. Jackson Memorial is operated by the Public Health Trust for Miami-Dade County.[1]

The University of Miami is a private university located in Miami. While Jackson Memorial Hospital, as a public hospital, currently is protected under sovereign immunity, the university and its professors are not. The University of Miami School of Medicine is the teaching affiliate with Jackson Memorial Hospital.

State-supported medical schools throughout the state are affiliated with teaching hospitals or medical centers. Tampa General is a private, not-for-profit hospital, whose primary teaching affiliate is the University of South Florida College of Medicine; Shands hospitals' primary teaching affiliate is the University of Florida College of Medicine; Orlando Regional Medical Center's primary affiliate is the University of Florida College of Medicine; and Mt. Sinai Hospital has teaching affiliations with both the University of Miami and the University of South Florida. Lake Erie College of Osteopathic Medicine is scheduled to begin operating in Bradenton during the Fall, 2004.

The State Board of Education is authorized to secure, or otherwise provide as a self-insurer, or by a combination thereof, comprehensive general liability insurance including professional liability for health care and veterinary sciences, for:

- The State Board of Education and its officers and members.
- A university board of trustees and its officers and members.
- The faculty and other employees and agents of a university board of trustees.
- The students of a state university.
- A state university or any college, school, institute, center, or program thereof.
- Any not-for-profit corporation organized pursuant to ch. 617, F.S., and the directors, officers, employees, and agents thereof, which is affiliated with a state university, if the corporation is operated for the benefit of the state university in a manner consistent with the best interests of

[1] See <http://um-jmh.org/JHS/Jackson.html>.

the state, and if such participation is approved by a self-insurance program council, the university president, and the board of trustees.[2]

Any self-insurance program established under s. 1004.24, F.S., must report to the Office of Insurance Regulation (OIR) 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 medical physicians, osteopathic physicians, physician assistants, podiatric physicians, and dentists. Such reported claims or actions shall include those which are 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 self-insurance reports made to OIR must contain specified information, including 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.[3]

State universities or medical schools currently enjoy sovereign immunity under s. 768.28, F.S. No self-insurance program adopted by the State Board of Education may sue or be sued. The claim files of such self-insurance programs are privileged and confidential under the Public Records Law, and are only for the use of the program in fulfilling its duties. The University of Florida and the University of South Florida have their own medical malpractice (self-insurance) funds or coverage. The Florida State University College of Medicine provides students with the skills, knowledge, and values needed to practice medicine by developing partnerships with other health care organizations. The Florida State University Board of Trustees is authorized to negotiate and purchase policies of insurance to indemnify from any liability those individuals or entities providing sponsorship or training to the students of the medical school, professionals employed by the medical school, and students of the medical school.[4]

Florida Patient Safety Corporation

In 2004, the Florida Legislature created the Florida Patient Safety Corporation as a not-for-profit corporation to assist health care providers to improve the quality and safety of health care that is rendered and to reduce harm to patients. In the fulfillment of its purpose, the corporation must work with a consortium of patient safety centers and other patient safety programs in universities in Florida. Section 381.0271, F.S., specifies the duties of the corporation, the membership of a board of directors, and the advisory committees the corporation must establish. AHCA must assist the corporation in its organizational activities. The corporation is required to seek private funding and apply for grants to accomplish its goals and duties.

Sovereign Immunity

Article X, s. 13, of the State Constitution, authorized the Florida Legislature in 1868 to waive sovereign immunity by stating that, “Provision may be made by general law for bringing suit against the state as to all liabilities now existing or hereafter originating.” The doctrine of sovereign immunity prohibits lawsuits in state court against a state government, and its agencies

[2] See s. 1004.24, F.S.
[3] See s. 627.912(5), F.S.
[4] See s. 1004.42(14), F.S.

and subdivisions without the government's consent. Section 768.28, F.S., provides that sovereign immunity for tort liability is waived for the state, and its agencies and subdivisions. Section 768.28(5), F.S., imposes a $100,000 limit on the government's liability to a single person and for claims arising out of a single incident, the limit is $200,000. Section 768.28, F.S., outlines requirements for claimants alleging an injury by the state or its agencies. Section 11.066, F.S., requires a claimant to petition the Legislature in accordance with its rules, to seek an appropriation to enforce a judgment against the state or state agency. The exclusive remedy to enforce damage awards that exceed the recovery cap is by an act of the Legislature through the claims bill process. A claim bill is a bill that compensates an individual or entity for injuries or losses occasioned by the negligence or error of a public officer or agency.

The second form of sovereign immunity potentially available to private entities under contract with the government is set forth in s. 768.28(9), F.S. It states that agents of the state or its subdivisions are not personally liable in tort; instead, the government entity is held liable for its agent's torts. The factors required to establish an agency relationship are: (1) acknowledgment by the principal that the agent will act for him; (2) the agent's acceptance of the undertaking; and (3) control by the principal over the actions of the agent.[5] The existence of an agency relationship is generally a question of fact to be resolved by the fact-finder based on the facts and circumstances of a particular case. In the event, however, that the evidence of agency is susceptible of only one interpretation the court may decide the issue as a matter of law.[6]

Section 768.28(9), F.S., defines "officer, employee, or agent" to include, but not be limited to, any health care provider when providing services pursuant to s. 766.1115, F.S. (the Access to Health Care Act), any member of the Florida Health Services Corps, as defined in s. 381.0302, F.S., who provides uncompensated care to medically indigent persons referred by the Department of Health (DOH), and any public defender or her or his employee or agent, including among others, an assistant public defender and an investigator.

Hospital-Based Enterprise Liability

Under a theory of enterprise liability, individual health care practitioners would not be directly liable for the costs associated with injury that arises out the practitioner's provision of health care. The enterprise, would be the hospital, which would assume exclusive legal liability by meeting the costs of liability premiums for its medical staff. The hospital and covered health care practitioners would share liability. Assumptions underlying enterprise liability include: hospitals are involved in the majority of medical malpractice litigation and patients are exposed to the highest risks within a facility setting.

Financial Responsibility of Allopathic and Osteopathic Physicians

Chapter 458, F.S., provides for the regulation of the practice of medicine by the Board of Medicine within DOH. As a condition of licensure, licensure renewal, or reactivation of an inactive license, s. 458.320, F.S., requires applicants (allopathic physicians) to demonstrate financial responsibility by maintaining medical malpractice insurance, or establishing and

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

maintaining an escrow account, or obtaining and maintaining an unexpired, irrevocable letter of credit drawn from a United States financial institution, to satisfy medical malpractice claims in amounts specified in the section. The financial responsibility law requires physicians, upon presentment of any settlement or final judgment awarding damages to a party based on the physician's malpractice, to be able to satisfy individual professional liability claims of up to $100,000 per claim and have at least $300,000 available to cover all such claims 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 which is based on a claim arising out of the rendering of, or the failure to render, medical care and services. If the physician performs surgery in an ambulatory surgical center or has hospital privileges, the physician must be able to satisfy individual professional liability claims of up to $250,000 per claim and have at a minimum $750,000 available to cover all such claims 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 which is based on a claim arising out of the rendering of, or the failure to render, medical care and services.

Physicians may meet financial responsibility requirements using a surplus lines insurer as defined in s. 626.914(2), F.S., a risk retention group as defined in s. 627.942, F.S., through the Medical Malpractice Joint Underwriting Association established under s. 627.351(4), F.S., or a plan of self-insurance as provided in s. 627.357, F.S., that has authority to write casualty insurance. OIR has jurisdiction in Florida to regulate insurers.

Section 458.320, F.S., exempts several categories of persons from the financial responsibility requirements for licensed allopathic physicians including: a physician who is a government employee; a physician with an inactive license who is not practicing in Florida; retired professionals who are practicing with a limited license; a medical school faculty member who only practices medicine in conjunction with teaching duties; a physician with an active license who is not practicing medicine in Florida; and retired physicians who have practiced in Florida or another state for more than 15 years, maintain a part-time practice of no more than 1,000 patient contact hours annually, and meet certain additional requirements outlined in this provision of statute. In addition to these exemptions, paragraph 458.320(5)(g), F.S., allows a licensed physician to go "bare" (uninsured) for medical malpractice liability on the condition that such physician gives notice of this fact to his or her patients by posting a sign prominently displayed in the reception area and clearly noticeable to all patients or by providing a written statement to any person to whom medical services are being provided.

Uninsured physicians who do not maintain hospital privileges, must pay the entire amount of any final judgment or settlement arising from their medical malpractice or $100,000, whichever is less, within 60 days of the judgment unless the parties agree otherwise. Uninsured physicians with hospital privileges must pay the entire amount of their medical malpractice claims or $250,000, whichever is less. If DOH is notified of the existence of an unsatisfied judgment or medical malpractice claim against an uninsured physician who is exempt from the financial responsibility requirements under paragraph 458.320(5)(g), F.S., DOH must notify the licensee by certified mail that he is subject to disciplinary action unless, within 30 days from the date of mailing, the physician furnishes the department with a copy of a timely filed notice of appeal and

either a copy of a supersedeas bond[7] posted in the amount required by law or a copy of an order from a court staying the execution on the final judgment pending disposition of the appeal. The licensed physician must have completed a form supplying necessary information as required by the department.

If the uninsured physician fails to act within 30 days after receiving notice from DOH of an unsatisfied medical malpractice claim against him or her, then upon the next meeting of the probable cause panel of the Board of Medicine, the panel must determine whether probable cause exists to take disciplinary action against the licensee. If the Board of Medicine makes a factual determination that the licensee has not paid the lesser of $100,000 or $250,000, or the medical malpractice claim, it must take disciplinary action against the physician. The disciplinary action must include, at a minimum, probation of the physician's license with the restriction that the physician make payments to the judgment creditor of the malpractice claim on a schedule determined by the board to be reasonable and within the financial capability of the physician. The section also authorizes the board to impose a disciplinary penalty which may include licensure suspension of up to 5 years. In the event that an agreement to satisfy the judgment has been met, the board must remove any restriction on the license.

Chapter 459, F.S., provides for the regulation of osteopathic medicine by the Board of Osteopathic Medicine. The chapter also requires osteopathic physicians applying for initial licensure, licensure renewal, or reactivation of an inactive license to demonstrate financial responsibility for medical malpractice claims and provides exemptions to this requirement.[8]

Notices of Intent and Unsworn Statements in Medical Malpractice Actions

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

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

At or before the end of the 90 day presuit screening period, the defendant's insurer must, pursuant to s. 766.106(3)(b), F.S., respond to the claimant by rejecting the claim, making a settlement offer, or making an offer of admission of liability and for arbitration on the issue of

[7] A supersedeas bond is a bond required of a person who petitions to set aside a judgment or execution and from which the other party may be made whole if the action is successful.
[8] See s. 459.0085, F.S.

damages. If the defendant makes an offer to arbitrate, the claimant has 50 days, pursuant to s. 766.106(10), F.S., to accept or reject the offer. The claimant cannot force the defendant to arbitrate under s. 766.106, F.S. Acceptance of the offer waives recourse to any other remedy by the parties. The parties then have 30 days to settle the amount of damages and, if they cannot reach a settlement, they must proceed to binding arbitration to determine the amount of damages.

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

Florida Birth-Related Neurological Injury Compensation Association (NICA)

The Florida Birth-Related Neurological Injury Compensation Plan was enacted by the Legislature in 1988.[9] Currently, Virginia is the only other state in the nation that has a no-fault coverage plan that is similar to Florida's plan.[10] The compensation plan was created to provide compensation, long-term medical care, and other services to persons with birth-related neurological injuries. Although the benefits paid under the plan are more restricted than the remedies provided by tort law, the plan does not require the claimant to prove malpractice and provides a streamlined administrative hearing to resolve the claim.[11] The entity charged with administering the plan is the Florida Birth-Related Neurological Injury Compensation Association (NICA). A "birth-related neurological injury" as defined in s. 766.302(2), F.S., is an injury to the brain or spinal cord of a live infant caused by oxygen deprivation or by mechanical injury occurring in the course of labor, delivery, or resuscitation in the immediate postdelivery period in a hospital. An injury addressed by this statute renders the infant permanently, substantially mentally, *and* physically impaired.[12]

Section 766.316, F.S., requires each hospital with a physician participating in the plan and each physician participating in the plan to provide notice to the obstetrical patients as to the limited no-fault alternative for birth-related neurological injuries. The notice must be provided on forms furnished by NICA and must include a clear and concise explanation of a patient's rights and limitation under the plan. The hospital or participating physician may elect to have the patient sign a form acknowledging receipt of the notice. Signature of the patient acknowledging receipt of the notice form raises a rebuttable presumption that the notice requirements have been met.

---

[9] Sections 60-75, ch. 88-1, L.O.F., were enacted by the Legislature in an attempt to stabilize and reduce malpractice insurance premiums for physicians practicing obstetrics, according to the legislative findings and intent cited in s. 766.301(1)(c), F.S.
[10] Governor's Select Task Force on Healthcare Professional Liability Insurance, *Report and Recommendations*, p. 307 (2003).
[11] See *Florida Birth-Related Neurological Injury Compensation Ass'n v. McKaughan*, 668 So.2d 974, 977 (Fla. 1996).
[12] The Governor's Select Task Force on Healthcare Professional Liability Insurance (the "task force") suggested that the definition of "birth-related neurological injury" could be expanded to include mental *or* physical injury, but the task force recommended against making any changes to plan eligibility until further inquiry has been conducted. See *supra* note 2, at p. 308. The Office of Program Policy Analysis and Government Accountability conducted a study of NICA eligibility requirements and issued a report January, 2004. (OPPAGA Report #04-04)

Itemized Verdicts and Alternative Methods of Payment of Damage Awards

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

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

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

Joint and Several Liability

Under the doctrine of joint and several liability, all defendants are responsible for the plaintiff's damages regardless of the extent of each defendant's fault in causing the plaintiff's damages.[13] Under the doctrine of contributory negligence, any fault on the part of the plaintiff bars recovery. Various methods of apportioning damages have been used in Florida. Under the doctrine of comparative fault, each party is responsible to the extent of its proportion of fault and the court enters a judgment in a negligence case based on each party's proportion of liability. Until recently, the doctrine of joint and several liability applied to joint tortfeasors such that the court entered a judgment with respect to the economic damages against the party holding him or her responsible for those damages for all parties until the plaintiff recovered all damages completely. However, in 1999, Florida law was amended to abolish the doctrine of joint and several liability for non-economic damages, and to limit its applications as to economic damages. See ch. 99-225, L.O.F.; s. 768.81, F.S. As to economic damages, it established new limitations and maximum liability amounts, which increase with a defendant's share of fault and dependent on whether the plaintiff was at fault or not. Section 768.81, F.S., requires the court to enter judgment based on fault of the parties rather than joint and several liability in negligence cases. Section 768.81(3), F.S., provides a formula to be used by the courts to apportion damages when the plaintiff is found to be at fault.

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

Section 768.81(5), F.S.,[14] provides that notwithstanding any law to the contrary, in any action for damages for personal injury or wrongful death arising out of medical malpractice, whether in tort or contract, when an apportionment of damages pursuant to this subsection is attributed to a statutory teaching hospital, the court shall enter judgment against the statutory teaching hospital on the basis of such party's percentage of fault and not on the basis of the doctrine of joint and several liability. Subsection (2) of s. 766.112, F.S., also provides that a claimant's sole remedy to collect a judgment or settlement against a board of trustees of a state university in a medical malpractice action is through the legislative claim bill process as provided in s. 768.28, F.S.

Medical Malpractice Caps on Noneconomic Damages

In 2003, the Legislature adopted several medical malpractice reforms, including caps on noneconomic damages in an action for personal injury or wrongful death arising from medical negligence by a practitioner or nonpractitioner:

- For an injury other than a permanent vegetative state or death, noneconomic damages are capped at $500,000 from each practitioner defendant and $750,000 from a nonpractitioner defendant. However, no more than $1 million and $1.5 million can be recovered from all practitioner defendants and all nonpractitioner defendants, respectively, regardless of the number of claimants. Alternatively, the $500,000 cap and $750,000 cap can be "pierced" to allow an injured patient to recover up to $1 million and $1.5 million aggregated from all practitioner defendants and all nonpractitioner defendants, respectively, if the injury qualifies as a catastrophic injury and manifest injustice would occur if the cap was not pierced.
- For an injury that is a permanent vegetative state or death, noneconomic damages are capped at $1 million and $1.5 million from practitioner defendants and nonpractitioner defendants, respectively, regardless of the number of claimants.
- For any type of injury resulting when a practitioner provides emergency services in a hospital or life support services including transportation, provided there is no pre-existing health care patient-practitioner relationship, noneconomic damages are capped at $150,000 per claimant but cannot exceed $300,000, regardless of the number of claimants or practitioner defendants. This cap only applies to injuries prior to the patient being stabilized.
- For any type of injury resulting when a nonpractitioner provides emergency services in a hospital or prehospital emergency treatment pursuant to statutory obligations, provided there is no pre-existing health care patient-practitioner relationship, noneconomic damages are capped at $750,000 per claimant from all nonpractitioner defendants but cannot exceed $1.5 million, regardless of the number of claimants or nonpractitioner defendants.
- Allows for setoff against noneconomic damages exceeding the statutory caps, provided a reduction is made first for comparative fault.
- Requires reduction of any award for noneconomic damages by any settlement amount received in order to preclude recovery in excess of the statutory cap.
- Clarifies that the caps on noneconomic damages applicable in medical negligence trials are applicable to trials that take place following a defendant's refusal to accept a claimant's offer of voluntary binding arbitration.
- Caps recovery of noneconomic damages in voluntary binding medical negligence arbitration involving wrongful death.

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

III. Effect of Proposed Changes:

Section 1. Provides a title for the bill - the "Enterprise Act for Patient Protection and Provider Liability."

Section 2. Provides legislative findings. The bill lists 17 findings. Among these findings, the Legislature finds that Florida is in the midst of a prolonged medical malpractice crisis that has serious adverse effects on patients, practitioners, licensed health care facilities, and all residents of Florida. Modern hospitals are complex organizations and, increasingly, medical care and treatment in hospitals is a common enterprise involving an array of responsible employees, agents, and other persons who are authorized to exercise clinical privileges within the premises. The Legislature finds an overwhelming public necessity to impose reasonable limitations on actions for medical malpractice against statutory teaching hospitals and hospitals that are owned and operated by universities that maintain accredited medical schools, in furtherance of the critical public interest for access to high-quality medical care, medical education, and innovative approaches to patient protection. The Legislature also finds an overwhelming public necessity: for statutory teaching hospitals and hospitals owned and operated by universities that maintain accredited medical schools to implement innovative measures for patient protection and provider liability to generate data for state policymakers on the effectiveness of these measures; and to promote the academic mission of such hospitals.

Section 3. Amends s. 381.0271, F.S., to revise the powers and duties of the Florida Patient Safety Corporation (FPSC) to authorize FPSC to intervene as a party in administrative actions related to patient safety in licensed health care facilities, including hospitals.

Section 4. Amends s. 395.0197, F.S., to encourage licensed hospitals to extend risk management activities for providers' offices and assume provider liability for acts and omission occurring within the licensed facility pursuant to the Enterprise Act for Patient Protection and Provider Liability which is created in the bill.

Sections 5 and 6. Amend ss. 458.320 and 459.0085, F.S., to exempt from financial responsibility requirements medical and osteopathic physicians who only perform surgery or who have only clinic privileges or admitting privileges in one or more certified patient safety facilities, which are legally liable for medical negligence of affected practitioners pursuant to the Enterprise Act for Patient Protection and Provider Liability. Medical and osteopathic physicians who are covered for claims of medical negligence arising from care and treatment of patients in a hospital that assumes sole and exclusive liability for all such claims pursuant to the Enterprise Act for Patient Protection and Provider Liability must 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 for whom the physician may provide medical care and treatment in any such hospital.

Section 7. Creates s. 627.41485, F.S., to authorize insurance carriers to issue professional liability coverage for physicians licensed under ch. 458 or ch. 459, F.S., that specifically excludes coverage for claims related to acts of medical negligence occurring within a certified patient safety facility that bears sole and exclusive liability for acts of medical negligence pursuant to the Enterprise Act for Patient Protection and Provider Liability or within a statutory

teaching hospital that has agreed to indemnify medical or osteopathic physicians for legal liability subject to the usual underwriting standards.

Section 8. Amends s. 766.3316, F.S., to require hospitals that assume liability for affected physicians pursuant to the Enterprise Act for Patient Protection and Provider Liability, to provide notice to obstetrical patients as to the limited no-fault alternative for birth-related neurological injuries under NICA.

Section 9. Amends s. 766.110, F.S., to require hospitals, except those that receive sovereign immunity under s. 768.28, F.S., that assume liability under the Enterprise Act for Patient Protection and Provider Liability to carry liability insurance in the amounts of $2.5 million per claim, $7.5 million annual aggregate to cover all medical injuries to patients resulting from negligent acts or omissions by staff covered by an enterprise plan. The hospital's insurance or self-insurance must satisfy the physician financial responsibility requirements of ch. 458 and 459, F.S. A statutory teaching hospital, other than a hospital that receives sovereign immunity, may assume liability under the Enterprise Act for Patient Protection and Provider Liability for some or all members of its medical staff, including physicians having clinical privileges who are not employees or agents of the hospital and any organization, association, or group of persons liable for the negligent acts of such physicians, and some or all medical, nursing, or allied health students affiliated with the hospital, collectively covered persons, other than persons covered by sovereign immunity. Any hospital that agrees to provide malpractice coverage for such persons must acquire an appropriate policy of professional liability insurance or self-insurance. Any hospital that provides such malpractice coverage through self-insurance must submit a certified financial statement regarding the soundness of the reserve funds to AHCA. A hospital’s assumption of liability under this paragraph does not constitute a waiver of sovereign immunity.

Section 10. Creates s. 766.401, F.S., to provide definitions that apply to the proposed Enterprise Act for Patient Protection and Provider Liability. “Certified patient safety facility” means any eligible hospital that is solely and exclusively liable for acts or omissions of medical negligence with the licensed facility in accordance with an agency order approving an enterprise plan for patient protection and provider liability, except an eligible hospital that meets the requirements of s. 768.28(12(c)3, F.S., will be solely and exclusively liable for the medical negligence of affected physicians and affected practitioners who are employees and agents of a state university and the employees and agents of the hospital.

The bill defines “medical negligence” as medical malpractice whether grounded in tort or in contract and provides that the term does not include intentional acts. An "eligible hospital" or "licensed facility" is defined as a statutory teaching hospital or a hospital that is wholly owned by a university with an accredited medical school. Those hospitals may become a "certified patient safety facility" by petitioning AHCA to have an order issued approving the hospital's enterprise plan for patient protection and provider liability. “Enterprise plan” means a document adopted by the governing board of an eligible hospital and the executive committee of the medical staff or the board of trustees of a state university, manifesting concurrence with certain rights, duties, privileges of the health care facility and medical staff. The enterprise plan, in effect, establishes a plan for patient protection and provider liability in that facility. The bill defines “premises” and to include the buildings, beds, and equipment located at the address of the licensed facility and all other buildings, beds, and equipment under the dominion and control of the facility. “Within

the licensed facility" or "within the premises" is defined as anywhere on the premises of the licensed facility or the premises of any office, clinic, or ancillary facility that is owned, leased and operated, or controlled by the licensed facility.

"Medical staff" is defined as a medical or osteopathic physician or other practitioner having clinical privileges in a licensed facility and includes any affected physician regardless of his or her status as an employee, agent, or independent contractor. "Affected physician" means a medical staff member who is covered by an enterprise plan for patient protection and provider liability in a certified patient safety facility. "Affected practitioner" means any person who is credentialed by the eligible hospital to provide health care services who is covered by an enterprise plan for patient protection and provider liability in a certified patient safety facility. "Medical negligence" is defined to mean medical malpractice whether grounded in tort or in contract, including statutory claims arising out of any act or omission related to the rendering or failure to render medical or nursing care.

"Health care provider" is defined to include an eligible hospital, a medical or osteopathic physician, physician assistant, registered nurse, nurse midwife, or any facility that employs nurses to supply all or part of the care delivered by that facility, a health care professional association and its employees or a corporate medical group and its employees, any other medical facility the primary purpose of which is to deliver human medical diagnostic services or which delivers nonsurgical human medical treatment, including an office maintained by a provider, a free clinic that delivers only medical diagnostic services or nonsurgical medical treatment free of charge to all low-income recipients, and any other health care professional, practitioner, or provider, including a student enrolled in an accredited program that prepares the student for licensure for any profession specifically listed in the definition. "Health care provider" includes any person, organization, or entity that is vicariously liable under the theory of respondent superior or any other theory of legal liability for medical negligence committed by any licensed professional listed in the definition; a nonprofit corporation, including a university or medical school that employs licensed professionals listed in the definition; any federally-funded community health center; and any volunteer corporation or volunteer health care provider that provides health care services.

Section 11. Creates s. 766.402, F.S., to require AHCA, in accordance with ch. 120, F.S., to enter an order certifying approval of the eligible hospital, in conjunction with either the executive committee of its medical staff, or the board of trustees of a state university, if applicable, as a "certified patient safety facility" on the basis of a petition by the facility that shows that the facility is in compliance with the provisions of ss. 766.401-766.410, F.S., which are created by this bill. The bill authorizes FPSC to intervene as a party or to otherwise present relevant testimony in any administrative hearing conducted in connection with this section.

Section 12. Creates s. 766.403, F.S., to establish criteria for satisfying the requirement that a petitioner facility be engaged in a common enterprise for the care and treatment of hospital patients, as required in s. 766.402(2)(a), F.S., or in compliance with s. 766.410, F.S., which specifies the procedures for petitioning AHCA to have an order issued identifying the facility as a certified patient safety facility. The criteria include setting up a process for quarterly reporting by the patient safety committee; establishing a system within the facility for reporting near misses to FPSC; designing and making available a patient safety curriculum, including annual

reporting to AHCA; implementing a program to identify staff eligible for an early-intervention, assessment and training program on skills; implementing a simulation-based program for skills assessment, training, and retraining of facility staff in tasks identified by AHCA; designating a patient advocate and advisory panel; establishing a procedure for biennial review of the patient safety program by an independent organization or other organization approved by AHCA, with a report presented to the governing board; establishing a system for trending and tracking patient safety and quality indicators that may be established by rule of AHCA; and providing assistance to affected physicians in evaluating risk-management, patient-safety, and incident-reporting systems in settings outside the premises of the licensed facility. The provision assistance to affected physicians under this section may not be the basis for finding or imposing liability on the licensed facility for the medical negligence of the affected physician in clinical settings outside the premises of the licensed facility.

Section 13. Creates s. 766.404, F.S., to authorize AHCA to enter an order that certifies a facility as a certified patient safety facility on the basis of information presented in a petition for such an order by an eligible hospital. For petitioner-hospitals meeting the requirements of s. 768.28(12(c)3., F.S., enterprise liability must be limited to apply to affected physicians and affected practitioners who are employees or agents of a state university and the employees and agents of the hospital. The order may also provide that the hospital would bear sole and exclusive liability for any and all acts of medical negligence within the licensed facility including acts of negligence by any other provider, person, organization, or entity that commits medical negligence within the premises, irregardless of whether such provider, person, organization, or entity, was an employee or agent of the facility. Any other provider, person, organization, or entity that commits medical negligence within the premises resulting in damages to a patient, and any other provider, person, organization, or entity that is vicariously liable for medical negligence under the theory of respondent superior or otherwise, may not be named as a defendant in any such action and any such provider, person, organization, or entity is not liable for the medical negligence of a covered practitioner.

Affected practitioners must post a notice or provide written advice, referring to the administrative order of AHCA, that claims for medical negligence must be initiated against the facility rather than against the practitioner. Notice is waived under specified circumstances.

The order issued by AHCA certifying approval of an enterprise plan must, as a matter of law, constitute conclusive evidence that the hospital complies with all applicable patient safety requirements in ss. 766.401-766.410, F.S. Evidence of noncompliance with an order pursuant to an enterprise plan may be not admissible for any purpose in any action for medical malpractice. The order issued by AHCA for patient protection and provider liability applies prospectively to causes of action for medical negligence that arise on or after the effective date of the order.

AHCA is authorized to conduct on-site examinations of the facility to assure continued compliance with the terms of the order. The order would remain in effect until revoked. The revocation of an order approving an enterprise plan terminates the plan on January 1 of the year following entry of the order or six months after the entry of the order, whichever is longer.

Affected physicians must cooperate in good faith with an affected facility in the investigation and defense of any claim for medical malpractice. An affected facility must have a cause of

action for damages against an affected physician for bad faith refusal to cooperate in the investigation and defense of any claim of medical negligence against the licensed facility. To maintain a cause of action against an affected facility, the claimant must allege and prove that an employee or agent of the licensed facility, or an affected member of the medical staff who is covered by an approved enterprise plan for patient protection and provider liability committed an act or omission within the licensed facility which constitutes medical negligence under Florida law, even though an active tortfeasor is not named or joined as a party in the lawsuit. The bill does not create an independent cause of action against any health care provider, does not impose enterprise liability on any health care provider, except as provided in the bill, and may not be construed to support any cause of action other than an action for medical negligence as expressly provided against any person, organization, or entity. The bill does not waive sovereign immunity except as expressly provided in s. 768.28, F.S.

Section 14. Creates s. 766.405, F.S. to specify that enterprise plans are elective and not mandatory for eligible hospitals. An eligible hospital and its medical staff must adopt an enterprise plan in order to be approved by AHCA as a certified patient safety facility. At a minimum, the enterprise plan must contain provisions covering: compliance with a patient protection plan; internal review of medical incidents; timely reporting of medical incidents to state agencies; professional accountability of affected physicians and affected practitioners; and financial accountability of affected physicians and affected practitioners. For eligible hospitals meeting the requirements of s. 768.28(12(c)3., F.S., enterprise liability must be limited to apply to affected physicians and affected practitioners who are employees or agents of a state university. If multiple campuses share one license, the enterprise plan must be limited to the primary campus or the campus with the largest number of beds and, if applicable, associated outpatient facilities. If the enterprise plan is so limited, it must specify the campus and any outpatient ancillary facilities that will constitute the enterprise.

Section 15. Creates s. 766.406, F.S., to require a certified patient safety facility to report medical incidents occurring in the affected facility to the Department of Health in accordance with s. 395.0197, F.S. which relates to adverse incidents. A certified patient safety facility must continue to perform all peer review functions.

Section 16. Creates s. 766.407, F.S., to authorize an enterprise plan to include provisions for non-employee medical staff to share equitably in the cost of medical liability insurance premiums. The bill does not permit a licensed facility and affected practitioners to agree on charges for an equitable share of medical liability expense based on the number of patients admitted to the hospital by individual practitioners, patient revenue for the licensed facility generated by individual practitioners or overall profit or loss sustained by the certified patient safety facility. A licensed facility may impose a reasonable assessment against an affected practitioner that commits medical negligence in its facility. The medical staff of a licensed facility must agree to a schedule of assessments, criteria for levying of assessments, procedures for levying assessments and any due process rights afforded to an affected practitioner. The licensed facility may exempt employees and agents from the assessments. Failure to pay an assessment constitutes grounds for suspension of clinical privileges by the licensed facility. Employees and agents of the State of Florida, its agencies, and subdivisions as defined in s. 768.28, F.S., are exempt from the assessments. An assessment levied pursuant to this section is not discoverable or admissible as evidence in any legal action.

Section 17. Creates s. 766.408, F.S., to require each certified patient safety facility must submit an annual report to AHCA with data sufficient to evaluate the enterprise plan. AHCA must aggregate the data and evaluate the performance and effectiveness of the enterprise approach in an annual report to the Legislature before March 1. The reports must include but are not limited to data on the number and names of affected facilities; number and types of patient protection measures currently in effect; number of affected practitioners; number of affected patients; number of surgical procedures by affected practitioners on affected patients; number of medical incidents, claims of medical malpractice, and claims resulting in indemnity; average time for resolution of contested and uncontested claims of medical malpractice; percentage of claims that result in civil trials; percentage of civil trials resulting in adverse judgments against affected facilities; number and average size of an indemnity paid to claimants; number and average size of assessments imposed on affected practitioners; estimated liability expense, inclusive of liability insurance premiums, and other information that AHCA deems appropriate. The reports may include information and data obtained from the Department of Financial Services (DFS) on the availability and affordability of enterprise-wide medical liability insurance coverage for affected facilities. OIR must cooperate with AHCA in the reporting of information specified. These records are specifically designated as public records.

Section 18. Creates s. 766.409, F.S., to authorize AHCA to adopt rules to administer the provisions of ss. 766.401-766.410, F.S., the "Enterprise Act for Patient Protection and Provider Liability."

Section 19. Creates s. 766.410, F.S., to established the limits of liability for medical malpractice for care by eligible hospitals. Eligible hospitals may petition AHCA for issuance of an order showing that the hospital complies with the patient safety measures specified in s. 766.403, F.S. The limits of liability for medical malpractice for a hospital covered by an order shall be $500,000 in the aggregate for claims or judgments for non-economic damages arising out of the same incident or occurrence. The claims or judgments for noneconomic damages must be offset by collateral sources at the time of final settlement. Any awards of future economic damages, after being offset by collateral sources, at the option of the teaching hospital, must be reduced by the court to present value and paid in full or paid by means of periodic payments in the form of annuities or reversionary trusts. The payment of such future economic damages must be paid for the life of the claimant or for so long as the condition for which the award was made persists, whichever is shorter, without regard to the number of years awarded by the trier of fact, at which time the obligation to make such payments terminates. A company that underwrites an annuity to pay future economic damages must have a Best Company rating of not less than A. The terms of the reversionary instrument used to periodically pay future economic damages must be approved by the court and such approval may not be reasonably withheld. The bill specifies that the order issued by AHCA certifying approval of an enterprise plan for patient protection remains in force until revoked, constitutes conclusive evidence that the hospital complies with all applicable patient safety requirements, or does not impose enterprise liability for acts or omissions of medical negligence.

Section 20. Amends s. 768.28, F.S., relating to a waiver of sovereign immunity in tort actions, to revise the payment limits for certified patient safety facilities that are already covered by sovereign immunity who bear liability pursuant to the Enterprise Act for Patient Protection and

Provider Liability. Neither the state or its agencies or subdivisions are liable to pay a claim which exceeds $150,000 for a single claim and a total of $300,000 for all claims arising out of a single incident. Notwithstanding the limited waiver of sovereign immunity, such certified patient safety facilities may agree within the limits of insurance coverage to settle a claim or judgment rendered against it for tortious acts in excess of the limitations ($150,000 for a single claim and a total of $300,000 for all claims arising out of a single incident) without further action by the Legislature.

The bill provides that a certified patient safety facility wherein a minimum of 90 percent of the members of the medical staff consist of physicians who are employees or agents of a state university, is an agent of the respective state university board of trustees for purposes of the waiver of sovereign immunity, only to the extent that the licensed facility, in accordance with an enterprise plan for patient protection and provider liability, approved by AHCA, is solely and exclusively liable for acts of medical negligence of physicians providing health care services within the licensed facility. Subject to the acceptance of the Florida Board of Governors and a state university board of trustees, such a licensed facility may secure the limits of liability protection from a self-insurance program. In effect, this would extend an immunity of liability for the licensed facility so that its tort exposure would be limited to a claim of $150,000 for a single claim and a total of $300,000 for all claims.

A notice of intent to commence an action for medical negligence arising from the care or treatment of a patient in a statutory teaching hospital with an approved enterprise plan subject to the sovereign immunity limitations must be sent to the licensed facility, as the statutory agent created pursuant to an enterprise plan of the related board of trustees of a state university for the limited purposes of administering an enterprise plan. A complaint alleging medical negligence resulting in damages to a patient in a certified patient safety facility subject to the provisions of s. 768.28(12)(c), F.S., must be commenced against the applicable board of trustees of a state university on the relation of the licensed facility, and the doctrines of res judicata and collateral estoppel shall apply. The complaint shall be served on the licensed facility. Any notice of intent mailed to the licensed facility, any legal process served on the licensed facility, and any other notice, paper, or pleading that is served, sent or delivered to the licensed facility pertaining to a claim of medical negligence, must have the same legal force and effect as mailing, service, or delivery to a duly authorized agent of the board of trustees of the respective state university, notwithstanding any provision of law the contrary. Upon receipt of any such notice of intent, complaint for damages, or other notice, paper or pleading pertaining to a claim of medical negligence, a licensed facility subject to the provisions of s. 768.28(12)(c), F.S., must give timely notice to the related board of trustees of the state university, although failure to give timely notice does not affect the legal sufficiency of the notice of intent, service or process, or other notice, paper, or pleading.

A final judgment or binding arbitration award against the board of trustees of a state university on the relation of a licensed facility, arising from a claim of medical negligence resulting in damages to a patient in a certified patient safety facility subject to s. 768.28(12)(c), F.S., may be enforced in the same manner, and is subject to the same limitations on enforcement or recovery, as any final judgment for damages or binding arbitration award against the board of trustees of a state university, notwithstanding any provision of law to the contrary. Any settlement agreement executed by the board of trustees of a state university on the relation of a licensed facility arising

from a claim of medical negligence resulting in damages to a patient in a certified patient safety facility subject to the provisions of s. 768.28(5)(c), F.S., may be enforced in the same manner, and is subject to the same limitations, as a settlement agreement executed by an authorized agent of the board of trustees. The board of trustees of a state university may make payment to a claimant in whole or in part of any portion of a final judgment or binding arbitration award against the board of trustees of a state university on the relation of a licensed facility, and any portion of a settlement of a claim for medical negligence arising from a certified patient safety facility subject to the provisions of this paragraph, which exceeds the amounts of the limited waiver of sovereign immunity specified in s. 768.28 (5)(c), F.S., only as provided in that paragraph.

Section 21. Provides a severability clause.

Section 22. Specifies that, if any conflict with specified provisions (s. 17.505, F.S., which does not exist; s. 456.052, F.S., which relates to financial disclosures by health care practitioners to patients regarding an investment interest; s. 456.053, F.S., which relates to financial arrangements between referring health care providers; s. 456.054, F.S., which relates to prohibited kickbacks between health care providers; ss. 458.331 and 459.015, F.S., which relates to grounds for which a medical or osteopathic physician may be subject to discipline) exist in this bill, the provisions of this bill govern.

Section 23. Provides that the bill's provisions are self-executing.

Section 24. Provides that the bill takes effect upon becoming a law.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

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

B. Public Records/Open Meetings Issues:

The provisions of this bill have no impact on public records or open meetings issues under the requirements of Art. I, s. 24(a) and (b) of the Florida Constitution.

C. Trust Funds Restrictions:

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

D. Other Constitutional Issues:

The bill limits the recovery that medical malpractice claimants may get to the limitations as specified in the bill against a licensed facility and health care practitioners working within the premises of such a facility. Additionally, during 2003, the Legislature adopted several medical malpractice reforms, including caps on noneconomic damages in an

action for personal injury or wrongful death arising from medical negligence by a practitioner or nonpractitioner. It is unclear how the caps for recovery proposed in the bill will affect those existing limitations on recovery. The bill's revision to the requirements to bring a cause of action to allege a medical malpractice claim raises questions about possible infringements on the right of access to the courts. Section 21, Art I of the State Constitution provides that the courts shall be open to all for redress for an injury. To impose a barrier or limitation on litigants right to file certain actions it would have to meet the test announced by the Florida Supreme Court in Kluger v. White[15]. Under the constitutional test established by the Florida Supreme Court in *Kluger v. White*, the Legislature would have to: (1) provide a reasonable alternative remedy or commensurate benefit, or (2) make a legislative showing of overpowering public necessity for the abolishment of the right and no alternative method of meeting such public necessity.

Section 25, Art. X of the Florida Constitution known as "Patient's Right to Know About Adverse Medical Incidents," was proposed through the citizens' initiative process and was approved on November 2, 2004. Section 25, Art. X of the Florida Constitution provides patients with access to records made or received in the course of business by a health care facility or provider relating to any adverse medical incident and states:

> (a) In addition to any other similar rights provided herein or by general law, patients have a right to have access to any records made or received in the course of business by a health care facility or provider relating to any adverse medical incident.
>
> (b) In providing such access, the identity of patients involved in the incidents shall not be disclosed, and any privacy restrictions imposed by federal law shall be maintained.
>
> (c) For purposes of this section, the following terms have the following meanings:
>
> (1) The phrases "health care facility" and "health care provider" have the meaning given in general law related to a patient's rights and responsibilities.
>
> (2) The term "patient" means an individual who has sought, is seeking, is undergoing, or has undergone care or treatment in a health care facility or by a health care provider.
>
> (3) The phrase "adverse medical incident" means medical negligence, intentional misconduct, and any other act, neglect, or default of a health care facility or health care provider that caused or could have caused injury to or death of a patient, including, but not limited to, those incidents that are required by state or federal law to be reported to any governmental agency or body, and incidents that are reported to or reviewed by any health care facility peer review, risk management, quality assurance, credentials, or similar committee, or any representative of any such committees.

[15] See *Kluger v. White*, 281 So.2d 1 (Fla. 1973).

(4) The phrase “have access to any records” means, in addition to any other procedure for producing such records provided by general law, making the records available for inspection and copying upon formal or informal request by the patient or a representative of the patient, provided that current records which have been made publicly available by publication or on the Internet may be “provided” by reference to the location at which the records are publicly available.

To the extent that the bill makes certain documents or records maintained by a certified patient safety facility immune from discovery or production in a civil action, it raises constitutional questions that implicate s. 25, Art. X of the Florida Constitution, which have not yet been resolved by courts.

V. Economic Impact and Fiscal Note:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

Physicians and other affected health care practitioners may share a reduced liability for any medical claims that arise within the context of a certified patient safety facility with an approved enterprise plan.

C. Government Sector Impact:

AHCA will incur costs to implement the bill’s requirements to adopt rules and to review petitions and reports of patient safety facilities for purposes of approving an enterprise plan, and for performing on-site evaluations to determine compliance. AHCA officials indicated that the agency would require an additional staff person with experience and qualifications at the level of a Health Services and Facilities Consultant, Pay Grade 24.

VI. Technical Deficiencies:

On page 56, line 24, the bill refers to s. 17.505, F.S., which does not exist.

VII. Related Issues:

The bill definition of "premises" and "within the premises" or “within the facility” to include the buildings, beds, and equipment located at the address of the licensed facility and all other buildings, beds, and equipment in reasonable proximity to the facility under the dominion and control of the facility. It is unclear how the immunity extended under the bill will attach to consultations recognized and authorized by law for the purpose of improving patient care, which may include consultative, diagnostic, and treatment services.

Provisions in the medical and osteopathic practice acts and the closed claims reporting system under s. 627.912, F.S., which require physicians and their insurers, as applicable, to report

professional liability claims may need to be revised to require a certified patient safety facility to report professional liability claims for the acts or omissions of medical negligence for physicians under such plans.

This Senate staff analysis does not reflect the intent or official position of the bill's sponsor or the Florida Senate.

VIII. Summary of Amendments:

None.

This Senate staff analysis does not reflect the intent or official position of the bill's sponsor or the Florida Senate.