Health Law Advisory – Fall 2003

FLORIDA ENACTS MEDICAL MALPRACTICE LEGISLATION

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After a great deal of debate, both in public and in private, the Florida Legislature has finally passed legislation that is intended to address Florida's medical malpractice crisis. The provisions of this bill take effect on September 15, 2003, assuming that there is no court challenge which delays its effective date. This article offers readers a summary of the highlights of this legislation[1].

A. Caps on Non-Economic Damages

Clearly, the headline concerning this legislation involves the limitations it places on medical malpractice judgments. Notwithstanding those who sought to establish a single cap for non-economic damages, the Legislature decided to adopt a much more complicated scheme that depends upon the facts and circumstances of each case.

1. Caps in Standard Medical Malpractice Cases:
   - For practitioners (physicians and healthcare providers), the bill establishes a $500,000 cap on non-economic damages per claimant, regardless of the number of defendant physicians;
   - $1,000,000 is the maximum amount of non-economic damages all claimants can recover in the aggregate against all physicians;
   - For non-practitioners (health care facilities), non-economic may not exceed $750900 per claimant/$1.5 million in aggregate for all claimants.
2. Cases in Which the Cap Maybe Pierced

   Under certain circumstances, the caps discussed above may be exceeded:
   - Cases involving wrongful death and permanent vegetative state, all claimants may recover a total of $1 million from all practitioners without any special findings by the court;
   - Cases involving non-practitioners (hospitals, nursing facilities, etc.), all claimants may recover a total of $1.5 million;
   - Cases not involving wrongful death or permanent vegetative state, but the trial court finds that a manifest injustice would occur if the lower cap was imposed and the finder of fact finds that a catastrophic injury has occurred, only the injured patient may recover from a physician an additional amount up to $1_million in non-economic damages, or $1.5 million from non-practitioners;
3. Caps in Emergency Room Situations[2]:
   - For physicians, non-economic damages shall not exceed $150,000 per claimant and the total non-economic damages recoverable by all claimants from all physicians is $300,000;

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[1] NOTE, as with most legislation, there are many details that cannot be included within this limited space, but which may be of critical interest. Please feel free to contact any member of the Firm's Health Law Practice Group if you have questions regarding this new legislation.

[2] The Emergancy Room cap applies for any type of injury resulting when a practitioner provides emergency services prior to stabilization in a hospital or life support services including transportation, to someone with whom the practitioner has no pre-existing health care patient-practitioner relationship. In addition, for any type of injury resulting when a non-practitioner provides emergency services prior to stabilization in a hospital or pre-hospital emergency treatment pursuant to statutory obligations, to somone with whom the non-practitioner has no pre-existing healthcare patient-practitioner relationship.

- For facilities, non-economic damages shall not exceed $750,000 per claimant and the total non-economic damage award recoverable by all claimants from all facilities is $1.5 million.

B. Medical Malpractice Insurance

The bill does little to reduce malpractice insurance rates. Despite the efforts of members of both chambers of the Legislature, their efforts to rollback rates were defeated. However, it does require all medical malpractice insurers to make rate filings that reflect a rate reduction factor that will be determined by the Florida Office of Insurance Regulation ("0113"). The issue of medical malpractice insurance rates is addressed by implementing the following requirements:

- A rate freeze and mandatory rate filing to reflect the savings of the bill. Rates approved on, before Ely 1, 2003 for medical malpractice insurance remain in effect until the effective date of the new rate filing required by the act. Insurers must make a rate filing effective no lager than January 1, 2004. The new rate will apply to policies issued or renewed on or after the effective date of the act, requiring insurers to provide a refund for policies issued between the effective date of the act and the effective date of the rate filing.
- Medical malpractice insurers must notify insured at least 60 days prior to the effective date of a rate increase and at least 90 days prior to cancellation or non-renewal.
- Medical malpractice insurers must notify policyholders upon making a rate filing that would have a statewide average increase of 25 % or greater.
- Medical malpractice insurers must make a rate filing at least once annually (current law requires rate filings are only when rates are increased). Two officers of the medical malpractice insurance company must swear to annual rate filings;
- For policies issued or renewed between September 15, 2003 (the effective date of this bill) and the effective date of the new rate filing, the insurer must refund the difference between the rate actually charged and the rate finally approved by the OIR.
- If the insurance company believes the rate reduction would result in an inadequate rate and files a rate that deviates from the presumed factor, it has the burden of proving that the forced rate would be unlawful and must provide specific information that defends this position. The rate deviation cannot go into effect without OIR approval.
- Bad faith judgments cannot be factored into the rates.
- Prohibits the inclusion of costs attributed to investment losses.
- Authorizes a group of 10 or more health care providers to establish a commercial self-insurance fund for providing medical malpractice coverage.

- Eliminates an existing prohibition against creating new medical malpractice self-insurance funds and authorizes the Financial Services Commission to adopt rules relating to such funds.

C. Immunity

- Revises the circumstances under which immunity from civil liability under the Good Samaritan Act applies, by including any health care provider providing emergency services pursuant to obligations imposed by federal and state statutes and revises the definition of "reckless disregard" for purposes of extending such immunity. This act also extends the immunity to any health care practitioner who is in a hospital and who voluntarily provides immediate emergency care or treatment to a non-patient of his or hem.
- Extends sovereign immunity to health care practitioners who have contractually agreed to act as agents of a state university board of trustees to provide medical services to student-athletes for participation in or as a result of intercollegiate athletics.

D. Litigation Reform

- During pre-suit process, the defendant will be able to take the unsworn statements of the plaintiff's treating physicians, but must provide noticed and the opportunity for all parties to be present.
- Provides for new standards as to who may testify as an expert witness in a medical negligence trial.
- Provides that the expert who signs the pre-suit affidavit must have the same qualifications as the expert who testifies on trial. Currently any physician can sign the pre-suit affidavit.
- Makes pre-suit medical expert opinions discoverable.
- Provides for mandatory mediation of all medical negligence suits within 120 days after suit is filed.
- Requires the Department of Health ("DOH") to study and report by December 31, 2003 on whether medical review panels should be created for use during the pre-suit process. If DOH recommends that such panels should be created, then the report must include draft legislation to implement that recommendation.

E. Vicarious Liability

- An HMO will not be automatically liable for a physician's negligence because that physician is on the HMO's panel.
- Health insurers and HMOs will fall under the same non-economic damages cap as health care providers and an HMO or health insurer will not be liable for the medical negligence of a physician unless it specifically directed and actually controlled the conduct that caused the injury.

F. Bad Faith

- A professional liability insurer may not be held to have acted in bad faith for failure to timely pay policy limits if it tenders its policy limits and meets other reasonable conditions of settlement before the earlier of two events: the 210th day after service of the complaint, or the 60th day after the conclusion of the depositions of parties and expert witnesses, the initial disclosure of witnesses and production of documents, and required mediation.
- If either party is responsible for unreasonable delays, they lose the benefit of the more favorable safe harbor.

- The failure to offer W settle during the safe harbor period does not create a presumption that the insurance company acted in bad faith.

G. Physician Financial Responsibility

- A physician may self-insure or "go bare".
- For physicians who meet their financial responsibility by obtaining a irrevocable letter of credit or an escrow account, the required amount must be used to satisfy a judgment or settlement, it cannot be used for attorney fees or defense costs.
- If a physician fails to pay at least $100,000 ($250,000 if the physician has hospital staff privileges) of a medical malpractice award within 30 days of the award, then DOH must suspend that physician's license.
- If a physician's license is suspended for failure to pay a malpractice claim, be amount required by statute must be satisfied before the license can be reinstated.

H. Physician Discipline

- Clarifies that first offense citations an no discipline and do not need to be reported to the National Practitioner Databank. A citation cannot be given in the case of an adverse incident, but can be used to close minor standard of care cases. These cases can now be closed with Board (discipline and no report to the Databank.
- Deletes the 10 percent limit on licensure fee increases.
- Requires DOH to create a workgroup to study the physician discipline process.
- Allows DOH to obtain patient records without patient consent or the approval of a probable cause panel.
- Clarifies what costs shall be recovered when a physician is administratively disciplined.
- Clarifies that the boards shall make the final determination regarding the amount of costs.
- Allows DOH to investigate a closed claim of over $50,000 if it is less than 6 years old, even in the statute of limitation has passed.
- Provides that the determination of whether a licensee has violated the standard of care is a conclusion of law to be determined by the appropriate licensing board or DOH.
- Provides that DOH shall notify the Division of Administrative Hearings ("DOAH") within 45 days if DOH determines a formal hearing is required;
- Provides that successful mediation of disputes does not constitute discipline and is not reportable to the Databank.

I. Physician Profiles

- DOH has 30 days to update a physician profile after receiving new information. DOH must investigate all information received, provide a "reader friendly" description of all final disciplinary actions, and include a link to the final order.
- For MDs and Dos, only those liability cams over $100000 will go on the physician's profile. Currently the threshold it is $5,000.
- Requires DOH to include on the profiles information regarding hospital disciplinary actions.

- A physician who becomes licensed in Florida has 30 days to verify the contents of his initial profile. A currently licensed practitioner has 15 days to update his profile after information changes.
- Requires that all closed claims information is to be reported, and the information goes to OIR instead of DON.
- Requires closed claim information be included on the physician's profile within 30 days.

J. Patient Safety

- Requires hospitals to establish patient safety plans and committees.
- Broadens immunity for hospitals and staff who take disciplinary actions against medical staff.
- Requires hospitals and physicians to inform patients of an adverse incident.
- Requires college and university health care training programs to provide instruction in patient safety.

The future of the Florida Legislature's most recent attempt to establish non-economic damage caps, as well as the other provisions of this legislation, is uncertain. Groups that are disappointed with various aspects of this bill already are discussing court challenges and legislative initiatives for the next session of the Florida Legislature. It is too soon to speculate whether any of these efforts will be successful. Thus, for the time being, we believe that physicians and other health care providers should begin to study this legislation, understand its provisions and take steps to ensure their future compliance with its provisions.

One area that is most likely to survive challenge involves the physician financial responsibility provisions of this bill. For sometime now, we have seen a growing chorus of concern regarding those physicians who believe (erroneously) that they can go "bare" and escape liability through the bankruptcy courts. It still may be difficult to collect a judgment from a bankrupt physician. This bill makes (Near the Florida Legislature's commitment to having a physician, who attempts to avoid their financial liability obligation, "pay" by having their license to practice medicine suspended.