HB
472
(File 6 of 7)

Governor's Select Task Force on Healthcare Professional Liability Insurance

Office of the President

January 29, 2003

The Honorable Jeb Bush
Office of the Governor
State of Florida
PL-05 The Capitol
4000 South Monroe Street
Tallahassee, Florida 32399-0001

Dear Governor Bush:

I am pleased to transmit with this letter a copy of the report and recommendations of the Governor's Select Task Force on Health Care Professional Liability Insurance. In addition, we are submitting 13 volumes of reports, presentations, letters, and testimony.

During the past five months, the task force studied the history of medical malpractice and the current medical malpractice crisis in Florida, heard extensive testimony from healthcare providers and malpractice victims at hearings throughout the state, read hundreds of letters from concerned citizens, and conducted our own independent research of published studies and relevant literature.

The task force has taken great care to conform its recommendations to the requirements of the Florida Constitution and case law and to incorporate the thoughts and comments of the various stakeholders who addressed our group on this complex issue.

My fellow task force members and I are hopeful that this report will make a significant contribution to solving this crisis. We are grateful for the opportunity to serve, and we offer our continued assistance in the upcoming legislative session.

Cordially yours,

John C. Hitt
President

JCH/sc
enclosures

c: The Honorable Johnnie Byrd, Speaker of the House
The Honorable Jim King, President of the Senate

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Executive Summary

"Is there a doctor in the house? Increasingly, in Florida and around the country, the answer is no—not in the house, not in the doctor's office, and not in the hospital. Many physicians are choosing to retire early or to practice in other states because medical malpractice insurance in Florida has become unaffordable and, in some cases, unavailable."

James C. McDowell, Is There a Doctor in the House?, 23 The Journal of the James Madison Institute 10 (Winter 2003)

Florida is among the states with the highest medical malpractice insurance premiums in the nation. This increase in healthcare liability insurance rates is forcing physicians to practice medicine without professional liability insurance, to leave Florida, to not perform high-risk procedures, or to retire early from the practice of medicine.

In April 2002, the American Medical Association issued a report declaring Florida one of the twelve states in the midst of a medical liability insurance crisis. This crisis in the availability and affordability of medical malpractice insurance is causing a critical reduction in the quality of healthcare available in Florida. If no corrective action is taken, this crisis will lead to the continued deterioration of patient access to medical care.

During the past three years, numerous healthcare liability insurance carriers in Florida have been liquidated, forced into rehabilitation, or have decided to stop selling medical malpractice insurance in Florida. In the late 1990s, there was an industry high of sixty-six insurance companies active in Florida. Since that time, the number of companies has decreased to only twelve. Those remaining companies are quickly reaching capacity and are unable to expand their risk base to cover the physicians whose policies are being terminated by other companies.

The Governor's Select Task Force on Healthcare Professional Liability Insurance was created on August 28, 2002 by Executive Order No. 02-041, to examine Florida's current crisis in the availability and affordability of medical malpractice insurance. The Executive Order also directed the Task Force to make

recommendations for "protecting Floridians' access to high-quality and affordable healthcare."

The Task Force had ten meetings. During these meetings, the Task Force received testimony and information in five major areas which impact Floridians' access to high-quality and affordable healthcare. The Task Force examined healthcare quality issues and how those issues are impacted by medical malpractice insurance rates. The Task Force further reviewed state procedures for healthcare professional discipline. Likewise, the tort system's impact on the frequency and severity of claims was examined extensively. Moreover, the Task Force examined alternative dispute resolution processes in order to ensure victims of medical malpractice are fairly compensated for injuries in a timely manner. Finally, the Task Force examined factors influencing medical malpractice insurance rates and the regulation of rate setting by the state along with suggestions for improving the rate setting process to reduce the impact of the insurance business cycle. In sum, these areas can be divided into the following five categories: (1) healthcare quality; (2) physician discipline; (3) the need for tort reform; (4) alternative dispute resolution; and (5) insurance premiums and markets.

In addition to receiving information on the medical malpractice crisis the Task Force requested interested persons and entities to provide proposed solutions to the problem. The Task Force, as a result of this request, received over 100 proposals for change. In reviewing the proposals the Task Force used the following four criteria:

- Would the proposed change improve access to specialists, critical care providers, medical facilities for emergency care, obstetrical services, neurological services, or surgery?

- Would the proposed change facilitate the availability of malpractice insurance or other means for injured parties to recover reasonable compensation for injuries caused by the negligent acts of healthcare providers?

- Would the proposed change facilitate identifying and addressing healthcare provider problems as soon as possible to reduce or eliminate the risk to patients?

- Would the proposed change assist in reducing or holding down the cost of medical care to citizens and their health insurance providers to facilitate access to healthcare?

The reports and information received by the Task Force as well as transcripts of the meetings are compiled in the thirteen volumes that accompany the main report. The Governor, the President of the Senate, the Speaker of the House of Representatives, and the Legislative Library will be presented with the main report and the thirteen volumes. Thus, it must be emphasized that in order to properly understand the context of these findings and recommendations, we encourage the reader to read the entire text of the main report. The contents of this report were approved by the Task Force in a 4-0 vote on January 30, 2003.

The Task Force proposes a comprehensive solution, in the following five areas of reforms: (1) healthcare quality (2) physician discipline; (3) tort compensation; (4) alternative dispute resolution; and (5) insurance code reform.

Based on the testimony and information received and legal research of the Task Force's staff, the Task Force makes the following findings and recommendations to address the medical malpractice crisis in Florida.

Findings

Affordability: The cost of medical malpractice insurance has increased dramatically during the last few years. In 2002 the average medical malpractice premium per doctor in Florida was 55 percent higher than the national average. Florida's average insurance premiums have increased 64 percent since 1996 while nationally the average insurance premiums have increased 26 percent.

Availability: The number of insurance companies writing medical malpractice policies in Florida went from a high of sixty-six companies in 1999 to twelve currently, and of the twelve currently writing premiums only four are generally writing medical malpractice insurance. The remaining eight are writing only selected policies.

Impact of the Underwriting Cycle: The business cycle for medical malpractice insurance companies has had a significant impact on the increases in medical malpractice insurance levels in Florida but

claims paid has been the main cause of such increases. The late-1990s produced some of the largest investment gains for the market since the mid-1980s, but this increased income was not sufficient to offset the large increases in claims paid for the industry. As a result, insurance companies writing medical malpractice insurance suffered a loss ratio of 184 percent.

Frequency of Claims Payments: Florida's claims frequency which was an average of 4.82 claims per 100,000 population in 1991 has increased to an average of 7.56 claims per 100,000 in 2000. The national average has been between 5.11 and 5.77 claims from 1991 to 2000 with an average of 5.54 claims per 100,000 population in 2000. Thus, in 2000, Florida's frequency of claims was 36 percent higher than the national average.

Severity of Claims Payments: The severity of claims in Florida and nationally showed a significant increase between 1998 and 2000. Further, the average "per premium" loss per Florida doctor has grown from 15 percent above the national average in 1991 to 50 percent above that average in 2000.

Variations Among Medical Specialties: Specialists and other physicians performing high-risk procedures are much more likely to be sued. These specialists, particularly obstetricians and neurosurgeons, also pay much higher medical malpractice insurance rates, regardless of their litigation history.

Changes in the Law: The very existence of the continuing medical malpractice crisis is proof that the previous reforms have failed to provide a solution to the problem. Florida's use of many of the reforms considered or adopted by other states further demonstrates that the provisions related to medical malpractice adopted in Florida have not been sufficient in addressing the problem. The limitation on damages, the only provision proven to be effective in reducing the severity of judgments, was stricken by the Florida Supreme Court.

Access to Healthcare Services: The concern over litigation and the cost and lack of medical malpractice insurance have caused doctors to discontinue high-risk procedures, turn away high-risk patients, close practices, and move out of the state. In some communities, doctors have ceased or discontinued delivering babies and discontinued hospital care.

Compensation of Victims: As the cost of medical malpractice insurance has increased some healthcare providers carry only

minimum insurance of $250,000 or are "going bare." This leaves victims with minimal or no compensation should they be injured.

Professional Regulation of Medical Care: The current disciplinary process requires the Division of Administrative Hearings judges to make the determination when conduct fails to meet minimum standards of care and is formally charged against a healthcare provider or facility. Frequently those rulings frustrate and thwart the ability of the healthcare provider regulatory boards to appropriately discipline healthcare providers. Issues such as defining the standard of care in a given set of facts and whether the practitioner breached that standard are responsibilities best left to the professional boards. Additionally, hospitals find it very difficult to discipline or remove healthcare professionals for actions below the accepted standard of care.

Recommendations

Healthcare Quality

Recommendation 1. The Legislature should establish a Patient Safety Authority, or an entity similar in concept, as both a short-term and long-term strategy to improve patient safety. There are two options that should be considered. The first option, which is recommended by the Institute of Medicine (IOM), is to have two systems, one for the mandatory reporting of adverse events and another system for the voluntary reporting of near misses. The second option is similar to the Patient Safety Authority established and existing in Pennsylvania, which analyzes all adverse events and near misses in that state. Experts employed by both systems would analyze data received and make recommendations about how to reduce these adverse events and near misses. Information would not be subject to discovery in lawsuits.

Recommendation 2. The Legislature should timely develop or adopt statewide electronic medical records and protocols for a physician medication ordering system. The system should be developed collaboratively with hospitals, physicians, and other healthcare providers. The physician medication ordering system should be implemented first. The system could be implemented initially with a web-based data exchange platform which establishes interconnectivity among providers. Another possibility is to begin with business functions, which provide an early return on investment, and then include clinical functions.

Recommendation 3. The Legislature should consider creating a statutory public-private non-profit entity that would administer the Patient Safety Authority, statewide electronic medical records, and build an information technology infrastructure to support the delivery of healthcare that would include a statewide physician medication ordering system. Funding could possibly come from a $1 per year surcharge on all health professional licenses; all hospital, ambulatory care surgery center, nursing home, home health agency, and birth center discharges; and all individuals in managed care plans and insurance plans licensed under chapters 627 and 640, Florida Statutes. Healthcare providers, insurers, businesses, and government would be represented on the governing board of directors. Options for implementation include:

- Affiliating with a university for the analysis of voluntarily reported adverse events and "near misses."
- Contracting with an Information Technology firm(s) for a statewide physician medication ordering system, web-based platform for health provider interconnectivity, and electronic patient record.
- Developing a business plan and future financing strategy to supplement the $1 annual surcharge, which will likely be necessary to achieve full implementation.
- Including in the business plan a strategy to begin with computerizing business functions, for providers to quickly achieve cost-savings due to automation efficiencies, and then include clinical functions.

Recommendation 4. The Legislature should be encouraged to authorize the two "no fault" medical malpractice demonstration projects recommended in the November 2002 report, Fostering Rapid Advances in Healthcare, by the IOM at a university healthcare system or statutory teaching hospital. This project would be governed by criteria compatible with that proposed by the IOM.

Recommendation 5. If Recommendation 4 is implemented, contingency fees for attorneys should be eliminated from the claims bill process in the no-fault demonstration project.

Recommendation 6. The Legislature should require each hospital and ambulatory surgery center to have a patient safety plan, a patient safety committee, and a patient safety officer. Members of the public should have representation on patient safety committees.

Recommendation 7. The Legislature should require healthcare providers to notify patients who experience serious medical injuries to be notified of the injury in person.

Recommendation 8. The Legislature should examine the feasibility of using Medicaid funding to create a pilot project for an electronic medical record and a physician medication ordering system for Medicaid patients.

Recommendation 9. The Legi. lature should examine the feasibility of developing a process in the Insurance Code for hospitals and other healthcare facilities to receive malpractice insurance discounts if they implement certified patient safety programs.

Recommendation 10. The Legislature should establish a high-technology simulation center for use by all health providers. Florida should encourage use of this center by practitioners in other states to help offset the costs for the center.

Recommendation 11. The Legislature should require all medical schools, nursing schools, and allied health schools to include in their curricula courses on patient safety and patient safety improvement.

Recommendation 12. The Legislature should require the Agency for Health Care Administration (AHCA) to conduct a study to determine if it is feasible to provide information to the public to help them make better healthcare decisions regarding the choice of a hospital. The information would not be presented in a "report card" format. AHCA should be provided with sufficient resources to conduct the study in cooperation with hospitals, physicians, and other healthcare providers and provide the Governor and Legislature with a report.

Physician Discipline

Recommendation 13. The Legislature should allow the healthcare provider regulatory boards to appoint administrative law judges with expertise in the profession to hear standard of care cases.

Recommendation 14. The Legislature should statutorily provide that standard of care decisions are, as a matter of law, infused with

overriding policy considerations best left to the healthcare provider regulatory boards.

Recommendation 15. The Legislature should authorize the healthcare provider regulatory boards to reassess and resolve conflicting evidence in standard of care cases based on the record in the case.

Recommendation 16. The Legislature should require physician profiles to provide professional qualifications information regarding physicians to consumers.

Recommendation 17. The Legislature should provide for an audit of the Department of Health's (DOH) disciplinary process and closed claims files.

Recommendation 18. The Florida Legislature should strengthen Florida's peer review requirements so they can lead to earlier dismissal of meritless claims brought against hospitals by aggrieved physicians and protect physicians and hospitals from costly lawsuits and liability.

Recommendation 19. The Legislature should expand the DOH's subpoena authority to include the retrieval of patient records when the patient refuses to cooperate, is unavailable, or fails to execute a patient release. Records obtained under these circumstances would be confidential.

Recommendation 20. The Legislature should require that all first offense citations be non-disciplinary and non-reportable to the national data banks.

Recommendation 21. The Legislature should expand the timeframe for forwarding cases to the Division of Administrative Hearings from fifteen days to forty-five days when a demand for a formal hearing, pursuant to section 120.57(1), Florida Statutes, is received.

Recommendation 22. The Legislature should require all healthcare provider regulatory boards to designate those violations that may be handled in a one-time, non-reportable, and confidential mediation proceeding. Appropriate standard of care cases should be included.

Recommendation 23. The Legislature should modify upward the dollar amount threshold for closed claims cases to be reported and investigated by the Department.

Recommendation 24. The Legislature should grant exclusive authority to the healthcare provider regulatory boards to determine the amount of administrative costs to be recovered when final action occurs and a respondent is disciplined.

Recommendation 25. The Legislature should change the burden of proof in disciplinary actions from the "clear and convincing evidence" standard, to the "greater weight of the evidence" standard, which is the same burden of proof for a medical malpractice case.

Recommendation 26. The Legislature should expand the healthcare provider regulatory board's rulemaking authority in the areas of Internet prescribing and sexual misconduct cases so as to better address critical areas of discipline.

Tort Reform

Cap on Non-Economic Damages

Recommendation 27. The Legislature should, in medical malpractice cases, cap non-economic damages at $250,000 per incident. The Task Force believes that a cap on non-economic damages will bring relief to this current crisis. Without the inclusion of a cap on potential awards of non-economic damages in a legislative package, no legislative reform plan can be successful in achieving the goal of controlling increases in healthcare costs, and thereby promoting improved access to healthcare. Although the Task Force was offered other solutions, there is no other alternative remedy that will immediately alleviate Florida's crisis of availability and affordability of healthcare. The evidence before the Task Force indicates that a cap of $250,000 per incident will lead to significantly lower malpractice premiums.

The Legislature should commission and fund a study of the impact of the $250,000 cap on non-economic damages. An interim report should be submitted to the legislature five years after date of enactment.

Communications with Subsequent Treating Physicians

Recommendation 28. The Legislature should amend the statutes to allow *ex parte* communication between defense counsel for a defendant in a medical malpractice lawsuit and the plaintiff's treating physicians.

Recommendation 29. As an alternative, the Legislature may consider requiring the plaintiff to execute a medical information release when filing a lawsuit that would allow for the defendant to conduct *ex parte* interviews with the plaintiff's treating physicians only in areas potentially relevant to the plaintiff's alleged injury or illness.

Expert Witness Qualifications

Recommendation 30. The Legislature should examine ways to improve the use of in-kind experts at trial.

Limitation on Liability Related to Emergency Services

Recommendation 31. The Legislature should retain the definition of "reckless disregard," as that term is currently defined by statute, as it is sufficient.

Recommendation 32. The Legislature should repeal references to patient stabilization in section 768.13(2)(b)2a, Florida Statutes.

Sovereign Immunity

Recommendation 33. The Legislature should amend section 768.28, Florida Statutes, to define healthcare professionals providing services in emergency rooms or trauma centers as agents of the state for purposes of sovereign immunity.

Periodic Payment of Damages

Recommendation 34. The Legislature should amend the statutes to allow the periodic payment of future non-economic damages.

Recommendation 35. The Legislature should amend the statutes to terminate the payment of future economic and non-economic damages upon the death of the plaintiff.

Pre-Suit Reform

Recommendation 36. The Legislature should require experts reviewing pre-suit claims and defenses and rendering opinions be qualified, in that they possess similar if not identical credentials and expertise in the field of healthcare services of the defendant's particular specialty.

Recommendation 37. The Legislature should require the expert who reviews pre-suit claims and defenses and renders opinions be subject to discovery and his or her testimony be admissible in any future proceeding.

Joint and Several Liability

Recommendation 38. Joint liability has a negative impact on a medical malpractice insurer's ability to forecast future losses and contributes to the insurer's paid losses. Accordingly, the Legislature should amend section 768.81, Florida Statutes, to provide that a defendant's liability for both economic and non-economic damages be several only.

Set Off of Settlement Proceeds

Recommendation 39. The Legislature should amend the set off statutes, sections 46.015 and 768.041, Florida Statutes, to clarify that set off amounts should be applied to jury damage awards, including both economic and non-economic damages, even when fault is several only.

Alternative Dispute Resolution

Mandatory Mediation

Recommendation 40. The Legislature should encourage pre-suit mediation by providing for confidentiality of any pre-suit

mediation in a medical malpractice case in the same manner as is provided for mediation occurring after suit is filed.

Recommendation 41. The Legislature should amend the mandatory mediation provisions of section 766.108, Florida Statutes, to require mediation within 120 days of filing suit and to provide sanctions if a good faith offer of settlement is refused.

Recommendation 42. The Legislature should not make admissible at trial the fact that mandatory mediation occurred or that offers of settlement were made, but should make this fact admissible for purposes of enforcing the attorney fees and costs. The mediator should maintain a report of the issues and facts presented at the mediation and the final settlement offers of each party at the mandatory mediation.

Recommendation 43. The Legislature should enact specific criteria similar to those in the offer of judgment statute to be considered by the court in making the determination as to how close in amount the judgment must be to the offer and the criteria to be used in evaluating the amount of the attorney fees and costs to be awarded in addition to the standards generally considered in awarding fees and costs.

Recommendation 44. The Legislature should require the court to consider, in addition to all other criteria, whether the issues and facts presented at mediation were significantly the same issues presented at trial.

Voluntary Binding Arbitration

Recommendation 45. The Legislature should amend the definitions of "economic damages" and "non-economic damages" as provided in sections 766.202 and 766.207, Florida Statutes, to provide that such damages are recoverable in voluntary binding arbitration only if the claimant has the right to recover such damages under general law, including the Wrongful Death Act.

Recommendation 46. The Legislature should provide for an aggregate cap on non-economic damages in arbitrated cases of multiple defendants.

Insurance Reform

NICA

Recommendation 47. The Legislature should maintain the NICA program because of its success and should further consider and study the issues for broadening the NICA program, as discussed in this report.

Bad Faith

Recommendation 48. The Legislature should restore the insured as the owner of the bad faith cause of action. The common law cause of action, as outlined by the Supreme Court in 1980 should be legislatively cured so that the Florida Legislature preempts that rule and only insureds, not third party plaintiffs, can bring a bad faith cause of action against its insurer. In addition, section 624.155, Florida Statutes, should be amended to also limit the proper party in a bad faith cause of action to the insured only.

Recommendation 49. The Legislature should articulate standards of what constitutes bad faith on the part of an insurer.

Recommendation 50. The Legislature should require that the maximum liability for bad faith be calculated as the amount of damages that were actually caused by the acts of bad faith, limited by the amount of the reachable assets of the insured.

Recommendation 51. The Legislature should require that, if an insurer is found to be in bad faith or settles a case for bad faith, the Department of Insurance be notified of such finding.

Recommendation 52. The Department of Insurance should conduct an investigation into the specific allegations of the insurer and into the insurer's general practices and should take necessary action against the insurer to punish and prevent future bad faith practices.

Alternative Insurance Products

Recommendation 53. The Legislature should repeal the prohibition against creating Medical Malpractice Risk Management Trust Funds in section 627.357, Florida Statutes.

Recommendation 54. The Legislature should encourage the creation of self-insured options for healthcare providers.

Recommendation 55. The Legislature should expand the rulemaking authority of the Department of Insurance for self-insurance programs to ensure they remain solvent and provide the insurance coverage purchased by participants.

Insurance Company Regulation

Recommendation 56. The Legislature should authorize the Department of Insurance to require insurers to provide additional information on closed claims and to penalize the insurers for failure to provide the required data.

Recommendation 57. The Department of Health should forward the information collected pursuant to section 456.049, Florida Statutes, to the Department of Insurance.

Recommendation 58. The Legislature should require every entity reporting to the National Practitioner Data Bank to report the same information to the Department of Insurance for inclusion in the closed claim data files.

Recommendation 59. The Legislature should require the Department of Insurance to compile and review the collected data and fine those entities failing to fully comply with the requirements of law.

Recommendation 60. The Legislature should include in section 627.062, Florida Statutes, related to the setting of rates for most insurers, the provisions of section 627.0651(12), Florida Statutes, prohibiting the inclusion of payments made by insurers for bad faith or punitive damages claims.

Conclusion

Although all of the above recommendations are important, the most important one is a cap on non-economic damages in the amount of $250,000. In an Issue Brief on federal medical malpractice tort reform, the American Academy of Actuaries recommend that Congress look to California's successful experience with a cap on non-economic damages. The Academy concluded:

For reform to be effective in reducing costs, the cap on non-economic awards should be established on a per-medical-injury basis at a level low enough to have an impact (e.g., $250,000).

In light of this recommendation of the Academy of Actuaries and California's successful experience at the $250,000 level, the Task Force finds that a cap at the level of $250,000 on a per incident basis will be effective.

The Task Force finds that actual and potential jury awards of non-economic damages (such as pain and suffering) are a key factor (perhaps the most important factor) behind the unavailability and un-affordability of medical malpractice insurance in Florida. The Task Force further finds that malpractice insurance premiums are a large component of the cost and availability of healthcare in Florida.

Based upon the evidence before it, including evidence of Florida's unsuccessful previous efforts to eliminate the ongoing medical malpractice crises, and the successful experiences of other states that have imposed caps on potential jury awards of non-economic damages, the Task Force finds that imposing caps on non-economic damages in medical malpractice cases will significantly reduce the exposure of Florida healthcare providers to risk of loss from jury awards of inherently subjective damages. Such a reduction of risk will make malpractice losses much more predictable, and thereby lead to stability in malpractice insurance premium rates.

A reduction in potential liability and resulting stability will encourage more malpractice insurers to participate in the Florida market. This, along with the reduced exposure to risk, will permit insurers to charge lower premiums, on a sound financial basis. Lower premiums will encourage providers (particularly those in high-risk specialties) to offer healthcare services to Floridians, and persons visiting this state, and to do so at lower prices.

The Task Force respectfully finds and concludes that the proposed recommendations will provide a benefit to the citizens of the State of Florida. The Task Force is of the opinion that, while these comprehensive reforms are important, the centerpiece and the recommendation that will have the greatest long-term impact on healthcare provider liability insurance rates, and thus eliminate the crisis of availability and affordability of healthcare in Florida, is a $250,000 cap on non-economic damages. The Legislature should

commission and fund a study of the impact cf the $250,000 cap on non-economic damages. An interim report should be submitted to the Legislature five years after date of enactment.

Chapter 1 - INTRODUCTION

"'The quality of medical care today is threatened by the pervasive, unwelcome, crushing embrace of the law. Every participant in the health care system is beset by an onslaught of new laws and regulations. Worst of all, because it is the most personal, physicians are forced to live with the specter of malpractice litigation constantly in their mind's eye. This legal assault has occurred so swiftly and has been implemented so harshly that it has begun to erase some of the very attractions long associated with pursuing a medical career—autonomy, independence, approbation, inquiry.' In sum, it is this peculiar combination of financial cost and psychological stress that has generated the passionate resentment that so many doctors feel toward the malpractice regime."

Paul C. Weiler, Medical Malpractice on Trial 7 (1991) (quoting Leon Rosenberg, Dean of the Yale Medical School)

The Governor's Select Task Force On Healthcare Professional Liability Insurance

Physicians and hospitals in Florida currently are experiencing a crisis in the availability and affordability of healthcare liability insurance. This crisis has adversely affected patient access to medical care in Florida.

Florida is among the states with the highest medical malpractice insurance premiums in the nation. This increase in healthcare liability insurance rates is forcing physicians to practice medicine without professional liability insurance, to leave Florida, to not perform high-risk procedures, or to retire early from the practice of medicine.

During the past three years, numerous healthcare liability insurance carriers in Florida have been liquidated, forced into rehabilitation, or have decided to stop selling medical malpractice insurance in Florida. Those companies that remain are quickly reaching capacity and are unable to expand their risk base to cover the physicians whose policies are being terminated by other companies. Recognizing this crisis existed, Governor Jeb Bush created a Task Force to study this crisis' effects and to offer solutions.

On August 28, 2002, Executive Order No. 02-241 created the Governor's Select Task Force on Healthcare Professional Liability Insurance (Task Force), which has the ultimate goal of "protecting Floridians' access to high-quality and affordable healthcare." Governor Jeb Bush directed the Task Force to:

- Examine Florida's healthcare liability insurance market, pertinent tort laws, claims, and premium data compared to other states of similar size and diversity;
- Assess the impact of the cost, accessibility, and availability of healthcare liability insurance on the cost, accessibility, and availability of high quality healthcare in this state;
- Examine specific strategies to ease the healthcare liability insurance crisis faced by Florida's physicians, hospitals and other healthcare providers; and
- Provide a written report and recommendations to the Governor, the President of the Senate, and the Speaker of the House of Representatives by January 31, 2003.

Task Force Appointments and Process

The five members of the Task Force are:

John C. Hitt, Ph.D., Chair
President, University of Central Florida

Richard A. Beard
Trustee, University of South Florida

Marshall Criser, Jr., J.D.
President Emeritus, University of Florida

Fred Gainous, Ph.D.
President, Florida A & M University

Donna E. Shalala, Ph.D.
President, University of Miami

During the past five months, the Task Force studied the history of medical malpractice, and the current medical malpractice insurance crisis in Florida, through extensive testimony, hundreds of letters, and its own independent research. Representatives of various healthcare professions, as well as those who have been injured as a result of medical mal-occurrences and their lawyers, spoke frequently and passionately about the medical malpractice insurance situation at publicly-noticed hearings throughout the state. The Task Force met on the following occasions:

- October 21, 2002 Orlando
- November 4, 2002 Miami
- November 22, 2002 Orlando
- December 3, 2002 Tallahassee
- December 20, 2002 Tallahassee
- January 8, 2003 Telephone Conference
- January 16, 2003 Tallahassee
- January 28, 2003 Telephone Conference
- January 29, 2003 Telephone Conference
- January 30, 2003 Telephone Conference

These meetings were designed to provide Task Force members with general background information about medical malpractice issues. In addition, the Task Force undertook a comprehensive review of published studies and relevant literature.

Task Force Overview

This current Task Force follows in the footsteps of two previous task forces and three previous task force reports that addressed this same problem. After reviewing the 1985, 1987, and1988 Task Force reports, the current Task Force was reminded of an often-quoted remark usually attributed to Yogi Berra: "Its *déjà vu* all over again." Indeed, many of the factual findings of the preceding panels are as valid today as they were fifteen years ago. If anything, the problem has only compounded.

At the December 20, January 8, January 16, January 28, January 29, and January 30 Task Force meetings, specific proposals were voted on for inclusion in the report. Those proposals were grouped into five broad categories:

- Quality healthcare reform
- Physician discipline reform
- Tort reform
- Alternative dispute resolution reform
- Insurance reform

The Task Force evaluated each proposal using the following criteria:

- Would the proposed change improve access to specialists, critical care providers, medical facilities for emergency care, obstetrical services, neurological services, or surgery?

- Would the proposed change facilitate the availability of malpractice insurance or other means for injured parties to recover reasonable compensation for injuries caused by the negligent acts of healthcare providers?

- Would the proposed change facilitate identifying and addressing healthcare provider problems as soon as possible to reduce or eliminate the risk to patients?

- Would the proposed change assist in reducing or holding down the cost of medical care to citizens and their health insurance providers to facilitate access to healthcare?

The background of the medical malpractice insurance problem as presented to the Task Force is included in chapters 1-4 of this report. A review of laws enacted by Florida and other states to address the problem is also included. The first four chapters also include definitions, testimonials, stakeholder perspectives at the national level, a review of

Florida's past legislative action, a summary of the testimony and letters received, and research conducted by the current Task Force.

Task Force policy recommendations are presented in chapters 6-10. These recommendations were derived from careful deliberations of testimony, letters, and research presented to the Task Force. The Task Force conclusion and recommendations are presented in chapter 11.

In addition to this report, the Task Force is submitting thirteen volumes containing reports, presentations, letters, and testimony received by the Task Force. These volumes will be submitted along with the report to the Governor, the President of the Senate, the Speaker of the House of Representatives, and the legislative library.

The Task Force has taken great care to conform its recommendations to the requirements of the Florida Constitution and case law to ensure the continued success of the necessary reforms recommended herein. Any legislation seeking to reform the current system of remuneration for medical malpractice damages must take into consideration important limitations on such initiatives presented under the requirements of the Florida Constitution. These requirements have been explained in several Florida Supreme Court decisions, which the Task Force discusses, where relevant, in chapters 6 through 10.

Chapter 2 - MEDICAL MALPRACTICE: THE NATIONAL PERSPECTIVE

"[From 1840 and 1860 the number of malpractice cases . . . roared ahead 950%.] The vast majority of lawsuits . . . involved orthopedic cases in which a limb had healed to a shortened, deformed or frozen position following compound fracture. . . . Patients found themselves with an unambiguous . . . problem and sued the physicians who had set their bone fragments and dressed their wounds. What made this situation ironic was that 20 years earlier, most compound fractures would have been amputated. The patient would have had no limb at all, but no malpractice case either, since the physician would have been following safe and standard procedures."

James C. Mohr, American Medical Malpractice Litigation in Historical Perspective, 283(13) Journal of the American Medical Association 4 (April 5, 2000)

Medical Malpractice Synopsis

A claim for medical malpractice means a claim arising out of the rendering of, or the failure to render medical care or services.[1] An "action for medical malpractice" is a tort or contract claim for damages due to the death, injury, or monetary loss to any person arising out of any medical, dental, or surgical diagnosis, treatment, or care by any provider of healthcare.[2]

In any action for recovery of damages based upon medical malpractice, the claimant has the burden of proving the alleged actions of the healthcare provider represented a breach in the prevailing standard of care for that healthcare provider. The prevailing professional standard of care for a given healthcare provider is that level of care, skill, and treatment which, in light of all relevant surrounding circumstances, is recognized as acceptable and appropriate by reasonably prudent, similar healthcare providers.[3]

There is a threefold purpose for medical malpractice awards:

[1] Section 766.106(1)(a), Florida Statutes.
[2] 36 Florida Jurisprudence 2d Medical Malpractice, section 1 (2002).
[3] Section 766.012(1), Florida Statutes.

- Compensate the injured
- Deter further injuries
- Gain retribution.[4]

Most commentators agree that compensation is the paramount goal of medical malpractice awards.[5] Malpractice awards can be divided into two categories:

- Prevention costs
- Injury costs.[6]

Prevention costs are those expenditures made to reduce the number of future injuries.[7] In other words, by assessing penalties for failure to use the prevailing standard of care, the system is designed to send a message to healthcare providers that they will bear the cost of such failure.[8] Additionally, the healthcare provider is required to balance the cost of preventing the injury against the cost of paying the injured patient through the tort system.[9] In a non-medical business transaction or purchase of goods or services the consumer can evaluate the risks of making the purchase and from whom they want to make the purchase. In a medical environment where the professional has specialized knowledge and expertise, the consumer typically lacks information to make that evaluation.[10]

"In a simple model, with perfect information and homogenous physicians, a negligence rule of liability with an appropriately defined due care standard should induce complete compliance: there should be no malpractice, no malpractice claims and no demand for malpractice insurance."[11]

Although the medical malpractice system is designed to prevent injuries, empirical evidence proving it does is often lacking.[12] One speaker addressing the Task Force noted, "One reason for the paucity of information on the system's performance in deterring injuries, compensating victims, and providing a safety valve for victims' grievances is that the requisite data are so difficult and expensive to

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[4] Vasanthakumar N. Bhat, Medical Malpractice 10 (2001).
[5] Id.
[6] Id.
[7] Id.
[8] Frank A. Sloan et al., Suing for Medical Malpractice 1 (1993).
[9] Patricia M. Danzon, Medical Malpractice: Theory, Evidence, and Public Policy 9 (1985).
[10] Id.
[11] Patricia M. Danzon, Liability for Medical Malpractice, 5(3) Journal of Economic Perspectives 51 (Summer 1991).
[12] Frank A. Sloan et al., Suing for Medical Malpractice 1 (1993).

collect. Or more cynically, the various interested parties do not want to let the facts interfere with their arguments."[13]

Injury costs can be further divided into the following four categories: (1) medical and non-medical costs, (2) morbidity costs, (3) mortality costs, and (4) costs of pain and suffering.[14] Examples of medical costs would include: hospital care, physician examinations, prosthetics, occupational therapy, and so on. Examples of non-medical costs might include home modifications.[15] Morbidity costs are the value of goods and services a person would have produced if that person were not injured.[16] Mortality costs are the net present value of future earnings lost due to death.[17] Pain and suffering costs are meant to compensate a plaintiff for emotional distress caused by injury. Examples would include: worry, anxiety, embarrassment, and the loss of the pleasures and enjoyment of life.

Prevention costs are those monies spent on reducing injuries. Examples of these costs would include: costs of physician discipline, continuing medical education, additional testing, and so on.[18] The supposed goal of the medical malpractice system is to reduce injury and prevention costs.[19]

Medical Malpractice: A National Crisis

Affordability and Availability of Insurance

Although the concept of holding a physician responsible for medical malpractice may seem like a new phenomenon, it has actually been around since the beginning of time. The first instances of holding medical providers liable for their mistakes occurred in the second century B.C.[20] According to the Babylonian legal code of Hammurabi, healthcare providers could be punished for the death or injury of a patient.[21] For example, a physician's finger could be cut off if he caused someone to die, and a nurse had to sacrifice her breasts if she accidentally exchanged two infants at birth.[22]

The first recorded malpractice lawsuit in the United States occurred in 1794 in Connecticut, and involved a surgeon named Guthrie and a plaintiff

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[13] Id. at 2.
[14] Id.
[15] Id.
[16] Id.
[17] Id.
[18] Id.
[19] Guido Cabresi, The Cost of Accidents (1970).
[20] Vasanthakumar N. Bhat, Medical Malpractice 5 (2001).
[21] Id.
[22] Id., citing Marshall B. Kapp, Our Hands Are Tied: Legal Tensions and Medical Ethics 142 (1998).

named Cross.[23] After Mr. Cross' wife expired, he sued Dr. Guthrie, and a jury awarded him 40 pounds for loss of companionship.[24]

Although physicians have faced medical malpractice lawsuits for centuries, medical malpractice only became a focus on the part of policy makers in the latter part of the twentieth century.[25] However, some have argued that medical malpractice actually became a crisis as early as 1835.[26] There were 217 medical malpractice cases in federal appellate courts between 1790 and 1900.[27] That figure rose to 1,712 cases between 1900 and 1955.[28] Median jury awards calculated in 1999 dollars rose from $7,425 between 1843-1849 to $478,483 between 1935 and 1955.[29] This explosion in litigation was partially fueled by the decisions of the courts. "Between 1794 and 1861 various state supreme courts heard 27 malpractice appeals. Through their decisions, courts raised the applicable standard of care that physicians were required to use in the care of patients to a level consistent with modern medical practice. This upgraded standard of care fueled an increase in malpractice claims."[30]

The 1970s saw a sudden increase in medical malpractice cases. For the period between 1935 and 1975, 80 percent of all medical malpractice suits were filed during the last five years. This increase in claims caused significant losses to insurance companies, resulting in medical malpractice insurance companies and many of the commercial insurers leaving the market.[31] "[P]hysicians began to perceive the increase in the number, and size of malpractice claims as a growing threat to their profession. In response, members of the medical community instigated job actions, strikes, and sit-downs. Physicians, insurance companies, and state legislators referred to this phenomenon as a 'medical malpractice crisis.' Hospital malpractice insurance premiums rose from $61 million in 1960 to $1.2 billion in 1976. Additionally, insurance premiums for physicians skyrocketed."[32] By 1975, there were serious concerns as to whether

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[23] Vasanthakumar N. Bhat, Medical Malpractice 5 (2001), citing Frank J. Edwards, Medical Malpractice: Solving the Crisis 15-16 (1989).
[24] Id.
[25] Id.
[26] Id. at 26, citing Allen D. Spiegel & Florence Kavaler, America's First Medical Malpractice Crisis, 1835-1865, 22(4) Journal of Community Health 288 (Aug. 1997).
[27] Vasanthakumar N. Bhat, Medical Malpractice 5 (2001).
[28] Id.
[29] Id.
[30] Daryl L. Jones, Fein v. Permanente Medical Group: The Supreme Court Uncaps the Constitutionality of Statutory Limitations on Medical Malpractice Recoveries, 40 University of Miami Law Review 1075, 1077 (1986).
[31] Lawrence E. Smarr, testimony before the Subcommittee on Commercial and Administrative Law of the House Committee on the Judiciary (June 12, 2002).
[32] Daryl L. Jones, Fein v. Permanente Medical Group: The Supreme Court Uncaps the Constitutionality of Statutory Limitations on Medical Malpractice Recoveries, 40 University of Miami Law Review 1075, 1077-1078 (1986).

insurers would continue to offer liability insurance for medical malpractice. In states seriously impacted by the rise in medical malpractice cases, insurers claimed that providing malpractice insurance was risky and unprofitable.[33]

In 1973, the federal government concluded its first extensive study of the medical malpractice crisis. Its findings noted:

> In part, [the increase] was due to the simple fact that many more people were able to afford, and received, medical care, automatically increasing the exposure to incidents that could lead to suits.
>
> At the same time, innovations in medical science increased the complexities of the health care system. Some of the new diagnostic and therapeutic procedures brought with them new risks of injury; as the potency of drugs increased, so did the potential hazards of using them. Few would challenge the value of these advances, but they did tend to produce a concomitant number of adverse results, sometimes resulting in severe disability.[34]

In the 1980s, medical malpractice insurance premiums were once again growing rapidly with an increase in the frequency of claims, and the size of malpractice awards and settlements.[35] A study performed by the United States General Accounting Office in 1985 reported that total medical malpractice insurance costs for physicians and hospitals had increased from $2.5 billion in 1983 to $4.7 billion in 1985.[36] However, they also found the increases in insurance rates varied greatly by specialty and by state: "As of July 1, 1985, malpractice rates of $50,000 and above per year were concentrated in three specialties— obstetrics/gynecology, neurosurgery, and orthopedic surgery, and in Florida, Illinois, Michigan, New York, and the District of Columbia."[37] Plaintiff's representatives argued the increases were due to medical negligence and excessive profits of malpractice insurers.[38] The medical insurers argued the insurance premiums reflected funds needed to cover current, and anticipated future loss payments.[39]

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[33] Id. at 1078.
[34] Medical Malpractice: Report of the Secretary's Commission on Medical Malpractice 3 (1973).
[35] U.S. General Accounting Office, Medical Malpractice: A Framework for Action 8 (May 1987) (Vol. 1, Tab 10).
[36] Id.
[37] Id. at 9.
[38] Id.
[39] Id.

Now in this new millennium, medical providers are again facing a crisis in the availability and affordability of professional liability insurance, which is negatively impacting the provision of healthcare. Medical care is becoming less accessible, tests and treatments are occurring beyond what may be medically necessary, and the critical evaluation of the healthcare system is inhibited by a fear of increased litigation. This contributes to a deterioration of the healthcare system with increased costs to the patient, and his or her healthcare provider.

Availability of Care

Physicians are closing their practices or scaling back services, and hospitals are eliminating services because they are unable to find physicians willing or able to carry the required insurance.[40] A 2002 survey of physicians revealed that one-third of the doctors surveyed avoided practicing a certain specialty, because they feared it would subject them to greater liability exposure.[41]

Defensive Medicine

Patients are enduring and paying for additional tests and treatments that may be unnecessary as doctors practice defensive medicine to avoid potential malpractice claims. According to a physician survey, more than 76 percent of the respondents were concerned that malpractice litigation has hurt their ability to provide quality care to patients.[42] Seventy-nine percent indicated they had ordered more tests than they might otherwise believe were medically necessary.[43] Seventy-four percent stated they had referred patients to specialists more often than was medically necessary.[44] Further, 51 percent indicated they had recommended invasive procedures to confirm diagnoses more often than may have been medically necessary, 41 percent had prescribed more medications, and 73 percent had noticed other doctors similarly prescribing more medication than may be medically necessary.[45]

Empirical analysis of the extent to which the medical malpractice process has had an impact on the decisions healthcare providers make in treating patients, which could be classified as defensive medicine, has proved to be very difficult. A number of studies have attempted to use various

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[40] U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, Confronting the New Healthcare Crisis: Improving Healthcare Quality and Lowering Costs By Fixing Our Medical Liability System 2-4 (July 24, 2002).
[41] Id. at 4.
[42] Id.
[43] Id.
[44] Id.
[45] Id.

analytical methods to examine the practice of defensive medicine, and the results of those studies are heavily challenged.[46] In fact, it has been suggested that the incidence of defensive medicine may have diminished, if it ever occurred, as a result of managed care.[47]

However, one study did attempt to perform such an analysis. Claims regarding defensive medicine were examined at an empirical level in a 1996 study entitled Do Doctors Practice Defensive Medicine?[48] The study examined the impact of medical malpractice reforms in treatment of cardiac illness in the elderly.[49] The report found "malpractice reforms that directly reduce provider liability pressure led to reductions of 5 to 9 percent in medical expenditures without substantial effects on mortality or medical complications." [50] If reforms, such as caps on damages, abolition of punitive damages, no mandatory prejudgment interest, and reform of the collateral source rule, had been applied throughout the United States between 1984 and 1990, the study projected expenditures on cardiac disease would have been lowered by $450 million per year in each of the first two years after adoption, and close to $600 million per year for years three through five.[51]

Cost of Care

These reductions in healthcare services and the use of defensive medicine along with the increased cost of malpractice insurance result in an excessively expensive healthcare system. In 2000, doctors spent $6.3 billion in direct costs on medical malpractice insurance, which does not include the amounts spent on insurance by hospitals and nursing homes.[52] The U.S. Department of Health study calculated that the 5 to 9 percent reduction in costs of medical malpractice insurance could result in saving $60 billion to $108 billion in healthcare costs nationwide each year.[53]

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[46] Michelle M. Mello & Troyen A. Brennan, Deterrence of Medical Errors: Theory and Evidence for Malpractice Reform, 80 Texas Law Review 1595 (2002).
[47] Id. at 1607.
[48] Daniel Kessler & Mark McClellan, Do Doctors Practice Defensive Medicine?, The Quarterly Journal of Economics (May 1996).
[49] Id. at 367-368. Cardiac illness was selected for study because the researchers found that at the time it was the leading cause of medical expenditures and mortality in the United States. The elderly were chosen because of the frequency of this illness in the elderly providing a broad base of homogenous data for study.
[50] Id. at 370. The study classified tort reform changes into those believed to directly reduce malpractice awards and those believed to only reduce awards indirectly. The direct changes were those that cut off the upper levels of awards or otherwise reduced the amount of the award. These included: caps on damages, abolition of punitive damages, collateral source rule reform, and abolition of mandatory prejudgment interest. The indirect changes included: caps on contingency fees, mandatory periodic payments, reform of joint and several liability and patient compensation funds.
[51] Id. at 387.
[52] Id. at 7.
[53] Id.

These cost savings would positively impact the cost of medical malpractice insurance, and the cost of healthcare insurance to businesses and individuals.

The rapid rise in malpractice insurance rates has particularly impacted internists, general surgeons, and obstetricians/gynecologists, who have seen increases averaging 20 percent in December of 2001 on top of increases ranging from 11 percent to 17 percent in July 2000, and averaging 10 percent in July 2001.[54] It should be noted that the insurance premium increases are much higher in states without caps, and it particularly should be noted how rates in non-cap states compare to the insurance rates in California. California (a state with caps on non-economic damages) has much lower annual premiums for physicians.

Table 1

States with High Annual Premiums in 2001 by Specialty

Compared to California

	OB/GYN	Surgeon	Internists
Florida	$143K-203K	$63K-159K	$27K-51K
Michigan	$87K-124K	$67K-94K	$18K-40K
Illinois	$89K-110K	$50K-70K	$16K-28K
Ohio	$58K-95K	$33K-60K	$11K-16K
Nevada	$60K-95K	$32K-57K	$9K-16K
New York	$34K-115K	$19K-63K	$6K-22K
West Virginia	$63K-85K	$44K-56K	$8K-16K
California	**$23K-72K**	**$14K-42K**	**$4K-16K**

Source: Medical Liability Monitor's "Trends in 2001 Rates for Physicians' Medical Professional Liability Insurance," Vol.25, No. 10, October 2001.

Debate

Pressure groups have different perspectives on the medical malpractice debate depending on how malpractice affects their economic, social, political, and professional interests.[55] It seems there is little common ground between the different warring factions on this debate. In sum, the only point of agreement is that the medical malpractice system has failed as a compensation mechanism. The majority of testimony echoes the following themes:

[54] Id. at 12.
[55] Vasanthakumar N. Bhat, Medical Malpractice 7 (2001).

- The medical malpractice system does not reduce medical errors.[56]

- The medical malpractice system does not allow parties to learn from their mistakes.[57]

- The medical malpractice system does not adequately compensate the injured.[58]

- The medical malpractice system is in reality nothing more than "jack pot justice."[59]

- The medical malpractice system leads to unnecessary defensive medicine.[60]

- The medical malpractice system takes too long to resolve claims.[61]

- The medical malpractice system benefits the lawyers and not the injured.[62]

- The medical malpractice system makes it too difficult for the truly injured to bring suit.[63]

- The medical malpractice system is too costly.[64]

- The medical malpractice system leads to awards that are subjective and variable.[65]

In sum, there are various perspectives of this debate. Some interest groups offer concrete methods of reform, while others only offer vague proposals.

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[56] Steve Demontmolin, J.D., testimony, Oct. 21, 2002, pg. 112. In a national poll of physicians, the overwhelming majority of doctors say that the threat of malpractice lawsuits does not make them deliver better quality care.

[57] Troy Tippet, M.D., testimony, Oct. 21, 2002, pg. 90; Nick Bartol, testimony, Oct. 21, 2002, pgs. 139-141.

[58] Jackson Williams, testimony, Oct. 21, 2002, pg. 154; George Meros, J.D., testimony, Oct. 21, 2002, pg. 249.

[59] Robert Cline, M.D., testimony, Oct. 21, 2002, pgs. 23-24; David McKenney, testimony, Oct. 21, 2002, pg. 193.

[60] David Lubben, J.D., testimony, Oct. 21, 2002, pgs. 107-108.

[61] Richard Anderson, M.D., testimony, Nov. 4, 2002, pg. 52.

[62] George Meros, J.D., testimony, Oct. 21, 2002, pg. 249 (noting that, after a 40 percent contingency fee and costs are considered, patients often receive only 30 to 45 percent of an award).

[63] Jackson Williams, testimony, Oct. 21, 2002, pgs. 157-159.

[64] Robert Yelverton, M.D., testimony, Oct. 21, 2002, pgs. 55-60.

[65] Charles Bond, J.D., testimony, Nov. 4, 2002, pg. 67.

Some interest groups merely offer anecdotal data to support their position, while others offer hard data.

Medical Malpractice Law

Attempts to Address the Problem

No examination of this, the third medical malpractice insurance crisis in thirty years, can be complete without an examination of legislative attempts to address the problem in the past. Major changes in law were adopted in the 1970s and 1980s throughout the country, and legislatures hoped those changes would reduce the incidence of medical malpractice, provide for better run insurance companies, and would reduce the severity and frequency of claims. These reforms were intended to provide more stability and predictability in the insurance market, thus ensuring medical malpractice insurance would be available and affordable for medical professionals and healthcare institutions. In the early to mid 1990s, it appeared the desired result had been achieved, but as the country moved into the second half of the 1990s, the cost of personal injury generally, and specifically medical malpractice insurance, began to raise concerns again. Then in the late 1990s the Institute of Medicine released a report, To Err is Human, raising the issue of medical malpractice to new heights,[66] and in response, states enacted significant patient protection measures.

The reforms enacted over this thirty-year period can be categorized as quality-of-care reforms, healthcare provider discipline reforms, tort reforms, alternative dispute resolution reforms, and insurance reforms.

Many of these reforms, particularly the tort reform issues, were strenuously opposed in the state legislatures and once enacted many were attacked on constitutional grounds with some reforms stricken by state supreme courts.[67]

Healthcare quality improvement

Mandatory Reporting: In 1999, in response to the report To Err is Human, published by the Institute of Medicine, twenty-six state legislatures enacted patient safety reforms. Most of the reforms required reporting of hospital-based events that caused serious injury or death.[68] However, the

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[66] Mimi Marchev, National Academy for State Health Policy, The Medical Malpractice Insurance Crisis: Opportunity for State Action (July 2002).
[67] Daryl L. Jones, Fein v. Permanente Medical Group: The Supreme Court Uncaps the Constitutionality of Statutory Limitations on Medical Malpractice Recoveries, 40 University of Miami Law Review 1075, 1079 (1986).
[68] Common Good, The Effects of Law on Health Care (2002).

medical community has strongly objected to reporting unless it is voluntary and confidential.[69]

National Practitioner Database: The nation ' practitioner database was established in the Health Care Quality Improvement Act of 1986, to provide for reporting of claims and disciplinary actions against healthcare providers. The database was created so hospitals could determine the claims experience of doctors before allowing a doctor to provide services through the hospital. This was done to prevent doctors with numerous claims from simply moving to a new area and continuing in practice.[70] Additionally, the Health Insurance Portability and Accountability Act of 1996 created the Healthcare Integrity and Protection Data Bank. This data bank collects information regarding a person's exclusion from participation in federal and state healthcare programs, convictions and civil judgments and other adjudicative actions relating to fraud and abuse in healthcare insurance and delivery.

Healthcare provider discipline

Regulation through Boards or Councils: In the United States, most regulatory entities that police healthcare practitioners and the practice of the profession are commonly called "boards" or "councils." These boards or councils operate at arms-length from the government or explicitly through individual state statute. Members of these boards are generally members of the profession and/or the public. Irrespective of the jurisdiction, a number of common characteristics are found in the laws of the regulatory boards or councils:

- Boards are mandated to regulate the practice of a given profession in the public interest. Differing boards or councils may use different models of governance, however, the basic roles are to set policy direction and to oversee its function.
- Boards set standards for entry into the profession and ensure that practitioners offering healthcare services meet those standards.
- Registration is required, without which a person may not be entitled to practice the profession, and it is commonly in the form of a certification or license.
- Board members perform adjudicative responsibilities in determining guilt with respect to those practitioners who fail to meet the standards of practice or are accused of misconduct, incompetence, or incapacity.[71]

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[69] Mimi Marchev, National Academy for State Health Policy, The Medical Malpractice Insurance Crisis: Opportunity for State Action 18 (July 2002).
[70] Common Good, The Effects of Law on Health Care (2002).
[71] Barbara Smith, Council on Licensure, Enforcement, and Regulation (CLEAR), Role of a Person: The Governing Body of a Regulatory Entity (2000).

Professional regulation is generally a state's right. Although the federal government has taken some interest in healthcare regulation, the majority of disciplinary regulation is structured through individual state statutes. Former President Clinton's proposal for a federal override of state licensing laws attracted opposition from many stakeholders including professional associations; individual state licensing boards; the Council on Licensure, Enforcement and Regulation; and the Federation of State Medical Boards. Thus, disciplinary regulation has been left primarily to the individual states for licensure standards and regulatory discipline.[72]

Tort reforms

Statute of Limitations: During the 1975 medical malpractice reforms states shortened the statutes of limitations to reduce the number of potential claims. The statutory time periods generally adopted were from one to four years and the time from which the statute of limitations was measured varied from state to state. Some states used the date treatment was completed; others used the date of the act causing the injury; the date of the injury; or the date the injury should have been discovered.[73] Additionally, most states included a statute of repose to set the limit for bringing a claim regardless of when the injury had been discovered.[74]

Ad Damnum Clauses: This is a clause in a complaint stating the amount of damages claimed.[75] Generally, when a lawsuit is filed the complaint sets out the amount of damages the plaintiff is seeking to recover. In the early 1970s, these clauses were believed to influence the jury when the amounts requested were large.[76] Thus, in the 1975 malpractice reforms, states prohibited plaintiffs from including the amount of damages sought in the complaint.[77]

Collateral Sources: The so called "collateral source rule" prohibits the defendant from informing the jury that a plaintiff has or will recover damages for the plaintiff's injuries from some source other than the defendant. "Collateral sources" are often insurance policies the plaintiff or the plaintiff's employer has paid for or in some cases government benefits such as Medicaid, Medicare, or possibly military benefits. In 1975, a number of states altered the "collateral source rule" in one of two ways. The more common change allowed the defendant to introduce evidence of

[72] Richard Morrison, Council on Licensure, Enforcement, and Regulation (CLEAR), Webs of Affiliation: The Organizational Context of Health Professional Regulation (2000).
[73] Barry L. Anderson et al., Florida Medical Association, Medical Malpractice Policy Guidebook 56 (1985).
[74] Id. at 57.
[75] Black's Law Dictionary 37 (6th ed. 1990).
[76] Id.
[77] Id.

collateral payments and allowed the plaintiff to introduce evidence regarding the cost of the insurance and whether the insurance company had a subrogation right against any award of damages from the plaintiff.[78] The second type provided credit would be given against a judgment for some or all of the collateral sources, but no evidence of the collateral sources would be presented to the jury.[79] Thirty-four states passed changes to the collateral source rule but in three states those changes were found to be unconstitutional.[80]

Attorneys' fees: Most medical malpractice cases are funded on a contingency basis with the attorney not collecting fees or costs unless or until the plaintiff receives payment for damages. The 1975 medical malpractice acts often included a limit on the amount of the attorney contingency fees. The variations adopted included authorizing either party to request the court to review the other parties' attorneys' fees, establishing standards for the courts to use in reviewing contingency fees, and setting a fee schedule either as a flat percent of the award or a sliding scale.[81] Sixteen states have adopted some limits on attorneys' fees.[82]

Limitation on Recovery (Caps): Another method used to control the cost of medical malpractice insurance was caps on recovery for damages. Most of the states imposing caps limited recovery for non-economic damages and the caps ran from $150,000 to $750,000. California limited only non-economic damages to $250,000. Louisiana limited the recovery, excluding future medical care, to $500,000. Over the years, thirty-two states have adopted caps on damages. The courts in seven states, including Florida, found the caps to be unconstitutional.[83] A study performed by Patricia M. Danzon[84] found "[t]he average impact of the various statutes to cap all or part of the plaintiff's recover has been to reduce average severity by twenty-three percent."[85]

Periodic Payments: Another major component common to many states' medical malpractice reforms was a provision allowing periodic payment

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[78] Id. at 58.
[79] Id.
[80] Mimi Marchev, National Academy for State Health Policy, The Medical Malpractice Insurance Crisis: Opportunity for State Action (July 2002).
[81] Barry L. Anderson et al., Florida Medical Association, Medical Malpractice Policy Guidebook 59 (1985).
[82] Mimi Marchev, National Academy for State Health Policy, The Medical Malpractice Insurance Crisis: Opportunity for State Action (July 2002).
[83] Id.
[84] Patricia M. Danzon, The Frequency and Severity of Medical Malpractice Claims: New Evidence, 49(2) Law and Contemporary Problems 76 (Spring 1986).
[85] Id.

of damage awards.[86] This allowed payments for awards for future medical or future lost wages to be paid over time rather than in a lump sum.[87] The distinguishing characteristic of the various state laws was whether the payments ended on the death of the plaintiff or if that portion related to future expenses ended while payments for future pain and suffering or other damages were made to the plaintiff's estate.[88] At least 28 states have adopted some type of periodic payment of damages.[89]

Informed Consent: Prior to performing a medical procedure on a patient the doctor should have the patients "informed" consent. For the consent to be considered "informed" the patient must be told of the risks related to the procedure to be performed. When reviewing whether the patient has been properly informed of the risk, courts often look to what the "reasonable patient" would want to know. Some state legislatures changed the standard for determining whether the consent had been "informed" from the "reasonable patient" standard to what a "reasonable doctor" would have told the patient.[90]

Res Ipsa Loquitor: More than a dozen states tried to clarify that the burden of proving fault for medical malpractice remained with the plaintiff even when the court applied the *res ipsa loquitor* rule to find some actions carried a presumption of malpractice.[91] *Res ipsa loquitor* literally means "the thing speaks for itself." Under this doctrine, when a thing which causes injury, without fault of the injured person, is shown to be under exclusive control of the defendant, and injury is such that in the ordinary course of things it does not occur the defendant is presumed to have caused the harm.[92] An example in the medical malpractice setting would be a surgical sponge left in a patient after surgery.

Joint and Several Liability: Joint and several liability provides that all of the individuals or entities responsible for an injury are liable for the full amount of any judgment. If any liable party cannot pay his or her portion of the judgment the other defendants are responsible for the amount owed.[93] The doctrine is based on the premise that the plaintiff should be fully compensated for the injury and the plaintiff should not be required to bear the burden of an insolvent defendant.[94] Comparative fault provides

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[86] Barry L. Anderson et al., Florida Medical Association, Medical Malpractice Policy Guidebook 65 (1985).
[87] Id.
[88] Id.
[89] Mimi Marchev, National Academy for State Health Policy, The Medical Malpractice Insurance Crisis: Opportunity for State Action (July 2002).
[90] Barry L. Anderson et al., Florida Medical Association, Medical Malpractice Policy Guidebook (1985).
[91] Id.
[92] Black's Law Dictionary 1305 (6th ed. 1990).
[93] 32 Florida Jurisprudence 2d 448.
[94] Id.

that each defendant is only responsible for the portion of damages assigned by the jury or court to that defendant.[95] Some states have abrogated either partially or fully the doctrine of joint and several liability with "comparative fault." In two of those states the changes were found to be unconstitutional.[96]

Standard of Care: Courts in some states eliminated the requirement that a healthcare provider accused of malpractice should be judged against the standard of care prevalent in the doctor's community or a similar community. Legislatures in about a dozen states passed laws to return to the community standard of care in medical malpractice cases.[97]

Alternative dispute resolution reforms

Medical Review Panels: Medical review panels were created in some states to review medical malpractice claims outside the court system.[98] Review panels generally consisted of medical providers, attorneys, and at times, lay members.[99] The panels would hear testimony on the case and in some states the panel decided liability only; in some states the panel decided liability and damages; but in most states the panels simply made a recommendation that was admissible at trial.[100] Currently, eleven states have pre-trial screening through a medical review panel.[101]

Arbitration: Some states attempted to address faster resolution of medical malpractice claims by providing for a pre-suit arbitration process. In some states the arbitration was mandatory and in other states, such as Florida, the choice as to whether to enter into pre-suit arbitration was voluntary.[102] Currently, twenty-two states have some pre-suit arbitration process.[103]

Insurance reforms

Patients' Compensation Fund: Some states capped recovery using a patients' compensation fund. In those states using a patients compensation fund it served as a state insurance fund to address the medical malpractice insurance crisis. The money for the fund was

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[95] Id.
[96] Mimi Marchev, National Academy for State Health Policy, The Medical Malpractice Insurance Crisis: Opportunity for State Action (July 2002).
[97] Id.
[98] Barry L. Anderson et al., Florida Medical Association, Medical Malpractice Policy Guidebook 61 (1985).
[99] Id. at 58.
[100] Id.
[101] Mimi Marchev, National Academy for State Health Policy, The Medical Malpractice Insurance Crisis: Opportunity for State Action (July 2002).
[102] Section 766.207, Florida Statutes.
[103] Id.

collected from either participating healthcare providers, specified providers, or from all healthcare providers.[104] The fund generally served as a second tier of insurance to cover the healthcare provider when a claim exceeded the provider's insurance limits.[105] Usually, a medical provider had to qualify for coverage by maintaining certain insurance limits, and paying into the fund. When the amount of the fund was exceeded for a given year, the states provide various methods for addressing any shorfall; the claimants share in the fund on a pro rata basis, additional assessments were made to cover any shortfall, or the shortfall was carried over to successive fiscal years until paid.[106] Currently ten states have this system.[107] Florida has a patient's compensation fund but no doctors are participating at this time.

No-Fault Systems: Florida and Virginia adopted no-fault systems for payment for injuries to newborns with severe birth-related neurological impairments.[108] These systems provide that an obstetrician may elect to participate in this no-fault program.[109] To participate in the program a physician must either pay or be exempt from paying the assessment for the year coverage is sought. Further, the physician must provide notice to patients of participation in the no-fault program.[110] The program covers infants who suffer a "birth-related neurological injury."[111] The issues addressed regarding a claim are whether the physician is a participating physician, whether the injury is a covered injury, and how much compensation, if any, is awardable.[112] The program provides compensation to the parents or legal guardian of up to $100,000, and provides for lifetime care of the child and a set amount for funeral expenses.[113]

Joint Underwriting Associations (JUAs): This is a type of insurance program that provides insurance to healthcare providers who cannot otherwise obtain private insurance. JUAs are generally state-run insurance companies of last resort, funded by premiums, and when necessary assessments. JUAs are usually set up as non-profit pooling arrangements created by state legislatures. Although created by a number of states as

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[104] Barry L. Anderson et al., Florida Medical Association, Medical Malpractice Policy Guidebook 64 (1985).
[105] Id.
[106] Id.
[107] National Governors Association, Center for Best Practices, Health Policy Studies Division (Dec. 2002).
[108] Barry L. Anderson et al., Florida Medical Association, Medical Malpractice Policy Guidebook (1985).
[109] Section 766.302(7), Florida Statutes.
[110] Id.
[111] Id.
[112] Section 766.309(1), Florida Statutes.
[113] Sections 766.309, 766.31, Florida Statutes.

interim measures during the mid-1970s, JUAs continue to exist in many states.[114]

The effectiveness of these various reforms have been debated by pressure groups in the halls of Congress and in almost every state capitol. One study to look at the effect of 1970s-era changes was performed by Patricia Danzon. [115] Professor Danzon concluded:

- states with caps on awards had awards 19 percent lower two years after the effective date of the statues;
- states with contingency fee limits had a somewhat lower amount paid per claim and total claim cost;
- states eliminating the *ad damnum* clause had lower total claim costs; there was otherwise no effect on the frequency or amount paid per claim;
- states requiring collateral source offset had 50 percent lower awards two years after the statute's effective date, but states admitting evidence of collateral sources without required offset displayed no significant effect;
- several other reforms displayed no significant effects, including pretrial screening panels, arbitration, *res ipsa loquitur* or informed consent limitations, and periodic payments.

Another study done by Patricia Danzon updated her earlier studies based upon analysis of claims nationally over the decade 1975 to 1984. The study examined up to forty-nine states, based on data from insurance companies that insured approximately 100,000 physicians.[116] Her conclusions were:

- the severity of claims rose twice as fast as the Consumer Price Index, a fact related to a rise in healthcare prices that was faster than consumer prices, generally;
- claim severity continued to be higher in urbanized states, consistent with earlier studies, and was also higher in states "with a high ratio of surgical specialists relative to medical specialists";[117]
- severity was less in states with large elderly populations, a fact related to the low wage loss of the elderly and the low potential for damages in a tort suit;

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[114] B.R. Furrow et al., Health Law: Cases, Materials and Problems 4 (2001).
[115] Patricia Danzon, The Frequency and Severity of Medical Malpractice Claims (1982).
[116] Patricia Danzon, The Frequency and Severity of Medical Malpractice Claims: New Evidence, 49 Law & Contemporary Problems 57 (1986).
[117] Id. at 76.

- no correlation was found between the number of lawyers per capita and claim severity;
- the newer data was consistent with earlier findings as to the impact of tort reforms. Statutory caps reduced average severity by 23 percent. Collateral source offsets appeared to reduce awards by a range of 11 to 18 percent. Arbitration reduced claim severity by 20 percent, compared to states without such statutory arbitration. Screening panels did not have a consistent effect in reducing claims severity.

The ultimate conclusions as to the merits and nature of reform still depend upon the goals sought for the system.[118] Some of the reforms, such as caps and collateral source offset, appear to have slowed the growth of awards in some states. Some reforms, such as statutes of repose, reduced claim filings over the longer term.[119]

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[118] B.R. Furrow et al., Health Law: Cases, Materials and Problems 27 (2001).
[119] Id.

Chapter 3 - MEDICAL MALPRACTICE INSURANCE

"St. Paul Companies, which was the largest malpractice carrier in the United States, covering 9% of doctors, announced in December 2001 that it would no longer offer coverage to any doctor in the country."

U.S. Department of Health and Human Services, Confronting the Health Care Crisis: Improving Health Care Quality and Lowering Costs by Fixing Our Medical Liability System 14 (July 24, 2002)

Insurance

No analysis of the medical malpractice crisis could be done without a basic explanation of how medical malpractice insurance works. Medical malpractice insurance (as with all insurance) is about risk.[120] Medical malpractice insurance is meant to cover low-frequency, high-severity risk.[121] Medical malpractice insurance covers only the damage deemed the responsibility of the insured policyholder.[122] Unlike a typical insurance policy, claims are not filed with an insurance company. Instead, a claimant enters the complex world of tort law, where juries determine damages, or cases are settled in expectation of what juries might do.[123] Typically, there is a significant amount of time between premiums being paid and claims being paid out.[124] As a result, malpractice insurers have the opportunity to make money by investing premium dollars.[125] The variations in the investments can significantly affect the malpractice premiums a physician pays each year.[126]

The insurer is in the business of risk bearing and risk management.[127] A healthcare provider purchases malpractice insurance to pass the risk of that provider making a mistake on to the insurer. The insurer, when selling the insurance policy, must assess the risk of future claims against that policy and the cost of resolving those claims. Thus, the insurer uses underwriters to assess the risk of any given insured, claims managers to settle the claims and determine necessary reserves to resolve those claims, and

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120 Frank A. Sloan et al., Suing for Medical Malpractice 20 (1993).
121 Vasanthakumar N. Bhat, Medical Malpractice 95 (2001).
122 Frank A. Sloan et al., Suing for Medical Malpractice 22 (1993).
123 Id. at 23.
124 Id.
125 Vasanthakumar N. Bhat, Medical Malpractice 95 (2001).
126 Id.
127 Frank Sloan et al., Insuring Medical Malpractice 22 (1991).

actuaries to predict the course of future claims based on patterns of past and pending claims.[128] But, no matter how well a medical malpractice insurance company assesses its insureds, and predicts future claim costs, the results are uncertain.

The ideal insurance market consists of a pooling by the insurer of a large number of insureds.[129] A good example is the auto insurance market. The large number of insureds make outcomes for the insurance pool actuarially predictable.[130] The medical malpractice market is just the opposite: the pool of potential policyholders is small, as is the pool of claims.[131] Likewise, the awards vary tremendously, with 50% of the dollars paid out on 3% of the claims.[132]

The insurer is primarily interested in reducing uncertainty to the maximum extent possible but there are extensive unpredictable external forces. In medical malpractice the extent of the risk is not controlled solely by the terms of the contract but by the actions of the insured healthcare provider and the application of tort law of the state where the insured resides.[133] In predicting the risk related to tort law the insurer must consider the law in the applicable state, the propensity of patients to sue, and the general attitudes of juries in the state.[134] Additionally, when assessing a specific claim the insurer must examine the precedent for future cases that may be established in taking a case to trial.[135] This interest of the insurer may be adverse to the insured healthcare provider who is primarily interested in the impact on the healthcare provider's assets and reputation.[136]

Actuaries are retained by insurance companies to predict future premium needs based on past experience using various assumptions, numerical extrapolations, and professional judgment.[137] The goal of this process is for the insurer to be able to set a premium for specific insurance policies sold. The rates established must cover future claims losses and the associated expenses referred to as "loss adjustment expense,"[138] general operating expenses of the insurance company,[139] and profit.[140] Predictions

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[128] Id.
[129] Patricia Danzon, Medical Malpractice: Theory, Evidence, and Public Policy 90 (1985).
[130] Id.
[131] Id.
[132] Id.
[133] Id.
[134] Id. at 22-23.
[135] Id. at 23.
[136] Id.
[137] Sloan et al., Insuring Medical Malpractice 146 (1991).
[138] Id. "Loss adjustment expenses" generally include cost of investigation, cost of defense including fees paid to attorneys and court costs, and, finally, claims department expenses.
[139] Id. at 148. General operating expenses include commission paid to brokers and agents, costs of field staff, advertising printing, home office costs, and taxes.

can be very difficult because the length of time for medical malpractice claims to resolve requires the actuary to project expenses far into the future.[141]

To make predictions regarding the cost of future claims the actuary first examines historical claims data on a year-by-year basis.[142] In examining this data the actuary collects data over a number of years and determines what the payout or "runout" for each claim year has been to date. This is what amount of claims has been paid.[143]

Second, the actuary predicts the "ultimate" losses for each premium year examined. This requires a projection of what will be paid when all claims for the specific year are settled.[144]

Third, the actuary develops a "trend" to predict future premiums needed to cover predicted losses.[145] In developing the trend the actuary will examine the premiums divided by losses or "loss ratios" for past years.[146] The actuary will also examine changes in the frequency and severity of claims along with changes in state laws that may impact either of those factors.[147]

Based on this analysis the actuary will then project the premium needed to provide for payment of losses, costs of defending claims, overhead of the insurance company, and profits with any discount for projected investment income subtracted.[148]

Types of Medical Malpractice Insurance Vehicles

Commercial carriers are for-profit companies that are regulated by state departments of insurance.

Assessable insurance trusts are non-profit entities formed by physicians to insure against malpractice claims.[149] Typically, member physicians are assessed a fee at the end of each year based upon operating expenses and claim payouts.[150] In Florida, prior to October 1, 1992, a group or association of healthcare providers composed of any number of members

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[140] Id. Profit includes an allowance for contingencies.
[141] Id.
[142] Id. at 147.
[143] Id.
[144] Id.
[145] Id. at 152.
[146] Id. at 152-153.
[147] Id. at 153.
[148] Id. at 153.
[149] Id. at 96.
[150] Id.

could establish a self-insurance trust fund as long as the Department of Insurance approved the fund.[151] However, a self-insurance trust fund may no longer be formed, and only two have been found still to be in operation.[152]

Physician-owned companies are owned and operated by physicians. Most physician-owned companies are run on a not-for-profit basis. Supposedly, this leads to lower expense ratios. The physician-owners are the ones that make the decision on who to insure and who not to insure.

Surplus-line companies are entities that specialize in providing coverage to physicians who can't get insurance from traditional sources. These companies typically charge higher premiums.[153]

Risk retention groups are organized corporations or limited liability companies that spread the malpractice risk exposure among their members.[154]

Joint underwriting associations (JUAs) are non-profit entities established by state legislatures to provide malpractice insurance within the state. Florida's JUA was established in 1975.[155]

Reinsurers are entities that purchase risk contracts from other types of insurers. Typically an insurer makes a contract with a reinsurer to protect the first insurer from a risk it has already assumed.[156] A reinsurance contract seeks to diversify the risk of loss from one insurer to another by providing that the reinsured insurer cedes all or part of its risk to the reinsurer.[157] The reinsurance market was tightened significantly after the terrorist events of September 11, 2001.

Types of Medical Malpractice Insurance Policies

Medical malpractice insurers provide coverage using two types of policies: occurrence based and claims-made policies.[158]

Occurrence Policies: Most non-medical malpractice insurance policies have coverage triggered by an "occurrence" of an event or an accident

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[151] Section 627.357(2), Florida Statutes.
[152] Section 627.357(10), Florida Statutes.
[153] Vasanthakumar N. Bhat, Medical Malpractice 96 (2001); see also section 626.915, Florida Statutes.
[154] Vasanthakumar N. Bhat, Medical Malpractice 96 (2001); see also chapter 627, part XIX, Florida Statutes.
[155] Chapter 75-9, Laws of Florida.
[156] 30 Florida Jurisprudence 2d Insurance, section 24 (2002).
[157] Id. at section 46.
[158] Robert E. Keeton & Alan I. Widiss, Insurance Law 594 (1988).

within the time period specified in the policy.[159] Most automobile insurance policies operate under occurrence policies. For example, an insured has coverage for claims made, and damages awarded, years after the policy may have terminated, if the accident resulted from an "occurrence" within the stated time limits.[160]

Claims-Made Policies: Beginning in the 1970s, most medical malpractice insurers discontinued use of "occurrence" policies and offered coverage only on a "claims-made" basis.[161] These types of policies are written to provide indemnification for claims that are made during the coverage period, hence the name "claims made."[162] A typical medical malpractice policy will read as follows:

> To pay on behalf of the physician all sums which the physician must become legally obligated to pay as damages because of any claim or claims made against the physician during the policy period arising out of the performance of professional services rendered or which should have been rendered, subsequent to the retroactive date by any person for whose acts or omissions the physician partnership, corporation, or professional association is legally responsible.[163]

One disadvantage of claims-made policies is the need for "tail coverage." A physician who has a claims-made policy must make arrangements to protect against risks of claims made in future years, including for those periods long after the insured has retired from the profession.[164]

While the change from occurrence policies to claims-made policies should not change the filing of claims by patients or the actions of doctors, it can impact the data collected and the projection of trends.[165] This is because the number of claims reported tends to be low in the early years of claims-made coverage, rising as the policy matures.[166]

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[159] Id.
[160] Id.
[161] Id. at 598.
[162] Id.
[163] Id.
[164] Id. at 598-599.
[165] Patricia M. Danzon, The Frequency and Severity of Medical Malpractice Claims: New Evidence, 49(2) Law and Contemporary Problems 60 (Spring 1986).
[166] Id.

Characteristics of Medical Malpractice Insurance

Low-Frequency, High-Severity Risk: Traditionally, medical malpractice insurance has featured low claims frequency, yet high severity.[167] Depending on the medical specialty, approximately 5 to 20 percent of physicians may face a claim during the policy period.[168]

Lag Time Between Premium Inflows and Cash Outflows: All types of insurance companies operate under a lag time. Before claims are paid out, premiums must be paid in advance. Claims for automobile insurance, for example, will typically come in quickly during a claims year and be settled in short order. The same is true for workers compensation and health insurance claims. Medical malpractice insurance, on the other hand, has a significant lag time between when the premium is paid and when the claim is paid out.[169] Medical malpractice claims are only paid after liability is proved, or when the insurer believes that there is the likelihood that liability will be proved. The time it takes to determine possible liability is significant in the typical medical malpractice case, hence the long lag time.

For example, in Florida, the statute of limitations in a medical malpractice action must be started within two years from the time the incident giving rise to the action occurred, or, with the exercise of due diligence, within two years from the time the incident is discovered. However, in no event can the action be started later than four years from the date of the incident or occurrence out of which the cause of action originated.[170]

There also is a fraud exception that allows claims to be filed up to seven years from the date of occurrence.[171] The Florida Supreme Court ruled the statutory section prescribes a statute of:

- Limitations of two years;
- Repose of four years, absent fraud or intentional misconduct; and
- Repose of seven years, where there are allegations that fraud, concealment, or intentional misrepresentation of fact prevented discovery of the negligent conduct.[172]

Under the statute of limitations a claimant is required to file a medical malpractice action within two years of the time that the person had knowledge, or reasonably should have had knowledge of the injury, and

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[167] Frank A. Sloan et al., Suing for Medical Malpractice 24 (1993).
[168] Id.
[169] Frank Sloan et al., Insuring Medical Malpractice 24 (1991).
[170] Section 95.11(4)(b), Florida Statutes.
[171] Id.
[172] Carr v. Broward County, 656 So. 2d 248, 250 (Fla. 2d DCA 1995).

the knowledge that there was a reasonable possibility that medical malpractice caused the injury.[173]

The statute of repose, however, operates in a different manner by banning a cause of action, if that action is filed after a specified time period.[174] A statute of limitation will only bar the cause of action after a specified period of time has elapsed since the accrual of the cause of action.[175] These time limitations mean that in some instances, causes of action will not be filed until four or seven years after the alleged medical malpractice occurred. From there, once a case is filed, the case may have a life span of two to five years before it is tried or settled.[176] This creates a very long lag time between the time insurance premiums are received and the time they are eventually paid.

This lag time is a complicating factor in medical malpractice lines of insurance because the database used for estimating future losses may not reflect actual losses.[177] For example, one insurer, St. Paul (which is no longer writing this type of insurance) reported the manner in which claims were made: "30 percent in the year after treatment, 25 percent in the third year, 7 percent in the fourth year, and 8 percent in years five through 10."[178]

Investment Income: The core business of insurance companies is to assume the risk of an uncertain event in exchange for an insurance premium.[179] Profits are derived from the difference between premiums taken in and claims paid out.[180] However, insurers also derive income from investments. Insurers resemble a bank in many ways since income earned from premiums is available for investment until a claim is paid. Insurers hold premiums received from their customers, and pay them out when there is a claim.[181] Thus, these variables determine an insurance companies' real profits: how much is earned from risk premiums charged; the lag time for claims payment; and the actual return derived from investments made with the premiums in the interim.[182]

Some commentators have stated that the medical malpractice insurance industry engages in cash flow underwriting, in which insurers invest the

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[173] Tanner v. Hartog, 618 So. 2d 177, 181 (Fla. 1993).
[174] Kush v. Lloyd, 616 So. 2d 415 (Fla. 1992).
[175] Id. at 481.
[176] Frank Sloan et al., Insuring Medical Malpractice 24 (1991).
[177] B.R. Furrow et al., Health Law: Cases, Materials and Problems 5 (2001).
[178] Id.
[179] Frank A. Sloan et al., Suing for Medical Malpractice 25 (1993).
[180] Id.
[181] Id.
[182] Id.

premiums they collect.[183] "When interest rates and investment returns are high, insurance companies accept riskier exposures to acquire more investable premiums. . . If underwriting and investment results are combined during this period, investment gains more than offset losses."[184] In 1987, the Government Accounting Office contended that the medical malpractice insurance crisis of the 1980s resulted, in part, from "the industry's cash flow underwriting policy strategy in which companies sacrificed underwriting gains in an attempt to attract more business and thereby enhance investment gains."[185]

Insurance Cycles: Medical malpractice insurance has been subject to sudden jolts, both in availability of coverage and cost.[186] An entire cycle has been defined as the period of years in which insurer underwriting profits cycle from above average to below average. These cycles have always occurred in the insurance industry, particularly in medical malpractice insurance.[187]

The cycle begins when insurance is profitable thus attracting capital and the formation of new companies.[188] The new companies lower rates to attract business away from existing companies because the number of healthcare providers requiring insurance is fairly stable but the providers will change companies to acquire the best rates.[189] The cutting of rates by new companies forces the existing companies to also cut rates to protect their market share.[190] This rate cutting can continue until underwriting losses exceed the amount that insurers are willing to bear.[191] This will cause some insurers to withdraw from the market and the remaining insurers will raise rates.[192] These rate increases are usually accompanied by tighter standards regarding what providers the remaining companies will insure.[193] The higher rates and resulting profitability will attract new business to the industry and the cycle begins again.[194]

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[183] B.R. Furrow et al., Health Law: Cases, Materials and Problems 7 (2001).
[184] Id.
[185] Government Accounting Office, Insurance: Profitability of Medical Malpractice and General Liability Lines (1987).
[186] Id. at 27.
[187] Academic Task Force for Review of the Insurance and Tort Systems, Preliminary Fact-Finding Report 89 (Aug. 14, 1987).
[188] Id.
[189] Id.
[190] Id.
[191] Id.
[192] Id.
[193] Id.
[194] Id.

State Regulation of Medical Malpractice Insurance

The Department of Insurance governs medical malpractice insurance.[195] All medical malpractice policies must include the following policy clauses:

- Directing the insured to cooperate in the statutory review process if a notice of intent to file a claim for medical malpractice is made against the insured.[196]
- Authorizing the insurer to determine, make, and conclude, without the permission of the insured, any offer of admission of liability and of arbitration, settlement offer, or offer of judgment within policy limits if in good faith and in the best interests of the insured.[197]
- Requiring the insurer to give a specified amount of notice of cancellation or non-renewal to the insured.[198]

Each insurer may require the insured to be a member in good standing of a duly recognized state or local professional society of healthcare providers that maintains a medical review committee.[199]

Department of Health/Board of Medicine: As a condition of licensing, and prior to the issuance or renewal of an active license or reactivation of an inactive license for the practice of medicine, a physician must demonstrate to the Department of Health and the Board of Medicine his or her financial responsibility to pay claims and costs.[200]

Hospital Privileges: Physicians with hospital staff privileges are required to establish financial responsibility as a continuing condition of hospital staff privileges.[201]

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[195] Se_ chapters 626, 627, Florida Statutes.
[196] Section 627.4147(1)(a), Florida Statutes; see also 36 Florida Jurisprudence 2d Medical Malpractice, section 88 (2002).
[197] Section 627.4147(1)(b), Florida Statutes; see also 36 Florida Jurisprudence 2d Medical Malpractice, section 88 (2002).
[198] Section 627.4147(1)(c), Florida Statutes; see also 36 Florida Jurisprudence 2d Medical Malpractice, section 88 (2002).
[199] Section 627.4147(2), Florida Statutes; see also 36 Florida Jurisprudence 2d Medical Malpractice, section 88 (2002).
[200] Section 458.320(1), Florida Statutes.
[201] Section 458.320(2), Florida Statutes.

Chapter 4 - MEDICAL MALPRACTICE: THE FLORIDA PERSPECTIVE

"At its core, malpractice law involves a set of adversarial proceedings, beginning with a patient's allegation of negligence against an individual provider. Processes of care are relevant only insofar as they prove or disprove the defendant's negligence against an individual provider. Malpractice litigation induces silence and bitterness."

David M. Studdert & Troyen A. Brennan, The American Medical Association, No-Fault Compensation for Medical Injury: The Prospect for Error Prevention (2001)

Florida Medical Malpractice Synopsis

1970s Medical Malpractice Law Changes

In 1975, the state refused a request for a rate increase from the Argonaut Insurance Company, which during 1974 insured 5,342 of Florida's 8,103 physicians.[202] Argonaut then threatened to discontinue malpractice insurance in Florida, which would have left 60 percent of Florida's physicians without malpractice coverage.[203] This precipitated the 1975 Legislature's determination that there was a medical malpractice insurance crisis, resulting in the enactment of a series of reforms to ensure the availability of malpractice insurance to physicians and hospitals, and to change the process of addressing medical malpractice claims.[204] The provisions of the bill addressed four issues:

- Healthcare quality improvement
- Tort reform
- Alternative insurance
- Alternative dispute resolution

Healthcare Quality of Care Improvement

Risk Management Programs: The 1975 act required every facility with more than 300 beds for in-house patient care to establish a risk management program. All injuries and adverse incidents were to be

[202] Representative Barry Kutun, comments to Southern Legislative Conference, Human Resources and Urban Affairs Committee, Malpractice Legislation in Florida (Nov. 11, 1975).
[203] Id.
[204] Chapter 75-9, Laws of Florida.

reported to the risk manager. The risk management program was to provide for investigation and analysis of the causes of adverse incidents, the establishment of processes to minimize the risk of injury and adverse incidents, and a process for addressing patient grievances.[205]

Increase Healthcare Provider Regulation: The 1975 act provided tougher discipline procedures to be applied by the Board of Medicine.[206]

Tort reform

Statute of Limitations: In the 1975 act, the Legislature clarified the statute of limitations to provide a two-year limit from the time the incident occurred, or from the time the incident was discovered or should have been discovered. The bill also created a four-year statute of repose ending all rights to file a claim after four years, regardless of whether the injury had been discovered or not. Additionally, a provision was added to extend the statute of repose to two years beyond the date of discovery of the injury, if fraud prevented discovery. However, in no instance could the case be brought more than seven years after the incident occurred that gave rise to the injury.[207]

Ad Damnum Clauses: The 1975 act prohibited a statement of the requested amount of general damages in a complaint, but did allow a statement of the jurisdictional amount and the amount of special damages.[208]

Informed Consent: The 1975 act established criteria for what constituted informed consent to ensure patients were informed of the risks associated with medical procedures.[209]

Insurance Reform

To improve the availability of malpractice insurance, the 1975 act established alternative methods to insure healthcare providers.[210]

Joint Underwriting Association: The 1975 act created a Joint Underwriting Association to spread the risk of insuring hospitals and physicians over casualty insurers, generally.[211]

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[205] Chapter 75-9, section 3, Laws of Florida.
[206] Chapter 75-9, sections 13-14, Laws of Florida.
[207] Chapter 75-9, section 7, Laws of Florida.
[208] Chapter 75-9, section 8, Laws of Florida.
[209] Chapter 75-9, section 11, Laws of Florida.
[210] Chapter 75-9, sections 4, 13-15, Laws of Florida.
[211] Chapter 75-9, section 4, Laws of Florida.

Medical Malpractice Risk Management Fund: The 1975 act allowed a group of physicians or healthcare facilities to establish a medical malpractice risk management fund to self-insure.[212]

Patients Compensation Fund: The 1975 act created a Patients Compensation Fund to pay claims over $100,000 for participating physicians, who pay into the fund and maintain the required level of personal coverage.[213] In 1985, the Florida Supreme Court ruled on a constitutional challenge to the limits included in the Patients Compensation Fund, and determined that the limits were constitutional. In Florida Patients Compensation Fund v. Von Stetina,[214] the court concluded the Legislature could reasonably find that "the increasing costs of medical malpractice insurance posed a threat to the continued availability and adequacyof health care services, and that the public health could be protected by the enactment of the subject measures, which were designed to reform the medical malpractice insurance system."[215] The court further found that the Legislature had provided a source for paying malpractice judgments, which was within the Legislature's constitutional prerogative, but had not modified the dollar amount of the judgment rendered.[216]

Alternative dispute resolution

Medical Review Panels: To assist in resolving claims, the 1975 act created a procedure for establishing three-member, medical liability mediation panels in each judicial circuit.[217] These panels were authorized to make findings as to liability and recommend the amount of damages, except punitive damages. The Florida Supreme Court twice reviewed the constitutionality of medical review panels. The first review, in Carter v. Sparkman,[218] found the provision to be constitutional. In the second review in 1980, Aldana v. Holub,[219] the Florida Supreme Court found the statute to be unconstitutional, and in violation of the due process rights of both the state and Federal constitutions. In Aldana, the court stated "[I]t should be emphasized that today's decision is not premised on a re-evaluation of the wisdom of the Carter decision. Rather, it is based on the unfortunate fact that the medical mediation statute has proven unworkable and inequitable in practical operation."[220]

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212 Id.
213 Chapter 75-9, section 15, Laws of Florida.
214 Florida Patients Compensation Fund v. Von Stetina, 474 So. 2d 787, 789 (Fla. 1985).
215 Id.
216 Id.
217 Chapter 75-9, section 5, Laws of Florida.
218 335 So. 2d 802 (Fla. 1976), cert. denied, 429 U.S. 1041 (1977).
219 381 So. 2d 231 (Fla. 1980).
220 Id. at 237.

In 1976, the Legislature added three additional reforms to the tort laws impacting medical malpractice.

Remittitur and Additur: The 1976 act authorized the courts to review the amount of damages awarded by a jury in a malpractice case to determine if the award was clearly excessive or inadequate based on the evidence presented. If the judge found the award excessive, the court could reduce it, or if the award was found inadequate, the court could increase the award. If the negatively impacted party objected to the court's action, the judge was required to order a new trial on damages.[221]

Collateral Source Rule: The 1976 act provided that all medical malpractice awards must be reduced by the amount paid from all collateral sources to the plaintiff, except where the payer of the benefit has a right to claim reimbursement from any award of damages.[222] In 1981, the Florida Supreme Court upheld this amendment to the collateral source rule. In the case of Pinillos v. Cedars of Lebanon Hospital Corp.,[223] the court stated: "We hold that the classification created by section 768.50, Florida Statutes, bears a reasonable relationship to the legitimate state interest of protecting the public health by ensuring the availability of adequate medical care for the citizens of this state."[224]

Periodic Payment of Damages: This provision of the 1976 act allows the court, upon the request of either party, to provide for periodic payment of future losses. The act specified the payments must be made over the time period for the losses determined by the jury; however, the defendant must pay the actual economic losses during the period, even if they exceed the scheduled payment. If the patient dies before all of the payments are made, then the payments for pain and suffering and medical care may stop. However, if the plaintiff lives beyond the period of the scheduled payments, the defendant must continue to pay at the amount of the last scheduled payment.[225]

1980s Medical Malpractice Law Changes

In the early-1980s medical malpractice insurance rates were again increasing.[226] Florida experienced increases in the frequency of claims

[221] Chapter 76-260, Laws of Florida.
[222] Id.
[223] 403 So. 2d 365 (Fla. 1981).
[224] Id. at 368.
[225] Chapter 76-260, Laws of Florida.
[226] Governor's Task Force on Medical Malpractice, Report of the Governor's Task Force on Medical Malpractice (March 1985).

generally, increases in the cost per claim, and particularly, increases in the frequency of claims in excess of $100,000.[227] In 1984, an attempt was made to address some of these issues by amending the constitution. An amendment petition was filed to place a cap of $100,000 on non-economic damages, eliminate joint and several liability, and make changes to the summary judgment process. The Supreme Court held the petition to be unconstitutional on the basis of violations of the single subject and ballot summary requirements, and the proposed amendment did not appear on the ballot.[228]

Report of the 1984 Florida Governor's Task Force on Medical Malpractice

In 1984, recognizing there still existed medical malpractice insurance problems, the Governor created the 1984 task force by Executive Order (1984 task force)[229] and directed that the 1984 task force recommendations be submitted by April 1985.[230] The 1984 task force found that the factors contributing to the medical malpractice insurance problems were the:

- Medical advances that had taken place in medicine with the increased use of unknown specialists in large institutions;
- Increased access to the courts; and
- General rise in consumerism.[231]

After four months of study, the 1984 task force made recommendations to address maximizing the quality of care provided while minimizing injury. Additionally, recommendations hoped to address the high cost of the existing dispute resolution process through incentives and mechanisms to induce earlier settlement of disputes.[232] The specific recommendations were:[233]

Healthcare Quality Improvement

- Section 768.40, Florida Statutes, must be amended to expand civil immunity for peer review participants to include all persons who provide information, serve as witnesses, or conduct investigations.

[227] Id. at 1.
[228] Evans v. Firestone, 457 So. 2d 1351 (Fla. 1984).
[229] Executive Order No. 84-202.
[230] Governor's Task Force on Medical Malpractice, Report of the Governor's Task Force on Medical Malpractice 2 (March 1985).
[231] Id.
[232] Transmittal letter from M. Anthony Burns to Governor Graham (April 1, 1998).
[233] Governor's Task Force on Medical Malpractice, Report of the Governor's Task Force on Medical Malpractice 3-15 (March 1985).

- A person who files a civil action seeking damages against a peer review participant must be required to post a bond sufficient to pay cost and attorney's fees in the event the plaintiff is unsuccessful.

- A statutory presumption of good faith must be established for peer review participants.

- All information and records used by a peer review committee must be discoverable by a healthcare provider in a civil action brought by the provider. However, the deliberations of the peer review committee must not be discoverable in any civil action.

- The governing boards of hospitals must be required to demonstrate and document a consistent effort to deliver high quality medical services through operation of a quality assurance program in accordance with Joint Commission on Accreditation of Hospitals standards for the governing body, medical staff, and quality assurance. Hospitals must be required to investigate conduct that would constitute good cause for action upon a physician's staff privileges.

- Florida should participate in a joint effort with the Florida Medical Association, the Florida Osteopathic Association, Florida Hospital Association, and insurance companies to provide funding for research on risk management, voluntary resolution, and quality assurance programs.

- Insurers should be encouraged to develop premium discounts for utilization of effective risk management programs by healthcare providers.

- Improved doctor-patient communication should be encouraged, and toward that end providers should be encouraged to better inform patients of the patient's physical and mental condition.

- In order to gather the necessary information for future policy-making regarding medical malpractice, there should be ongoing data collection and special studies.

Regulation and discipline of healthcare providers

- No graduate of an unaccredited foreign educational institution should be eligible for licensure, unless the Department certifies that institution.

- The penalty for knowingly giving false information when obtaining a new or renewed license as a healthcare practitioner (licensed under chapters 458, 459, 460, 461, 463, 464, 465, 466, 474, or 490, Florida Statutes), should result in a third degree felony.

- Obtaining a license to practice medicine by fraudulent misrepresentation or fraudulently misrepresenting education, training or experience in obtaining a position as a medical practitioner or medical resident, should result in a third degree felony.

- The number of times an individual may take the state licensure exam must be limited to four. After failing three times, the applicant must be required to take one year of postgraduate training in a program approved by the American Medical Association prior to attempting the examination for a fourth, and final, time.

- Continuing medical education should be required as a condition of re-licensure for physicians.

- The Department of Insurance should be required to notify and send reports to the Department of Business and Professional Regulation on any individual healthcare provider, who has three or more claims paid in excess of $10,000 over a five-year period, and is subject to regulation by the Department of Business and Professional Regulation.

- Hospitals, licensed under chapter 395, Florida Statutes, should be required to provide the reason for disciplining a member of the medical staff and the action that was taken. Peer review records should be made available to the Department, upon subpoena, to be used in disciplinary proceedings.

- The resources of the Department of Business and Professional Regulation and health provider boards should be increased to support increased investigation staff to review and investigate reports from hospital governing boards, and trigger reviews of providers.

- The Board of Medical Examiners should be expanded to thirteen members. Four of those members should be laypersons. At least one member of the probable cause panel should be a layperson.

- As a condition of licensure and licensure renewal, all physicians should be required to carry professional liability insurance or demonstrate alternative means of financial responsibility. The amount of required coverage should be between $500,000 per occurrence/$1,500,000 annual aggregate, and $1,000,000 per occurrence/$3,000,000 annual aggregate.

Tort reform

- Any plaintiff's attorney who brings three cases in five years, which are unsuccessful in both arbitration and trial, and where a formal offer of judgment or settlement was not made, should be reviewed by the grievance committee of the Florida Bar, and appropriate action taken upon review of the case.

- Section 768.56, Florida Statutes, which requires the court to award attorney's fees to the prevailing party in medical malpractice cases, should be repealed.

- Section 768.49, Florida Statutes, regarding remittitur and additur should be amended to delete the word "clearly" from the requirement that "any judgment be clearly excessive or inadequate before the judge may exercise remittitur and additur powers."

- Any provision for contracting out of the tort system must have clearly-drawn safeguards. The 1984 task force stated there had been insufficient time to address this issue with the detailed attention it requires. Others, or the 1984 task force if it is continued, should further explore this issue.

- No other tort reforms should be undertaken. Specifically, there should be no caps placed on damages, no further caps on attorney's fees, and joint and several liability should be retained.

Alternative dispute resolution

- A procedure should be established which would require the defendant(s) in a medical malpractice action to choose either binding or non-binding arbitration within ninety days from the date a complaint is filed. This procedure is designed to provide for early resolution, and encourage early settlement of claims.

- Either party can make offers of judgment or settlement after the complaint is filed.

Insurance Reform

- The Department of Insurance should explore the feasibility of malpractice insurance programs that provide integrated or linked rates for hospitals and their medical staff.

- The 1984 task force expressed antipathy toward further, privately financed, subsidization for malpractice liability coverage, and encouraged the Legislature to explore the necessity and feasibility of public subsidization alternatives. However, given the constraints of time and resources, the 1984 task force felt unable to adequately explore or further advise on the specifics of such alternatives.

- A study should be conducted in order to: develop estimates of the number of medical injuries in Florida, determine the availability of third party collateral sources of payment and therefore an estimate of net economic losses, and apply such findings to alternative proposals in order to determine variously designed system costs.

1985 Legislative Changes

Following receipt of the report of the 1984 task force, the 1985 Legislature in chapter 85-175, Laws of Florida, set out findings related to the medical malpractice insurance crisis in the preamble to the act.[234]

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[234] WHEREAS, high-risk physicians in this state sometimes pay disproportionate amounts of their income for malpractice insurance, and

WHEREAS, professional liability insurance premiums for Florida physicians have continued to rise and, according to the best available projections, will continue to rise at a dramatic rate, and

WHEREAS, the maximum rates for essential medical specialists, such as obstetricians, cardiovascular surgeons, neurosurgeons, orthopedic surgeons, and anesthesiologists have become a matter of great public concern, and

WHEREAS, these premium costs are passed on to the consuming public through higher costs for health care services in addition to the heavy and costly burden of "defensive medicine" as physicians are forced to practice with an overabundance of caution to avoid potential litigation, and

WHEREAS, this situation threatens the quality of health care services in Florida as physicians become increasingly wary of high-risk procedures, and are forced to downgrade their specialties to obtain relief from oppressive insurance rates, and

WHEREAS, this situation also poses a dire threat to the continuing availability of health care in our state as new young physicians decide to practice elsewhere because they cannot afford high insurance premiums, and as older physicians choose premature retirement in lieu of a continuing diminution of their assets by spiraling insurance rates, and

WHEREAS, our present tort law/liability insurance system for medical malpractice will eventually break down and costs will continue to rise above acceptable levels, unless fundamental reforms of said tort law/liability insurance system are undertaken, and

WHEREAS, the magnitude of this compelling social problem demands immediate and dramatic legislative action, and

Based on these findings, the Legislature enacted a number of changes to improve prevention of medical malpractice, resolution of claims when an injury occurs, and to spread the cost of insurance beyond those specialists currently impacted most significantly.[235] These changes included:

Healthcare Quality Improvement

Risk management programs at medical facilities: The bill clarified the responsibility of healthcare facilities to not only implement a risk management program, but to assure the implementation of the risk management program, and the competence of the staff. Failure to use due care to comply with the act, would expose the facility to liability for injury resulting from the failure to implement the laws.[236]

Discipline and licensing of healthcare providers

Discipline of providers: To improve prevention of medical malpractice the requirements for investigation and discipline of healthcare practitioners/providers were increased, and the Board of Medicine was required to investigate a healthcare practitioner/provider when there were two or more claims of $10,000 or more paid within a five-year period. These incidents were to be reported to the Board of Medicine by the Department of Insurance.[237]

Risk management programs: The responsibility of the Board of Medicine, relative to review of risk management programs, was increased; and, the bill improved testing, continuing education requirements, and increased penalties for misrepresentation related to licensing.[238]

Tort reform

Pre-suit screening and investigation: The bill established a ninety-day notice of intent to initiate litigation, with a required investigation by the defendant. Additionally, the plaintiff's attorney was required to certify that a reasonable investigation had been conducted prior to filing the claim. If the court determined that the certification was not made in good faith, and

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WHEREAS, medical injuries can often be prevented through comprehensive risk management programs and monitoring of physician quality, and

WHEREAS, it is in the public interest to encourage health care providers to practice in Florida, NOW THEREFORE, ...

[235] Chapter 85-175, Laws of Florida.
[236] Chapter 85-175, section 23, Laws of Florida.
[237] Chapter 85-175, sections 1, 5, Laws of Florida.
[238] Chapter 85-175, section 9, Laws of Florida.

that no issue requiring the court's attention was presented, the court could award attorney fees and costs against the claimant's counsel, and submit the issue to the Florida Bar for disciplinary review.[239]

Voluntary binding arbitration: The bill established a non-binding arbitration process for resolving claims of medical malpractice. The process allowed either party to request arbitration. The arbitration panel considered the evidence and decided the issues of liability and damages, and apportionment of responsibility among the parties. The arbitration panel was prohibited from awarding punitive damages.[240]

Offer of judgment and demand for judgment: This bill allowed a defendant to file an offer of judgment that would subject the plaintiff to payment of the defendant's costs and attorney fees, if the final judgment was at least 25 percent less than the offer.[241]

Changes to periodic payment of damages: The bill authorized the periodic payment of future losses exceeding $500,000. The bill provided for the periodic payments to be for the term upon which the jury calculated the damages, and the payments could be in equal or unequal amounts based on the needs of the plaintiff. Upon the plaintiff's death the remaining benefits were to be paid to the estate of the plaintiff in a lump sum. The defendant posted security for the payments at the time judgment was entered, and paid the attorneys' fees due on the periodic payments at the time of the judgment.[242]

Attorneys' fees: A schedule of attorneys' fees was set out in the bill to expire in 1988. The fee schedule began with a limitation on recoveries under $2 million at 15 percent of a settlement, where an offer was made and accepted within the ninety-day period, and extended to 45 percent where the case went to appeal. For cases resulting in more than $2 million, the fee was limited to 15 percent of the award. For all actions, a client could request the court to review the requested attorney fee to determine if it was illegal or excessive.[243]

Mandatory settlement conference: The bill required a settlement conference at least three weeks before the case went to trial.[244]

Joint and several liability: The bill codified joint and several liability and amended liability and prior practice to allocate any un-collectable portions

[239] Chapter 85-175, sections 12, 14, Laws of Florida.
[240] Chapter 85-175, sections 14, 15, Laws of Florida.
[241] Chapter 85-175, section 16, Laws of Florida.
[242] Chapter 85-175, section 13, Laws of Florida.
[243] Chapter 85-175, section 17, Laws of Florida.
[244] Chapter 85-175, section 19, Laws of Florida.

of a judgment across all solvent defendants in proportion to each defendant's portion of fault. The act included provisions for addressing joint and several liability in settlements and releases.[245]

Insurance reform

Mandatory insurance for healthcare providers: The bill required physicians and osteopathic physicians to maintain insurance equivalent to $100,000 per claim with an aggregate amount of not less than $300,000. To maintain staff privileges at a hospital, a physician had to have insurance equivalent to $250,000 per claim with an aggregate amount of not less than $750,000.[246]

1986 MEDICAL MALPRACTICE LAW CHANGES

In 1986, the Legislature identified a financial crisis in the entire liability insurance industry that it believed caused a serious lack of many lines of commercial liability insurance, including medical malpractice insurance, and a dramatic increase in the cost of insurance coverage.[247] In response, the Legislature passed the Tort Reform and Insurance Act of 1986.[248]

The Legislature stated that the absence of insurance was seriously adverse to sectors of the Florida economy, and that if the problem was not addressed many people would not be able to purchase insurance, and thus many injured persons would be unable to recover damages for their economic or non-economic losses.[249] Further, the Legislature stated, "the current tort system has significantly contributed to the insurance availability and affordability crisis.[250] Chapter 86-160, section 2, Laws of Florida, set out the legislative findings that were the basis for the bill:

> The Legislature finds and declares that a solution to the current crisis in liability insurance has created an overpowering public necessity for a comprehensive combination of reforms to both the tort system and the insurance regulatory system. This act is a remedial measure, and is intended to cure the current crisis, and to prevent the recurrence of such a crisis. It is the purpose of this act to ensure the widest possible availability of liability insurance at reasonable rates, to ensure a stable market for

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[245] Chapter 85-175, section 20, Laws of Florida.
[246] Chapter 85-75, section 28, Laws of Florida.
[247] Chapter 86-160, Laws of Florida.
[248] Id. at section 1.
[249] Id.
[250] Id.

> liability insurers, to ensure that injured persons recover reasonable damages, and to encourage the settlement of civil actions prior to trial.[251]

As a result of these findings the Legislature enacted a series of reforms to the tort system and the insurance regulatory system, some of which impacted medical malpractice actions and the financial responsibility requirements for physicians. Those impacting medical malpractice cases included:

Tort reform

Cap on Damages: A $450,000 cap was placed on non-economic damage awards, and a cap of three times compensatory damages was placed on punitive damages, unless the plaintiff showed that a greater cap was not excessive.[252] The Supreme Court of Florida struck down the caps on non-economic damages in 1987.[253] In Smith,[254] the court found that the statute did not offer any reasonable alternative remedy or commensurate benefit, and that there was no showing that the imposition of the cap was "based on a legislative showing of 'an overpowering public necessity for the abolishment of such right, and no alternative method of meeting such public necessity can be shown.'"[255]

Immunity for Emergency Room Services: Licensed physicians providing "code blue" services in an emergency room were provided immunity under the Good Samaritan law,[256] and contributory and joint and several liability provisions were modified for those physicians.[257]

Contributory Negligence: Contributory negligence was modified to reduce the total award to a plaintiff by the amount of negligence assigned to the plaintiff.[258]

Joint and Several Liability: The application of joint and several liability was modified, first to apply to awards under $25,000, and to apply in other cases only when the percentage of fault assigned to the defendant exceeded the fault assigned to the plaintiff.[259]

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[251] Chapter 86-160, Laws of Florida.
[252] Chapter 86-160, section 59, Laws of Florida.
[253] Smith v. Department of Insurance, 507 So. 2d 1080 (Fla. 1987), reh'g denied (June 2, 1987).
[254] Id.
[255] Id. at 1089.
[256] Chapter 86-160, section 62, Laws of Florida.
[257] Chapter 86-160, section 60, Laws of Florida.
[258] Id..
[259] Id.

Financial Responsibility Requirements for Healthcare Providers: The financial responsibility requirements for physicians were modified to ease the burden on physicians. A physician was allowed to meet financial responsibility requirements with a letter of credit for the required amounts of coverage. Additionally, the bill allowed a physician to "go bare," if notice was given to patients through the posting of a notice and the physician covered all judgments of malpractice up to the amount of the financial responsibility limits.[260]

THE 1986 ACADEMIC TASK FORCE FOR REVIEW OF THE INSURANCE AND TORT SYSTEMS

The 1986 bill also created within the Executive Office of the Governor, the Academic Task Force for Review of the Insurance and Tort Systems, to serve from July 1, 1986 through adjournment of the 1988 legislative session.[261] The 1986 task force was directed by the Legislature to investigate the insurance and tort systems, generally, as indicated by the title of the 1986 task force. However, as the 1986 task force began their review the members and staff recognized that medical malpractice was the area of the insurance and tort systems most in jeopardy.[262]

In July of 1987, Governor Martinez informed Marshall Criser, Chairman of the 1986 task force, that a special session would be called in the fall of 1987 to focus on medical malpractice, and Governor Martinez requested the 1986 task force to assist in preparing for that special session.[263] In response to that request, the 1986 task force issued a Preliminary Fact-Finding Report on Medical Malpractice.[264] The interim report was intended to "analyze the extent of the problems in Florida regarding the affordability and availability of medical malpractice insurance."[265] The report then discussed the underlying causes of the problems.[266]

Specific 1986 Academic Task Force Findings Made in 1987

Affordability: The cost of medical malpractice liability insurance had increased dramatically during the previous eight years, with the largest share of this increase coming during the most recent two years. The extent

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[260] Chapter 86-160, sections 47-48, Laws of Florida.
[261] Chapter 86-160, section 63, Laws of Florida.
[262] Academic Task Force for Review of the Insurance and Tort Systems, Executive Summary of the Preliminary Fact-Finding Report on Medical Malpractice (Aug. 14, 1987).
[263] Id.
[264] Id.
[265] Id.
[266] Id.

of the problem of affordability varied greatly among medical specialties, and among South Florida physicians and those in the remainder of the state.

Availability: At that time, the availability of liability insurance for physicians did not pose a serious problem in Florida.

Cause of Price Increase: The primary cause of increased malpractice premiums was the substantial increase in loss payments to claimants.

Profitability: During the period 1977 through 1985, medical malpractice insurers were slightly more profitable than the property-liability insurance industry as a whole. For the same time period, the profitability of the property-liability insurance industry was slightly less than that of American industrial and financial corporations. The profitability of insurance companies varied dramatically from year to year.

Market Structure: The medical malpractice insurance market in Florida was highly concentrated, but that market concentration did not appear to have contributed to the problem of affordability of liability insurance.

Impact of Underwriting Cycle: The rate of price increases during the period 1983 through 1987 was disproportionately dramatic, because of the insurance underwriting cycle. Over the course of an entire underwriting cycle, however, it was the increase in paid claims that caused higher premiums.

Risk Classes: The practice of dividing Florida physicians into risk classes by specialty, and into two different geographic areas for rating and pricing purposes, contributed to the affordability problems for high risk specialty practitioners, particularly those in South Florida.

Frequency of Claims Payments: The frequency of claims payments in Florida had increased 4.6 percent when adjusted for the increase in population.

Amounts of Claims Payments: The average cost of paid claims had increased at a compound rate of 14.8 percent per year since 1975. The increase in the size of loss payments was a substantially more important factor in the overall increase in paid claims than was the increasing frequency of paid claims.

Geographic Variations in Claims Payments: The frequency of paid claims per capita was twice as great in Dade and Broward Counties as in the rest of the state. The severity of claims also was greater in South Florida than in the remainder of the state, but the difference was not nearly so dramatic.

Variations Among Medical Specialties: There were considerable variations both in frequency and in severity of paid claims among medical specialties. Obstetrics and gynecology accounted for 13.5 percent of all paid claims, while specialties such as endocrinology, psychiatry and thoracic surgery each accounted for less than 2 percent of all paid claims. The largest average claims payments (1986) were in pediatrics, neurosurgery and thoracic surgery, with the average claim payment for pediatrics exceeding $350,000.

Multiple Claims: Physicians with two or more paid claims accounted for nearly half of the amount of paid claims during the period 1975-1986. Physicians with two or more paid claims during this eleven-year period were not necessarily "bad doctors."

Changes in the Law: During the previous thirty years, there had been a national trend toward expanded legal liability for medical malpractice. The research conducted for this report did not reveal any major pro-plaintiff development in medical liability rules of law in Florida during the previous two decades, but overall changes in the environment of the legal system appeared to benefit plaintiffs.

Attorneys' Fees and Other Litigation Costs: Attorneys' fees and other litigation costs represented approximately 40 percent of the total incurred costs of insurance carriers, with claimants receiving 43.1 percent of the total incurred costs. The total amount of attorneys' fees was divided approximately equally between plaintiff's attorneys and defense attorneys. During the previous eleven years, the average legal cost of defending a malpractice claim had increased at an annual compound rate of 17 percent.

Possible Explanations for Increased Claims Frequency: Increased claims frequency probably resulted both from a greater number of injuries occurring as a result of medical mal-occurrences, and from a much greater likelihood that injured plaintiffs would file claims. Any increase in the aggregate number of contacts between physicians and patients as the number of Florida residents and physicians both increased, and did not imply any increase in the frequency of medical mal-occurrences per physician.

Professional Regulation of Medical Care: The Department of Business and Professional Regulation disciplined a relatively low percentage of physicians with multiple paid claims.

Specific 1986 Academic Task Force Recommendations Made in 1988

In 1988, the Academic Task Force made specific recommendations for changes to address the medical malpractice insurance crisis in response to the Governor's request for the task force to make such recommendations.[267] The recommendations were formulated to "address the underlying causes of Florida's medical malpractice problems."[268]

Healthcare Quality:

- Create a separate division, to be known as the Division of Medical Quality, within the Department of Business and Professional Regulation to discipline and license healthcare providers. This division would be funded, entirely or in part, by increases in professional licensing fees for healthcare providers.

Discipline of Healthcare Practitioners/Providers:

- Substantially strengthen regulation of healthcare providers in Florida. This more robust professional regulation was to include, not only a commitment by the Legislature to provide more resources, but also an improved administrative structure that would enable the state agency to pursue vigorously its obligation to discipline physicians whose incompetence resulted in medical malpractice.

- Pass legislation to require the state healthcare regulatory division to assume greater responsibility for medical professional discipline and quality assurance at the local level. The division was to establish local quality assurance boards to identify healthcare provider competency and disciplinary problems at their source, and coordinate with peer review and quality assurance programs conducted by local medical societies and hospitals.

Tort reform:

- Adoption of the "Prompt Resolution of the Meritorious Medical Negligence Claims Plan" that included the following provisions:

    - Claims against physicians, and denials of such claims, must be preceded by reasonable investigation and accompanied by an expert's written opinion.

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[267] Id.
[268] Id. at 9.

- o Incentives should be provided for claimants and healthcare providers to submit claims to a binding arbitration proceeding to determine the amounts of economic damages, non-economic benefits not to exceed $250,000, and reasonable attorneys' fees.

- o If the defendant refuses to submit a claim to arbitration, the plaintiff would retain all existing rights to a jury trial.

- o If the plaintiff refused to submit a claim to arbitration, plaintiff's non-economic damages at trial would be limited to $350,000.

This was intended to "stabilize and reduce" premiums for medical malpractice insurance and was to be accomplished through a balance of civil justice reforms aimed at addressing the 1986 task force findings. The 1986 task force anticipated there would be substantial cost savings from the reduced litigation expenses, and anticipated a reduction in frivolous claims and defenses as well as the limits on non-economic damages.

- Do not adopt any plan that would eliminate recovery for all non-economic damages and the right to jury trial, while requiring the claimant to prove fault.

- Rejection of any plan to limit recovery of non-economic damages to $100,000 in all tort cases, including claims for medical negligence, as an attempt to solve Florida's medical malpractice problems.

Insurance Reform:

- Adoption of legislation allowing physicians and hospitals to participate in a no-fault plan limited to birth-related neurological injuries (NICA).

- Adoption of the "Premium Impact Equity Plan." This plan would provide equity payments for those physicians who could demonstrate affirmatively that high medical malpractice premiums were creating genuine financial difficulties. The plan was to be financed solely by a small tax on all medical malpractice insurance premiums.

- Rejection of any risk class compression plan requiring a state-operated (or other mandatory) insurance pool.

- Rejection of any proposal that uses existing tax revenues, or any other general revenues, to subsidize high medical malpractice insurance premiums.

1988 MEDICAL MALPRACTICE LEGISLATION

In a 1988 special session, the Legislature passed chapter 88-1, Laws of Florida, to address medical malpractice issues in Florida. The preamble to the bill enumerates many of the same issues facing Florida today, such as the inability of practitioners to find and purchase reasonably priced liability insurance, the rising costs of litigation, and the arbitrary nature of damage awards. The Legislature declared in this bill, "the primary cause of increased medical malpractice liability insurance premiums has been the substantial increase in loss payments to claimants caused by tremendous increases in the amounts of paid claims."

Discipline of healthcare providers

The centerpiece of the bill was healthcare practitioner regulatory reform. The legislative goal was expressed in the finding that:

> ...the strict regulation of healthcare practitioners is imperative to maintaining the quality of health care delivered in the state. It is, therefore, the intent of the Legislature to encourage healthcare practitioners to report possible instances of malpractice by offering them protection from civil suit. It is, further, the intent of the Legislature to facilitate the maintenance of medical practice in Florida by promptly and fairly disciplining healthcare practitioners whose performance is outside acceptable limits.

Division of Medical Quality Assurance: To this end, the bill created, staffed, and funded the Division of Medical Quality Assurance (MQA) within the Department of Business and Professional Regulation (DBPR)[269] to concentrate resources in identifying and disciplining unsafe professionals. All regulatory boards that licensed health professionals were established within this new division.[270] Included among the statutory authority and responsibilities granted to this new division, were the following:

- Established a disciplinary training program for division staff and board members.

[269] This Division was subsequently moved to the Florida Department of Health in 1997.
[270] Chapter 88-1, sections 2-44, Laws of Florida.

- Mandated facilities to report to MQA within ten days, any final disciplinary action against staff, and to report any physician who resigned or withdrew from practice to avoid such disciplinary action.

- Required all adverse incident reports by facilities to be forwarded to MQA for review for potential disciplinary action against practitioners involved.

- Required the Secretary of DBPR to review for emergency suspension any practitioner who has been found by a probable cause panel to practice below the standard of care in the treatment of three or more patients.

- Subjected to discipline any physician, who knew a second physician, working in the same facility, had violated the Medical Practice Act.

- Allowed MQA to petition circuit courts to enjoin from practice any physician who presented a danger to patients.

- Required unlicensed residents, house physicians and interns to register every two years, and disallowed such registration for persons under investigation.

- Mandated the review of all pre-suit notices, and closed claims for damages against licensees, to determine if disciplinary action should be taken.

Tort reform

Pre-suit investigation: The pre-suit investigation provisions adopted in 1976 were amended to require the plaintiff to investigate the claim prior to filing a notice of claim, instead of prior to filing suit, so the defendant would have the physician affidavit to use in evaluating the claim. The defendant was then required to obtain a similar affidavit if claiming no malpractice occurred. Additionally, the bill provided for sanctions against attorneys who failed to comply with these requirements, and against medical professionals who completed an affidavit without reasonable investigation.[271]

Pre-suit arbitration: The pre-suit arbitration process was amended to its current format to allow the parties to select pre-suit arbitration, and when selected by or agreed to by the plaintiff, it was binding with limited appeal rights. When offered by the defendant, the bill provided caps on non-economic damages in the arbitration process, and when the claimant

[271] Chapter 88-1, sections 50-53, Laws of Florida.

refused arbitration. All defendants who participated in arbitration were jointly and severally liable to the claimant for damages.[272]

Immunity for emergency room services absent reckless disregard: Absent any reckless disregard, civil immunity in hospital emergency rooms was altered to provide immunity for hospitals, hospital employees, and persons licensed to practice medicine and rendering medical care, in an emergency room. The immunity was in effect only while the patient was being treated for an emergency, and did not apply after the patient had been stabilized, unless surgery was required.[273]

Expert testimony: Expert testimony against a physician, osteopath, podiatrist, or chiropractor, who provided emergency medical services in a hospital emergency department, was limited to testimony from other like healthcare providers who had substantial professional experience within the preceding five years while assigned in an emergency department. Further, the bill requested the Florida Supreme Court to develop a standard jury instruction for use in medical negligence cases involving alleged negligence occurring in hospital emergency rooms.[274]

Payment of future economic damages: The bill established a periodic payment provision specific to medical malpractice. The bill provided for payment of an award for future economic damages to be made as a lump sum reduced to present value; or, at the request of either party, the court would order the award to be paid by periodic payments offset by collateral sources. Where periodic payments were made the defendant posted a bond or other security to assure full payment.[275]

Insurance reform

NICA: To address particular problems of obstetricians found by the 1986 task force, the bill created the Florida Birth-Related Neurological Injury Compensation Act (NICA). The plan provides a no-fault compensation plan for specified birth-related injuries.[276]

With the exception of the review of pre-suit notices, which was terminated by legislation on July 1, 2000, all of the above measures are still in effect.

[272] Chapter 88-1, sections 54-58, Laws of Florida.
[273] Chaper 88 -1, section 46, Laws of Florida.
[274] Chapter 88-1, section 78, Laws of Florida.
[275] Chapter 88-1, section 47, Laws of Florida.
[276] Chapter 88-1, sections 60-75, Laws of Florida.

1988 Proposed Constitutional Amendment On Caps

In 1988, a proposed constitutional amendment petition, proposed by the Florida Committee for Liability Reform, to place a $100,000 cap on non-economic damages was defeated at the polls.[277]

1990s Medical Malpractice Law Changes

1999 Tort Reform Act

It was a full ten years before even general tort reform, again, became a major issue warranting the Legislature's attention. In 1998, the Legislature began examining the need for general tort reform, and in 1999, a comprehensive package of tort reform legislation was passed. While chapter 99-225, Laws of Florida, did not specifically address medical malpractice, a few provisions did impact the apportionment of fault, and the collection of punitive damages in medical malpractice cases.

Tort reform

Joint and Several Liability: The bill amended joint and several liability to further limit its application to damage awards. It was completely eliminated for all non-economic damages, and its application to economic damages was based on a scale of fault. Where the defendant had a lower percentage of fault than the plaintiff, or the defendant was 10 percent or less at fault, joint and several liability was eliminated for economic damages. When the defendant was found more than 10 percent, but less than 25 percent at fault, joint and several liability was capped at $200,000. When the defendant was found to be 25 percent or more at fault but not more than 50 percent at fault, joint and several liability was capped at $500,000. When the defendant was found to be more than 50 percent at fault, joint and several liability was capped at $2,000,000.[278]

Unknown Defendant Defense: The bill also addressed when a defendant might claim that a non-party was liable for the injury to the plaintiff. In order to claim a non-party to be at fault, the defendant must affirmatively plead that defense, and absent a showing of good cause, the defendant must identify the non-party. To include the non-party on the verdict form, the defendant must prove the non-party's fault in causing the claimant's injuries by a preponderance of the evidence.[279]

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[277] Florida Constitution Revision Commission website (www.law.fsu.edu/crc/conhist/1988amen.html).
[278] Chapter 99-225, section 27, Laws of Florida.
[279] Id.

Punitive Damages: Punitive damages were significantly altered to limit claims for punitive damages, and to limit the amount of any award. The standard of culpability required to hold a defendant liable for punitive damages was changed. A defendant might only be liable for punitive damages, if the plaintiff proved by clear and convincing evidence that the defendant was personally guilty of intentional misconduct or gross negligence. "Intentional misconduct" was defined as conduct the defendant knew was wrongful, and there was a high probability it would result in injury or damage to the claimant, but intentionally pursued anyway. The term "gross negligence" was defined as conduct so reckless or wanting in care that it constituted a conscious disregard or indifference to the life, safety, or rights of persons exposed to such conduct. Further, the legislation provided for structured caps on punitive damages. These provisions were made applicable to arbitration proceedings.[280]

2000s Medical Malpractice Law Changes

The Florida Commission on Excellence in Health Care

The Florida Commission on Excellence in Health Care was created in 2000 by chapters 00-256 and 00-367, Laws of Florida, to assist in the development of a comprehensive statewide strategy for improving the healthcare delivery system. The Commission report addressed improvements in reporting standards, data collection and review, and quality measurement. It recommended the Legislature provide for the implementation of public reporting systems so clinical outcomes would be available to consumers, and recommended the creation of a Center for Public Safety and Excellence in Health Care to collect and analyze healthcare errors, adverse incidents, and near misses.

2001 Legislation

Chapter 01-277, Laws of Florida, was enacted by the 2001 Legislature as a comprehensive healthcare package. Included were provisions to implement the recommendations of the Commission on Excellence in Health Care. These recommendations included:

- Continuing Education: The 2001 act required all healthcare personnel in hospitals and ambulatory surgical centers complete a two-hour course approved by the Board of Medicine relating to the prevention of medical errors.[281]

[280] Chapter 99-225, sections 21-25, Laws of Florida.
[281] Chapter 01-277, Laws of Florida.

- Acts for Which a Physician May Be Disciplined: The 2001 act added specific standards of care, including wrong site surgery and leaving a foreign body in the patient, to the acts for which a licensee may be disciplined.[282]

- Risk Management: The 2001 act required risk management programs in hospitals and ambulatory surgical centers implement measures to minimize surgical mistakes.[283]

- Notice Regarding Disciplinary Investigations: The 2001 act allowed the Department of Health, if requested, to notify patients, or their legal representatives, of the status of disciplinary investigations, and to provide any reports from experts held by the Department.[284]

- Notice to Public: The 2001 act required the Department of Health maintain a website that contains copies of healthcare regulatory board newsletters, information relating to adverse incident reports, and information about error prevention and safety strategies.[285]

Access to Medical Malpractice Insurance

Like the rest of the nation, Florida is again facing a crisis in the availability and affordability of medical malpractice insurance that is causing a critical reduction in the quality of healthcare available in Florida. The state has lost several major carriers of medical malpractice insurance, and has seen major reductions in the availability of insurance products from the remaining providers with astronomical price increases for the coverage offered.

During 2001 and 2002, five of the major insurance companies have withdrawn from the Florida market. Table 2 listing the companies includes the reason each insurance company provided for leaving the market, and the loss ratio for each company for the years 1999 through 2001.[286] With the loss of American Physicians Assurance Corporation, St. Paul Fire & Marine Insurance Company, and American Healthcare Indemnity Company, Florida lost coverage for 12.3 percent of the total market in Florida.[287]

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[282] Id.
[283] Id.
[284] Id.
[285] Id.
[286] The loss ratio is the amount of premiums collected divided by the claims paid.
[287] Table 2.

Of the remaining twelve top companies listed in Table 3, only four are accepting new business generally, and three are accepting only specific types of new business. These companies were writing 64 percent of the insurance in Florida. This means that companies previously writing only 23.7 percent of Florida's medical malpractice business are trying to cover at least the 12.3 percent of the business from insurance companies leaving the state, and any new business for Florida.[288]

The speed with which lack of insurance has become a problem is further illustrated by the tremendous growth in the use of the insurer of last resort, the Joint Underwriting Association. Table 4 shows that in November 2001 only eighteen doctors were covered by the JUA; by November 2002 that number had increased to 460.

[288] Table 3.

TABLE 2
Physicians and Surgeons Liability Insurers (Medical Malpractice)

Departures from Florida Market

Company	Year Left Florida	Reason	2001* Direct Written Premium	2001* Loss Ratio	2000* Direct Written Premium	2000* Loss Ratio	1999* Direct Written Premium	1999* Loss Ratio
American Healthcare Indemnity Company	March-03	1. Notified the Department pursuant to section 624.430, Florida Statutes, they would no longer be writing. Effective 3/03	20,235,101	157.5%	18,275,286	88.1%	12,743,355	75.6%
American Physicians Assurance Company	2002	2. Announced on 6/24/02 that they were pulling out of Florida due to legal climate and inability to write business profitably.	26,690,239	120.2%	20,181,528	92.6%	13,857,344	62.3%
Frontier	2001	3. COA was suspended in Florida on 6/21/2001.	0	0.0%	2,228,932	22.9%	4,090,855	58.4%
PHICO	2002	4. Company placed in liquidation in Pennsylvania on 2/1/2002.	0	0.0%	15,786,263	157.1%	24,062,278	151.7%
St. Paul Fire & Marine Insurance Company	2002	5. Announced on 12/12/2001 that they would exit medical malpractice business nationwide to improve profitably.	24,422,097	170.3%	12,744,190	227.5%	21,372,913	125.3%

*Direct Written Premium Reported in Annual Statement 12/31/01 (includes all medical specialties and facilities).

1. Source: Letter dated 10/4/2002 from American Healthcare Indemnity Company advises intention to leave market March 2003.
2. Source: Press release from Business Insurance.
3. Source: CORE - DOI Database.
4. Source: CORE - DOI Database.
5. Source: The St. Paul News Release website.

TABLE 3
Professional Liability Insurance (Medical Malpractice)
Status of Writing New Business for Physicians and Surgeons as of November 30, 2002
Top 15 Writers and Other Known Active Writers

Ranking	Name	Market Share*	Type	Have rates currently filed with Department	Accepting new business
1	First Professionals Insurance Company	19.10%	Company	yes	no, will add to existing groups
2	Health Care Indemnity, Inc. (Hospitals Only)	15.50%	Company	yes	yes, their hospital group only
3	Pronational Insurance Company	9.60%	Company	yes	yes
4	Truck Insurance Exchange	6.10%	Company	yes	no
5	The Medical Protective Company	5.40%	Company	yes	yes
6	***American Physicians Assurance Corporation****	4.60%	SI Fund	yes	no new business; intend to withdraw
7	MAG Mutual Insurance Company	4.60%	Company	yes	yes
8	***St. Paul Fire & Marine Insurance Co.****	4.20%	Company	yes	no
9	Continental Casualty Company	4.10%	Company	yes	no doctors yes nurses, others
10	The Doctors' Company, An Interinsurance Exchange	4%	Company	yes	yes
11	TIG Insurance Company	3.70%	Company	yes	yes surgeons no physicians
12	Clarendon National Insurance Company	3.70%	Company	yes	no
13	***American Healthcare Indemnity Company****	3.50%	Company	yes	no effective 3/03
14	Chicago Insurance Company	2%	Company	yes	no
15	Anesthesiologists' Professional Assurance Co. Company (Anesthesiologists Only)	2%	Company	yes	no, will add to existing groups
	FL Medical Malpractice Joint Underwriting Assoc.		Residual Market	yes	yes
	Ophthalmic Mutual Insurance Co. - RRG (Ophthalmologists Only)		Risk Retention	yes	yes
	Preferred Physicians Medical - RRG (Anesthesiologists Only)		Risk Retention	yes	yes

*Direct Written Premium as reported in 12/31/01 Annual Statement. (includes all medical specialties and facilities)

**Companies in *italics* have indicated departure from the Florida market.

TABLE 4

Florida Medical Malpractice Joint Underwriting Association[289]

Policy Count for MD's and DO's	
November –01	18
December-01	25
January-02	46
February-02	63
March-02	72
April-02	95
May-02	117
June-02	133
July-02	181
August-02	192
September-02	311
October-02	415
November-02	460

Table 5 illustrates the growth of Florida's medical malpractice insurance industry during the late-1990s into 2001. There was a high of sixty-six insurance companies active in Florida in 1999. Since that time, the number of companies has decreased such that only twelve companies are writing over 99 percent of the business in Florida with only four of the top companies writing new general business.[290] These charts list the insurance companies collecting premiums in Florida since 1999, with the companies ranked from the highest to the lowest premiums collected in 2001. The charts dramatically illustrate the drop in insurance companies over the past three years.

In April 2002, the American Medical Association issued a report declaring Florida one of twelve states in the midst of a medical liability insurance "crisis." Many Florida doctors are reporting that their insurance premiums have doubled or tripled in the past two years. Their plight was demonstrated in an October 2001 survey of rates in Miami/Fort Lauderdale, and five other metropolitan areas, conducted by the Medical Liability Report. (The other areas were Detroit, Chicago, Dallas/Houston, New York City/Long Island and Los Angeles.) That study reported:

- Florida internists paid the highest rates among internists, ranging from a low of $17,611 to a high of $50,744.

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[289] Department of Insurance report (Nov. 2002).
[290] See Table 2.

- Florida general surgeons paid the second highest rates, ranging from $57,762 to $126,599.
- Florida obstetrician/gynecologists paid the highest rates of the obstetricians and gynecologists surveyed, ranging from $108,043 to $202,949.

Table 5 Company Name	2001 Med Mal Dir Prem Written	2001 Med Mal Dir Prem Earned	2001 Med Mal Dir Losses Incurred	2001 Med Mal Loss Ratio	2000 Med Mal Dir Prem Written	2000 Med Mal Dir Prem Earned	2000 Med Mal Dir Losses Incurred	2000 Med Mal Loss Ratio	1999 Med Mal Dir Prem Written	1999 Med Mal Dir Prem Earned	1999 Med Mal Dir Losses Incurred	1999 Med Mal Loss Ratio
First Professionals Ins Co	109,672,505	89,044,736	60,151,888	67.6%	69,981,763	65,649,122	36,456,829	55.5%	70,073,897	70,853,737	30,410,053	42.9%
Health Care Ind Inc	88,970,154	88,970,154	95,305,166	107.1%	79,146,087	79,146,087	55,599,597	70.2%	74,707,458	74,707,458	61,986,675	83.0%
Pronational Ins Co	55,259,931	57,149,827	51,412,895	90.0%	57,609,425	56,801,083	82,177,140	144.7%	57,114,420	56,442,471	10,419,812	18.5%
Truck Ins Exch	35,245,611	28,668,519	15,102,796	52.7%	23,585,973	23,381,222	40,439,254	173.0%	12,885,174	15,432,591	31,141,555	201.8%
Medical Protective Co	31,096,627	30,731,371	33,677,746	109.6%	25,368,190	21,618,073	39,506,544	182.7%	23,368,640	19,921,593	11,901,815	59.7%
American Physicians Assur Corp	26,690,235	21,451,709	25,789,305	120.2%	20,181,528	17,094,630	15,834,126	92.6%	13,857,344	9,682,763	6,029,043	62.3%
MAG Mut Ins Co	26,525,321	19,808,077	22,262,490	112.4%	11,788,918	9,493,590	7,392,550	77.9%	6,612,025	8,121,409	10,123,100	124.6%
St Paul Fire & Marine Ins Co	24,422,097	21,024,763	35,808,730	170.3%	12,744,190	12,941,477	29,444,458	227.5%	21,372,913	25,902,809	32,443,850	125.3%
Continental Cas Co	23,542,376	22,609,659	5,398,082	23.9%	7,661,250	6,689,494	(1,261,220)	-18.9%	4,970,235	6,933,732	5,719,685	82.5%
Doctors Co An Interins Exchn	23,223,681	20,422,981	10,707,616	52.4%	15,855,742	12,617,508	5,576,532	44.2%	8,450,127	5,158,899	3,545,474	68.7%
TIG Ins Co	21,469,578	21,880,706	15,938,329	72.8%	18,604,025	16,545,926	11,658,616	70.5%	15,081,057	14,017,435	7,830,855	55.9%
Clarendon Natl Ins Co	21,456,110	24,438,787	39,960,548	163.5%	20,192,134	16,650,086	16,648,711	100.0%	17,981,931	16,871,289	11,309,121	67.0%
American Healthcare Ind Co	20,235,101	16,151,733	25,445,948	157.5%	18,275,286	13,121,060	11,561,639	88.1%	12,743,355	11,824,723	8,940,951	75.6%
Chicago Ins Co	12,461,372	10,546,455	12,555,545	119.0%	7,850,374	6,719,822	5,161,593	76.8%	5,052,089	4,586,244	3,402,503	74.2%
Anesthesiologists Pro Assur Co	11,835,465	10,699,479	3,539,170	33.1%	8,812,061	8,332,314	5,091,966	61.1%	7,465,806	7,122,492	3,628,839	50.9%
Zurich American Ins Co	7,617,101	12,588,915	25,236,100	200.5%	14,358,978	11,176,269	28,761,206	257.3%	13,125,285	12,149,144	16,125,585	132.7%
American Cas Co Of Reading PA	4,828,738	5,460,507	15,265,523	279.6%	6,091,375	6,753,200	83,204	1.2%	6,561,361	6,814,985	14,179,758	208.1%
Medical Assur Co Inc	4,748,067	6,923,930	2,917,197	42.1%	7,414,448	6,410,726	1,865,946	29.1%	3,993,603	5,022,572	2,783,222	55.4%
Firemans Fund Ins Co	4,306,718	3,719,127	2,147,009	57.7%	1,261,151	1,053,226	776,676	73.7%	1,501	1,501	167,281	11144.6%
Harbor Specialty Ins Co	3,577,711	3,130,497	2,438,083	77.9%	-	-	-	0.0%		-	-	0.0%
NCMIC Ins Co	3,221,697	2,926,417	(108,985)	-3.7%	2,739,235	2,745,040	900,126	32.8%	2,710,058	2,840,440	619,627	21.8%
American Continental Ins Co	2,515,415	8,519,103	21,726,601	255.0%	15,177,864	14,911,499	68,482,569	459.3%	17,650,592	17,048,975	5,997,640	35.2%
Legion Ins Co	2,464,430	2,266,809	2,353,200	103.8%	2,597,484	2,084,319	1,214,946	58.3%	961,926	1,485,250	3,418,506	230.2%
Ace American Ins Co	1,695,846	1,501,882	1,119,254	74.5%	1,058,425	637,922	(37,321)	-5.9%	264,246	215,039	66,904	31.1%
Gulf Ins Co	1,536,909	1,659,953	2,243,578	135.2%	1,783,470	1,750,743	600,716	34.3%	1,824,791	1,693,975	2,055,132	121.3%
Cincinnati Ins Co	1,068,916	895,455	(198,771)	-22.2%	741,307	746,353	298,481	40.0%	735,195	737,913	665,290	90.2%
Executive Risk Ind Inc	843,225	1,109,823	2,863,729	258.0%	1,946,504	1,721,801	3,082,116	179.0%	1,243,690	1,091,131	581,355	53.3%
PACO Assur Co Inc	493,747	189,124	-	0.0%	-	-	-	0.0%	-	-	-	0.0%
Westport Ins Corp	464,552	420,165	555,596	132.2%	183,838	175,049	24,939	14.2%	139,392	131,796	(401)	-0.3%
St Paul Mercury Ins Co	445,701	947,995	(45,410)	-4.8%	991,794	701,423	7,810,017	1113.5%	688,296	715,412	10,304,841	1440.4%
Lion Ins Co	435,418	556,913	3,211,788	576.7%	550,608	566,952	1,445,236	254.9%	884,975	303,292	215,000	70.9%
St Paul Guardian Ins Co	427,533	571,934	4,387,539	767.1%	1,560,427	2,543,116	10,851,298	426.7%	1,498,684	3,437,219	4,531,489	131.8%
Connecticut Ind Co	368,422	342,100	76,530	22.4%	338,905	257,483	40,791	15.8%	108,731	33,133	-	0.0%
Granite State Ins Co	366,510	355,814	1,162,430	326.7%	344,304	322,409	196,636	61.0%	280,273	132,617	1,278,693	964.2%
Athena Assur Co	350,252	440,000	908,730	206.5%	945,801	1,596,217	3,593,057	225.1%	2,163,918	2,297,639	1,825,485	79.5%
American Home Assur Co	264,868	179,213	(674)	-0.4%	-	-	-	0.0%	100,000	447,398	(202,367)	-45.2%
National Union Fire Ins Co Of Pitts	186,737	223,577	8,033,243	3593.1%	374,626	1,269,119	8,536,785	672.7%	2,468,114	3,461,738	8,639,937	249.6%
TIG Ind Co	152,070	220,934	624,110	282.5%	261,085	245,785	308,179	125.4%	185,387	104,399	73,821	70.7%
General Ins Co Of Amer	135,311	104,883	36,276	34.6%	47,605	32,478	(10,538)	-32.4%	7,246	5,120	13,332	260.4%
National Fire Ins Co Of Hartford	56,211	619,348	8,919,312	1445.0%	3,445,058	2,977,794	(1,328,018)	-44.6%	977,662	861,878	1,726,026	200.3%
Church Mut Ins Co	43,062	30,669	51,106	166.6%	23,950	23,880	152,658	639.3%	24,475	24,313	65,902	271.1%
Lawrenceville Prop & Cas Co	34,226	32,493	25,011	77.0%	26,182	24,801	16,232	65.4%	-	-	-	0.0%

Company explanations for abnormal loss ratios include the following: (1) several large paid losses in a given year, (2) only one or two polices written in respective year, (3) reserve strengthening, and (4) decreases in the amount of new medical malpractice business written, due to an unfavorable pricing environment and unacceptable loss experience

Company Name	2001 Med Mal Dir Prem Written	2001 Med Mal Dir Prem Earned	2001 Med Mal Dir Losses Incurred	2001 Med Mal Loss Ratio	2000 Med Mal Dir Prem Written	2000 Med Mal Dir Prem Earned	2000 Med Mal Dir Losses Incurred	2000 Med Mal Loss Ratio	1999 Med Mal Dir Prem Written	1999 Med Mal Dir Prem Earned	1999 Med Mal Dir Losses Incurred	1999 Med Mal Loss Ratio
National Cas Co	11,631	178,765	1,147,391	641.8%	484,414	485,078	1,974,421	407.0%	453,257	454,467	292,509	64.4%
National Surety Corp	5,143	3,392	-	0.0%	2,160	630	-	0.0%	-	-	-	0.0%
Insurance Co Of The State Of PA	1,987	3,076	(7,543)	-245.2%	4,385	5,117	(7,446)	-145.5%	9,457	15,177	(11,935)	-78.6%
Colony National Ins Co	1,875	2,454	(105,377)	-4294.1%	2,042	75,148	98,400	130.9%	219,817	302,389	(30,952)	-10.2%
Nationwide Mut Fire Ins Co	1,787	1,787	(391)	-21.9%	1,774	2,048	207	10.1%	2,061	2,237	(169)	-7.6%
Kemper Cas Ins Co	1,443	544	-	0.0%	-	-	-	0.0%	-	-	-	0.0%
Bankers Standard Ins Co	882	4,526	(1,209)	-26.7%	8,133	6,383	(6,646)	-104.1%	4,206	7,054	(2,928)	-41.5%
Nationwide Mut Ins Co	512	918	100	10.9%	918	1,443	(656)	-45.5%	2,295	2,283	267	11.7%
American States Ins Co	486	486	154	31.7%	486	486	-	0.0%	486	486	(2)	-0.4%
Reciprocal of America	-	-	-	0.0%	5,157	645	(15,013)	-2327.6%	-	-	-	0.0%
Valley Forge Ins Co	-	-	-	0.0%	739	739	-	0.0%	-	-	-	0.0%
Continental Ins Co	-	-	-	0.0%	1,307	1,307	163,205	12487.0%	-	-	-	0.0%
Phico Ins Co	-	-	-	0.0%	15,786,263	22,919,498	36,004,638	157.1%	24,062,278	19,204,861	29,136,738	151.7%
Unisource Ins Co	-	-	-	0.0%	1,709,190	4,456,439	6,187,349	138.8%	7,454,123	7,672,664	12,153,382	158.4%
Genesis Ins Co	-	-	-	0.0%	35,983	35,982	12,000	33.4%	32,424	37,699	26,000	69.0%
Insurance Co Of North Amer	-	-	-	0.0%	4,802	3,960	786,052	19849.8%	-	-	-	0.0%
Travelers Ind Co Of IL	-	-	-	0.0%	231,102	231,102	1,565,948	677.6%	141,914	998,579	314,138	31.5%
Frontier Ins Co	-	-	-	0.0%	2,228,932	3,429,691	786,007	22.9%	4,090,855	5,882,715	3,435,236	58.4%
Transportation Ins Co	-	-	-	0.0%	15,901	20,144	-	0.0%	7,687	23,953	12,763	53.3%
Valiant Ins Co	-	-	-	0.0%	-	-	-	0.0%	89	89	-	0.0%
Fremont Ind Co	-	-	-	0.0%	-	-	-	0.0%	21,660	29,119	-	0.0%
Ace Fire Underwriters Ins Co	-	-	-	0.0%	-	-	-	0.0%	309,689	365,073	4,297,778	1177.2%
Nationwide Prop & Cas Ins Co	-	-	-	0.0%	-	-	-	0.0%	308	308	5	1.6%
Reliance Natl Ind Co	-	-	-	0.0%	-	-	-	0.0%	134,402	140,935	(49,232)	-34.9%
Century American Cas Co	-	-	-	0.0%	-	-	-	0.0%	11,077	14,146	958,668	6777.0%
Reliance Natl Ins Co	-	-	-	0.0%	-	-	-	0.0%	1,138	1,033	13	1.3%
Odyssey American Reins Co	-	-	-	0.0%	-	-	-	0.0%	2,760	58,117	310,622	534.5%
Pennsylvania General Ins Co	-	-	-	0.0%	-	-	-	0.0%	2,192	1,331	24,070	1808.4%
Reliance Ins Co	-	-	-	0.0%	-	-	-	0.0%	100,637	99,419	(73,780)	-74.2%
OneBeacon Ins Co	-	-	-	0.0%	-	-	-	0.0%	2,409	1,939	20,870	1076.3%
Illinois Natl Ins Co	-	-	-	0.0%	-	-	-	0.0%	28,524	125,480	(77,816)	-62.0%
Interstate Ind Co	-	-	-	0.0%	-	-	-	0.0%	10,400	10,400	1,095	10.5%
Travelers Ind Co	-	-	-	0.0%	-	-	-	0.0%	-	-	-	0.0%
American Guarantee & Liability Ins	-	-	-	0.0%	-	-	-	0.0%	-	-	-	0.0%
Century American Ins Co	-	-	-	0.0%	-	-	-	0.0%	-	-	-	0.0%
Ace Prop & Cas Ins Co	-	-	-	0.0%	-	-	-	0.0%	-	-	-	0.0%
Home Ins Co	-	-	-	0.0%	-	-	-	0.0%	-	-	-	0.0%
Glens Falls Ins Co	-	-	-	0.0%	-	-	-	0.0%	-	-	-	0.0%
Kansas City Fire & Marine Ins Co	-	-	-	0.0%	-	-	-	0.0%	-	-	-	0.0%
Century Ind Co	-	-	-	0.0%	-	-	-	0.0%	-	-	-	0.0%
Fidelity & Cas Co Of NY	-	-	-	0.0%	-	-	-	0.0%	-	-	-	0.0%
Travelers Ind Co Of Amer	-	-	-	0.0%	-	-	-	0.0%	-	-	-	0.0%

Company explanations for abnormal loss ratios include the following: (1) several large paid losses in a given year, (2) only one or two polices written in respective year, (3) reserve strengthening, and (4) decreases in the amount of new medical malpractice business written, due to an unfavorable pricing environment and unacceptable loss experience

Testimony About The Florida Problem

Consumer Perspective

Upon being injured, the victim of medical malpractice is forced to step into the legal system in order to receive some type of remedy. At the same time, patients are aware of the need to have access to affordable healthcare. The Task Force heard that consumers want a system that ensures quality medical coverage is available in Florida.[291] Consumers also want a system that minimizes medical errors; and, when they are made, to hold medical care providers responsible.[292] Finally, consumers want a system that allows physicians to learn from their mistakes.[293]

Some consumers argue that this so-called "crisis" is nothing more than the underwriting cycle of the insurance industry, and driven by the same factors that caused the "crises" in the 1970s and 1980s.[294] According to consumer activist, Ms. Joanne Doroshow, with each crisis, there has been a severe drop in the investment income for insurers, which has been compounded by sever under-pricing of insurance premiums in the prior years.[295] Ms. Doroshow explained, during years of high interest rates or excellent insurer profits that are invested for maximum return, the insurance companies engage in fierce competition for premium dollars by selling under-priced premiums and insuring very poor risks.[296] Then, Ms. Doroshow noted, when investment income drops, either due to decreases in interest rates or the stock market, or due to low income resulting from unbearably low premiums, the insurance industry responds by sharply increasing premiums and reducing coverage.[297]

Thus, tort reform changes will do nothing to alleviate the insurance crisis, but will impact significantly injured patients.[298] The tort reform changes in the 1980s had nothing to do with the flattening of rates. The flattening was caused instead by modulations in the insurance cycle throughout the country.[299]

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[291] Nick Bartol, testimony, Oct. 21, 2002, pg. 138.
[292] Id. at 112.
[293] Id.
[294] Joanne Doroshow, testimony before the U.S. House Subcommittee on Commercial and Administrative Law, Oversight Hearing on Healthcare Litigations Reform, "Does Limitless Litigation Restrict Access To Health Care?" (June 2, 2002).
[295] Id. at 2.
[296] Id. at 6.
[297] Id.
[298] Id.
[299] Id. at 3.

To illustrate this and support their claim, the Center for Justice and Democracy presented actuarial data to the Task Force. The data show tort reform changes in California, including the cap on damages, did not cause the rate of change in insurance premiums in California to be significantly different from the rate of change in the rest of the country.[300] The Center further argued that, although the California law had little impact on premiums, it had a devastating impact on people injured by malpractice.[301]

Testimony to the Task Force meetings included the following statements regarding consumer concerns:

- The 1999 Institute of Medicine (IOM) report stated that 44,000 to 98,000 patients die every year as a result of medical errors in hospitals.[302]

- Evidence indicates that between 8 to 15 percent of companies are dropping health insurance coverage for their employees. In small companies, those with between two and fifty employees, the figure is much higher.[303]

- About 14 to 15 percent of Americans are uninsured. Last year there were 142 million Americans who had employer-sponsored coverage. If one in seven of them fell out of the system, the number of uninsureds would increase by approximately 20 million people, which would be a 50 percent increase.[304]

- The message from the IOM report regarding patient safety has become distorted. A Kaiser Family Foundation survey done after the release of the IOM report found that about one-third of the public believes that the IOM report was about bad doctors and that the necessary solution is more punitive malpractice laws to punish those doctors.[305]

- In the 1990s, numerous insurance companies with no experience in medical malpractice entered Florida's medical malpractice insurance market. Their inexperience led them to take bigger risks than other companies, which drove up costs, because of their mishandling of claims. These insurers also kept rates artificially low as they tried to

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[300] Id. at 4. J. Robert Hunter, former Texas Insurance Commissioner and Federal Insurance Administrator under Presidents Ford and Carter, compared national malpractice premiums trends to those in California.
[301] Id. at 4.
[302] Becky Cherney, testimony, Oct. 21, 2002, pgs. 123-125.
[303] Brian Klepper, Ph.D., testimony, Nov. 4, 2002, pgs. 231-232.
[304] Id. at 233-234.
[305] Michelle Mello, J.D., Ph.D., testimony, Nov. 4, 2002, pg. 293.

undercut the established insurers, and write as many policies as possible to better turn this capital into investment income.[306]

- At the same time doctors are being squeezed by their malpractice insurers, they also are facing reduced reimbursement rates from Medicare and HMOs.[307]

- According to the National Practitioner Data Bank, the average payout to victims of medical negligence in Florida for the year 2000 is only $259,000. This places Florida twenty-first in the nation in average payout to victims.[308]

- Punitive damages are very rare. According to the Bureau of Justice Statistics, only 1.1 percent of medical malpractice plaintiffs, who won their cases, were awarded punitive damages in 1996.[309]

- According to the American Medical Association, states without caps have 4.4 percent more physicians per capita than those states that do have caps on damages. Also, the average malpractice premium for doctors of internal medicine is 2.2 percent higher in states that cap damages than in states that do not cap damages.[310]

- In Nevada, even after caps were passed, the insurance companies stated that they would not bring down rates. In Mississippi, they said the same thing. Even after tort reform was enacted in Florida in 1986, capping non-economic damages, Aetna and St. Paul said they were not going to reduce rates.[311]

- Filings by 104 insurers in Florida in 1986 showed that out of 277 filings, 175, or 63 percent, showed no savings from tort reform, while none showed savings of more than 10 percent.[312]

- In a 1999 study, trends in insurance rates since the mid-1980s in every state in the country were plotted against and correlated with the exact tort reforms that had passed. The study found absolutely no correlation between the enactment of tort reform and insurance rates.

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[306] Academy of Florida Trial Lawyers, Medical Malpractice: The Facts Behind the Insurance Rate Increases, 1-2.
[307] Id. at 2.
[308] Id. at 3.
[309] Id.
[310] Id.
[311] Joanne Doroshow, testimony, Oct. 21, 2002, pg. 150.
[312] Id.

Many states that had enacted severe tort reform saw approximately the same kind of rate increases as states that did nothing.[313]

- The cost of medical negligence has been estimated variously at $20 billion to $29 billion a year, depending on the source. The total cost of medical liability insurance in this country is $6.4 billion, or approximately one-third the cost of medical errors.[314]

- There are approximately 710,000 adverse events a year. However, there are only 10,000 payments made a year to plaintiffs for medical malpractice.[315]

- Physicians tend to misjudge their legal risks on a radical scale. Physicians have about a 2 percent risk of being sued over a negligent injury. Nonetheless, when physicians are surveyed about their perceived risk, they believe it is closer to 60 percent. Additionally, physicians underestimate the link between injuring their patients negligently, and being sued.[316]

- A company with 5,000 active employees and approximately 1,500 retirees is forecasting double-digit benefit cost increases for the next five years. Its costs will escalate from $41 million in 2002, $49 million in 2003, $58 million in 2004, and $68 million by the year 2005 if changes are not made to its benefits program. Owing to costly ineffective insurance products, in order to afford retiree healthcare costs, this company is going to have to either reduce its costs or make reductions in benefits.[317]

- Iris Roche is a 94-year-old woman who has just learned that her own surgeon is retiring early because his insurance costs increased greatly.[318]

- In the thirtieth week of her pregnancy, Carla Rachel Borchers' obstetrician informed her that her doctor would not longer practice obstetrics due to rising malpractice insurance costs. Ms. Borchers had to find a new obstetrician to deliver her daughter, even though she was well into her third trimester.[319]

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[313] Id. at 150-151.
[314] Jackson Williams, testimony, Oct. 21, 2002, pg. 155.
[315] Id. at 157.
[316] Michelle Mello, J.D., Ph.D., testimony, Nov. 4, 2002, pg. 295.
[317] Wendy McCoy, testimony, Oct. 21, 2002, pgs. 126-129.
[318] Iris Roche, testimony, Oct. 21, 2002, pgs. 129-133.
[319] E-mail from Carla Rachel Borchers to William Large, Counsel, Governor's Select Task Force on Healthcare Professional Liability Insurance (Jan. 27, 2003) (Vol. 11, Tab 585).

- In June 1980, Nick Bartol's wife died of a malpractice issue. He believes there should be fair compensation for individuals affected by medical errors and related medical costs and loss of income potential where applicable. However, with regard to medical care, he is also concerned that physicians will not try new procedures because of the risk.[320]

- Two academic studies have found that the number of medical errors greatly exceeds the number of claims for malpractice. Data from the Florida Agency for Health Care Administration indicate that reports of preventable adverse incidents coming from Florida hospitals exceed malpractice claims reported by those hospitals by a ratio of six-to-one.[321]

- In 1999, Jacqueline Imbertson's husband was the victim of medical negligence, when he was hospitalized for heart by-pass surgery. A nurse mistakenly gave him an entire bag of Lidocaine in less than five minutes, instead of the Hespan that he was supposed to have received. As a result, he went into cardiac arrest, suffered catastrophic damage, is in constant and excruciating pain and must now undergo a heart transplant. Jacqueline Imbertson has taken on the role of her husband's full-time caregiver.[322]

- Charles Dubie's mother died after having negligently been given an overdose of a heart medication at a nursing home. Although he and his brother retained legal counsel, he states that he would trade any amount of money to have his mother back or at least know that her final days were peaceful.[323]

- Data from the Department of Insurance shows that, per 100,000 people, from 1991 to 2001, there has been no dramatic increase in the number of claims being paid or the number of lawsuits being brought. In fact, they are now looking to be below the 1991 level.[324]

- The average paid claim for 2001 was $249,000, which was below the national average of approximately $310,000. The National Practitioner Database ranks Florida 21st in the nation in average payouts.[325]

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[320] Nick Bartol, testimony, Oct. 21, 2002, pgs. 138-139.
[321] Jackson Williams, testimony, Oct. 21, 2002, pgs. 153-154.
[322] Jacqueline Imbertson, testimony, Oct. 21, 2002, pgs. 162-165.
[323] Charles Dubie, testimony, Oct. 21, 2002, pgs. 349-350.
[324] Neal Roth, J.D., testimony, Oct. 21, 2002, pg. 273.
[325] Id.

- Florida has seen a 40 percent increase in the number of physicians practicing in the state over the last forty years.[326]

- Florida's two largest medical malpractice insurers are FPIC and Pro Assurance. Both are healthy and very profitable. FPIC has made a profit in each of the last ten years and Pro Assurance has made profits in nine out of the last ten years. FPIC and Pro Assurance also saw their surpluses grow from 1991 to 2001, by over 259 percent and 563 percent, respectively.[327]

Healthcare Provider Perspective

The testimony of healthcare providers indicated a very different perspective. As a group, physicians and hospitals are reeling from the rapid increase in medical malpractice insurance premiums. Physicians are being forced to leave Florida to practice in other states where insurance rates are more acceptable or obtainable.[328] The Task Force heard that the financial burden of escalating liability insurance premiums makes the continued practice of medicine in Florida increasingly unsustainable.[329] The immediate and long-term affects of this crisis are a decreasing number of doctors staying in practice.[330] The doctors that remain are forced to practice unnecessary defensive medicine.[331]

Many high-risk specialties are even more acutely affected by this crisis. Obstetricians in Florida have seen a 40 percent increase in premium rates since 1999, with even more substantial increases looming on the immediate horizon.[332] At present, obstetricians contracting for the statutorily required $250,000 worth of coverage pay premiums ranging from $90,000 to $107,000 a year. In addition, many of these obstetricians are seeing their insurance carriers leave the market, and find themselves unable to find coverage elsewhere.[333] The results are that hospitals are discontinuing obstetrical services and obstetricians are curtailing medical care to high-risk patients for fear of liability exposure.[334]

At the same time, physicians that do continue to practice, practice expensive and unnecessary defensive medicine. One physician noted,

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[326] Id. at 274.
[327] Id. at 275.
[328] Joel Rose, D.O., testimony, Oct. 21, 2002, pg. 37.
[329] Joel Saranko, M.D., testimony, Oct. 21, 2002, pg. 39.
[330] George Tershakovec, M.D., testimony, Oct. 21, 2002, pg. 45.
[331] Robert W. Yelverton, M.D., The Impact of the Professional Liability Insurance Crisis on Quality Healthcare for Florida Women, presentation, Oct. 20, 2002.
[332] Robert Yelverton, M.D., testimony, Oct. 21, 2002, pg. 56.
[333] Id.
[334] Id. at 56–61.

"Defensive medicine is the seldom-discussed tragedy of the litigation crisis. Unable to rely any longer on sound judgment molded by years of training and experience, OB/GYNs, by necessity, are performing more Cesarean sections and ordering expensive diagnostic procedures in order to protect themselves legally, . . . discontinuing or severely limiting high risk or technically sophisticated surgical procedures."[335]

Testimony from the Task Force meetings, related to doctors' concerns, included the following statements:

- 1975 was the first year that actuaries informed insurance carriers that they could not guarantee the premiums that they were recommending the carriers charge today, would pay tomorrow's claims.[336]

- What we have, after 27 years of studying and trying to solve this problem, is a problem that is 3,074 percent worse than it was when we started.[337]

- The Physician Insurers Association of America (PIAA) Data Sharing Project is a medical cause-of-loss database with information from nearly 190,000 claims made since 1985. Data from this source show that the mean average indemnity payment over this period of years has risen precipitously. Today, the average indemnity payment is about $326,000 per defendant in a medical malpractice case, and in each malpractice claim, there is usually more than one defendant.[338]

- If an indemnity payment is made on a claim, the average payment is about $43,000 in mostly legal fees. If an indemnity payment is not made, insurance companies still pay about $23,000 to $24,000 in legal fees just to handle those claims.[339]

- Of all claims reported to the database in 2001, 61 percent were dropped or dismissed, because they were without merit; in 5.7 percent, there was a verdict for the defense. In two-thirds of all claims, there was no payment to the plaintiff. Only 1.3 percent of the claims ever reported, were paid verdicts; the remaining payments were made via settlements.[340]

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[335] Robert W. Yelverton, M.D., The Impact of the Professional Liability Insurance Crisis on Quality Healthcare for Florida Women, presentation, Oct. 20, 2002.
[336] Robert E. White, Jr., testimony, Oct. 21, 2002, pg. 181.
[337] Id.
[338] Lawrence Smarr, testimony, Oct. 21, 2002, pgs. 201-202.
[339] Id. at 202.
[340] Id. at 202-203.

- The mean verdict was almost $500,000 on behalf of an individual doctor and claim. When an insurance company wins at trial, it pays $91,000 to win the case. If it loses, it spends about $86,000. Whether or not the suit is dropped or dismissed, the company still spends almost $17,000 to handle those cases.[341]

- Between 1997 and 2000, the average jury award in medical malpractice cases doubled from about $500,000 to about $1,000,000. Settlements also have gone up commensurately.[342]

- On average nationally, there are 10,454 services per thousand; in Florida, there are 12,602. On a national basis, radiology services represent 252 per thousand, but 368 in Florida; nationally there are 758 lab services per thousand, but 1,087 in Florida.[343]

- In a national poll of physicians, the overwhelming majority of doctors say that the threat of malpractice lawsuits does not make them deliver better quality care. Over nine out of ten doctors think the threat of liability suit has increased defensive medicine. And over half of the physicians surveyed say that the current medical liability system makes physicians less willing to report medical errors.[344]

- The average neurosurgeon has a claim every other year. Fifty percent of neurosurgeons are sued every year, 40 percent of plastic surgeons, 35 percent of orthopedists, 30 percent of general surgeons, and 30 percent of obstetricians. We are not suing America's bad doctors; we are suing all physicians in America.[345]

- A 1996 Harvard Medical Practice study that appeared in the New England Journal of Medicine concluded that there is no correlation between the presence or absence of medical negligence, and the outcome of malpractice litigation. The only variable that they could find that related to the outcome of medical malpractice litigation was the degree of injury. If you are more severally injured, you are more likely to be compensated.[346]

- Health and Human Services estimates that the cost of defensive medicine is $100 billion a year.[347]

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[341] Id. at 203.
[342] Richard Anderson, M.D., testimony, Nov. 4, 2002, pgs. 41-42.
[343] David Lubben, J.D., testimony, Oct. 21, 2002, pgs. 107-108.
[344] Steve Demontmolin, testimony, Oct. 21, 2002, pgs. 111-113.
[345] Richard Anderson, M.D., testimony, Nov. 4, 2002, pg. 37.
[346] Id. at 48-49.
[347] Id. at 59.

- Over the past twenty years, healthcare premiums have risen at a constant multiple of twice the general inflation. In 2001, those premiums increased an average of 12.7 percent across the United States. This was eight times the rate of general inflation. In 2002, healthcare premiums are expected to go up between 15 and 23 percent, or about ten to eleven times the general inflation.[348]

- Many hospitals are facing premium increases of 300 percent.[349]

- Many physicians on staff at statutory teaching hospitals are refusing to continue voluntary teaching. These physicians do not want the liability associated with the medical students and high-risk patients, given the kind of medical malpractice verdicts that are occurring.[350]

- At the same time, as not-for-profit hospitals find their insurance premiums increasing, they are unable to invest services back into their hospital.[351]

- Although hospitals realize that they may be able to operate without capital, they are fearful that they will not be able to operate without physicians.[352]

- In Broward County alone, 400 physicians have left the state, or retired early in the past year. Nationally, since 1991, overhead costs have increased by 48 percent. In Florida, due to the increase in premiums for liability insurance, [overhead costs] have increased about 60 percent. In South Florida, physicians are working seven to eight months of the year to simply pay their overhead costs, and much of the overhead dollars are attributed to liability premiums. In one instance, a Fort Lauderdale pediatric orthopedic surgeon's premiums went from $32,000 to $96,000 a year. Because of the increase, this physician is planning to return to his home state, Louisiana, as that state has tort reform.[353]

- In Florida, one in every two neurosurgeons and one in every three general surgeons will be sued at some point.[354]

- Palm Beach Gardens Hospital has lost all but one of its neurosurgeons, and this particular surgeon can take calls only part of

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[348] Brian Klepper, Ph.D., testimony, Nov. 4, 2002, pgs. 230-231.
[349] Rich Reiner, testimony, Oct. 21, 2002, pg. 296.
[350] John Hillenmeyer, testimony, Oct. 21, 2002, pg. 289.
[351] Id. at 294.
[352] Rich Reiner, testimony, Oct. 21, 2002, pg. 298.
[353] Robert E. Cline, M.D., testimony, Oct. 21, 2002, pgs. 19-20.
[354] Id. at 21.

the time. As a result, neurological surgical care is void for a couple of weeks a month.[355]

- Jacksonville's forty-four obstetricians will see their premiums go from $40,000 to $100,000 per year per person. The same is true for the fifty-two physicians providing obstetrical services in Tampa.[356]

- Teriesita Hernandez, M.D. completed a geriatric fellowship because she wanted to help nursing home patients, but has since found that she is unable to practice that profession because the malpractice insurance is so high. She is unable to find a carrier outside the state, and for part-time coverage, she would have to pay $31,000. She has become so frustrated that she is no longer seeing patients.[357]

- According to testimony provided by a representative of the Florida Medical Directors Association (FMDA) to the Florida House Select Committee on Liability Insurance for Long Term Care Facilities, medical malpractice premiums for medical directors increased 500 percent in the last year. In addition, results from a recent FMDA survey showed that 27 percent of the physicians who practice in nursng homes have been notified that their medical malpractice insurance will either not be renewed or that their premiums will increase further specifically because they are primary care physicians for nursing home residents. Fifty-six percent of the medical directors who responded to the survey indicated that they would not continue to serve as a medical director if their professional liability insurance is cancelled.[358]

- Largo Medical Center is just one of six obstetrical centers that has closed, or will be closing, its maternity ward by the end of the year, because it has lost two obstetricians because of the soaring costs of liability insurance. Liability rates for one of the obstetricians went from $43,000 per year to $180,000, which forced her to stop practicing. The patients left behind are impacted because they must find another physician to deliver their babies, if they can.[359]

- Nearly 70 percent of all residents trained in family medicine traditionally have remained in Florida to practice their specialty. Conversely, in 2002, new residency graduates often cannot practice in

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[355] Id. at 26.
[356] Id. at 27.
[357] Teriesita Hernandez, M.D., testimony, Oct. 21, 2002, pg. 35.
[358] Letter from Janegale Boyd, President/CEO & Jack M. Norton, Chair, Florida Association of Homes for the Aging, to William Large, Counsel, Governor's Select Task Force on Healthcare Professional Liability Insurance (Oct. 14, 2002) (Vol. 11, Tab 480).
[359] Joel Rose, D.O., testimony, Oct. 21, 2002, pg. 37.

Florida because they cannot obtain or afford the insurance necessary to do so.[360]

- Insurance premiums for general surgeons have skyrocketed 300 percent from 1999 to 2001. The rates for 2002 will increase another 20 to 30 percent and it is anticipated that the following two to three years will show a continued upward increase in premium charges at that rate or higher.[361]

- This past May, one physician group that staffs six emergency departments in South Florida experienced a 400 percent increase in its malpractice premiums.[362]

- OB/GYN physicians have experienced a 40 percent increase in medical malpractice premiums beginning in 1999.[363]

- One million dollars in coverage, a traditional policy amount for OB/GYNs, costs $70,000 to $110,000 per year for those OB/GYN physicians who can even find such a policy. Policy coverage in the amount of $250,000 is what most Florida obstetricians have had to settle for, and this minimum policy amount ranges in price from $90,000 to $107,000 per year.[364]

- Most Florida obstetricians are taking legal measures to protect assets with plans to meet the state requirements for practicing without professional liability insurance. For example, in Miami, 80 percent of the OB/GYNs currently carry no insurance, and it is anticipated that the rest will follow their lead in 2003.[365]

- Orlando has lost twelve OB/GYNs in the last year, which represents 10 percent of their work force. Twenty to 25 percent of the OB/GYNs now work without insurance.[366]

- In Tampa, a similar phenomenon is occurring. Three OB/GYNs have quit or retired early and many more are planning to practice without insurance.[367]

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[360] Id. at 38.
[361] George Tershakovec, M.D., testimony, Oct. 21, 2002, pg. 44.
[362] Arthur Diskin, M.D., testimony, Oct. 21, 2002, pg. 50.
[363] Robert Yelverton, M.D., testimony, Oct. 21, 2002, pg. 56.
[364] Id. at 56-57.
[365] Id. at 58-60.
[366] Id. at 59.
[367] Id. at 59-60.

- Judeo Christian Clinic is going to have to close its gynecological clinic for lack of staffing. Largo Medical Center and Doctors' Hospital have also closed.[368]

- Because of the egress of doctors from the state, Arnold Lazar, M.D., an OB/GYN, has several patients in his practice who have seen two other obstetricians during their current pregnancy.[369]

- Collier County has 50,000 residents under the age of eighteen. Although there are five neurosurgeons in Collier County, none of them see pediatric patients. Last year, 139 Collier trauma patients had to be transported by helicopter to the nearest Level II trauma center in Lee County for treatment. Some of these were pediatric patients who had suffered head trauma. However, neurosurgeons in Lee County also avoid taking on patients under the age of eighteen. Thus, these patients are typically flown in a second helicopter to Tampa for treatment. The reason neurosurgeons in Collier County and Lee County are avoiding these young patients is because of the risk of $10,000,000 jury awards.[370]

- Rates for physicians practicing in skilled nursing facilities and nursing homes have increased by as much as 500 percent.[371]

- A survey requested by the Florida House Select Committee on Liability Insurance for Longer-Term Care Facilities and conducted by the Florida Medical Directors Association shows that 16 percent of physicians have stopped following nursing home patients in the last twelve months due to the liability coverage. Another 22 percent of physicians in nursing homes report they will not be able to see patients due to the liability rate increases in the coming year. And 27 percent report that they have been notified that their insurance will not be renewed this year due to the fact that they follow nursing home residents.[372]

- Fleur Sack, M.D. is a physician who, although trained to take care of fractured fingers, is no longer able to do so as her insurance carrier does not support this. Dr. Fleur must now refer those patients to orthopedists who in turn are starting to refer the patients to even more specialized hand surgeons who already have high caseloads.[373]

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[368] Id. at 60.
[369] Arnold Lazar, M.D., testimony, Oct. 21, 2002, pg. 65.
[370] Frank Schwerin, M.D., testimony, Oct. 21, 2002, pgs. 67-70.
[371] John Potomski, M.D., testimony, Oct. 21, 2002, pgs. 75-76.
[372] Id. at 77-79.
[373] Fleur Sack, M.D., testimony, Oct. 21, 2002, pgs. 80-83.

- Florida neurosurgeons get sued once every 2.5 years. As a result, many neurologists are no longer performing brain surgery. For example, one neurosurgery group is no longer performing pediatric neurosurgery after having done so for the last twenty years because of the threat of suit.[374]

- In 1988, Florida was the site of 25 percent of all the United Health Group Company's professional liability litigation; it has now become home to 42 percent of such litigation. During the same period, Florida's share of the company's litigation costs for the entire enterprise has increased from 30 to 42 percent. Over half of the company's professional liability suits are in Florida.[375]

- According to the National Practitioner's Data Bank, $326,000,000 was paid out on behalf of Florida physicians only last year, and the total paid to patients has increased 33 percent since 1999.[376]

- The top-ten jury awards in Florida have all occurred since 1998.[377]

- Nationally, one out of every forty-four doctors pays an indemnity payment; in Florida, it is one out of every eighteen doctors.[378]

- The most prevalent rate in the rest of the United States for a doctor is one million dollars per claim. Many states' doctors carry multi-million dollar claim limits. However, in Florida, over half the doctors that carry insurance today can only afford to carry a $250,000 policy limit.[379]

- In Georgia, physicians pay from $5,000 to $6,000 for $1,000,000 of coverage. Thirty miles south, in Jacksonville, that costs $27,000. This difference is due to the difference in the tort system between the two states.[380]

- The nation's second largest medical malpractice carrier, St. Paul, had its loss ratio from 1997 to 2001 range from 107.5 percent to 365 percent. They withdrew from the Florida market.[381]

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[374] Id. at 87.
[375] David Lubben, J.D., testimony, Oct. 21, 2002, pgs. 106-107.
[376] Robert E. White, Jr., testimony, Oct. 21, 2002, pgs. 181-182.
[377] Id. at 182.
[378] Id. at 183.
[379] Id.
[380] Id. at 185.
[381] David McKenney, testimony, Oct. 21, 2002, pg. 191.

- Nationwide, just over 30 percent of plaintiffs receive an indemnity payment; in Florida, one out of every two individuals receives an indemnity payment.[382]

- The GE Medical Protective Insurance Company is the oldest writer of medical malpractice insurance in the United States. In Florida, its frequency of claims has been consistently higher compared to those countrywide. In 2001, there were approximately fourteen claims per 100 physicians insured in Florida, versus approximately nine claims per 100 physicians insured on a nationwide basis.[383]

- It is more difficult to close non-meritorious claims here in Florida as compared to the rest of the country. On a paid-to-reported basis in 1996, it was paying out approximately 44 percent of the cases that were reported in Florida; on a nationwide basis, this figure is between 32 to 33 percent. In 1996, its average Florida payment was $200,000, compared to the nationwide average of $210,000. However, by 2001, the average had increased to approximately $280,000 per Florida case, versus $225,000 countrywide.[384]

- From 1981 to 1991, Florida has experienced an 86 percent increase in litigation as its population increased only 41 percent.[385]

- Orlando Regional Healthcare's medical liability insurance program, which was a $2 million self-insured retention with up to $40 million in aggregate coverage, was costing it $1.3 million a year. Beginning May 1, 2002, its self-insured retention was raised to $5 million, and for the same $40 million coverage, Orlando Regional Healthcare's new premium is $9.8 million a year.[386]

- Orlando Regional Healthcare's Level I trauma center is at risk because it takes in the highest-risk cases from a twenty to twenty-five county area. It now has physicians who will not take Level I trauma calls.[387]

- On average, statutory teaching hospitals lose about $93,000 per resident each year, because training residents requires more time and additional staff. Orlando Regional Healthcare depends on private community physicians to help train its residents. But, it is finding that more and more physicians are refusing to continue the voluntary

[382] Id. at 194.
[383] William E. Daley, testimony, Oct. 21, 2002, pgs. 208-209.
[384] Id. at 209-210.
[385] George Meros, J.D., testimony, Oct. 21, 2002, pg. 249.
[386] John Hillenmeyer, testimony, Oct. 21, 2002, pg. 286.
[387] Id. at 287.

teaching, because they do not want the liability associated with the students.[388]

- The Florida Hospital Association's most pressing issue is dealing with the physician shortage. Some of its member facilities are unable to provide basic services such as orthopedics. For example, a hospital in Highlands County has four orthopedists on the medical staff. One, in his middle-50s and who has served that community for twenty-five years, cannot afford the 100 percent increase in his insurance premiums and will leave by January 1. Three remaining orthopedists in the community may pick up the slack, or may alternatively choose to limit their exposure. Thus, people living in this rural community may have to go to Orlando emergency rooms for their care.[389]

- In East Pasco, two OB/GYNs—half the OB department—have dropped off staff because they were unwilling to pay the insurance premiums.[390]

- The Orlando area has lost four neurosurgeons this year because they will not pay the increases. These doctors are going to states where there is a better environment for the practicing of medicine.[391]

- Because of this crisis, one large radiology group cannot recruit new radiologists, using the same caliber and yardstick of quality they historically have wanted to use. This radiology group recently found that their rates had tripled, yet their coverage had been reduced by two thirds. Most of the radiologists are contemplating eliminating the reading of any mammograms, in order to eliminate that high-risk exposure.[392]

- Between eight to ten OBs in Central Florida have left the state, or have dropped their OB privileges. This will translate into longer emergency room waits.[393]

- An OB/GYN recently came to work in Central Florida and was told by her group that her medical malpractice insurance was going to be $137,000 for $250,000 worth of coverage, so they revoked her offer of employment.[394]

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[388] Id. at 289-290.
[389] Rich Reiner, testimony, Oct. 21, 2002, pg. 297.
[390] Id.
[391] Id. at 298.
[392] Id.
[393] Id. at 299.
[394] Id. at 302-303.

- The malpractice crisis is affecting the midwives profession in a manner similar to the way it is affecting the other practitioners. However, midwives are unique in that the JUA is their only source of malpractice coverage at this time. Their premiums constitute 10 to 20 percent of their annual income. In the last year, their premiums have increased about 25 percent. Fees in Florida are about 30 to 40 percent higher than the fees of other midwives in other states.[395]

- Dr. Elizabeth Hancock, a family physician in private practice in Indialantic does not offer health insurance to her employees, nor does she herself have it. She does not give her employees paid days off because she cannot afford to. Dr. Hancock states that she is looking for a job in radio broadcasting.[396]

- Florida has thirty-three rural counties, twelve of which have been designated as severely underserved with less than fifty physicians per 100,000 population.[397]

- We have major disparities in healthcare delivery, particularly for minorities in our cities and rural areas. The infant mortality rate is over twice that of Caucasians in the African-American population in Florida.[398]

- Although we are the state with the largest percentages of geriatric patients, we already have a shortage of geriatricians.[399]

- Because healthcare represents one in every eleven jobs in the workforce right now, and one dollar in every seven in the economy right now, the dramatic reductions in funding healthcare in the economy would ripple throughout all healthcare and would also ripple through the economy at large, and it would be a very catastrophic event that would be unprecedented.[400]

- In 1995, average nursing home insurance costs were $240 a bed. In 2001, they were almost $2,400 a bed, or a 100-fold increase over six years. In Florida, the average cost is even higher than that, in excess of $10,000 a bed, according to some data.[401]

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[395] Rebecca Ricco, testimony, Oct. 21, 2002, pgs. 315-316.
[396] Elizabeth Hancock, M.D., testimony, Oct. 21, 2002, pgs. 321-322.
[397] Robert Brooks, M.D., testimony, Nov. 4, 2002, pg. 191.
[398] Id.
[399] Id.
[400] Brian Klepper, Ph.D., testimony, Nov. 4, 2002, pgs. 234-235.
[401] William Sage, M.D., J.D., testimony, Nov. 4, 2002, pg. 261.

- In 1998, there were thirty-two carriers that were writing premiums in Florida. In 2001, that number has fallen to twenty-six insurance companies. Since the beginning of 2001, nine insurance companies have notified the Department of Insurance that they are leaving the state; this represents 18 percent of 2001's written premiums. Of the top fifteen carriers that remain here in the state, four of them have said that they will not be writing any new business.[402]

- A collective of five nursing home facilities in Florida experienced a 57.42 percent increase in their insurance rates. Additionally, although one of the companies that currently writes for them, Hartford, has renewed this year, it is not going to renew next year. More significantly, another one of their current insurance companies, Lloyds of London, has withdrawn their umbrella this year, so now the facilities are unable to get umbrella insurance.[403]

- Don Robertson, M.D. is a family physician with fourteen years experience in Florida, and who has never been sued for malpractice. Nevertheless, Dr. Robertson's malpractice insurance rate has increased over 400 percent in thirteen months. He can find only one malpractice carrier who will write him a policy. After fourteen years in practice, he had to borrow money from the bank to pay his malpractice premiums.[404]

- Aaron Elkin, M.D.[405] has been in practice for eight years and has no claims. In spite of this, his rates have increased 55 percent this year. He cannot afford to carry insurance anymore. Aventura Hospital, where Dr. Elkin is the Vice Chief of Obstetrics, will no longer be delivering babies, even though it has had no claims. It costs the hospital $1,000 per birth just for insurance, while the average reimbursement for the hospital is just $2,500 per delivery.[406]

- Raymond S. Waters, M.D. is a cardiovascular surgeon who has practiced for twenty-three years, and has practiced fourteen years at Bayonet Point Regional Medical Center in Hudson; earlier this year, Bayonet Point was ranked 27th in the nation in the latest U.S. News and World Report categories for cardiovascular surgery. Although Dr. Waters himself has never had a successful malpractice claim placed against him, this year his insurance company is leaving the state because it can no longer practice under the business pressures that it finds itself. He notes that the company has asked him to

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[402] Steve Roddenberry, testimony, Nov. 4, 2002, pgs. 386-388.
[403] Judy Boco, testimony, Nov. 4, 2002, pgs. 417-418.
[404] Don Robertson, M.D., testimony, Nov. 4, 2002, pgs. 418-419.
[405] In the Nov. 4, 2002 transcript, Dr. Elkin is improperly identified as "Dr. Narkin."
[406] Dr. Aaron Elkin, M.D., testimony, Nov. 4, 2002, pgs. 425-427.

purchase "tail" coverage for $146,000, which Dr. Waters cannot afford. On December 31, he will therefore have no malpractice insurance. His partner, Dr. Marshall DeSantis, just accepted a premium of $120,000 a year for $250,000 worth of coverage per year with a $20,000 deductible from FPIC.[407]

- John D. Guarneri, M.D., FACOG, an obstetrician in Winter Park, states that "[i]t is simply not possible for physicians to continue to practice in Florida if the medical liability insurance rates continue to skyrocket." According to Dr. Guarneri, patients are having to wait longer to see doctors, and sometimes cannot get an appointment for months. Dr. Guarneri has personally had to book patients two months in advance. This added stress is leading many doctors to restrict taking on new patients or to retire early. In fact, he notes, if the Legislature fails to act, he will forced to give up his obstetrics practice.[408]

- Elizabeth M. Louie, M.D., 43-years-old, will be retiring from medicine on February 28 because her malpractice has risen to a point where she can no longer afford to practice medicine. She is not willing to risk going bare although she has very few assets at this time in her life. Her malpractice insurance cost just went up to 58 percent of her gross income. She works part-time, three days a week. The cost of her malpractice insurance went from just over $8000 to $40,000. It has increased almost five-fold. She makes about $69,000 a year gross income. After taxes, answering service, beeper and cell phone expenses for the year, she has very little income left to continue to live on. She is leaving the practice of medicine to start a center to evaluate children with learning differences.[409]

- Richard L. Beck, M.D., F.A.C.S., P.A., is an Altamonte Springs plastic surgeon who recently learned that his medical malpractice insurance rate for 2003 increased 75 percent. Dr. Beck has tried to obtain the services of M.D. anesthesiologists, but has had no success.[410]

- Dale L. Lind has been a nursing home professional for nearly 30 years. He currently serves as the Executive Director of Waterman Village of Mount Dora, a facility that has been widely recognized as a quality provider, traditionally receiving good state surveys and

[407] Letter from Raymond S. Waters, M.D. to Governor Jeb Bush (Nov. 5, 2002) (Vol. 10, Tab 313).
[408] Letter from John D. Guarneri, M.D., FACOG to Governor Jeb Bush (Sept. 26, 2002) (Vol. 10, Tab 120).
[409] E-mail from Elizabeth M. Louie, M.D. to William Large, Counsel, Governor's Select Task Force on Healthcare Professional Liability Insurance (Jan. 9, 2003) (Vol. 11, Tab 487).
[410] Letter from Richard L. Beck, M.D., F.A.C.S., P.A. to Governor Jeb Bush (Sept. 27, 2002) (Vol. 10, Tab 121).

experiencing no major lawsuits. In fiscal year 2000, Waterman Village of Mount Dora enjoyed liability insurance coverage with $1,000,000/$3,000,000 coverage and a $5,000,000 umbrella; the cost for this coverage was $70,000 for the year. In fiscal year 2001, the facility's costs had skyrocketed to $400,000 for the year for $1,000,000/$3,000,000 coverage with no umbrella and a $100,000 deductible. In fiscal year 2002, faced with a premium increase to $550,000, and acting on the advice of its insurance consultant and attorney, Waterman Village of Mount Dora elected to self-insure. When it became clear that the law required the facility to be insured, it purchased a $50,000 compliance policy at a cost of $57,000.[411]

- Nadia Hilal, R.Ph. is the Administrator of the MNH Surgical Center in Maitland. She states that its tail coverage quote is $63,000 per year. They started their surgery center (Endoscopy Suite) in 1998, and were then paying $5,000 annually for facility malpractice insurance. This year they had to go with a new company at $30,000 annually, and next year they are looking at malpractice premiums of $90,000 per year.[412]

- Scott Ravede, D.O., an emergency room physician in Volusia County, writes that his malpractice insurer is no longer providing coverage for emergency medicine, and as a result, his group is scrambling to find alternate coverage.[413]

- Elizabeth A. Etkin-Kramer, MD, FACOG had to give up obstetrics because she could not afford professional liability insurance. In the 1990s she was insured through her employer and now has a tail for those years. However, since 2001, she has been financially responsible for her own insurance. With a clean record, her rates for 250K/750K went from $18,000 in 2000, to $48,000 in 2001. If she had continued to practice obstetrics, the rates would have increased again to $96,000 in 2002. Also, these rates do not include the NICA assessment of $5,000 per year. After her partner and she realized that they could not afford to practice obstetrics with insurance unless they did very high volume (which could have significantly compromised patient care), they made the decision to practice gynecology only. However, now they are finding that, essentially, they cannot get professional liability insurance for gynecology only. As a result, they have been forced to self-insure or go bare. There are two firms that write for OB/GYN in South Florida. The first, FPIC, would only

[411] Letter from Dale L. Lind, Executive Director, Waterman Village of Mount Dora, to John C. Hitt, Ph.D., President, University of Central Florida (Nov. 8, 2002) (Vol. 11, Tab 328).
[412] Letter from Madia Hilal, R.Ph., Administrator, MNH Surgical Center, to Governor Jeb Bush (Nov. 6, 2002) (Vol. 10, Tab 316).
[413] Letter from Scott Ravede, D.O. to U.S. Representative John Mica (Aug. 13, 2002) (Vol. 10, Tab 93).

offer gynecology-only coverage at $40,000 a year if Dr. Etkin-Kramer and her partner maintained tail insurance for the two years of obstetrics (2001 and 2002) at an additional flat rate of $123,000. The second company, Pronational/Proassurance denied them any quotes. Many of Dr. Etkin-Kramer's patients have begged her to deliver their babies, and have asked her whether they could not just sign a form stating that they would not sue.[414]

- Timothy H. Tillo, DPM, President of the Florida Podiatric Medical Association, writes that the medical malpractice crisis will have a number of adverse effects on the delivery of podiatric medical care in Florida. For example, he explains that the risk of a malpractice claim is higher in the diabetic podiatric patient, and that in an attempt to lower their exposure to this risk, podiatric physicians may refuse to treat the diabetic patient. As a result of this denied access to healthcare, important preventative foot care is not rendered, leading to a possible increase in complications related to diabetes, as well as an increase in healthcare costs.[415]

- Michael Branch, M.D., an ear, nose, and throat physician in Central Florida, has been trying to recruit a partner to expand his practice and fill a void in a nearby city where there is no ear, nose, and throat physician. However, because of the malpractice crisis in Florida, the candidate for the position is declining to relocate from another state. Thus, patients in that city will continue to go without a local ear, nose, and throat physician. Dr. Branch also notes that he must restrict his practice from doing some of the high-risk surgical procedures he is trained to do because of the serious and ever-present threat of malpractice lawsuits. As a result, Dr. Branch's patients are often required to travel long distances to undergo these procedures.[416]

- Jason Conley, M.D., a second-year emergency medicine resident in Orlando writes: "I truly want to stay and practice in Central Florida, but I am afraid that the current medical liability crisis will make that unfeasible. Once I am finished with residency, I will have put in 13 years of higher education and assumed almost $150,000 in debt. I have taken on these responsibilities so that I may have the privilege of taking care of my patients. It is disheartening to know that after all of

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[414] E-mail from Elizabeth A. Etkin-Kramer, MD, FACOG to William Large, Counsel, Governor's Select Task Force on Healthcare Professional Liability Insurance (Jan. 9, 2003) (Vol. 11, Tab 494).
[415] Letter from Timothy H. Tillo, DPM, President, Florida Podiatric Medical Association, to unidentified recipient (Oct. 2002) (Vol. 10, Tab 127).
[416] Letter from Michael Branch, M.D. to William Large, Counsel, Governor's Select Task Force on Healthcare Professional Liability Insurance (Oct. 16, 2002) (Vol. 10, Tab 243).

my studying, all of my tests and years of training, that my best may not be good enough."[417]

- Tom Mahan, M.D., F.A.C.S. is a general surgeon in his fourth year of practice in Winter Park and at Florida Hospital. As of January 1, 2003, he will have no insurance, and may end up having to leave the state for the safety of his career and family. Alternatively, if he remains in Florida, he will have to practice without insurance.[418]

- Tom Hicks, M.D. is one of sixteen family doctors in the Patients First group in Tallahassee. The 80 percent increase the group experienced in PLI premiums in January 2002 had to be recovered in order for the group to stay in practice. The entire increase was distributed to the very patients who often are the least able to pay—the uninsured or underinsured. These patients now pay a 20 percent surcharge for PLI premiums when they come to Dr. Hicks' office. His question to these patients is "Do you value [the] unlimited right to sue me enough to pay a 20 percent tax on your bill?"[419]

- David P. Johnston, Jr., M.D. practices general surgery and is Chief of the Department of Surgery at St. Vincent's Medical in Jacksonville. His group has elected to cease performing high-risk surgery such as pancreatic surgery. If the group's radiologists cannot obtain adequate malpractice insurance before January 1, 2003, it will elect to discontinue performing all breast surgery.[420]

- Mark Antony LaPorta, M.D., FACP found that his MLI went from $5,000 to $21,000 the same year. His office is now closed.[421]

- Gerald Tuite, M.D. is a pediatric neurosurgeon in Tampa Bay. His practice is cutting its coverage to $250,000/$750,000, is not seeing certain patients who may require high-risk procedures, and is considering positions in other states where the medical malpractice risk is less.[422]

- Hieu T. Nguyen, M.D. recently received a letter of non-renewal of the general practitioner's malpractice insurance from the carrier APA Capital. The company asked for $25,000 for only the tail coverage.

[417] Letter from Jason Conley, M.D. to William Large, Counsel, Governor's Select Task Force on Healthcare Professional Liability Insurance (Oct. 25, 2002) (Vol. 10, Tab 288).
[418] E-mail from Tom Mahan, M.D., F.A.C.S. to Michelle Jacquis (Dec. 7, 2002) (Vol. 11, Tab 406).
[419] E-mail from Thomas Hicks, M.D. to Michelle Jacquis (Dec. 9, 2002) (Vol. 11, Tab 422).
[420] E-mail from David P. Johnston, Jr., M.D., Chief, Department of Surgery, St. Vincent's Medical, to Michelle Jacquis (Dec. 10, 2002) (Vol. 11, Tab 428).
[421] E-mail from Mark Antony LaPorta, M.D., FACP to Michelle Jacquis (Dec. 9, 2002) (Vol. 11, Tab 421).
[422] E-mail from Gerald Tuite, M.D. to Michelle Jacquis (Dec. 9, 2002) (Vol. 11, Tab 419).

Dr. Nguyen's 2001 premium was $7,200. Dr. Nguyen tried to apply for insurance with several other insurance companies, but was declined; one company gave a premium quote of $46,995.[423]

- Steven Varady, M.D. is a urologist whose group has stopped seeing pregnant patients since they represent an overwhelming level of risk. The practice has been much more likely to refer complex and risky patients to tertiary referral centers. It has had to deal with the stress of looking at every single patient, every single day, as a potential threat. Dr. Varady writes that "it is very difficult to be caring when every patient is a potential threat; I often feel as though a man or a woman enters the examination room and aims a bow and arrow at me, pulls back on the bow and says, 'Help me.'"[424]

- Scott Posgai, M.D. is a family practitioner in Orlando who has stopped doing hospital admissions.[425]

- Gary J. Bowers, M.D. is a general surgeon and surgical oncologist practicing with North Florida Surgeons in Jacksonville. Because of the current malpractice climate, he no longer offers limb perfusions for melanoma patients. This is a high-risk procedure for select patients with extremity disease. He is the only surgeon in North Florida who has offered this procedure for the past nine years. Recently, he was referred a patient from within the community who was in need of the procedure, but because of the present situation, he referred the patient out-of-state.[426]

- Dolores Lowe, M.D. and her partner found out that their carrier is leaving the state; the carrier offered to put them in a "pool" with other physicians that were "rated" at more than twice the cost. She writes that "a career at McDonald's sounds inviting about now!"[427]

- Ivan Castro, M.D. is a practicing general internist in Winter Park. For the second year in a row, his malpractice carrier has left Florida, necessitating him to obtain tail coverage two years in a row. From last year to this year, he has experienced a 100 percent increase in his yearly premium. Finally, as of this year, due to stipulations from his new carrier, he can no longer see patients in nursing homes.[428]

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[423] Letter from Hieu T. Nguyen, M.D. to unidentified Senator (date unknown) (Vol. 11, Tab 426).
[424] E-mail from Steven Varady, M.D. to Michelle Jacquis (Dec. 9, 2002) (Vol. 11, Tab 420).
[425] E-mail from Scott Posgai, M.D. to Michelle Jacquis (Dec. 8, 2002) (Vol. 11, Tab 407).
[426] E-mail from Gary Bowers, M.D. to Michelle Jacquis (Dec. 9, 2002) (Vol. 11, Tab 418).
[427] E-mail from Dolores Lowe, M.D. to Michelle Jacquis (Dec. 8, 2002) (Vol. 11, Tab 410).
[428] E-mail from Ivan Castro, M.D. to Michelle Jacquis (Dec. 8, 2002) (Vol. 11, Tab 409).

- Nigel A. Spier, M.D., FACOG was forced to cut his practice's staff positions by four employees. As a result, patients now have longer waiting times to get an appointment, longer waiting times for the phones to be answered, and longer waiting times to speak to a physician.[429]

- Marcelle G. Habib, M.D., FAAP, P.A., a pediatrician who opened his own practice in Palm Harbor in early 2001 has found that his already-high malpractice insurance has increased to the point where it is unaffordable for the year 2003.[430]

- Scott A. Rodger, M.D., a family practitioner in the small town of Eustis, states that his malpractice carrier has left the state, as have most of the other insurance carriers. This has forced him to buy two policies, resulting in an increase in his insurance costs of over 400 percent. At 49 years of age, Dr. Rodger is strongly considering early retirement, or moving to a more favorable malpractice climate. In Eustis alone, he notes, two of the community's best gastroenterologists have elected to retire early, and one of its best surgeons was lured to another state without malpractice policies such as those currently found in Florida.[431]

- Alexis Rojas, M.D. is an OB/GYN in Leesburg. Dr. Rojas' insurance carrier left the state and now this physician is finding it increasingly difficult to find adequate liability coverage.[432]

- Lubomir Yazov, M.D., is a doctor in Fort Lauderdale who is facing double or triple increases in his medical malpractice insurance premium (which, he notes, is for one-fourth his previous coverage, and which offers no coverage for past events). According to Dr. Yazov, this precludes him from practicing normal medical and compels him to close his office.[433]

- Wei-Shen Chin, M.D., a radiologist in Orlando, writes that the escalating cost of malpractice insurance has placed the doctor in a difficult situation. Dr. Chin explains, ". . .either I stop reading the

[429] E-mail from Nigel A. Spier, M.D., FACOG to Michelle Jacquis (Dec. 8, 2002) (Vol. 11, Tab 408).
[430] Letter from Marcelle G. Habib, M.D., FAAP, P.A. to Governor Jeb Bush (Oct. 25, 2002) (Vol. 10, Tab 289).
[431] Letter from Scott A. Rodger, M.D. to William Large, Counsel, Governor's Select Task Force on Healthcare Professional Liability Insurance (Oct. 17, 2002) (Vol. 10, Tab 253).
[432] Letter from Alexis Rojas, M.D. to unidentified recipient (Oct. 17, 2002) (Vol. 10, Tab 255).
[433] Letter from Lubomir Yazov, M.D. to Governor Jeb Bush (Oct. 22, 2002) (Vol. 10, Tab 271).

approximately 4000 mammograms that walk through my clinic each year or I leave the state in order to protect my family."[434]

- Silvia F. Garcia, M.D. is a solo practitioner who recently found that the insurance company that underwrote her policy for the past two years (AP Capital) decided to leave Florida in order to remain financially solvent, due to the very high numbers of claims and awards. As a result, this dermatologist will be underwritten by a new plan at a much higher (125 percent) rate increase, and she must pay $11,785 in tail insurance. Like many other doctors, Dr. Garcia has dropped the most risky procedures from her practice, in her case, the skin surgeries and flaps and grafts; she notes that if other dermatologists follow suit, such advanced treatments will no longer be available in Collier County. Dr. Garcia notes that she has a spotless liability record with absolutely no claims and asserts that she should not be penalized with such heavy fees for malpractice insurance because of the litigious nature of the Florida healthcare system.[435]

- Gaspar R. Salvador, M.D., a physician who has practiced family medicine in Sun City Center since 1979, recently found his medical professional liability policy with Interstate Fire and Casualty "non-renewed" when the company stopped writing medical liability insurance. Through an insurance agency, Dr. Salvador applied to seven carriers to obtain coverage. Five of these carriers turned him down due to "nursing home exposure" because, in addition to his private practice, for twenty-three years he has also been the Medical Director of a nursing home. Two companies turned him down due to "claims history"—although, he notes, he has not had a claim in almost ten years. Thus, he writes that he was forced to turn to the Florida Medical Malpractice Joint Underwriting Association for coverage for an annual premium of $31,103, which does not include any prior acts coverage. Interstate offered an "Extended Reporting Period" option, which would cover his "prior acts" for one year for $49,596. Because he cannot afford this astronomical premium, Dr. Salvador reports that he has no choice but to go "bare" on his prior acts coverage.[436]

- Dumitru-Dan Teodorescu, M.D. is an Arcadia-based OB/GYN who has been in practice since 1981, and is one of two obstetricians who

[434] Facsimile from Wei-Shen Chin, M.D., Chairman, Department of Radiology, Orlando Regional Medical Center, to William Large, Counsel, Governor's Select Task Force on Healthcare Professional Liability Insurance (Oct. 28, 2002) (Vol. 10, Tab 294).
[435] Letter from Silvia F. Garcia, M.D. to Governor Jeb Bush (Oct. 25, 2002) (Vol. 10, Tab 295).
[436] Letter from Gaspar R. Salvador, M.D. to John C. Hitt, Ph.D., President, University of Central Florida (Oct. 21, 2002) (Vol. 10, Tab 270).

take care of the obstetrical needs of the population of DeSoto County and part of Hardee County. One week before writing to Governor Jeb Bush, Dr. Teodorescu was informed that American Healthcare Indemnity Company, Physicians Protection Plan will not be renewing the doctor's medical professional liability insurance for the coming year (2003). Thus, if Dr. Teodorescu cannot find another carrier, the doctor will no longer be able to practice in Florida. "There will be only one obstetrician left here in DeSoto County and I am not sure that he will not be in a similar position," Dr. Teodorescu laments.[437]

- George H. Pope, M.D. is a plastic surgeon in Winter Park who has been in private practice in the Orlando area for fifteen years, and a member of a four-surgeon group, the largest plastic surgery group in Central Florida. His group is losing its medical liability insurance after December 31, 2002, because its insurance company will no longer be writing medical liability insurance in Florida after that date. The cost of tail coverage for Dr. Pope is $94,044. His group has been unable to find a new liability insurance carrier. The two largest general surgery practices in Orlando area in the same situation. Dr. Pope's fear is that any new premium for coverage will be exorbitant. With his three children rapidly approaching college age, he is worried about his ability to pay for their college educations. His wife and he may need to sell their home. Dr. Pope currently holds a medical license in Louisiana, the state where he was raised and trained, and although he considers Florida his home state, he hopes that he will not have to return to Louisiana (a state which has a cap on "pain and suffering" awards) to be able to work with medical liability insurance.[438]

- Sebastian J. Ciancio, M.D. is an urologist in private practice in Orlando. His group of three urologists has cut back on the number and types of patients they will operate on because of concerns regarding liability. They are unable to afford to see Medicaid patients anymore, and the group's most senior partner is considering retiring early to avoid the ominous malpractice issues.[439]

- Douglas Slotkoff, M.D. practices in Miami, where he cares for a population of developmentally disabled children and adults at Sunrise Communities in South Miami. Although he has cared for them for about eight years, this year may be the last that he is able to do so, because of the rise in malpractice insurance rates.[440]

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[437] Letter from Dumitru-Dan Teodorescu, M.D. to Governor Jeb Bush (Oct. 25, 2002) (Vol. 10, Tab 296).
[438] Letter from George H. Pope, M.D. to John Hitt, President, University of Central Florida (Nov. 18, 2002) (Vol. 11, Tab 350).
[439] E-mail from Sebastian Ciancio, M.D. to Michelle Jacquis (Dec. 7, 2002) (Vol. 11, Tab 404).
[440] E-mail from Douglas Slotkoff, M.D. to Michelle Jacquis (Dec. 7, 2002) (Vol. 11, Tab 403).

- Gerald Alan Spunt, M.D., FAAP is a pediatrician in Broward County, who has been in private practice for the last twenty-five years. Last year, when his group's malpractice insurance was due to renew, it found that its insurance cost had doubled. This year, the group received notice from its insurance carrier that the carrier is leaving the state. There are now only two malpractice insurance companies available to the group, and if it can obtain malpractice insurance, the rate will double again. According to Dr. Spunt, the best-case scenario is that the group will pay four times the rate it did two years ago. The worst-case scenario is that either it will be unable to afford malpractice insurance, or will be denied malpractice insurance and will be forced to go bare.[441]

- Larry Vickman, M.D., MHA, FACEP, FACPE received his license to practice medicine in Florida in May 2002, and has been looking for a part-time position doing urgent care. Dr. Vickman interviewed at one site in Pinellas County, where he discovered that of the four companies that offered to insure him, two would not even consider him because of their all-or-none rule (i.e., if the company does not insure all the members of the group offering service at a site, it will not insure an individual doctor). Of the two remaining groups, the costs of the insurance were too high for him to consider. One group quoted him $6,380 for the first year, leveling off at $15,820 at the fifth year; the other group quoted him $9,050 for the first year, and only told him it would be into the mid-$20,000 level by the fifth year. The tail policy would be double or triple last year's premium.[442]

- Leffie M. Carlton, III, M.D. is a urologist and urologic surgeon who has scaled back his practice by no longer performing any open abdominal or pelvic cancer surgeries from a urologic standpoint.[443]

- Larry Fishman, M.D. is a neurosurgeon who has practiced in Hillsborough County for the past fourteen years. There are now many procedures which Dr. Fishman does not feel comfortable performing anymore due to the fact that they are high-risk, such as aneurysm surgery, surgery on many brain tumors, and most pediatric neurosurgery. For the past six months, he has also basically stopped providing care to Medicaid patients, because the potential risks and liability are simply too great. As time goes on, he is cutting back on his practice more and more and is basically just trying to do "simple

[441] Letter from Gerald Alan Spunt, M.D., FAAP to Governor Jeb Bush (Dec. 4, 2002) (Vol. 11, Tab 367).
[442] Letter from Larry Vickman, M.D., MHA, FACEP, FACPE to Debbie Zorian, Executive Director, Hillsborough County Medical Association (Dec. 5, 2002) (Vol. 11, Tab 370).
[443] Letter from Leffie M. Carlton, III, M.D. to Debbie Zorian, Executive Director, Hillsborough County Medical Association (Dec. 11, 2002) (Vol. 11, Tab 370).

bread and butter" procedures. He refers anything more complicated to a major medical center, which is often time-consuming, quite costly, and not covered by his patients' insurance.[444]

- Carlos J. Vazquez, M.D. had a very successful OB/GYN practice in Pinellas County. However, his malpractice insurance went up from $30,000 to $160,000, and he had no resort but to liquidate his practice and move to Broward County were he was permitted to practice without malpractice insurance.[445]

- Peter J. Pernicone, M.D., a physician based in Orlando, came to Florida ten years ago after completing a five-year training program in pathology at the Mayo Clinic in Rochester, Minnesota. Last year, he came very close to accepting a position in Idaho in an effort to escape the stress of the litigious climate of Florida. He notes that he knows of several young, competent physicians who have left Florida to find employment in other, friendlier, states.[446]

- Michael P. Kahky, M.D. is a general surgeon and surgical oncologist practicing in Orlando. In the past year he has referred many patients with complex problems to either Gainesville or Tampa. These are patients who he would have cared for locally a year ago, but now the risk is too great. Additionally, his six-person surgical group will be self-insured as of January 1, 2003.[447]

- Scottie Whiddon, M.D. is a family physician practicing in a rural setting for the last sixteen years. He is a medical director of a long-term care facility and all but one of the sixty patients there are under his care. This nursing home is now being threatened with closure, as a number in Florida already have, because of the incredible rise in malpractice insurance. If the nursing home goes "bare," then Dr. Whiddon, as the medical director of the facility, would be the one the lawyers would go after, even though his is a minimally compensated position. As a result, Dr. Whiddon may be forced out of seeing patients in the long-term care setting.[448]

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[444] Letter from Larry Fishman, M.D. to Debbie Zorian, Executive Director, Hillsborough County Medical Association (Dec. 4, 2002) (Vol. 11, Tab 370).
[445] E-mail from Carlos J. Vazquez, M.D. to Michelle Jacquis (Dec. 6, 2002) (Vol. 11, Tab 385).
[446] Letter from Peter J. Pernicone, M.D. to William Large, Counsel, Governor's Select Task Force on Healthcare Professional Liability Insurance (Oct. 17, 2002) (Vol. 10, Tab 256).
[447] E-mail from Michael P. Kahky, M.D. to Michelle Jacquis (Dec. 6, 2002) (Vol. 11, Tab 387).
[448] E-mail from G.R. (Scottie) Whiddon, M.D. to Michelle Jacquis (Dec. 6, 2002) (Vol. 11, Tab 340).

- Kenneth Beer, M.D. is a physician who has had to fire employees. He has also stopped performing liposuction, and will stop taking melanoma patients because of the risk.[449]

- Suzan Streichenwein, M.D. practices geriatric psychiatry. Due to the malpractice crisis, she has stopped seeing patients at skilled nursing facilities and nursing homes, and has decided not to do inpatient psychiatry. Dr. Streichenwein is also decreasing the number of hours she spends seeing patients due to the high cost of insurance. Her carrier, FPIC, was just downgraded from an "A-" to a "B+"; she says she is holding her breath dreading a letter that the company will be leaving Florida any day.[450]

- Michael Binder, M.D. is a Tampa urologist. As of January 1, 2003, his malpractice insurance payments will have increased 113 percent over the past two years, in spite of the fact that he has never been sued in fifteen years of private practice. To help keep his rates down, he has given up performing any radical surgery, such as cystectomies and prostatectomies. He no longer performs any cosmetic surgery, and is also considering eliminating prosthetic surgeries. If these efforts fail to improve the situation, he will be forced to leave the state or retire. Finally, Dr. Binder notes, it has proven impossible to bring an associate in to help him.[451]

- Nak Y. Paek, M.D. has been practicing general surgery in Jacksonville for the last twenty-two years. In 2002, Dr. Paek's liability insurance premium was $26,000. In November 2002, Dr. Paek received a letter from the insurance company stating that it was pulling out of Florida. After two months of searching for coverage for general surgery, the best quote this surgeon received for 2003 was $91,000. Dr. Paek cannot afford this more than 300 percent increase. Faced with losing hospital staff privileges, the only option Dr. Paek has is to try general practice.[452]

- Brad Chayet, M.D. is a member of a seven-person multi-specialty orthopedic group in West Broward. His medical premiums have just doubled, and are now more that $90,000 per doctor for $250,000/$750,000 coverage. His intention is to go bare, and to avoid very high-risk procedures.[453]

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[449] E-mail from Kenneth Beer, M.D. to Michelle Jacquis (Dec. 6, 2002) (Vol. 11, Tab 389).
[450] E-mail from Suzan Streichenwein, M.D. to Michelle Jacquis (Dec. 7, 2002) (Vol. 11, Tab 390).
[451] E-mail from Michael Binder, M.D. to Michelle Jacquis (Dec. 7, 2002) (Vol. 11, Tab 398).
[452] E-mail from Nak Y. Paek, M.D. to William Large, Counsel, Governor's Select Task Force on Healthcare Professional Liability Insurance (Jan. 6, 2002) (Vol. 11, Tab 474).
[453] E-mail from Brad Chayet, M.D. to Michelle Jacquis (Dec. 7, 2002) (Vol. 11, Tab 399).

- Wayne Maxson, M.D. is a doctor who has responded to the malpractice crisis by dropping coverage and discontinuing hysterectomies, and by not performing more complicated operative laparoscopies.[454]

- Marc A. Melser, M.D., F.A.C.S. is an urologist who has never been sued. Nevertheless, his malpractice insurance has increased 88 percent this year. As a result, he may have to stop performing bladder removal surgery; he may also have to have a lower threshold for sending patients to a major referral center.[455]

- Desiree A. Rosenthal, M.D., a 54-year-old family practice physician who had practiced in Florida for the past twenty-two years, was forced to resign from her part-time practice of clinical medicine on November 1, 2002, some fifteen years before she had planned. In her letter to her patients informing them of her resignation, Dr. Rosenthal explained that she was no longer able to pay her malpractice insurance premium. The $26,000 premium for her part-time work exceeded her part-time earnings of $22,000. Dr. Rosenthal's premium increased from $6,000 in 1999, to $7,5000 in 2000, to $10,000 in 2001, to $12,500 in 2002, and finally, to $26,400 for 2003.[456]

- Kathryn Pearson, M.D. is a fellowship-trained, breast-imaging radiologist in Jacksonville. Dr. Pearson believes that she may end up eliminating screening mammography with her forty-person radiology group if additional radiologists refuse to read mammography, and/or insurance companies refuse to cover mammography, as the limited manpower will only allow for diagnostic mammography. Furthermore, if her group's current insurance carrier (Mag Mutual) is forced to drop mammography from its coverage, she is prepared to leave Florida to return to California (where she has a medical license and is pursuing renewal of the same for this purpose alone).[457]

- Jonathon Bloch, M.D., a general surgeon, reiterates the point that many talented physicians are being forced to either retire early or leave Florida because of escalating malpractice costs and decreasing reimbursements.[458]

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[454] E-mail from Mayne Maxson, M.D. to Michelle Jacquis (Dec. 6, 2002) (Vol. 11, Tab 400).
[455] E-mail from Marc A. Melser, M.D., F.A.C.S. to Michelle Jacquis (Dec. 7, 2002) (Vol. 11, Tab 401).
[456] Letter from Desiree A. Rosenthal, M.D. to Patricia Handler, Executive Vice-President, Dade County Medical Association (Nov. 8, 2002) (Vol. 10, Tab 327).
[457] E-mail from Kathryn L. Pearson, M.D. to Michelle Jacquis (Dec. 7, 2002) (Vol. 11, Tab 402).
[458] E-mail from Jonathan Bloch, M.D. to William Large, Counsel, Governor's Select Task Force on Healthcare Professional Liability Insurance (Nov. 17, 2002) (Vol. 11, Tab 347).

- Richard M. Gray, M.D. is an orthopedic surgeon who specializes in hand and microvascular surgery. Doctors such as him are seeing rate increases of 100 percent last year and expect them to probably double again this year. This is not because of pending lawsuits, but rather because of their specialized field of practice, orthopedic surgery. The financial impact on Dr. Gray's group has prevented any further recruitment of new physicians. Also, patients are having to wait longer to see doctors and sometimes cannot get an appointment for months. Dr. Gray has personally had to increase new and follow-up patients slots and is now seeing patients from 8:30 a.m. until 7:00 p.m. His group is overbooking patient slots by 20-30 percent, and has also had to increase its operating room time, which now spans from 7:30 a.m. until 7:00 p.m.[459]

- Peter Marmerstein is the Chief Executive Officer of St. Mary's Medical Center in West Palm Beach. St. Mary's operates one of only eleven Regional Perinatal Intensive Care Centers (RPICC) in the state. These centers are designed to ensure that poor and low-income women who are high-risk obstetrical patients are provided with necessary perinatal services. The St. Mary's RPICC physician group has been confronted with a 124.8 percent ($911,566) increase in their malpractice insurance premiums for 2003. As a result, these physicians have been confronted with the choice of paying this increased premium or foregoing medical malpractice insurance; should they choose the latter, the group has determined that it would be forced to abandon its coverage of St.Mary's RPICC and indigent obstetrical programs. Without physician providers, these programs cannot continue.[460]

- Celestino Palomino, M.D. has been with the same insurance company (Farmer's Insurance Group) for seventeen years, and has never been named in a malpractice suit. Nevertheless, two months ago, the company informed Dr. Palomino that his policy would not be renewed. As of January 1, 2003, he has not been issued a new policy and was forced to ask for a leave of absence from all three hospitals where he practices, as well as the five dialysis units where he has patients.[461]

- Arthur Graves, M.D. is Chief of the Medical Staff at South Bay Hospital in Sun City Center. Thus far, the hospital has lost five qualified and competent physicians due to the medical liability problem. He writes that the hospital is finding it increasingly difficult

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[459] Letter from Richard M. Gray, M.D. to William Large, Counsel, Governor's Select Task Force on Healthcare Professional Liability Insurance (Nov. 17, 2002) (Vol. 11, Tab 348).

[460] Facsimile from Peter Marmerstein to Dwight Chenette (Dec. 6, 2002) (Vol. 11, Tab 393).

[461] Letter from Celestino Palomino, M.D. to Governor Jeb Bush (January 3, 2003) (Vol. 11, Tab 464).

to replace experienced, highly capable physicians who are restricting their practices or retiring early.[462]

- Thomas Peurifoy, M.D. is a general vascular surgeon who practiced in Sun City Center and Manatee County for nearly two decades. He moved to another state when his insurance carrier left the state and his premiums went up 300 percent.[463]

- John Dunne, M.D. is a board certified thoracic and vascular surgeon who has practiced in Sun City Center for twenty years. When his premiums went up to more than $120,000, he limited his practice to cosmetic vein surgery in his office. He currently has no insurance for thoracic and vascular surgery, will not practice "bare," and has therefore been removed from emergency room call.[464]

- Richard Landrigan, M.D. is an urologist who, in October 2002, resigned from South Bay Hospital's emergency staff because of his inability to obtain insurance. He is no longer practicing in a hospital setting.[465]

- Jorge J. Villalba, M.D. was unable to obtain coverage from any carrier other than the JUA, which he could not afford. His premiums increased from $3,800 for a $1,000,000 policy to $34,000 for a $250,000 policy. Dr. Villalba is a child and adolescent psychiatrist who had to stop seeing developmentally disabled children in group homes when his insurance carrier left the state. He has been offered employment as a child psychologist in New Zealand and is considering moving his family there, although he hopes that the system will be changed and that truth will prevail.[466]

- Ann Giganti, A.R.N.P. works with a physician in Palm Bay and Indian Harbor Beach. She notes that in Miami, it costs an obstetrician $200,000 for malpractice insurance. In Broward County, 400 physicians have left, and new graduates cannot afford to take their places. The surgeon who corrected undescended testes for their toddlers is no longer practicing, and she notes that his malpractice insurance would increase to $150,000 over the next few years. They

[462] Letter from Arthur Graves, M.D. to William Large, Counsel, Governor's Select Task Force on Healthcare Professional Liability Insurance (Jan. 2, 2003) (Vol. 11, Tab 463).
[463] Letter from Arthur Graves, M.D. to William Large, Counsel, Governor's Select Task Force on Healthcare Professional Liability Insurance (Jan. 2, 2003) (Vol. 11, Tab 463).
[464] Letter from Arthur Graves, M.D. to William Large, Counsel, Governor's Select Task Force on Healthcare Professional Liability Insurance (Jan. 2, 2003) (Vol. 11, Tab 463).
[465] Letter from Arthur Graves, M.D. to William Large, Counsel, Governor's Select Task Force on Healthcare Professional Liability Insurance (Jan. 2, 2003) (Vol. 11, Tab 463).
[466] E-mail from Jorge J. Villalba, M.D. to Michelle Jacquis (Dec. 6, 2002) (Vol. 11, Tab 386).

now must send their patients an hour and a half away, to Orlando, where there is a backlog of patients needing care. In fact, she notes, the majority of adult specialists refuse to see her pediatric patients at all.[467]

- Douglas L. Shepard, M.D. is a neurologist in Naples. Although no suits or claims have been made against him, his rates have escalated to the point that he will be going with minimum coverage to maintain hospital privileges. Although he realizes that this maneuver may be somewhat risky, Dr. Shepard believes that it is morally reprehensible to pay the outrageous premiums to subsidize a flawed legal and, perhaps, insurance system.[468]

- Frank Loh, M.D., P.A. has been a practicing neurologist for the last twelve years, and relocated his practice to Bradenton from New York City two years ago. While practicing in New York, Dr. Loh's malpractice premiums were about $22,000 per year. Last year, Dr. Loh was asked to pay $35,000 in malpractice; this year his premium has tripled to $104,000. Dr. Loh's earnings do not justify this expense. It was only two years ago that he was able to finish paying his medical school education loans. The thought of practicing without insurance causes him anxiety, and he has started to consider alternative occupations.[469]

- Marc A. Melser, M.D. is an urologist in Port Charlotte whose malpractice insurance went up 88 percent—from about $13,000 per year to $24,500 per year. Dr. Melser is in a multispecialty group; this group has opted to reduce its coverage in an effort to cut costs. Dr. Melser will also be reducing the services he provides, as he will no longer perform bladder removals. Patients needing this surgery will now have to go to a university setting.[470]

- Paul Shirley, M.D., who has been in practice for twenty-six years, has had to limit his Jacksonville practice to knee arthroscopy, a low-risk area of medicine. He had a $500,000/$1,500,000 policy, which increased 50 percent last year, from $24,000 to $36,000. In October, the insurance company informed Dr. Shirley that it would be leaving the market in Florida. He elected to "go bare," but has since discovered that many of the healthcare providers he contracts with do

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[467] Letter from Ann Giganti, A.R.N.P. to U.S. Senator Bill Nelson (Oct. 16, 2002) (Vol. 10, Tab 209).
[468] E-mail from Douglas L. Shepard, M.D. to William Large, Counsel, Governor's Select Task Force on Healthcare Professional Liability Insurance (Jan. 9, 2003) (Vol. 11, Tab 497).
[469] E-mail from Frank Loh, M.D., P.A. to William Large, Counsel, Governor's Select Task Force on Healthcare Professional Liability Insurance (Jan. 13, 2003) (Vol. 11, Tab 520).
[470] E-mail from Marc A. Melser, M.D., to William Large, Counsel, Governor's Select Task Force on Healthcare Professional Liability Insurance (Jan. 12, 2003) (Vol. 11, Tab 509).

not wish to keep providers who go bare. To maintain his practice, Dr. Shirley has again been soliciting quotes from insurance brokers. One quote he received was for $250,000/$750,000 for $90,000, up 175 percent for one-half the coverage. A second was for $250,000/$750,000 for $46,000. He is currently interviewing for positions in other states.[471]

- Jonathan Daitch, M.D. is a pain anesthesiologist who has been insured through FPIC for the past twelve years. Although he has no claims against him, his professional liability insurance costs increased 50 percent in 2002, from $14,000 to $21,000. In 2003, his rate (after a 15 percent discount for no claims) will increase to $52,000.[472]

- Robert S. Spiegel, M.D. is a St. Petersburg urologist who has been practicing in Florida for almost twenty years. Until October 2002, his malpractice carrier was Farmer's Insurance, and his premium for the last year of coverage was about $16,000 for $1,000,000 in coverage. Farmer's did not renew his policy and is pulling out of Florida. Dr. Spiegel obtained malpractice coverage from the South Pinellas Trust, also for $1,000,000 in coverage. That premium is $34,000 annually. He has curtailed some services due to concerns about liability/malpractice suits. For the past three years, he was the only urologist treating patients insured by Pinellas County Social Services, in the lower-third of Pinellas County. He has resigned as a participant in that plan because of his perception that those patients tended to be potentially more litigious than the population as a whole. He has also resigned from the staff at a local hospital, Northside, to avoid taking ER calls, which lead to potentially greater liability exposure. Finally, he has stopped performing a few surgeries, specifically cystectomies for bladder cancer, urinary diversions using segments of bowel, and penile prostheses. The reason for this change in practice is that these procedures are by their nature, more complex and more complications are possible. He prefers to avoid this exposure in today's medical-legal climate.[473]

- Thomas L. Greene, M.D. is a Tampa physician who has been practicing orthopedic hand surgery in Florida for twenty years, and who has not had any malpractice claims against him in that time. He has had the same carrier, The Medical Protective, for the past seven years. From March 2001 to March 2002, his annual premium was

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[471] E-mail from Paul Shirley, M.D. to William Large, Counsel, Governor's Select Task Force on Healthcare Professional Liability Insurance (Jan. 12, 2003) (Vol. 11, Tab 508).
[472] E-mail from Jonathan Daitch, M.D. to William Large, Counsel, Governor's Select Task Force on Healthcare Professional Liability Insurance (Jan. 12, 2003) (Vol. 11, Tab 510).
[473] E-mail from Robert S. Spiegel, M.D. to William Large, Counsel, Governor's Select Task Force on Healthcare Professional Liability Insurance (Jan. 12, 2003) (Vol. 11, Tab 512).

$19, 709 for coverage of $1,000,000/$3,000,000. From March 2002 to March 2003, the rate increased to $46,120, so Dr. Greene changed coverage at greater risk of personal exposure to $250,000/$750,000; for this coverage, his annual premium was $27,296. He has received notice that for March 2003 to March 2004, for the same $250,000/$750,000 coverage, the annual premium will increase 63 percent to $44,355. The new premium will be 125 percent more than what he was paying in 2001 to 2002 for one-third of the protection.[474]

- Matthew R. Mervis, M.D. is the administrative partner for a ten-physician OB/GYN practice in Winter Park. During the past six months, because multiple obstetricians have ceased practicing in metro Orlando, the practice has seen its wait times for new gynecological appointments balloon to four to six months. Additionally, its delivery volume has increased approximately 20 percent. Last year, the practice had liability coverage with limits of $500,000/$1,500,000, at $40,000 per physician. To receive equal coverage in February 2003 would cost $70,000 per physician. This practice has reduced coverage to $250,000/$750,000, at a cost of $55,000 per physician—a 37 percent increase for only half the coverage. This practice has provided services to patients at two hospitals (ORHS and FHS) for twenty-six years, but starting January 1, has curtailed its practice to a single hospital because of potential legal liability. Finally, with a changing liability climate, the practice has seen a significant increase in its caesarian rate. Dr. Mervis will leave Florida in three years (when his child completes high school), if the malpractice insurance crisis remains.[475]

- John Fifer, M.D. is an orthopedic surgeon who no longer goes to the emergency room or performs spine or pelvic fracture work. Dr. Fifer was sued after he consulted on a trauma case for which he did not get paid, and because he was the only party with insurance and not covered by sovereign immunity, he ended up becoming the deep pocket in a directed verdict.[476]

- Jeffrey Livingston, M.D., is a young ear, nose, and throat doctor who was almost forced out of practice because malpractice insurance was exceedingly difficult for him to obtain. The local hospital required a $250,000 letter of credit in lieu of insurance, and Dr. Livingston encountered great difficulty obtaining such a letter of credit because

[474] E-mail from Thomas L. Greene, M.D. to William Large, Counsel, Governor's Select Task Force on Healthcare Professional Liability Insurance (Jan. 13, 2003) (Vol. 11, Tab 518).
[475] E-mail from Matthew R. Mervis, M.D. to William Large, Counsel, Governor's Select Task Force on Healthcare Professional Liability Insurance (Jan. 12, 2003) (Vol. 11, Tab 513).
[476] E-mail from John Fifer, M.D. to William Large, Counsel, Governor's Select Task Force on Healthcare Professional Liability Insurance (Jan. 12, 2003) (Vol. 11, Tab 514).

he has no assets. Eventually, he obtained malpractice insurance in the minimum amount required by law from the JUA. However, this coverage came at a more than 600 percent increase. His 2001 $250,000/$750,000 coverage, which was written by Clarendon (which has left Florida) was $7,071; his 2002 insurance through the JUA increased to $42,945. Dr. Livingston received several other quotes. Pulic gave him a quote of $67,000 per year with a $10,000 deductible, and no tail coverage. Evanston gave him a quote of $87,000 per year plus taxes and fees, and no tail coverage. General Star gave him a quote of $47,458 per year with a $10,000 deductible, and no tail coverage. As a survival tactic, and for fear that a lawsuit could put him out of business, Dr. Livingston is limiting performance of complex otologic and head and neck procedures. He is also less able to participate in programs that do not reimburse well, and is considering canceling his contract with Children's Medical Services, even though he is the only CMS provider of ENT services in Indian River County that he is aware of.[477]

- Michael Widick, M.D. is an otolaryngologist in Cocoa Beach who recently separated from the Air Force. He has a "new physician's discount rate" that more than doubled last year, from $6,000 to $12,500. He anticipates that his rates will reach about $50,000 per year after the next three years.[478]

- Martin Rothberg, M.D. is an internist who has practiced in Miami for twenty-eight years. Last year, his malpractice premium for a $1,000,000/$3,000,000 policy was $21,000. His insurance company declined to reinsure him for this year, and made available a "tail" policy for $61,000. The only coverage he could find for this year was a $250,00/$750,000 policy with a $10,000 deductible for a premium of $32,000. Because he could not afford $93,000 in insurance premiums, he has been "bare" since October 1, 2002.[479]

- Mark Rubenstein, M.D. specializes in physical medicine and rehabilitation, and as such has always been on the "low end" of the malpractice insurance premium list. Nevertheless, his malpractice insurance has gone up by more than 200 percent, and his premium more than tripled from last year. After his insurance was renewed, the company informed him that it is leaving the state of Florida. He will therefore have to find replacement coverage in a market that is

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[477] E-mail from Jeffrey A. Livingston, M.D. to William Large, Counsel, Governor's Select Task Force on Healthcare Professional Liability Insurance (Jan. 12, 2003) (Vol. 11, Tab 511).
[478] E-mail from Michael Widick, M.D. to William Large, Counsel, Governor's Select Task Force on Healthcare Professional Liability Insurance (Jan. 12, 2003) (Vol. 11, Tab 515).
[479] E-mail from Martin Rothberg, M.D. to William Large, Counsel, Governor's Select Task Force on Healthcare Professional Liability Insurance (Jan. 11, 2003) (Vol. 11, Tab 502).

very difficult. As a result of this crisis, he has stopped taking referrals to do epidural steroid injections, a procedure he has been doing clinically in private practice for ten years. That procedure is the riskiest that he performs in his pain practice, so he has stopped performing it in an effort to avoid any insurance denial in the future.[480]

- Lee Fischer, M.D. has stopped admitting patients to the hospital and now uses hospitalists to care for his patients. Dr. Fischer has $500,000/$1,500,000coverage. The premium for this in 2001 was about $5,000, and in 2002, $8,000. The one company that offered him insurance for 2003 for $250,000/$750,000 coverage quoted him $19,000. He has elected to take it, and now has half the coverage and a 125 percent increase in his premium for doing nothing more then office family practice and no procedures.[481]

- Christina Delgado, M.D. is a young practicing anesthesiologist in the Tampa Bay area whose malpractice insurance premiums jumped from $12,000 with limits of $1,000,000/$3,000,000 to $17,000 with limits dropped to $250,000/$750,000. This is an almost 40 percent increase in her premium, in spite of the fact that her coverage decreased. She is very concerned about her future ability to practice as an anesthesiologist.[482]

- Patrick T.G. Hennessey, M.D., MPH, FACP practices in the Orlando area. In 2001, his group's malpractice premium for $500,000/$1,500,000/$3,000,000 shared policy was approximately $7,800. In 2002, this was increased to almost $18,000. Its renewal for 2003 was quoted at $38,000, an increase of 487 percent in eighteen months. The group has had to restrict some of its services due to malpractice concerns. It has stopped caring for Workers Compensation patients and injured hotel guests. Even minor procedures (e.g., simple wound care, and minor gynecologic problems) now must routinely be sent to the emergency room because of malpractice concerns. Pregnant patients with non-OB problems are seen only on a case-by case basis. Soon, the group will be unable to accept Medicare patients.[483]

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[480] E-mail from Mark Rubenstein, M.D. to William Large, Counsel, Governor's Select Task Force on Healthcare Professional Liability Insurance (Jan. 11, 2003) (Vol. 11. Tab 505).
[481] E-mail from Lee Fischer, M.D. to William Large, Counsel, Governor's Select Task Force on Healthcare Professional Liability Insurance (Jan. 11, 2003) (Vol. 11, Tab 506).
[482] E-mail from Christina Delgado, M.D. to William Large, Counsel, Governor's Select Task Force on Healthcare Professional Liability Insurance (Jan. 11, 2003) (Vol. 11, Tab 501).
[483] E-mail from Patrick T.G. Hennessey, M.D., MPH, FACP (Jan. 10, 2003) (Vol. 11, Tab 494).

- James Floyd, M.D. is an orthopedic surgeon in Bradenton. He recently moved here from Birmingham, Alabama, where he had coverage of $1,000,000/$3,000,000 for $16,500 per year. Here in Florida, he must pay $34,000 for only $250,000/$750,000 coverage. If this situation does not improve, Dr. Floyd will go back to Alabama by 2004.[484]

- A. Braun, M.D. is a busy surgeon in an Orlando hospital who has been voted one of Orlando's best doctors. His renewal for liability insurance is in June. His current policy is $46,000 per year for general surgery, and his carrier will not discuss coverage or rates until required by law, forty-five days before. He is considering moving to another state to practice medicine.[485]

- Regina Bland, M.D., F.A.A.P. and Val Wynne, M.D., F.A.A.P. have been pediatricians in Palm Beach County since 1983 and 1989, respectively. Rather than close their practices, they dropped their medical malpractice insurance in December 2002, due to a rate increase of 600 percent from the prior year. They also dropped their hospital privileges and are now self-insured with responsibilities of $100,000.[486]

- Gordon Rafool, M.D. is one of about forty-five physicians in a multi-specialty clinic in Winter Haven. The clinic's malpractice premium has increased this year from $1,200,000 to $1,800,000. The physicians are now self-insured for the first $50,000. One physician has given up obstetrics, and all of them have stopped doing any high-risk procedures.[487]

- Graham F. Whitfield, M.D. has dropped his professional liability insurance, effective January 1, 2003. The Medical Insurance Company of America (MICOA) notified him in October 2002 that it would no longer write medical professional liability insurance in Florida. He checked into the other plans that were writing in Florida but the premiums were triple in price without a tail. Dr. Whitfield

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[484] E-mail from James Floyd M.D. (Jan. 10, 2003) (Vol. 11, Tab 490).
[485] E-mail from A. Braun, M.D. to William Large, Counsel, Governor's Select Task Force on Healthcare Professional Liability Insurance (Jan. 10, 2003) (Vol. 11, Tab 491).
[486] E-mail from Regina Bland, M.D., F.A.A.P. and Val Wynne, M.D., F.A.A.P. to William Large, Counsel, Governor's Select Task Force on Healthcare Professional Liability Insurance (Jan. 10, 2003) (Vol. 11, Tab 492).
[487] E-mail from Gordon Rafool, M.D. to William Large, Counsel, Governor's Select Task Force on Healthcare Professional Liability Insurance (Jan. 10, 2003) (Vol. 11, Tab 493).

stopped doing spinal surgery a couple years ago due to the cost of the premiums.[488]

- Jon D. Wiese, M.D. is a general surgeon in Longwood, and has practiced in this area since finishing his residency in August 1988. His premium for professional liability insurance increased from $30,576 in December 2001 to $48,051 in December 2002 for $500,000/$1,500,000 coverage. He elected to drop the limits on his professional liability insurance to $250,000/$750,000, effective December 2002; the premium was $35,002. He has stopped doing some surgical procedures and is contemplating leaving the state.[489]

- R. Gregory Smith, M.D. has practiced cosmetic surgery and maxillofacial surgery for the past twelve years in the Jacksonville area without a lawsuit. His insurance company (MICOA) suddenly decided to leave the state due to the "unsettled climate of the industry in the State of Florida," citing the increase in amounts of awards in Florida and the frequency of the occurrence of lawsuits. The offered him tail coverage for $132,000. He is currently paying $34,000 a year for coverage that will soon end. He expects to eventually have to go bare.[490]

- Ray Kordonowy, M.D. is a member of a five-person general internal medicine practice. The group is experiencing an average increase in annual premiums of 48 percent. The physicians are currently paying about $20,000 per person (on average) per year through their present carrier (MICOA), which is going to pull out of the Florida market in August. They expect increases for comparable coverage to cost 100 to 300 percent more, based on information from two companies willing to give them bids. The group is being offered $250,000 coverage with premium quotes higher than they paid for $1,000,000coverage a year ago. Members of the group cease in-hospital coverage in the next 3 to 9 months, so that arrangements can be made for asset protection and no liability insurance. They have already stopped admitting to two of the three hospitals they were attending. They ultimately plan on leaving Florida.[491]

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[488] E-mail from Graham F. Whitfield, M.D. to William Large, Counsel, Governor's Select Task Force on Healthcare Professional Liability Insurance (Jan. 15, 2003) (Vol. 11, Tab 534).
[489] E-mail from Jon D. Wiese, M.D. to William Large, Counsel, Governor's Select Task Force on Healthcare Professional Liability Insurance (Jan. 15, 2003) (Vol. 11, Tab 535).
[490] E-mail from R. Gregory Smith, M.D. to William Large, Counsel, Governor's Select Task Force on Healthcare Professional Liability Insurance (Jan. 16, 2003) (Vol. 11, Tab 540).
[491] E-mail from Ray Kordonowy, M.D. to William Large, Counsel, Governor's Select Task Force on Healthcare Professional Liability Insurance (Jan. 14, 2003) (Vol. 11, Tab 532).

- Donald R. Dunlap, M.D. experienced a 36 percent rate increase in 2003. Rather than "go bare," he has decided to work part-time and pay 50 percent of the premium.[492]

- Joel A. Schneider, M.D. is a radiologist whose specialty is mammography. He has just paid $94,000 for $250,000 in malpractice insurance. This will be his last year of practice unless there is some reasonable relief.[493]

Data on the Problem

Office of Insurance Regulation Medical Malpractice Data Call

A recent data call by the Department of Insurance (now the Office of Insurance Regulation) ("Office") indicates that:

- There are fewer insurance companies writing new medical malpractice policies in Florida;

- There are fewer insurance companies willing to renew such policies in Florida; and

- Those that are providing coverage have implemented more restrictive eligibility criteria for health care providers.

In October 2002, the Office issued a data call to the top 15 writers of medical malpractice insurance in Florida. These insurers and their affiliates represent 94 percent of the market, as of December 31, 2001. By October 2002, three of these insurers had left or were in the process of leaving the market. The purpose of the data call was to determine the extent to which insurers were offering new and renewal medical malpractice policies. The data call was also designed to identify trends in the payment of claims at or in excess of policy amounts.

The requested information was due November 30, 2002, and was collected via the Internet. Responses were received from all fifteen insurers. Additionally, some respondents provided information on behalf of affiliated companies within their insurer group, even though the affiliated insurers are not actually ranked among the top fifteen writers. As a result,

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[492] E-mail from Donald R. Dunlap, M.D. to William Large, Counsel, Governor's Select Task Force on Healthcare Professional Liability Insurance (Jan. 2003) (Vol. 11, Tab 531).
[493] E-mail from Joel A. Schneider, M.D. to William Large, Counsel, Governor's Select Task Force on Healthcare Professional Liability Insurance (Jan. 17, 2003) (Vol. 11, Tab 548).

a total of twenty-six companies are represented in the responses. With two exceptions, (ProNational Insurance Company and Clarendon Insurance Company),[494] complete responses were received from all insurers. During the months of December and January, the Office reviewed the data received and contacted insurers for clarification or additional information where responses appeared inconsistent or incomplete.

The data call queried two areas: coverage and writing practices and closed claim experience. Inquiries regarding closed claim experience were limited to claims in which an insurer's payout met or exceeded policy limits as well as those claims that included punitive damages or extra contractual (bad faith) obligations.

The following highlights certain information contained in the responses received.

Coverage and Writing Practices

Most of the policies written are to physicians and surgeons. For these categories, since 2001, the number of insurers willing to write new risks has been reduced by approximately 50 percent. A similar reduction has been experienced relative to hospitals. The table below provides a summary of responses from insurers regarding their willingness to write new risks in the years indicated.

[494] ProNational, actively writing new business, is ranked third in direct written premium with approximately 9.6 percent of market share. ProNational provided written responses to some questions in the coverage and writing practices section. It provided no detailed response to the closed claim experience section. ProNational's legal counsel asserted confidentiality or trade secret concerns regarding certain questions and indicated that some information being requested was not "easily available" as it was not "stored in their computer system." Clarendon Insurance Company was ranked twelfth in direct written premium with approximately 3.7 percent of the market share. Clarendon Insurance Company is not actively writing new or renewal business. Clarendon Insurance Company provided complete responses to the coverage and writing practices section but provided no data for the closed claim experience section. These matters are being pursued with each insurer.

Table 6

Number of Insurers Writing New Risks in Years Indicated												
	2002		2001		2000		1999		1998		1997	
	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
Physicians	7	19	15	11	18	8	18	8	17	9	15	11
Surgeons	8	18	14	12	18	8	18	8	18	8	15	11
Hospitals	3	22	6	19	8	17	6	19	8	17	7	18
Pharmacists	5	20	6	19	6	19	6	19	5	20	5	20
Nurses	6	19	10	15	11	14	11	14	7	18	6	19
Occupational Therapists	6	19	7	18	6	19	7	18	6	19	5	20
Physical Therapists	6	19	7	18	8	17	6	19	6	19	5	20
Midwives	3	22	5	20	5	20	5	19	5	20	4	21
Others	9	16	14	11	17	8	19	6	20	5	18	7

Less than half of those responding to the data call have indicated a willingness to renew their existing risks. Insureds whose policies are not renewed must seek coverage from insurers with which they did not have an immediately preceding relationship.

Table 7

Number of Insurers Currently Renewing Existing Business as of November 2002		
	Yes	No
Physicians	12	14
Surgeons	12	14
Hospitals	4	21
Pharmacists	6	19
Nurses	8	17
Occupational Therapists	7	18
Physical Therapists	7	18
Midwives	4	21
Others	9	16

The reduction in the number of insurers renewing existing business, in conjunction with departures of several insurers and the unwillingness to write new policies by most of those remaining, have combined to severely restrict access to medical malpractice insurance in Florida. Healthcare providers that were previously insured by one of the insurers that has left the market, are attempting to find coverage in a market that is not universally writing new business. These healthcare providers are also competing for coverage with those insureds that are being nonrenewed by their current insurer.

Many insurers have indicated that they had implemented significant changes to their eligibility criteria in the last twenty-four months. These

changes have had the effect of reducing the number of applicants and insureds who would qualify for prospective coverage. These changes, when combined with the reduced number of insurers writing new and renewal business, have served to further restrict healthcare providers' access to coverage. The data call requested that responders explain the nature and reason for such changes.

Examples of changes in eligibility and underwriting criteria include:

- Enhanced limitation on willingness to provide coverage for prior acts ("tail") coverage.
- Restricting maximum limits of coverage to $1,000,000 per occurrence with a $3,000,000 policy aggregate.
- Reviewing all physicians with past or present claims or suits by re-underwriting the entire book of business.
- Non-renewing policies with losses
- Non-renewing medical groups with over three physicians and physicians practicing within certain specialties.

Thirty-one percent of insurers have policies which specifically exclude punitive damages. Arguably, the absence of this exclusion does not necessarily obligate an insurer to pay punitive damages.

Closed Claim Experience

The responses to the closed claim experience section obviously focus on claims that have been closed in the years indicated. The frequency and severity of claims closed in any one year will not likely reflect the frequency and severity of those claims currently being incurred. Typically, the frequency and severity of claims is reflected in loss reserves and reserves established relative to claims that have been incurred, but for which no claim has yet been filed.

Some insurers have indicated, and the responses seem to reflect, an inability to easily identify and distinguish payout amounts of punitive and bad faith damages from the total amounts paid on each claim.

Responses to the closed claim experience section indicate a measurable increase in the percentage of closed claims that were paid at or above policy limits. While the actual percentage relative to total closed claims for 2001 remains low at 5.5 percent, the substantial increase in the percentage from 1.5 percent in 1997, suggests an unfavorable trend that, if

continued, may further weaken the resolve of those insurers remaining in the market to continue to offer coverage.

The impact of these percentages is even more telling when taking into account that there are fewer large insurers writing medical malpractice insurance in Florida today than there were in 1997. A growing number of claims paid in excess of policy limits is being spread among a smaller population of insurance companies.

For a more detailed summary of responses, see Table 8.

Table 8

2001 - Market Share and Rank

Market Share Rank	Company Name	2001 Med Mal Dir Prem Written	Market Share
1	First Professionals Ins Co	109,672,505	19.1%
2	Health Care Ind Inc	88,970,154	15.5%
3	Pronational Ins Co	55,259,931	9.6%
4	Truck Ins Exch	35,245,611	6.1%
5	Medical Protective Co	31,096,627	5.4%
6	American Physicians Assur Corp	26,690,239	4.6%
7	MAG Mut Ins Co	26,525,321	4.6%
8	St Paul Fire & Marine Ins Co	24,422,097	4.2%
9	Continental Cas Co	23,542,376	4.1%
10	Doctors Co An Interins Exchn	23,223,681	4.0%
11	TIG Ins Co	21,469,578	3.7%
12	Clarendon Natl Ins Co	21,456,110	3.7%
13	American Healthcare Ind Co	20,235,101	3.5%
14	Chicago Ins Co	12,461,372	2.0%
15	Anesthesiologists Pro Assur Co	11,835,465	2.0%
17	American Cas Co Of Reading PA	4,828,738	0.8%
22	American Continental Ins Co	2,515,415	0.4%
32	St Paul Guardian Ins Co	427,533	0.07%
35	Athena Assur Co	350,252	0.06%
38	TIG Ind Co	152,070	0.02%
40	National Fire Ins Co Of Hartford	56,211	0.00%
53	Valley Forge Ins Co	-	
61	Transportation Ins Co	-	
	St Paul Mercury Insurance		
	TIG Insurance Co of Michigan		
	Transcontinental Insurance Co		
			93.45%

Source: Direct Written Premium as reported in 12/31/01 Annual Statement.

Florida Department of Health Financial Responsibility

Florida, unlike most other large states, requires as a matter of licensure that the licensee must demonstrate to the satisfaction of the licensing boards and the Department of Health financial responsibility to pay claims and costs arising out of the failure to render the appropriate medical care.[495] The Florida Department of Health maintains data on physician financial responsibility. As of January 30, 2003, the Department's data on this issue is reflected in Table 9.

Table 9 indicates:

- 35,416 Florida physicians carry medical malpractice insurance (32,500 medical doctors and 2,826 osteopathic doctors).
- 728 Florida physicians carry an irrevocable letter of credit (600 medical doctors and 128 osteopathic doctors).
- 2,076 Florida physicians do not carry medical malpractice (1,907 medical doctors and 105 osteopathic doctors).
- 18,587 physicians fall under one of the statutory exemptions listed above or do not practice in Florida (16,924 medical doctors and 1,663 osteopathic doctors).[496]

[495] Section 458.320(1), Florida Statutes.
[496] Section 458.320(5)(a)-(f), Florida Statutes.

Table 9

pro_cde	fin_resp_code	financial_exempt	CountOflicno
1501			67
1501		Government	3910
1501		Limited License	47
1501		Teaching	1074
1501		Not Practicing in Florida	8740
1501		Other Criteria	3086
1501	Liability under $100,000		3800
1501	Liability under $100,000	Government	16
1501	Liability under $100,000	Limited License	1
1501	Liability under $100,000	Teaching	3
1501	Liability under $100,000	Not Practicing in Florida	88
1501	Liability under $100,000	Other Criteria	46
1501	Liability under $250,000		28356
1501	Liability under $250,000	Government	18
1501	Liability under $250,000	Limited License	1
1501	Liability under $250,000	Teaching	12
1501	Liability under $250,000	Not Practicing in Florida	188
1501	Liability under $250,000	Other Criteria	61
1501	Irrevocable Letter of Credit $100,000		142
1501	Irrevocable Letter of Credit $100,000	Other Criteria	1
1501	Irrevocable Letter of Credit $250,000		452
1501	Irrevocable Letter of Credit $250,000	Not Practicing in Florida	4
1501	Irrevocable Letter of Credit $250,000	Other Criteria	1
1501	Not to Carry Medical Malpractice		1907
1501	Not to Carry Medical Malpractice	Government	3
1501	Not to Carry Medical Malpractice	Teaching	2
1501	Not to Carry Medical Malpractice	Not Practicing in Florida	20
1501	Not to Carry Medical Malpractice	Other Criteria	39
1901			19
1901		Government	250
1901		Limited License	9
1901		Teaching	40
1901		Not Practicing in Florida	1098
1901		Other Criteria	247
1901	Liability under $100,000		468
1901	Liability under $100,000	Not Practicing in Florida	11
1901	Liability under $100,000	Other Criteria	4
1901	Liability under $250,000		2303
1901	Liability under $250,000	Government	2
1901	Liability under $250,000	Not Practicing in Florida	24
1901	Liability under $250,000	Other Criteria	14
1901	Irrevocable Letter of Credit $100,000		31
1901	Irrevocable Letter of Credit $100,000	Government	1
1901	Irrevocable Letter of Credit $250,000		95
1901	Irrevocable Letter of Credit $250,000	Not Practicing in Florida	1
1901	Not to Carry Medical Malpractice		100
1901	Not to Carry Medical Malpractice	Not Practicing in Florida	2
1901	Not to Carry Medical Malpractice	Other Criteria	3

Florida Hospital Association, January 2002 Survey

In a survey conducted in January 2002, the Florida Hospital Association documented some of the difficulty in obtaining, or affording medical malpractice insurance.[497] Fifty-two percent of the acute care hospitals in Florida responded to the survey.[498] Seventy-five percent of the hospitals reported having problems obtaining professional liability coverage. Of those not reporting problems, many stated they had not yet received the 2002 renewal notice, but anticipated having problems.[499] Fourteen hospital systems reported their insurance company had refused to renew the policy.[500] Seven of those had been insured by St. Paul Insurance Company.[501] Seventeen hospitals reported premium amounts. For 10 of those hospitals, the liability costs more than doubled between 1999 and 2001, with premium increases averaging 140 percent for the two-year period.[502]

Florida Medical Association, September 2002 Survey

In September, the Florida Medical Association also conducted a survey of its members to determine the availability of medical malpractice insurance. This survey co .ected information on how physicians had changed their practice to deal with the high cost, and lack of available medical malpractice insurance. More than 2,647 physicians responded representing over 40 specialties, and 42 of 67 Florida counties.[503] Of the 2,647 respondents, 98 percent believed they were impacted by the increase in malpractice insurance, and provided the following explanations of the impact:[504]

- 98, or 3.7 percent of the respondents, reported discontinuing the practice of medicine as a result of the lack of availability of medical malpractice insurance.
- 624, or 23.57 percent, had discontinued calls at nursing homes.
- 915, or 34.57 percent, had cut back on hospital coverage.
- 1,080, or 40.8 percent, had stopped, or reduced emergency room calls.

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[497] Florida Hospital Association, Survey on the Availability and Affordability of Liability Coverage in Florida (May 2002).
[498] Id. at 5.
[499] Id.
[500] Id.
[501] Id.
[502] Id.
[503] Florida Medical Association & Florida Hospital Association, Access to Care Survey, presentation, Dec. 20, 2002.
[504] Id.

- 1,360, or 51.38 percent, had discontinued or cut back on Medicaid patients.

- 1,732, or 65.43 percent, had stopped seeing certain types of patients.

- 1,795, or 67.81 percent, had reduced or stopped certain procedures.

- 832, or 31.44 percent, had difficulty getting new partners.

- 981, or 37.05 percent, had changed referral patterns.

- 1,228, or 46.39 percent, were considering discontinuing the practice of medicine.

Floridians for Quality Affordable Healthcare 2002 Survey

Floridians for Quality Affordable Healthcare conducted a survey of physicians in Dade, Broward and Palm Beach Counties in late October and early November 2002 to assess the impact of the medical malpractice insurance crisis.[505] Surveys were sent to approximately 9,000 physicians in the area, and responses were received from 1,573.[506] The survey had the following findings:

- Most South Florida physicians have been sued at least once, with the odds of being sued highly correlated to certain specialties. (Table 10).[507] Every neurosurgeon and vascular surgeon in the survey had been sued, and for the 1,460 physicians who answered this question, the average number of suits was 1.44.[508] The highest number of lawsuits per individual physician occurred for neurosurgeons with an average of 5.2 suits per physician.[509]

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[505] RCH Healthcare Advisors, LLC, Floridians for Quality Affordable Healthcare, Summary of Results, Physician Professional Liability Survey 1.
[506] Id.
[507] Id.
[508] Id.
[509] Id.

Table 10. Average Number of Lawsuits and Percentage of Physicians Who Have Been Sued by Specialty

SPECIALTY	LAWSUITS Ave. No. Total	% Who Have Been Sued	Sample Size
Neurosurgery	5.21	100.0	14
Vascular Surgery	3.14	100.0	11
Cardiovascular or Thoracic Surgery	3.62	94.1	17
General Surgery	2.69	90.5	63
Radiology	3.31	88.9	27
OB-GYN	2.61	78.6	84
Emergency Medicine	1.69	77.8	9
Other Surgical[510]	1.89	76.9	13
Infectious Diseases	3.22	71.4	14
Radiation Oncology	1.33	71.4	7
Cardiology	1.37	71.1	76
Physical Medicine & Rehabilitation	1.70	70.0	10
Neurology	1.55	68.3	41
Pulmonary	1.56	67.4	43
Gynecology	2.63	66.7	18
Pediatric Medical Specialties	1.19	66.7	9
Orthodedic Surgery	1.97	61.5	96
Anesthesiology & Pain Management	0.97	61.1	18
Otolaryngology	1.44	60.9	23
Urology	1.02	58.8	34
Pediatric Surgery/Surgical Specialties	1.97	58.3	12
Internal Medicine	1.28	54.6	183
Ophthalmology	0.93	52.6	57
Plastic Surgery	1.62	52.1	73
Hematology-Oncology	0.91	50.0	32
Pathology	0.84	50.0	12
Other Medical[511]	2.00	50.0	8
Gastroenterology	0.92	48.4	64
Podiatry	1.48	47.1	17
Family Practice and General Practice	0.74	46.8	139
Dermatology	0.67	45.9	37
Unidentified Specialty[512]	0.72	41.7	17
Nephrology	0.70	38.5	13
Pediatrics	0.40	29.3	99
Psychiatry	0.48	28.2	39
Endocrinology	0.25	25.0	8
Rheumatology	0.22	22.2	9
Allergy and Immunology	0.00	0.00	14
Weighted Averages & Total Sample	**1.44**	**57.4**	**1,460**

Source: RCH Healthcare survey of South Florida physicians, November 2002.

[510] Includes hand surgery, maxillofacial, oculoplastics, oncologic, spine, and cataract surgery.

[511] Includes critical care, geriatrics, infertility, neonatology, and nuclear medicine.

[512] Specialty was not provided by respondent.

- The number of physicians "going bare" has increased. In 2001-02, 94.6 percent of the respondents had purchased medical malpractice insurance.[513] When asked if they had purchased medical malpractice insurance this year (2002) only 83.6 percent answered yes.[514]

- The amount of coverage purchased has also decreased.[515]

Table 11. Changes in Coverage Limitations

Percentage Buying	Last Year	This Year
$1,000,000/$3,000,000	35.0%	20.7%
$500,000/$1,500,000	12.5%	11.4%
$250,000/$750,000	47.1%	51.5%
No Malpractice Coverge	5.4%	16.4%
Total	100.0%	100.0%
Sample Size	1,506	1,454

Source: RCH Healthcare survey of South Florida physicians, November 2002

- More than 52 percent of the respondents indicated they were considering "going bare" in 2003.[516]

- The cost of medical malpractice between 2001 and 2002 has increased by 33 percent.[517]

- When the decrease in coverage is factored out of the increase in cost, then the cost for the same coverage has increased from an average of $4,667 per $100,000 to a cost of $8,400 per $100,000, or an increase of 80 percent.[518]

- Some specialties, such as neurosurgery, thoracic surgery, and obstetrics, pay well over $100,000 per physician, per year, for medical malpractice coverage.[519]

- Fifty-four respondents closed their practice, retired early, or moved to another state, and 34 percent of all respondents report they are considering this option.[520]

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513 Id. at 3.
514 Id.
515 Id.
516 Id.
517 Id.
518 Id.
519 Id.
520 Id. at 4.

- More than 41 percent, or 517 respondents, have already stopped offering some high-risk procedures.[521] An additional 15 percent are considering this action.[522]

- Eight of the 18 gynecologists responding to the survey have stopped delivering babies accounting for a loss of 745 deliveries.[523]

- Forty-five of the 94 obstetricians who responded have stopped some high-risk procedures.[524]

- Seven of the 29 radiologists responding have stopped reading mammograms taking more than 15,000 readings out of the system, and another eight radiologists are considering discontinuing this service.[525]

- About 41 percent, or 647 respondents, have cut back on staff or delayed purchasing equipment to reduce costs.[526] The types of equipment purchases delayed include: mammography, breast biopsy, ultrasound, laboratory, and x-ray equipment; a visual field machine, and retinal camera; electronic medical records software; computer upgrades; and office renovations.[527]

- Almost 31 percent, or 482 respondents indicated they have limited their hospital emergency room practice and 6 percent, or 87 respondents, are considering this reduction.[528]

- Approximately 16 percent, or 256 respondents, have limited nursing home practice and another 2 percent, or 30 respondents, are considering the reduction.[529]

- Approximately 11 percent, or 172 respondents, have limited services in ambulatory surgery centers and another 2 percent, or 23 respondents, are considering this limit on services.[530]

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[521] Id.
[522] Id.
[523] Id. at 5.
[524] Id.
[525] Id.
[526] Id.
[527] Id.
[528] Id.
[529] Id.
[530] Id.

- 50 percent, or 787 respondents, reported discontinuing services to some high-risk patients.[531]

- 44 percent, or 699 respondents, are discontinuing some high-risk services.[532]

- 66 percent, or 1,062 respondents, reported performing more tests for defensive reasons.[533]

- 30 percent, or 467 respondents, reported longer waiting times for an appointment.[534]

It should be noted that the Academy of Florida Trial Lawyers took exception to the techniques used by the Floridians for Quality Affordable Healthcare. According to the Academy, "the conclusions of the materials are based on reported survey data. However, the methodology of the reported survey is flawed to the point that the results would not be accepted in any way in terms of the social science academic community."[535]

According to Dr. James T. Kitchens, a statistician retained by the Academy, the use of mail or fax surveys always presents obstacles in obtaining valid results. The results of the materials presented represents one of the studies described by Norman Bradburn and Seymour Sudman, who have been honored for their contributions to methods of conducting surveys. In their book, Polls and Surveys: Understanding What They Tell Us, they write "There are so many examples of carefully conducted mail surveys with cooperation rates in the 80-90 percent range. There are also horrible examples of mail surveys with cooperation rates in the 10-20 percent range, or even lower. The biases in such studies are so great as to make the results almost meaningless." The cooperation rate for the Floridians for Quality Healthcare study is 17.5 percent. This means the actual finding could vary by as much as 82.5 percent if the cooperation rate had been 100 percent.[536]

Dr. Kitchens believes that without a true random sampling technique, the responses from a mail or faxed survey always have some built-in bias. The respondents to this study may be doctors more interested in the topic or they may have been sued more often than the average doctor. In this study, since there is no signature line on the response form, it is not even

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[531] Id. at 6.
[532] Id.
[533] Id.
[534] Id.
[535] James T. Kitchens, Ph.D., Analysis of Reports by RCH Healthcare Advisors (Jan. 2003).
[536] Id.

certain the responses are from doctors. The form may have been completed by anyone, such as an office administrator or nurse.[537]

Dr. Kitchen concluded, "this survey cannot claim a legitimate margin of error or statistical confidence level. Therefore, the conclusions and the assertions made on the basis of this survey data must be viewed as suspect considering the lack of discipline in terms of acceptable research methodology."[538]

Dr. Kitchen believes the survey and information presented to the Task Force amounts to no more than a public relations document presented by one side in a political policy debate. The methodology of this reported study is so flawed that the results have no statistical validity. If it were a research paper, it would receive a failing grade even in a basic undergraduate research course.[539]

The Task Force finds the comments of Dr. Kitchens to have some merit. Dr. Kitchens' main concern seems to be that there is a lack of responses from doctors to the survey. Dr. Kitchens notes, "if the data indicates the respondent physicians are angry or frustrated, it may explain why they responded to the survey and the other 82.5 percent of the physicians did not."[540] The Task Force would welcome Dr. Kitchens or any other stakeholder to attempt to reach out to the remaining 82.5 percent of the physicians in South Florida. However, the Task Force believes that, based upon the numerous letters, e-mails, and testimonials, that the remaining 82.5 percent of the physicians who did not respond to this survey (if they are still practicing) would mirror the responses of the 17 percent of the physicians that did respond. Although there is always going to be a need for more data on this problem, the Task Force finds the FMA and RCH survey to be compelling measures of physicians' attitudes in the state of Florida.

Closed Claim Data

In an effort to provide a quantitative analysis of the healthcare professional liability insurance problem and possible solutions, the Florida Hospital Association retained Milliman USA, Inc. to perform a data analysis. The Florida Academy of Trial Lawyers retained Dr. Lance deHaven-Smith to perform an analysis of the Florida problem as well, and provide an independent study. To assist the Task Force in considering the

[537] Id.
[538] Id.
[539] James T. Kitchens, Ph.D., Analysis of Reports by RCH Healthcare Advisors (Jan. 2003).
[540] Id.

extensive data analyses performed in these two reports, Task Force staff performed an independent analysis of each of the reports. [541]

Florida Hospital Association Report Analysis, Prepared by Milliman USA, Inc.

The Florida Hospital Association contracted with Milliman USA, Inc. to evaluate the healthcare professional liability insurance problem in Florida, and formulate recommendations for changes that would be effective in addressing the problem. The report examined data from the Florida Department of Insurance Medical Malpractice Closed-Claim Database, the National Practitioner Data Bank Public Use Data File (NPDB), the Texas Department of Insurance Closed-Claim Database, the Physicians Insurers Association of America Claim-Trend Analysis, and the statement of rate filings in insurance company annual statements.[542] The report compared Florida, and national data and trends, with loss payments, including average payouts, ratios of economic to non-economic damages, and premium increases.

Trends in Loss Payments and Premiums for Medical Liability Claims

Total loss payments

- Total amount of paid losses in Florida for 2000 is more than 150 percent higher than the amount paid in 1991. This includes an increase of 28 percent from 1999 to 2000.

- In comparison, the total amount of paid losses for the United States is 80 percent higher in 2000 than the amount paid in 1991.

- Florida losses are now in excess of $400 million per year.

[541] It should be noted that there have been previous well-documented attempts to study Florida's closed-claim data. A study of the Florida medical malpractice environment from 1975 to 1986 is particularly enlightening. See e.g., David J. Nye et. al., The Causes of the Medical Malpractice Crisis : An Analysis of Claim Data and Insurance Company Finance. 76 Georgetown Law Journal 1495 (1988). This study found that the primary cause of malpractice premium increases, measured over a nine-year period, was the increase in loss payments to claimants. The frequency of claims payments was not primarily responsible for increased claims costs, since the likelihood that a Florida physician would be sued for malpractice has not changed from 1975 to present. It is rather the "huge increase in the size of claims payments, particularly the increasing frequency of very large payments" that accounted for the total increase in paid losses. Nye et al. note: "The causes of the increases in claims payments in Florida are not clear. The increases may reflect the belief of defense lawyers and insurance claims managers that their risk at trial would be greater than in 1975. This might be derived from 'more serious iatrogenic injuries, a concern that juries are more likely to award larger verdicts and that judges are less likely to control them, a sense that the plaintiffs' trial bar is more able than before, or a concern that the insurer will be held liable under a bad faith claim if it fails to settle within policy limits.'" Id. at 1560.

[542] Richard S. Biondi et al., Milliman USA, Inc., Florida Hospital Association, Medical Malpractice Analysis (Nov. 7, 2002).

- Hospital losses account for 38 percent of total losses.
- Physician-paid losses grew from approximately $120 million in 1991 to more than $300 million in 2000 for an average annual growth of 10.8 percent.
- National losses are now in excess of $3.8 billion.
- Physician-paid losses grew only 6.8 percent from 1991 to 2000.

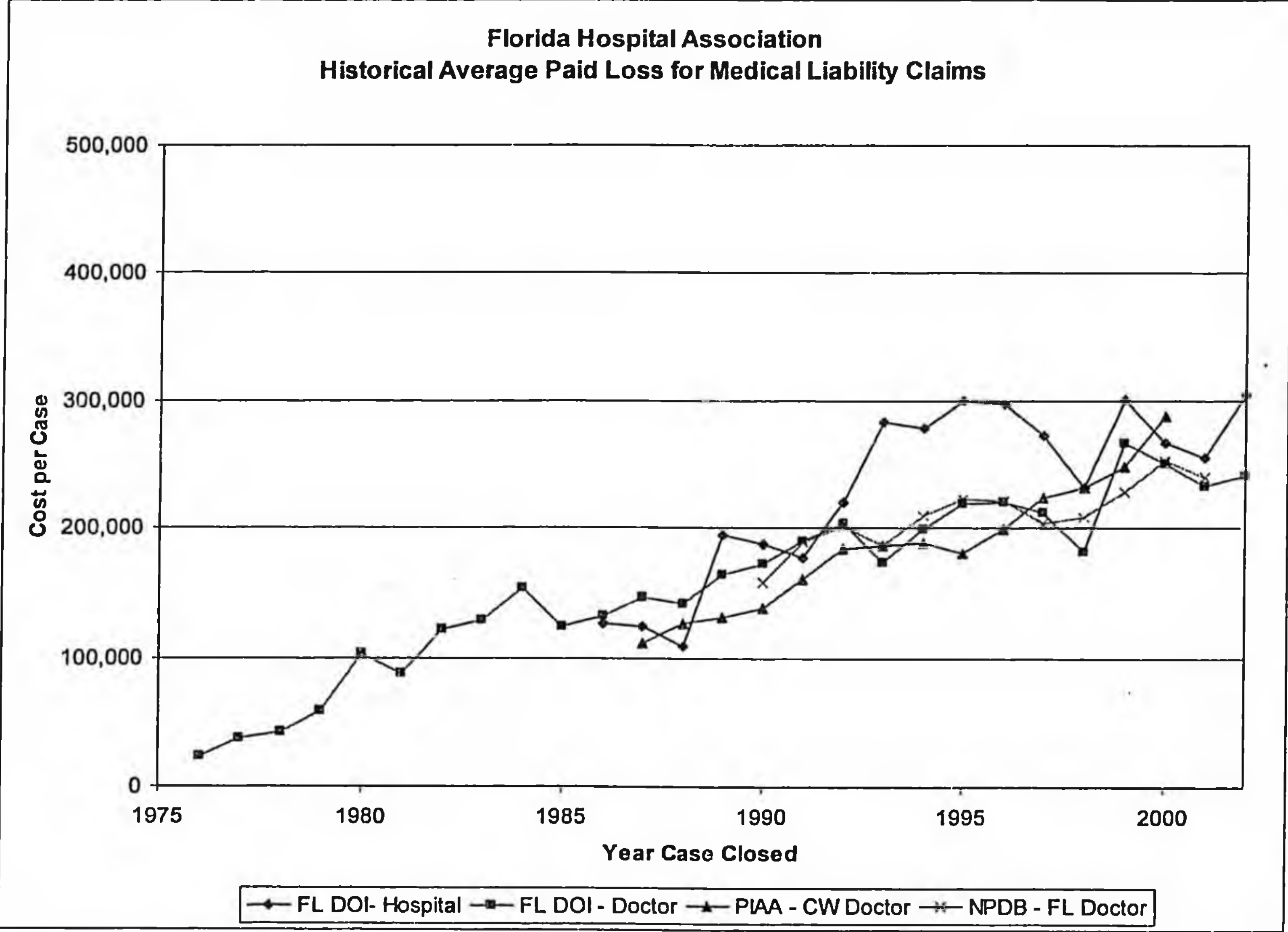
Average loss payments (severity of claims)

The average loss paid in Florida, and the nation, has shown an increasing trend since 1975. (Graph 1)[543]

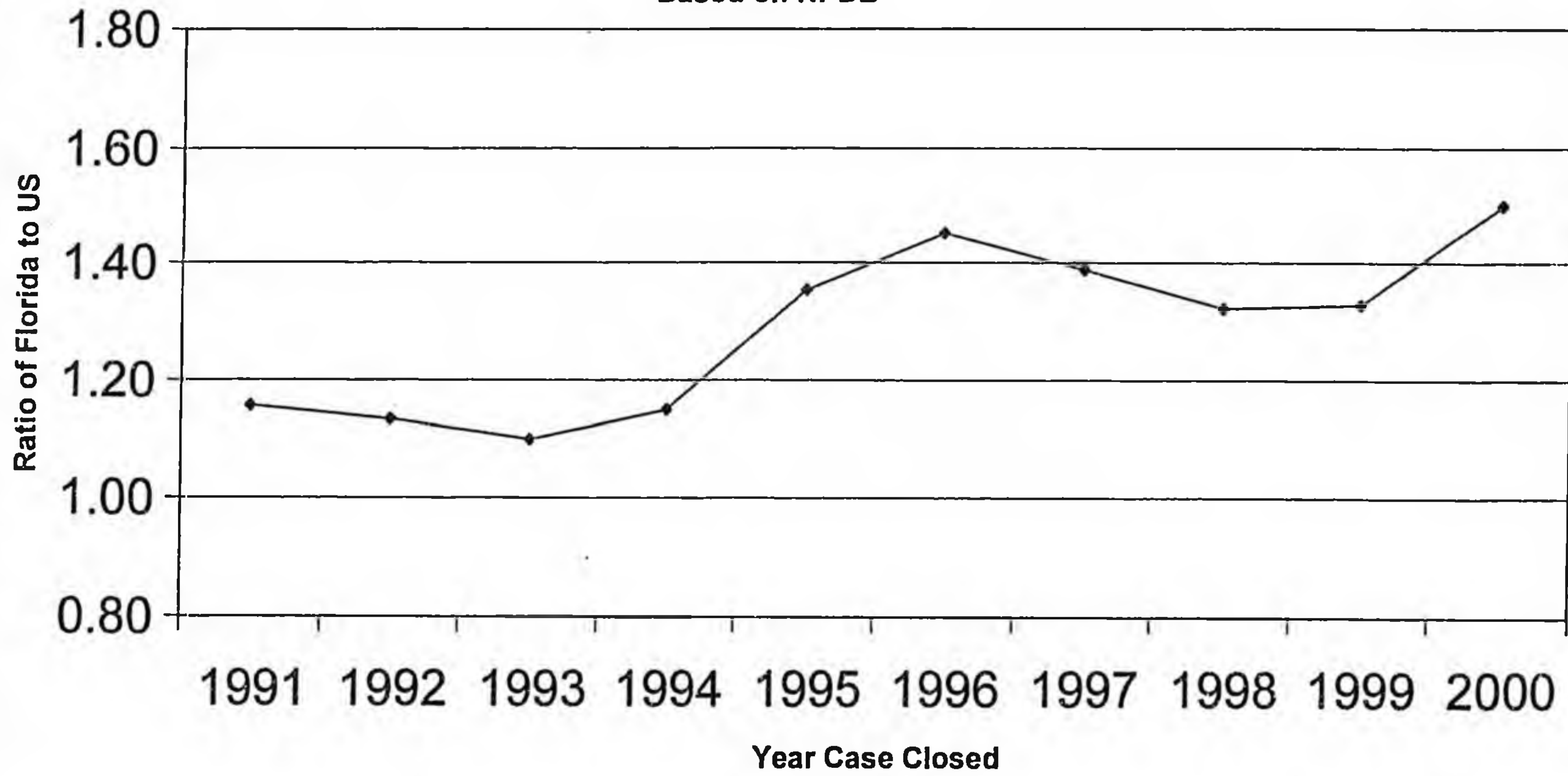
- The loss per Florida doctor exceeds the national average, and has grown from 15 percent above the national average in 1991, to 50 percent higher in 2000. (Graph 2)[544]

[543] Id., Graph 1.
[544] Id., Graph 2.

Graph 1



Graph 2



- California, Florida, Illinois, Massachusetts, Michigan, New Jersey, New York, Ohio, Pennsylvania, and Texas account for about two-thirds of medical malpractice losses in the United States.[545]

Frequency of claims

- Nationally, the frequency of claims based on number of claims per 100,000/population, has been relatively stable since 1991. The frequency of claims has varied from a low of 5.11 in 1998 to a high of 5.77 in 1994. (Graph 3)[546]
- Florida claims-frequency per 100,000/population increased over the same period with a low of 4.82 in 1991 to a high of 7.56 in 2000. (Graph 3)[547]
- This claims-frequency is only exceeded by Nevada, West Virginia, Pennsylvania, and Montana.[548]

Ratios of economic and non-economic damages

- A review of available[549] data in the Department of Insurance Closed-Claim Database indicated economic damages were approximately 25 percent of awards, and non-economic damages were approximately 77 percent. (Graph 4)[550]

Premium increases

- Since 1996, commercial insurance premiums for Florida have increased 64 percent to $650 million.[551]
- Since 1996, commercial insurance premiums nationally have increased only 26 percent.[552]
- The average malpractice premium, per doctor in Florida, is 55 percent greater than the national average.[553]

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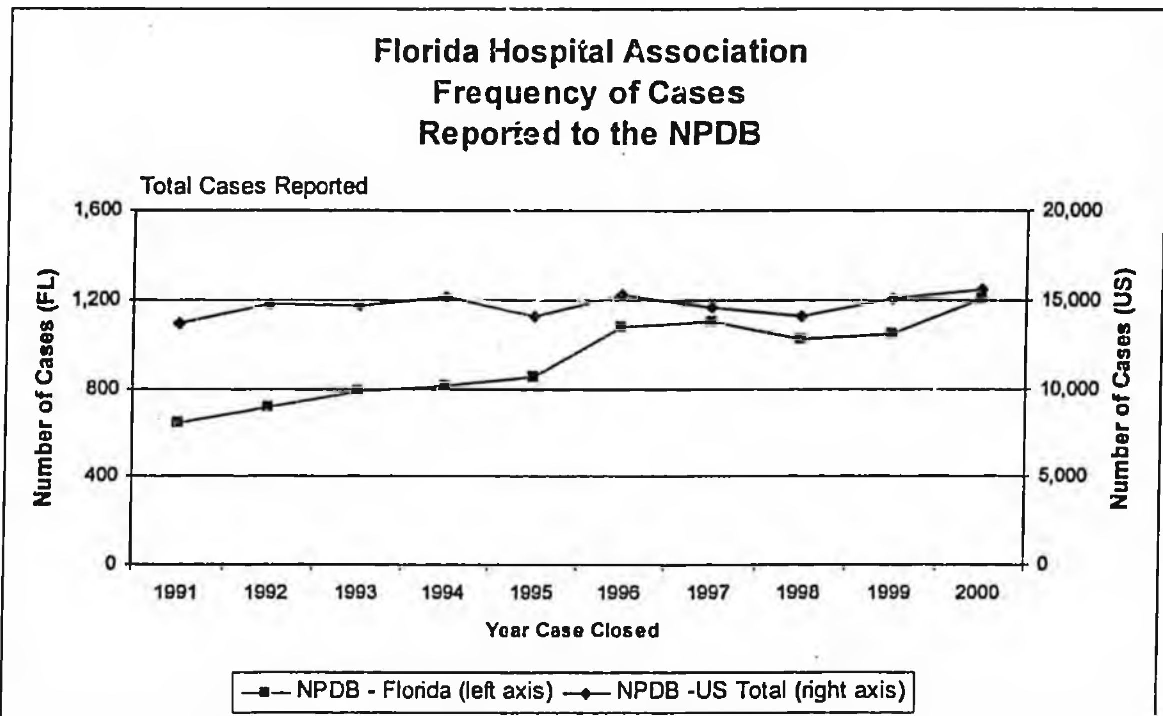
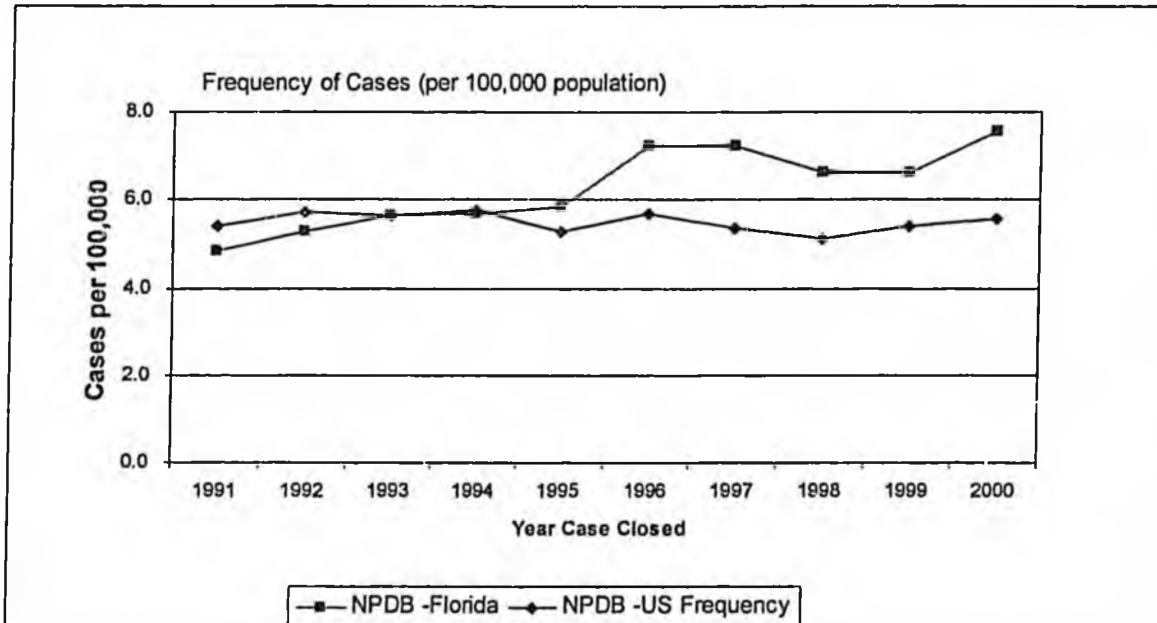
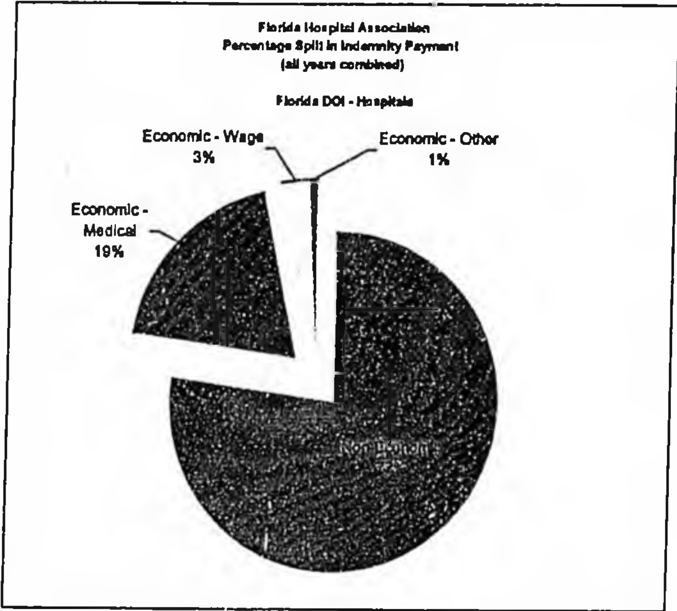
[545] Id. at 20.
[546] Id. at 17.
[547] Id.
[548] Richard S. Biondi et al., Milliman USA, Inc., Florida Hospital Association, Medical Malpractice Analysis 20, Exhibit 7 (Nov. 7, 2002).
[549] In Department of Insurance closed claim data, only about 25 percent of the archive database and about 87 percent of the current database contained a breakout of damages paid.
[550] In only 55 percent of the cases did the non-economic and economic damages stated add to the total of damages paid.
[551] Richard S. Biondi et al., Milliman USA, Inc., Florida Hospital Association, Medical Malpractice Analysis 13, Exhibit 2a. (Nov. 7, 2002).
[552] Id.
[553] Id. at 13, Exhibit 2b.

Graph 3





Graph 4



Florida Academy of Trial Lawyers Medical Malpractice Claims Analysis, Prepared by Lance deHaven-Smith

The Florida Academy of Trial Lawyers retained Dr. Lance deHaven-Smith to perform an analysis of closed-claims data in the Department of Insurance Closed-Claims Database for physicians and surgeons. His analysis did not include hospitals.

Total claims paid

- The claims-paid data for physicians, without an inflation adjustment, showed a 24 percent increase between 1999 and 2001.[554]

- Closed-claims peaked in 1996, dropped in 1997 and 1998, and began increasing again in 1999. (Graph 5)[555]

- When adjusted by medical-care inflation rates, the claims-paid have been down since 1996, and have just now reached the 1991 levels, approximately. (Graph 6)[556]

Average claims paid

- The average claim value, adjusted for medical-care inflation, is down from the levels in 1991, and is even below levels for 1995 and 1996. (Graph 7).[557]
- Severe claims are rare. (Graph 8).[558]

Non-economic damages vs. economic damages

According to Dr. Smith, there is a .110 correlation between economic and non-economic damages. This indicates, "if you get a high economic award, you're more likely to get a higher non-economic award. . . . [I]t is not a strong relationship, but it is statistically significant, and suggests that even those non-economic damages are not unexplainable or irrational."[559]

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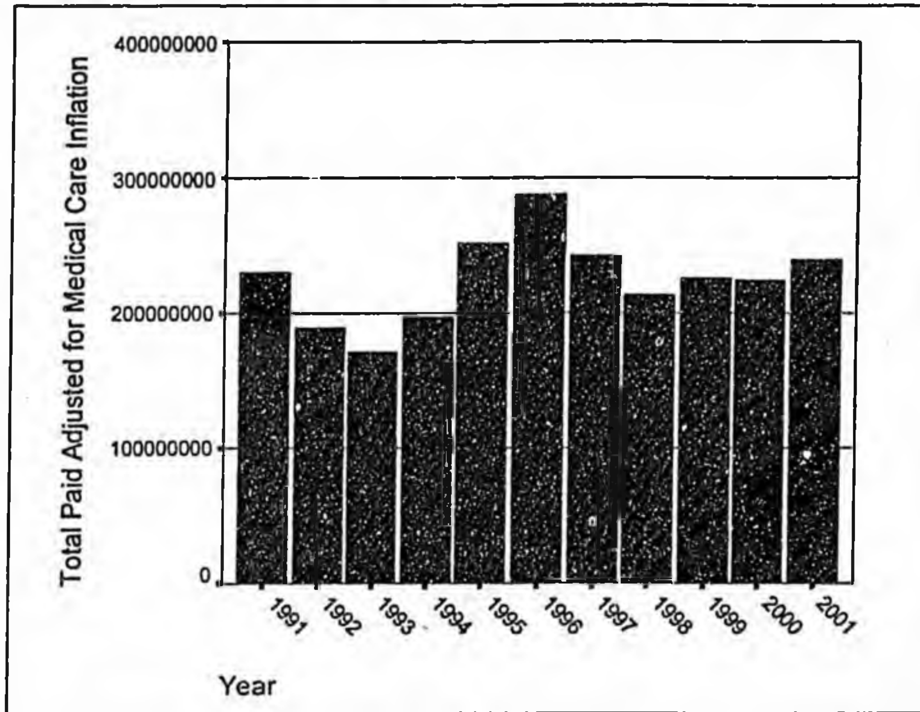
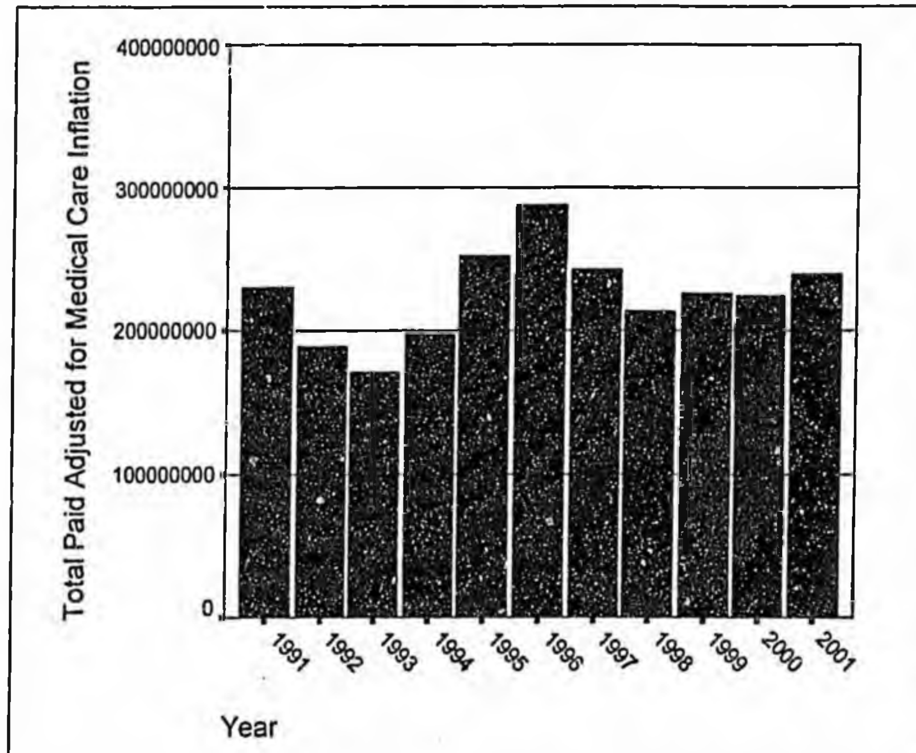
[554] Lance deHaven-Smith, Ph.D., Figure 1, Total Value of Claims 1999-2001.
[555] Lance deHaven-Smith, Ph.D., Figure 2, Claims Adjusted for Inflation Table, and testimony, Nov. 22, 2002, pg. 84.
[556] Id. Figure 3.
[557] Lance deHaven-Smith, Ph.D., Figure 5, Average Claim Value, Adjusted for Inflation.
[558] Lance deHaven-Smith, Ph.D., Figure 2, Outliers.
[559] Lance deHaven-Smith, Ph.D., testimony, Nov. 22, 2002, pg. 89.

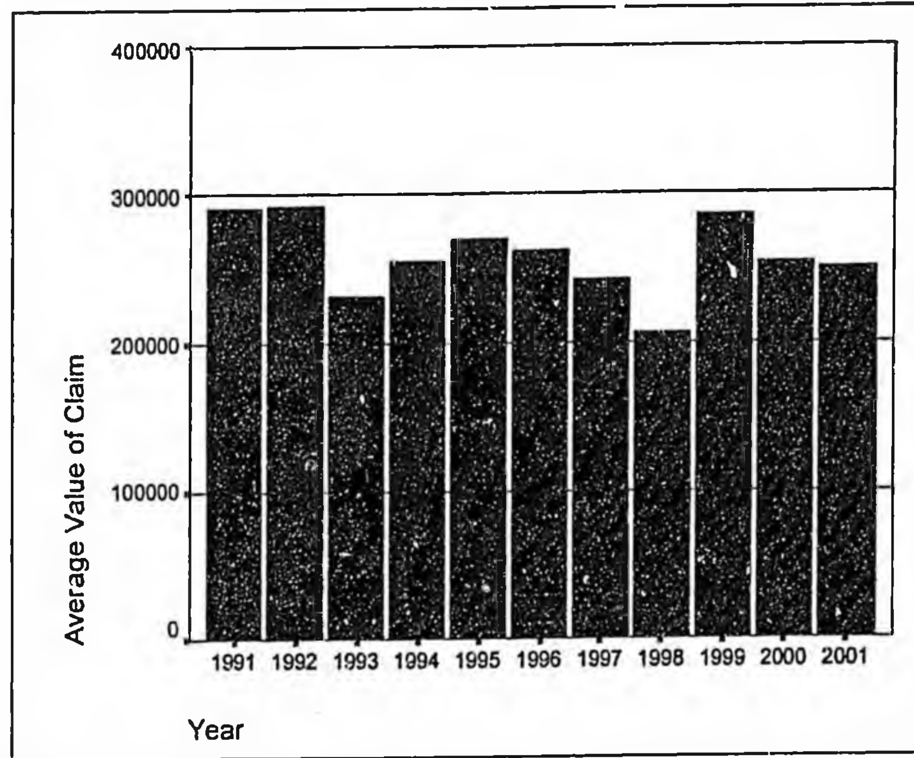
Graph 5: Total Payout per Year, Adjusted for Medical Care Cost Inflation



Graph 6: Total Payout per Year, Adjusted for Medical Care Cost Inflation

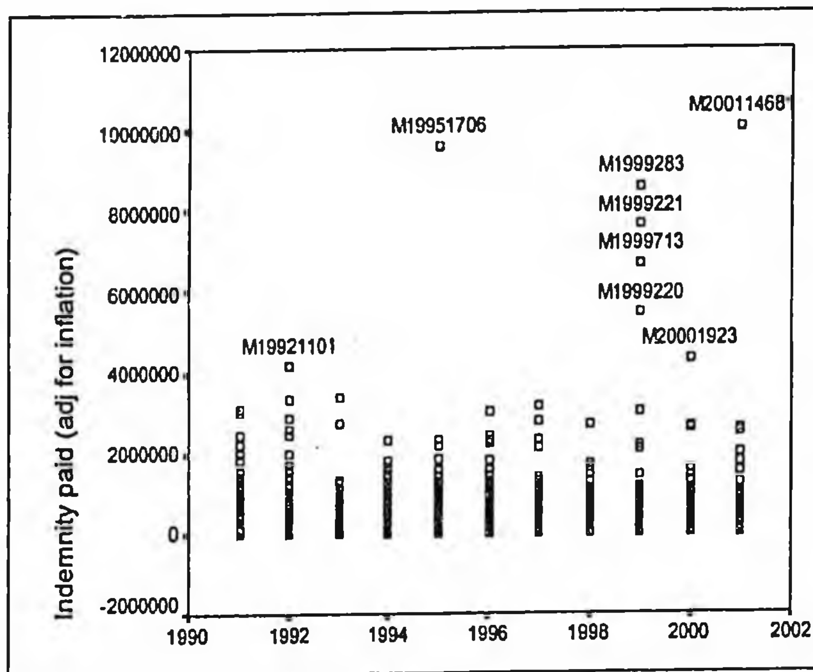


Graph 7: Average Payout Per Claim, Adjusted for Medical Care Cost Inflation



Graph 8

Scatterplot of Individual Payouts, Showing Outliers



Analysis for the Governor's Select Task Force on Healthcare Professional Liability Insurance

This analysis reviews the Florida Hospital Association Report prepared by Milliman USA, Inc., and the Florida Academy of Trial Lawyers Medical Malpractice Analysis prepared by Dr. deHaven-Smith, and independently evaluates the condition of the Florida professional healthcare liability insurance industry.

Comparison of Reports

Databases Used

The study by Dr. deHaven-Smith consists of basic statistical analyses of the Florida Department of Insurance (FLDOI) medical professional liability databases for years 1991 through 2001. Milliman performs similar analyses of the entire FLDOI databases for the years 1974 through 2002. However, limited analysis is done for the year 2002 and the years prior to 1991. Milliman's report is primarily for years 1991 through 2001.

The FLDOI database is composed of two different databases: "Archive" that contains data for claims closed before June 25, 1999 and "Current" that contains data for claims closed between June 25, 1999 and April 30, 2002. Milliman reports some adjustments to the two databases were required. Adjustments were made to the Current database to remove duplicate records in cases involving multiple defendants. The Archive database does not require this adjustment. However, the Archive database includes claims closed without payment while the Current database does not. To account for this discrepancy Milliman confined their analyses to claims closed with indemnity payments. Milliman performed overall analyses of the closed claim databases and they also examined closed claims broken down into physicians and hospitals. deHaven-Smith reports he also analyzed non-zero closed claims for physicians and surgeons. He states "the two datasets were restructured by the author to make them compatible and were then consolidated..." The specific steps taken were not reported.

Milliman's report also included several other analyses including an analysis of closed claims for physicians reported to the National Practitioner Data Bank (NPDB), an analysis of the Texas Department of Insurance Closed Claim Databases (Texas DOI), an analysis of the claim trends of the Physicians Insurers Association of America (PIAA) and analyses of other data obtained from annual statements and rate filings.

Statistical Methods Used

deHaven-Smith Report

deHaven-Smith first computes the raw totals of claim amounts and then adjusts them by the Medical Care Cost Index.[560] He then performs basic statistical analyses based on these adjusted numbers. These analyses include total payout per year, average payout per claim, distribution of claims by severity, average payout for claims broken down by the severity of injury and a scatter plot showing outliers. He also performs analyses based on the number of closed claims per year and runs Pearson Correlations between the payout and other factors as well as between economic and non-economic damages.

deHaven-Smith calculates the medical care cost index has increased 54 percent from 1991 to 2001 and 14 percent since 1997.[561] The Medical Care Price Index (MCPI), a component of the Consumer Price Index, is in Table 12.[562] While claim severity is certainly affected by medical costs, weaknesses in the construction of the MCPI must be considered. Graboyes (1994) writes a price index "measures the average price of a set of goods and services in one period against the average price of the same goods in another period." The index changes proportionally to the price of goods in the basket. Implicit in this calculation is that the basket of goods consumed does not change over time and the satisfaction level of the basket remains the same from period to period. Technological progress in the field of medicine has caused problems with accurately measuring the MCPI. Medical care received in 2001 greatly differs from medical care received in 1950. For example, diseases that were previously untreatable are now almost routine. Advanced techniques such as laparoscopic procedures now replace older ones. Advances such as antibiotics, vaccines, and electronic monitoring of patients have reduced costs. On the other hand the use of defensive medicine has increased costs.[563] In addition, the type and quality of medical care that people use over time changes.

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[560] Although this method is correct for adjusting prior years claims amounts to 2001 levels, one can't help but wonder what the effect would be if premiums were treated in a similar way.

[561] This is an error. The MCPI has actually increased 16 percent since 1997.

[562] Bureau of Labor Statistics, U.S. Department of Labor website (www.bls.gov).

[563] Brostoff (1993) refers to a study by Lewin-VHI, Inc. that estimates costs of $36 billion per year for defensive medicine.

Table 12
A Comparison of the Consumer Price Index and the Medical Care Price index

Year	CPI – All Items	YTY % change	MCPI	YTY % change
1991	136.2		177	
1992	140.3	0.03	190.1	0.074
1993	144.5	0.03	201.4	0.059
1994	148.2	0.026	211	0.048
1995	152.4	0.028	220.5	0.045
1996	156.9	0.03	228.2	0.035
1997	160.5	0.023	234.6	0.028
1998	163	0.016	242.1	0.032
1999	166.6	0.022	250.6	0.035
2000	172.2	0.034	260.8	0.041
2001	177.1	0.028	272.8	0.046

Berndt, Griliches, and Rosett (1993) found the Bureau of Labor Statistics (BLS) gives too little weight to new goods. At the same time, new goods tend to have lower price increases compounding the effect and causing the price index to be too high. Prior to January 1995, the CPI did not adequately measure generic drugs. Scherer (1993) found that generic drugs were considered new products in the market basket and the resulting effect of a price decrease for the older drug did not show up. However, since that time, the BLS has implemented changes to more accurately measure the impact of generic drugs on costs to consumers.[564]

Graboyes (1994) notes other problems with the price index. List prices are used instead of actual transaction prices. Prior to January 1997, the list price charged by a hospital was used in the calculation of the MCPI. However, beginning in January 1997 the BLS restructured the hospital portion of the CPI to focus more on treatment outcomes.[565] Now the unit of measure is a hospital visit rather than the individual components making up that visit. The BLS has also improved their data collection procedures and identifies the payor, diagnosis, and reimbursement agreement. Using the reimbursed rate for a hospital rather than the list price for services is a great improvement in the MCPI. There are also other sampling biases that occur. For example, a store may have a product listed at one price but actually sell it at another.

The MCPI practice of measuring payments by non-Medicare and Medicaid patients results in a higher index due to cost shifting. Graboyes

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[564] U.S. Department of Labor, Bureau of Labor Statistics, Measuring Price Change for Medical Care in the CPI website (www.bls.gov/cpi/cpifact4.htm).
[565] Id.

notes that the MCPI includes health insurance premiums paid directly by the consumer but not by employers who benefit from group discounts.

In summary, the MCPI most likely overstates the actual cost of medical care. Regardless, it is the best index that we have at this time to measure the cost of medical care.[566]

Milliman Report

Milliman performs many different statistical tests. As in deHaven-Smith, they also compute the raw claims totals. They then use this unadjusted data and perform the following analyses using the FLDOI databases:

- Calculate the historical average annual increase in loss payments.
- Categorize the loss payments between economic and non-economic damages, defense costs, wages, and medical bills.
- Compare the wages and medical increases to the inflation index for wages and healthcare.
- Examine the rate at which economic, non-economic, and defense costs are growing.
- Compute historical trends on claim frequency and that same trend adjusted for population growth.
- Perform a comparison of claims and premium data between South and North Florida.

Milliman also performs several other statistical tests using data other than that provided by the FLDOI. Using this other data they are able to make comparisons between Florida and the rest of the country.

Each study uses vastly different methods. Therefore, only the raw claim totals illustrated in Table 13 are directly comparable between these two reports. Both reports calculate the total unadjusted payout per year and the number of claims closed per year.

[566] Graboyes (1994) notes that some feel the MCPI is understated.

Table 13 Unadjusted Claim Totals

YEAR	DeHaven-Smith Florida DOI Databases		Milliman USA, Inc. Florida DOI Databases		Milliman USA, Inc. NPDB Database*	
	Total Amount Paid ($)	Claims Closed	Total Amount Paid ($)	Claims Closed	Total Amount Paid ($)	Claims Closed
1991	148,875,447	786	146,534,933	771	121,368,350*	644
1992	131,380,435	643	133,781,196	657	144,527,850	719
1993	126,156,950	736	125,845,187	724	146,440,000	786
1994	152,405,900	769	159,777,554	802	169,668,850	811
1995	203,347,516	933	206,449,199	942	188,983,050	849
1996	241,080,279	1,100	239,875,827	1,087	237,694,550	1,076
1997	208,843,088	1,003	202,750,624	955	223,530,000	1,100
1998	189,263,865	1,032	182,241,758	1,001	214,219,300	1,025
1999	207,541,531	791	220,966,498	828	238,864,100	1,045
2000	214,481,970	881	223,149,549	891	306,424,550	1,209
2001	239,237,089**	958	205,677,297**	882	102,483,600**	427

* National Practitioner Data Bank Public Use File, April 30, 2001, U.S. Department of Health and Human Services, Health Resources and Services Administration, Bureau of Health Professions, Division of Quality Assurance as cited by Milliman USA, Inc. in their report provided to the Governor's Select Task Force on Healthcare Professional Liability Insurance meeting on November 22, 2002.
**1991 was the first complete year that data was collected by the NPDB so the data may be incomplete.
**This data may be incomplete depending on when the data was obtained due to delays in reporting.

An examination of the raw numbers from the two reports reveals some mild to moderate discrepancies. While the total payout amounts appear to be similar in the earlier years appearing to diverge by only $1-2 million dollars from 1991 to 1993, beginning with 1994 the figures become more and more erratic. In 1999 there is a difference of $13 million, $9 million in 2000 and $34 million in 2001. Interestingly, deHaven-Smith's totals are higher in 1991, 1993, 1996, 1997, 1998, and 2001. Milliman's totals are higher in the other years. In 2001, deHaven-Smith's numbers are much larger but he may have had more complete data for 2001 if he obtained the data from the DOI much later in the year 2002 than did Milliman. The number of claims closed per year follows the same pattern as total amount paid. It appears these discrepancies result from different data screening procedures used by the researchers.

Analysis of Findings

deHaven-Smith Report

deHaven-Smith presents a summary of findings in his written report. His main finding is "the annual payout amount after adjusting for inflation has not escalated over the decade." He finds this holds for both annual payout totals and average payouts per claim. Based on the statistics and

adjustments that he performed and the information he provided the Task Force these are reasonable findings.

His second major finding is "payout amounts are quite rational and predictable." He appears to base this statement on the findings that (1) "the amount paid for any given claim is largely a function of the severity of the injury sustained..." and (2) there is a "statistically significant correlation between the payout for economic losses and payouts for non-economic factors."

The most complex statistical test that deHaven-Smith performs is a Pearson Product Moment Coefficient of Correlation. The other tests performed are simple basic statistical calculations of totals, averages, and identification of outliers. He illustrates these figures with histograms. There is no indication that any other tests are performed.

The Pearson correlation is a measure of the strength of the linear relationship between two random variables and ranges between +1 and –1. A value near or equal to 0 indicates there is little or no linear relationship between the two variables. The closer the value gets to 1, the stronger the relationship between the two variables. A –1 indicates a perfect negative relationship between the two variables. As the value of one variable decreases, the value of the other variable increases. A +1 indicates a perfect positive relationship between the two variables.

It should be noted that Pearson correlations are simple correlations and do not calculate or remove any influence that other variables may have. Also, correlations between two variables do not indicate causation. This being said, deHaven-Smith finds the Pearson correlation, r, for economic and non-economic damages is .110. Since r was found to be significant, he states there is a significant correlation between economic and non-economic losses. However, while significant, the value of .110 actually indicates a very weak, positive linear relationship between economic and non-economic damages. In fact, there is very little linear relationship between economic and non-economic damages.

deHaven-Smith finds four payments exceeded $5 million in 1999, one payment exceeded $4 million in 2000, and in 2001 one payment exceeded $10 million dollars and was the highest payment ever. It is common knowledge that once a very high award occurs all parties' expectations regarding the values of future, similar claims are raised accordingly. Therefore, even though the distribution of severity or the probability of the type of injury occurring may be highly predictable, the actual payout required to settle a claim may not be. deHaven-Smith's conclusions that payout amounts are "quite rational and predictable" and "future annual payouts can be predicted with a high degree of accuracy" is not reasonable

based on his findings in his report and on the very weak relationship found between economic and non-economic damages.

Lastly, deHaven-Smith states "payout amounts depend on injury severity." Once again, there is no statistical basis for making that conclusion. The simple correlations calculated between the payout and other variables appear to be the basis for this statement. As previously explained, correlation is not causation and should not be interpreted as such.

Milliman Report

In order to retain a common basis with the deHaven-Smith report the findings by Milliman using data from the Texas DOI, New York, and PIAA will not be discussed. This report will concentrate on those findings that can be obtained from data available from the FLDOI closed claim databases. The unadjusted claim totals referred to below are in Table 14. NPDB data are also discussed since it contains many of the same data items contained in the FLDOI database.

Milliman performed analyses based on FLDOI data and NPDB data. Their observations/conclusions are simply statements of statistical facts calculated by them. Their first conclusion is "Florida medical malpractice paid losses rose over 150 percent between 1991 and 2000" and 28 percent from 1999 to 2000. These figures were obtained from the NPDB. The corresponding analysis using Milliman's figures from the FLDOI closed claim database shows only a 52 percent increase from 1991 to 2000 and a 1 percent increase from 1999 to 2000. deHaven-Smith's unadjusted figures show a 44 percent increase from 1991 to 2000 and a 3 percent increase from 1999 to 2000.

Similarly, using NPDB data, Milliman finds that claim frequency has increased 57 percent from 1991 to 2000 and 14 percent from 1999 to 2000. They adjusted these figures for population growth. Using unadjusted data for 1991 to 2000, Milliman shows an 88 percent increase in NPDB closed claims and a 16 percent increase in FLDOI closed claims. deHaven-Smith's unadjusted figures reveal a 12 percent increase for this time period.

From these figures it appears that the concerns raised by stakeholders at Task Force meetings that the FLDOI closed claim database understates claim amounts, especially in the later years, are valid. In addition, the United States General Accounting Office performed a study of reports received by the NPDB in September 1999. They found 24.4 percent of the malpractice payment reports did not include amounts for damages.

Milliman also concludes non-economic damages account for approximately 77 percent of loss payments for hospitals in Florida. What

they do not point out is that they also find non-economic damages account for a similar large portion of loss payments for Florida physicians. In the last ten years non-economic damages have ranged from a low of 70 percent of total payout in 1998 to a high of 88 percent in 1992. Non-economic damages accounted for 72 percent of total loss payouts in 2001 and 80 percent in 2002.[567] deHaven-Smith did not provide information on this type of analysis so a direct comparison with his study on these figures cannot be made.

Finally, Milliman found that from 1991 to 2000, "medical malpractice paid loss dollars per unit of population increased 8.7 percent per year." deHaven-Smith did not perform this type of analysis so no comparison can be made.

Quality of Databases

Florida Department of Insurance Closed Claim Databases (DOI)

The FLDOI database is available on CD and comes with the following disclaimer.

> "Neither the Department of Insurance nor the State of Florida accepts legal liability or responsibility for the accuracy, completeness or usefulness of this information on closed claim reports filed by insurers. This information is unaudited."

The FLDOI database consists of two databases. "Archive" contains years 1975 up to mid-July 1999 and "Current" contains data from mid-July 1999 to present. The Department of Insurance provides very specific information regarding duplicate records and steps that need to be taken to successfully work with the data.

Concerns have been raised by some stakeholders at Task Force meetings that this database is incomplete due to underreporting of claims. Steve Roddenberry, Deputy Director of the Division of Insurer Services at the Florida Department of Insurance, confirms that some insurers may not report to the FLDOI as required. In addition, self-insurers, off-shore captive companies, risk retention groups, and surplus line companies do not report to the closed claim database.

[567] The 2002 FLDOI database was incomplete at the time Milliman obtained the data.

National Practitioner Data Bank Public Use File (NPDB)[568]

Under Title IV of Public Law 99-660, the Health Care Quality Improvement Act of 1986, each entity that makes a medical malpractice payment for a healthcare practitioner must report to the NPDB. Payments made solely on behalf of entities such as group practices and hospitals as well as clinics are not required to report. Eligible payments must be reported within 30 days of payment date. In contrast to the FLDOI databases, each practitioner's portion of the claim payment is reported. The FLDOI reports the total claim payment for each physician and/or hospital, hence the duplicate records. Therefore, the average claim payment should be lower for NPDB data.

As opposed to the FLDOI, the NPDB requires any entity that makes a payment on behalf of a healthcare practitioner to report that payment. This database should include those entities such as self-insurers, risk retention groups, etc., that are not included in the DOI database. As a result, the total amount paid out per year should be higher for NPDB data than for FLDOI figures. However, as previously mentioned, even the NPDB suffers from underreporting and incomplete filing of reports. In addition, neither database has ever taken legal action against entities that file late reports, do not file reports, or file incorrect or incomplete reports.

In addition to the underreporting problems the General Accounting Office uncovered in their report dated November 2000 and referred to earlier in this report, they also found significant delays between the time payment was made and the data was actually entered into the NPDB. First, it was found that on average 25 percent of the reports received by the NPDB in September 1999 were approximately 85 days late.[569] Second, delays occurred between the time the report reached the NPDB and the information was added into the database. These delays ranged from a low of 5 days to a length of 1 year before the information was added to the database. The median delay was calculated to be 13 days. On the bright side, the NPDB was scheduled to begin Internet-based reporting on October 1, 2000. However, without improved controls this form of reporting may actually worsen the problems of inaccurate and incomplete reports.

In summary, the NPDB requires more entities to report medical malpractice payments paid for healthcare practitioners. The NPDB total claim amount paid is more complete while the FLDOI database has more

[568] Richard Biondi, Florida Hospital Association Medical Malpractice Analysis, presentation, Nov. 22, 2002, citing National Practitioner Data Bank Public Use File, U.S. Department of Health and Human Services, Health Resources and Services Administration, Bureau of Health Professions, Division of Quality Assurance (April 30, 2001).

[569] Reports are supposed to be filed within 30 days of the initial payment date.

detailed information on specific claim information. For example, the FLDOI contains information on the injuries and types of damages paid including a breakdown of economic, non-economic, incurred, and future damages. The FLDOI also has claim information on hospitals while the NPDB does not. However, from the above information and reviewing Milliman's numbers for the year 2000, it is apparent that these numbers are incomplete.

Analysis of NPDB Data Adjusting for Medical Costs

Due to the very real concerns that more entities report payments to the NPDB and the increase in medical costs caused the increased claim payments, an analysis of the Milliman NPDB figures using deHaven-Smith's MCPI indexing formula is performed.[570] The results of this analysis are in Table 10.

This analysis finds after adjusting for increases in medical care costs from 1991 to 2000, the total amount paid out in medical malpractice payments increased 71.3 percent and the average claim paid decreased by 8.7 percent. Using unadjusted figures for the same time period the total amount paid out increased 152.5 percent while the average claim paid increased 34.5 percent. Further, the number of claims filed increased 87.7 percent from 1991 to 2000 while the total population of Florida increased approximately 23.5 percent from 1990 to 2000.[571] This implies the increase in total claims paid is largely attributed to the increased number of claims filed.

[570] The formula is as follows: $adjusted\ value_t = raw\ value_t * index\ value_{2001} / index\ value_t$ where t = the year ranging from 1991 to 2001.
[571] www.state.fl.us/edr/population.

TABLE 14
NPDB Data Using MCPI Indexing
Figures Adjusted to 2001 Values*

Year	Unadjusted Total Amount Paid	MCPI	Adjusted Total Amount Paid	% Change in Adjusted Total Paid	Number of Claims Closed	Adjusted Average Claim Paid	% Change in Adj. Average Claim Paid
1991	121,368,350	177	187,058,112		644	290,463	
1992	144,527,850	190.1	207,402,407	10.9%	719	288,460	-0.7%
1993	146,440,000	201.4	198,355,670	-4.4%	786	252,361	-12.5%
1994	169,668,850	211	219,363,328	10.6%	811	270,485	7.2%
1995	188,983,050	220.5	233,807,601	6.6%	849	275,392	1.8%
1996	237,694,550	228.2	284,150,189	21.5%	1076	264,080	-4.1%
1997	223,530,000	234.6	259,927,468	-8.5%	1100	236,298	-10.5%
1998	214,219,300	242.1	241,383,829	-7.1%	1025	235,496	-0.3%
1999	238,864,100	250.6	260,024,447	7.7%	1045	248,827	5.7%
2000	306,424,550	260.8	320,523,839	23.3%	1209	265,115	6.5%
2001**	102,483,600	272.8	102,483,600	-68.0%	427	240,008	-9.5%

* Using the formula provided by Dr. deHaven-Smith

**Data for this year is incomplete.

Analysis of Florida Department of Insurance Market Performance Reports

Overview of Florida Professional Healthcare Liability Insurance Market

Insurance market performance reports for years 1988 through 2000 were provided to the Task Force by the Florida Department of Insurance. These yearly reports detail the Florida experience of twelve different lines of insurance. Copies of these reports are provided in Appendix 5[572]. The lines of insurance contained in these reports are fire, homeowners, commercial multiple peril, medical malpractice, private passenger physical damage, private passenger auto liability, commercial auto liability, workers' compensation, other liability, product liability and directors and officers liability.[573] Section 627.915, Florida Statutes, requires insurers writing at least 0.5 percent of the Florida market to report this information.

A review of the healthcare professional liability insurance industry's performance reveals some disturbing trends in the Florida market. These trends are outlined in Graph 9. As can be seen, the market was profitable in the late 1980s and early 1990s. However, beginning with 1994 net income went negative and has been negative in 5 of the last 7 years. In fact, with the exception of spikes in years 1996 and 1998, industry profitability has steadily deteriorated. Although the year 2000 produced the largest investment gain for the market since 1988, this increased income was not enough to offset the large increase in direct losses incurred that year and shown in Graph 9.[574]

As seen in Graph 10 direct losses incurred shows an increase in amount over the past 10 years with a large increase observed from 1999 to 2000. Specifically, direct losses incurred have increased 614 percent from 1991 to 2000 and 64 percent from 1999 to 2000. Similarly, direct losses paid have increased 352 percent from 1991 to 2000 and 50 percent from 1999 to 2000.

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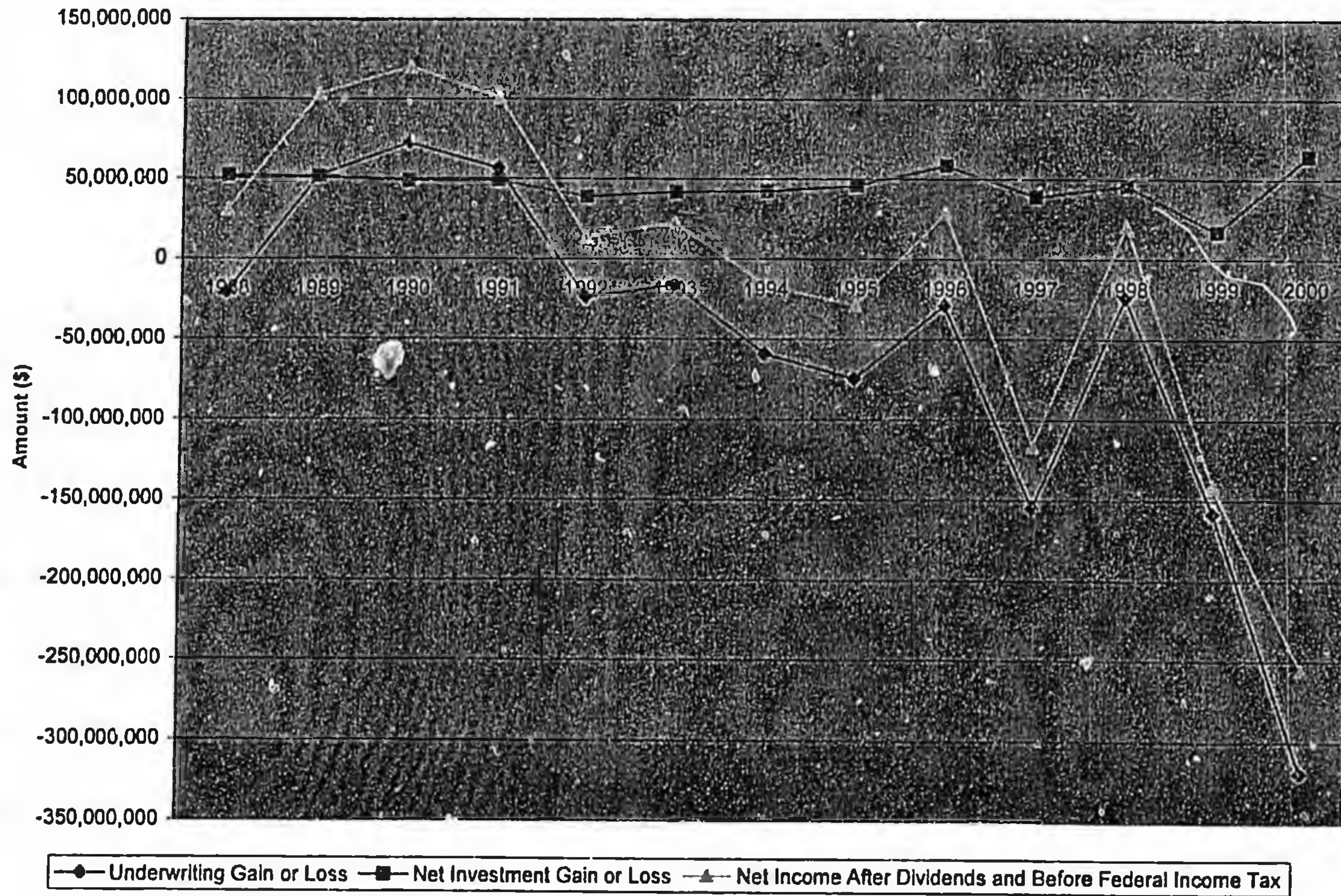
[572] Appendix 5 can be found in Volume 6, Speaker Comments, November 22, 2002 Task Force Meeting.

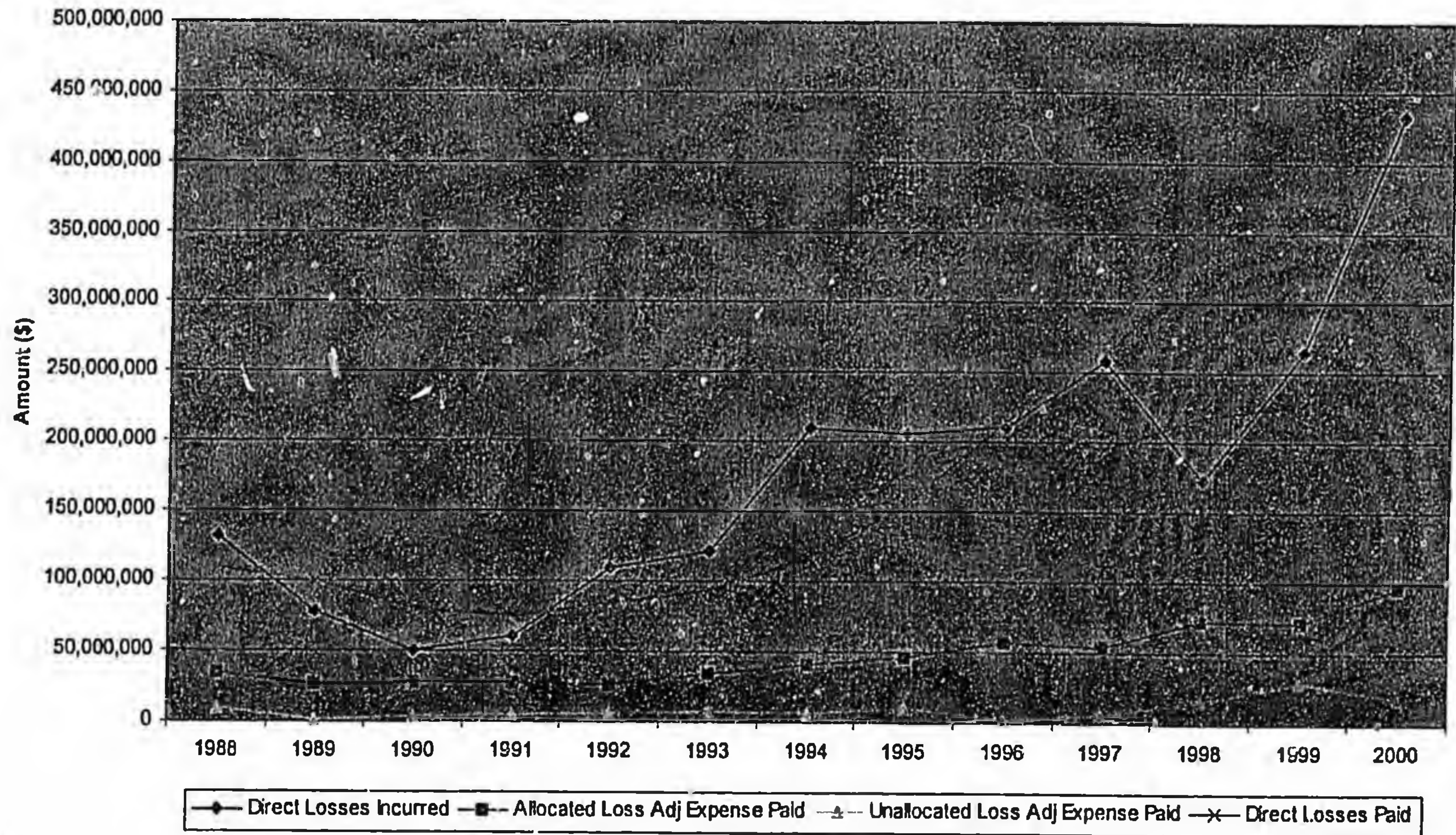
[573] The Florida Department of Insurance uses the term "medical malpractice." The Task Force prefers the term "healthcare professional liability." They are used interchangeably in this report.

[574] Section 625.305, Florida Statutes restricts insurers' costs of investments "in stock authorized by s. 625.324" to 15 percent of admitted assets, costs of investments in common stock to 10 percent of admitted assets, and costs of investment in "stock of any one corporation" to 3 percent of admitted assets. Regardless, investment income has become more erratic since 1995; see app. 1 for actual figures.

Graph 9



Graph 10



Allocated loss adjustment expense paid has increased over 111 percent in the last 6 years and 254 percent from 1991 to 2000.[575] Unallocated loss adjustment expense paid increased 258 percent from 1991 to 2000 and 85 percent in the past 6 years from 1995 to 2000.[576]

It should be noted these market reports reveal underreporting especially in later years when negative net income for the industry is experienced. Please see Appendix 1[577] for the percentage of total market share of insurers reporting. Therefore, in years with negative net income total amounts are understated relative to years with positive net income. As a result, actual industry experience is most likely worse than reported.

Analysis of Financial Ratios and Rankings of Insurance Lines

The overall performance of the professional healthcare liability insurance market in the state of Florida can be measured by comparing its annual financial ratios realized with the ratios from the other 11 lines sold and referenced above. The use of ratios should mitigate the effects of underreporting by insurers both within and across lines of insurance. The use of ratios should also alleviate concerns regarding the effect of inflation on values.

One measure of insurer performance is the loss ratio. The loss ratio is the ratio of direct losses incurred to premiums earned.[578] A 100 percent loss ratio means that for every $1 in premium earned there is $1 loss incurred. The annual loss ratios and resulting rankings for professional healthcare liability insurance are given in Table 15. The ratio of direct losses incurred to premiums earned and the resulting rankings for all lines is provided in Appendix 2.[579] The results show since 1994, excluding 1998, the professional healthcare liability industry has experienced high losses relative to other lines of insurance. Please see Appendix 3.[580] Interestingly, the cost to adjust these claims has always been relatively high compared to the cost of claims adjustment in other lines.

Underwriting results are measured by calculating the ratio of underwriting gain (loss) to premiums earned. The underwriting results and the resulting rankings are also in Table 15. The ratio of underwriting gain (loss) to premiums earned and the resulting rankings for all lines is provided in

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[575] Allocated loss adjustment expenses are specific charges that can be assigned to a claim. For example, defense attorney fees, photographer fees, appraisal fees, and independent physician reports.
[576] Unallocated loss adjustment expenses include charges such as overhead expenses and other expenses not included under allocated loss adjustment expenses.
[577] Appendix 1 can be found in Volume 6 Speaker Comments, November 22, 2002 Task Force Meeting
[578] Direct losses incurred to premiums earned are provided in the market performance reports by the Florida Department of Insurance.
[579] Appendix 2 can be found in Volume 6, Speaker Comments, November 22, 2002 Task Force Meeting.
[580] Appendix 3 can be found in Volume 6, Speaker Comments, November 22, 2002 Task Force Meeting.

Appendix 4.[581] It is clear from these results that underwriting performance for professional healthcare liability insurance has greatly deteriorated in the past few years. This deterioration appears to be due to both increased losses and expenses. From Table 15 the direct loss incurred ratio has increased (worsened) by a large percentage. It is also apparent that this industry ratio is highly variable. The total loss adjustment expense ratio has also worsened over the past years but not as drastically as the direct loss incurred ratio.[582]

TABLE 15
Ratio Analysis of Healthcare Professional Liability Market
Ranked Results with Total Market

Year	Direct Losses Incur / Premiums Earned	Rank	Total LAE Incur / Premiums Earned	Rank	UW Gain / Premiums Earned	Rank
1988	72.2%	10	24.1%	10	-11.6%	11
1989	44.7%	2	12.6%	8	29.8%	1
1990	29.2%	1	17.3%	9	41.7%	1
1991	34.5%	1	19.4%	10	32.0%	1
1992	68%	4	28.7%	8	-15.10%	5
1993	59.7%	5	26.8%	11	-8.0%	8
1994	75.5%	11	28.5%	11	-21.3%	11
1995	87.1%	11	25.6%	11	-31.6%	11
1996	71%	10	24.2%	10	-9.8%	8
1997	113.6%	12	37.4%	10	-68.0%	12
1998	55.6%	5	34.5%	12	-7.8%	9
1999	91.8%	12	38.3%	11	-55.0%	11
2000	136.8%	12	47.4%	12	-100.8%	11

*A rank of 1 means that line had the best ratio (most favorable experience) in the industry for that year.

581 Appendix 4 can be found in Volume 6, Speaker Comments, November 22, 2002 Task Force Meeting.
582 Total loss adjustment expense incurred to premiums earned is provided in the market performance reports by the Florida Department of Insurance. It is the sum of the allocated loss adjustment expense incurred and unallocated loss adjustment expense incurred.

TABLE 16

Combined Ratio for Healthcare Professional Liability Insurance

Year	Combined Ratio*
1988	96.3%
1989	57.3%
1990	46.5%
1991	53.9%
1992	96.7%
1993	86.5%
1994	104%
1995	112.7%
1996	95.2%
1997	151%
1998	90.1%
1999	130.1%
2000	184.2%

The combined ratio is the sum of the loss ratio and the expense (LAE) ratio. A ratio of 100 percent means losses and expenses equal the premium earned or, in other words, for every $1 earned there is $1 in loss and expenses.

The combined ratio is simply the sum of the loss and total loss adjustment expense ratios. A combined ratio of 100 percent means losses and expenses equal the premium earned. In Table 16 losses and expenses have exceeded the premium earned in 5 of the last 7 years. The year 2000 was particularly bleak for the industry as a whole with losses and expenses exceeding earned premium by 84.2 percent.

In summary, the last few years have resulted in a marked decrease in profitability for healthcare professional liability insurance in the state of Florida. With an industry-combined ratio of 184.2 percent and a corresponding underwriting ratio of –100.8 percent in 2000, the viability of this market may be threatened if conditions continue to deteriorate.

Chapter 5 - FINDINGS

"Even in a world of perfect experience rating, the deterrent signal would still be blunted by a second problem: the poor fit between instances of negligence and suing. Research has found that most instances of medical negligence never give rise to a malpractice claim, and that many malpractice lawsuits are brought and won by patients even though expert reviewers can identify no evidence of negligent care. . . . A similarly poor fit between negligent injuries and claims was found in the [Harvard Medical Practice Study] sample. The total number of malpractice claims filed was about 14% of the total number of negligent injuries. However, this figure masks the incredibly small overlap between the group of patients injured by negligence and the group who brought suit. Less than 2% of those who were actually injured due to negligence filed a claim, and only about a sixth of the claims that were filed involved both negligence and an injury."

Michelle Mello & Troyen A. Brennan, Deterrence of Medical Errors: Theory and Evidence for Malpractice Reform, 80 Texas Law Review 1595 (June 2002).

Task Force Findings

The Task Force received extensive testimony, documentation and letters related to the current medical malpractice insurance crisis. Based on the information and data received, the Task Force makes the following findings about the crisis:

Affordability: The cost of medical malpractice insurance has increased dramatically during the last several years. In 2002 the average medical malpractice premium per doctor in Florida was 55 percent higher than the national average. Florida's average premiums have increased 64 percent since 1996 while nationally the average premiums have increased only 26 percent.

Availability: The number of companies writing medical malpractice insurance in Florida went from a high of sixty-six companies in 1999 to only twelve currently. Further, of the twelve currently writing premiums only four are generally writing medical malpractice insurance. The remaining eight companies are writing only selected policies.

Impact of the Underwriting Cycle: The business cycle for medical malpractice insurance companies has exacerbated the increases in medical malpractice insurance rates in Florida but claims paid have had the most significant impact. The late-1990s produced some of the largest investment gains for the market since the mid-1980s, but this increased income was not sufficient to offset the large increase in direct losses for the medical malpractice insurance industry that year. As a result, insurance companies writing medical malpractice suffered a loss ratio of 184 percent.

Frequency of Claims Payments: Florida's claims frequency which was an average of 4.82 claims per 100,000 population in 1991 has increased to an average of 7.56 claims per 100,000 in 2000. The national average has been between 5.11 and 5.77 claims during this same period with an average of 5.54 claims per 100,000 population in 2000. Thus, in 2000, Florida's frequency of claims was 36 percent higher than the nationwide average.

Severity of Claims Payments: The severity of claims in Florida and nationally showed a significant increase between 1998 and 2000. Further, the average "pure premium" loss per Florida doctor has grown from 15 percent above the national average in 1991 to 50 percent above that average in 2000.

Variations Among Medical Specialties: Specialists and other physicians performing high-risk procedures are much more likely to be sued. These specialties, particularly obstetricians and neurosurgeons, also see much higher medical malpractice insurance rates, regardless of whether they have ever been sued.

Changes in the Law: The very existence of the continuing medical malpractice crisis is proof that the previous reforms have failed to address the problem. Florida's use of many of the reforms considered or adopted by other states further demonstrates that the provisions related to medical malpractice adopted in Florida have not been sufficient in addressing the problem. The limitations on damages, the only provision shown to be effective in reducing the severity of judgments, was stricken by the Florida Supreme Court.

Access to Healthcare Services: The concern over litigation and the cost and lack of medical malpractice insurance has caused doctors to discontinue high-risk procedures, turn away high-risk patients, close practices, and move out of state. In some communities, doctors have quit delivering babies and discontinued hospital care.

Compensation of Victims: As the cost of medical malpractice insurance has increased some healthcare providers carry only minimum insurance of $250,000 or are "going bare." This leaves victims with minimal or no compensation should they be injured.

Professional Regulation of Medical Care: The current disciplinary process requires the Division of Administrative Hearings judges to make the determination when conduct fails to meet minimum standards of care and is formally charged against a healthcare provider or facility. Frequently those rulings frustrate and thwart the ability of the healthcare provider regulatory boards to appropriately discipline healthcare providers. Issues such as defining the standard of care in a given set of facts and whether the practitioner breached that standard are responsibilities best left to the professional boards. Additionally, hospitals find it very difficult to discipline or remove healthcare professionals for actions below the accepted standard of care.

In addition to receiving extensive testimony regarding the existence of a medical malpractice insurance crisis and the current related law, the Task Force requested speakers and participants to offer the Task Force recommendations for addressing the problem. The Task Force requested proposals in the areas of:

- Improving the quality of medical care
- Discipline of healthcare practitioners/providers
- Tort reform
- Alternative dispute resolution
- Insurance reform

Proposals Heard

In total the Task Force heard testimony regarding over 100 proposals for change, which fell into one of the categories below:

(1) Improving healthcare quality
(2) Physician discipline
(3) Tort reform
(4) Insurance reform
(5) Alternative dispute resolution reform

The remainder of this report contains the specific recommendations of the Task Force and the rationale for each recommendation. It is organized according to the above five issue areas. Chapter six contains the healthcare quality issues. Chapter seven contains the physician discipline reform. Chapter eight contains the tort reforms. Chapter nine contains the insurance reforms. Finally, chapter ten contains the alternative

dispute resolution reforms. These recommendations recognize that it is possible to reduce the cost of medical malpractice and the severity and frequency of claims. These recommendations include a comprehensive reform package designed to strengthen quality healthcare in Florida. The Task Force believes that these recommendations constitute a carefully balanced set of ideas, the content of which has been determined by the results of extensive testimony and research. The Task Force recommends that the Florida Legislature adopt these proposals.

Chapter 6 - Improving Healthcare Quality

"The culture of medicine creates an expectation of perfection and attributes errors to carelessness or incompetence. Liability concerns discourage the surfacing of errors and communication about how to correct them."

"Patient safety is also hindered through the liability system and the threat of malpractice, which discourages the disclosure of errors. The discoverability of data under legal proceedings encourages silence about errors committed or observed. Most errors and safety issues go undetected and unreported, both externally and within health care organizations."

Institute of Medicine, To Err is Human: Building a Safer Health System 22, 43 (Linda T. Kohn et al. eds., 2000)

Issue

The Task Force voted on December 20, 2002, by a 5-0 vote, to examine the following issues with respect to reducing medical errors and improving healthcare quality:

Should a patient safety authority or patient safety center be created to:

- Require mandatory reporting of serious events or near misses?
  - Should information be confidential?
  - Should information be subject to discovery?
- Analyze and make recommendations directly to medical facilities to improve care?
  - Require retraining or mentors for those with adverse events?
- Require all hospitals to have patient safety plans, patient safety committees, and patient safety officers?
- Require written notice of serious events to impacted patients or their representatives?
- Evaluate objective criteria for evaluating the effectiveness of the current mandatory reporting system?
- Evaluate factors that limit the effectiveness of the current reporting system?
- Implement a system for reporting near miss events?
- Develop objective criteria for evaluating the effectiveness of a near miss reporting system?

- Analyze reported data and make recommendations directly to healthcare facilities and providers to improve care?
- Provide malpractice insurance discounts if a hospital implements a certified patient program?

In addition, the Task Force requested staff to include the recommendations included in the testimony made by Donald Berwick, M.D. Dr. Berwick's recommendations were:

- Implement a safety reporting system, based on the aviation model, which uses "the best people" to analyze medical mistakes. This recommendation is similar to the Patient Safety Authority model in Pennsylvania that is based, in part, on the Institute of Medicine's recommended model described in the To Err is Human and Fostering Rapid Advances in Health Care reports.
- Adopt a strategy to provide all hospitals with a computerized physician order medication system.
- Develop a single inexpensive electronic medical record at the state level that would contain essential information so that all physicians, hospitals, and other facilities would have access to the record.
- Conduct a four-year "no-fault" medical malpractice demonstration project that would use the Workers' Compensation method of compensation for injuries. The system would have five elements: (1) all patients are told when they are injured; (2) an apology to the patient is made; (3) injured patients are compensated just as in the workers' compensation system; (4) the "entity" would be responsible for liability, not the individual; and (5) the demonstration project should have a study component to study injuries to continually reduce risk.
- Include courses on patient safety and safety improvement in medical and nursing school curricula.
- Establish a simulation center for high technology intervention surgery and intensive care for use by all hospitals.

At the January 16 meeting of the Task Force, by a 4-0 vote, staff was directed to prepare a recommendation requiring state government to determine the feasibility of providing information to the public to assist in making better healthcare decisions. The information would not be made available as a "report card."

Current Situation

Florida law requires hospitals, ambulatory surgery centers and nursing homes to have internal risk management programs that are designed to identify and minimize the risk of adverse incidents to patients. Florida law governing risk management programs for hospitals and ambulatory