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11249 SENATE LABOR & COMMERCE

Task Force Appointments and Process

The five members of the Task Force are:

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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:

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[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 s[illegible] 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:

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[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 national 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

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[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]

[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 professior..[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.

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[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

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[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

[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.

- 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.

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

- 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.

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[272] Chapter 88-1, sections 54-58, Laws of Florida.
[273] Chapter 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.

[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 Direct Premiums Written	2001 Med Mal Direct Premiums Earned	2001 Med Mal Direct Losses Incurred	2001 Med Mal Loss Ratio	2000 Med Mal Direct Premiums Written	2000 Med Mal Direct Premiums Earned	2000 Med Mal Direct Losses Incurred	2000 Med Mal Loss Ratio	1999 Med Mal Direct Premiums Written	1999 Med Mal Direct Premiums Earned	1999 Med Mal Direct 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	21,451,705	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	25,902,869	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	2,917,199	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%
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	8,949,312	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 Direct Written	2001 Med Mal Direct Earned	2001 Med Mal Pre-Tax Income	2001 Med Mal Loss Ratio	2000 Med Mal Direct Written	2000 Med Mal Direct Earned	2000 Med Mal Pre-Tax Income	2000 Med Mal Loss Ratio	1999 Med Mal Direct Written	1999 Med Mal Direct Earned	1999 Med Mal Pre-Tax Income	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	1095	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 nursing 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

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[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

[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

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[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.

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[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).