ALASKA LEGISLATURE COMMITTEE FILES, 2003-2004 8672

11250 SENATE LABOR & COMMERCE

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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[459] Letter from Richard M. Gray, M.D. to William Large, Counsel, Governor's Select Task Force on Healthcare Professional Liability Insurance (Nov. 17, 2002) (Vol. 11, Tab 348).
[460] Facsimile from Peter Marmerstein to Dwight Chenette (Dec. 6, 2002) (Vol. 11, Tab 393).
[461] Letter from Celestino Palomino, M.D. to Governor Jeb Bush (January 3, 2003) (Vol. 11, Tab 464).

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Data on the Problem

Office of Insurance Regulation Medical Malpractice Data Call

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

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

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

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

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

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

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

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

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

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

The following highlights certain information contained in the responses received.

Coverage and Writing Practices

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

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

Table 6

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

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

Table 7

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

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

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

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

Examples of changes in eligibility and underwriting criteria include:

- Enhanced limitation on willingness to provide coverage for prior acts ("tail") coverage.

- Restricting maximum limits of coverage to $1,000,000 per occurrence with a $3,000,000 policy aggregate.

- Reviewing all physicians with past or present claims or suits by re-underwriting the entire book of business.

- Non-renewing policies with losses

- Non-renewing medical groups with over three physicians and physicians practicing within certain specialties.

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

Closed Claim Experience

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

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

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

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

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

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

Table 8

2001 - Market Share and Rank

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

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

Florida Department of Health Financial Responsibility

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

Table 9 indicates:

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

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

Table 9

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

Florida Hospital Association, January 2002 Survey

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

Florida Medical Association, September 2002 Survey

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

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

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

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

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

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

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

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

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

Floridians for Quality Affordable Healthcare 2002 Survey

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

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

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

Table 10. Average Number of Lawsuits and Percentage of Physicians Who Have Been Sued by Specialty			
SPECIALTY	LAWSUITS Ave. No. Total	% Who Have Been Sued	Sample Size
Neurosurgery	5.21	100.0	14
Vascular Surgery	3.14	100.0	11
Cardiovascular or Thoracic Surgery	3.62	94.1	17
General Surgery	2.69	90.5	63
Radiology	3.31	88.9	27
OB-GYN	2.61	78.6	84
Emergency Medicine	1.69	77.8	9
Other Surgical[510]	1.89	76.9	13
Infectious Diseases	3.22	71.4	14
Radiation Oncology	1.33	71.4	7
Cardiology	1.37	71.1	76
Physical Medicine & Rehabilitation	1.70	70.0	10
Neurology	1.55	68.3	41
Pulmonary	1.56	67.4	43
Gynecology	2.63	66.7	18
Pediatric Medical Specialties	1.19	66.7	9
Orthodedic Surgery	1.97	61.5	96
Anesthesiology & Pain Management	0.97	61.1	18
Otolaryngology	1.44	60.9	23
Urology	1.02	58.8	34
Pediatric Surgery/Surgical Specialties	1.97	58.3	12
Internal Medicine	1.28	54.6	183
Ophthalmology	0.93	52.6	57
Plastic Surgery	1.62	52.1	73
Hematology-Oncology	0.91	50.0	32
Pathology	0.84	50.0	12
Other Medical[511]	2.00	50.0	8
Gastroenterology	0.92	48.4	64
Podiatry	1.48	47.1	17
Family Practice and General Practice	0.74	46.8	139
Dermatology	0.67	45.9	37
Unidentified Specialty[512]	0.72	41.7	17
Nephrology	0.70	38.5	13
Pediatrics	0.40	29.3	99
Psychiatry	0.48	28.2	39
Endocrinology	0.25	25.0	8
Rheumatology	0.22	22.2	9
Allergy and Immunology	0.00	0.00	14
Weighted Averages & Total Sample	**1.44**	**57.4**	**1,460**
Source: RCH Healthcare survey of South Florida physicians, November 2002.			

[510] Includes hand surgery, maxillofacial, oculoplastics, oncologic, spine, and cataract surgery.
[511] Includes critical care, geriatrics, infertility, neonatology, and nuclear medicine.
[512] Specialty was not provided by respondent.

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

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

Table 11. Changes in Coverage Limitations

Percentage Buying:	Last Year	This Year
$1,000,000/$3,000,000	35.0%	20.7%
$500,000/$1,500,000	12.5%	11.4%
$250,000/$750,000	47.1%	51.5%
No Malpractice Coverge	5.4%	16.4%
Total	100.0%	100.0%
Sample Size	1,506	1,454
Source: RCH Healthcare survey of South Florida physicians, November 2002		

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

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

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

- Some specialties, such as neurosurgery, thoracic surgery, and obstetrics, pay well over $100,000 per physician, per year, for medical malpractice coverage.[519]

- Fifty-four respondents closed their practice, retired early, or moved to another state, and 34 percent of all respondents report they are considering this option.[520]

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[513] Id. at 3.
[514] Id.
[515] Id.
[516] Id.
[517] Id.
[518] Id.
[519] Id.
[520] Id. at 4.

- More than 41 percent, or 517 respondents, have already stopped offering some high-risk procedures.[521] An additional 15 percent are considering this action.[522]

- Eight of the 18 gynecologists responding to the survey have stopped delivering babies accounting for a loss of 745 deliveries.[523]

- Forty-five of the 94 obstetricians who responded have stopped some high-risk procedures.[524]

- Seven of the 29 radiologists responding have stopped reading mammograms taking more than 15,000 readings out of the system, and another eight radiologists are considering discontinuing this service.[525]

- About 41 percent, or 647 respondents, have cut back on staff or delayed purchasing equipment to reduce costs.[526] The types of equipment purchases delayed include: mammography, breast biopsy, ultrasound, laboratory, and x-ray equipment; a visual field machine, and retinal camera; electronic medical records software; computer upgrades; and office renovations.[527]

- Almost 31 percent, or 482 respondents indicated they have limited their hospital emergency room practice and 6 percent, or 87 respondents, are considering this reduction.[528]

- Approximately 16 percent, or 256 respondents, have limited nursing home practice and another 2 percent, or 30 respondents, are considering the reduction.[529]

- Approximately 11 percent, or 172 respondents, have limited services in ambulatory surgery centers and another 2 percent, or 23 respondents, are considering this limit on services.[530]

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[521] Id.
[522] Id.
[523] Id. at 5.
[524] Id.
[525] Id.
[526] Id.
[527] Id.
[528] Id.
[529] Id.
[530] Id.

- 50 percent, or 787 respondents, reported discontinuing services to some high-risk patients.[531]

- 44 percent, or 699 respondents, are discontinuing some high-risk services.[532]

- 66 percent, or 1,062 respondents, reported performing more tests for defensive reasons.[533]

- 30 percent, or 467 respondents, reported longer waiting times for an appointment.[534]

It should be noted that the Academy of Florida Trial Lawyers took exception to the techniques used by the Floridians for Quality Affordable Healthcare. According to the Academy, "the conclusions of the materials are based on reported survey data. However, the methodology of the reported survey is flawed to the point that the results would not be accepted in any way in terms of the social science academic community."[535]

According to Dr. James T. Kitchens, a statistician retained by the Academy, the use of mail or fax surveys always presents obstacles in obtaining valid results. The results of the materials presented represents one of the studies described by Norman Bradburn and Seymour Sudman, who have been honored for their contributions to methods of conducting surveys. In their book, Polls and Surveys: Understanding What They Tell Us, they write "There are so many examples of carefully conducted mail surveys with cooperation rates in the 80-90 percent range. There are also horrible examples of mail surveys with cooperation rates in the 10-20 percent range, or even lower. The biases in such studies are so great as to make the results almost meaningless." The cooperation rate for the Floridians for Quality Healthcare study is 17.5 percent. This means the actual finding could vary by as much as 82.5 percent if the cooperation rate had been 100 percent.[536]

Dr. Kitchens believes that without a true random sampling technique, the responses from a mail or faxed survey always have some built-in bias. The respondents to this study may be doctors more interested in the topic or they may have been sued more often than the average doctor. In this study, since there is no signature line on the response form, it is not even

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[531] Id. at 6.
[532] Id.
[533] Id.
[534] Id.
[535] James T. Kitchens, Ph.D., Analysis of Reports by RCH Healthcare Advisors (Jan. 2003).
[536] Id.

certain the responses are from doctors. The form may have been completed by anyone, such as an office administrator or nurse.[537]

Dr. Kitchen concluded, "this survey cannot claim a legitimate margin of error or statistical confidence level. Therefore, the conclusions and the assertions made on the basis of this survey data must be viewed as suspect considering the lack of discipline in terms of acceptable research methodology."[538]

Dr. Kitchen believes the survey and information presented to the Task Force amounts to no more than a public relations document presented by one side in a political policy debate. The methodology of this reported study is so flawed that the results have no statistical validity. If it were a research paper, it would receive a failing grade even in a basic undergraduate research course.[539]

The Task Force finds the comments of Dr. Kitchens to have some merit. Dr. Kitchens' main concern seems to be that there is a lack of responses from doctors to the survey. Dr. Kitchens notes, "if the data indicates the respondent physicians are angry or frustrated, it may explain why they responded to the survey and the other 82.5 percent of the physicians did not."[540] The Task Force would welcome Dr. Kitchens or any other stakeholder to attempt to reach out to the remaining 82.5 percent of the physicians in South Florida. However, the Task Force believes that, based upon the numerous letters, e-mails, and testimonials, that the remaining 82.5 percent of the physicians who did not respond to this survey (if they are still practicing) would mirror the responses of the 17 percent of the physicians that did respond. Although there is always going to be a need for more data on this problem, the Task Force finds the FMA and RCH survey to be compelling measures of physicians' attitudes in the state of Florida.

Closed Claim Data

In an effort to provide a quantitative analysis of the healthcare professional liability insurance problem and possible solutions, the Florida Hospital Association retained Milliman USA, Inc. to perform a data analysis. The Florida Academy of Trial Lawyers retained Dr. Lance deHaven-Smith to perform an analysis of the Florida problem as well, and provide an independent study. To assist the Task Force in considering the

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[537] Id.

[538] Id.

[539] James T. Kitchens, Ph.D., Analysis of Reports by RCH Healthcare Advisors (Jan. 2003).

[540] Id.

extensive data analyses performed in these two reports, Task Force staff performed an independent analysis of each of the reports. [541]

Florida Hospital Association Report Analysis, Prepared by Milliman USA, Inc.

The Florida Hospital Association contracted with Milliman USA, Inc. to evaluate the healthcare professional liability insurance problem in Florida, and formulate recommendations for changes that would be effective in addressing the problem. The report examined data from the Florida Department of Insurance Medical Malpractice Closed-Claim Database, the National Practitioner Data Bank Public Use Data File (NPDB), the Texas Department of Insurance Closed-Claim Database, the Physicians Insurers Association of America Claim-Trend Analysis, and the statement of rate filings in insurance company annual statements.[542] The report compared Florida, and national data and trends, with loss payments, including average payouts, ratios of economic to non-economic damages, and premium increases.

Trends in Loss Payments and Premiums for Medical Liability Claims

Total loss payments

- Total amount of paid losses in Florida for 2000 is more than 150 percent higher than the amount paid in 1991. This includes an increase of 28 percent from 1999 to 2000.
- In comparison, the total amount of paid losses for the United States is 80 percent higher in 2000 than the amount paid in 1991.
- Florida losses are now in excess of $400 million per year.

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[541] It should be noted that there have been previous well-documented attempts to study Florida's closed-claim data. A study of the Florida medical malpractice environment from 1975 to 1986 is particularly enlightening. See e.g., David J. Nye et. al., The Causes of the Medical Malpractice Crisis : An Analysis of Claim Data and Insurance Company Finance, 76 Georgetown Law Journal 1495 (1988). This study found that the primary cause of malpractice premium increases, measured over a nine-year period, was the increase in loss payments to claimants. The frequency of claims payments was not primarily responsible for increased claims costs, since the likelihood that a Florida physician would be sued for malpractice has not changed from 1975 to present. It is rather the "huge increase in the size of claims payments, particularly the increasing frequency of very large payments" that accounted for the total increase in paid losses. Nye et al. note: "The causes of the increases in claims payments in Florida are not clear. The increases may reflect the belief of defense lawyers and insurance claims managers that their risk at trial would be greater than in 1975. This might be derived from 'more serious iatrogenic injuries, a concern that juries are more likely to award larger verdicts and that judges are less likely to control them, a sense that the plaintiffs' trial bar is more able than before, or a concern that the insurer will be held liable under a bad faith claim if it fails to settle within policy limits.'" Id. at 1560.

[542] Richard S. Biondi et al., Milliman USA, Inc., Florida Hospital Association, Medical Malpractice Analysis (Nov. 7, 2002).

- Hospital losses account for 38 percent of total losses.

- Physician-paid losses grew from approximately $120 million in 1991 to more than $300 million in 2000 for an average annual growth of 10.8 percent.

- National losses are now in excess of $3.8 billion.

- Physician-paid losses grew only 6.8 percent from 1991 to 2000.

Average loss payments (severity of claims)

The average loss paid in Florida, and the nation, has shown an increasing trend since 1975. (Graph 1)[543]

- The loss per Florida doctor exceeds the national average, and has grown from 15 percent above the national average in 1991, to 50 percent higher in 2000. (Graph 2)[544]

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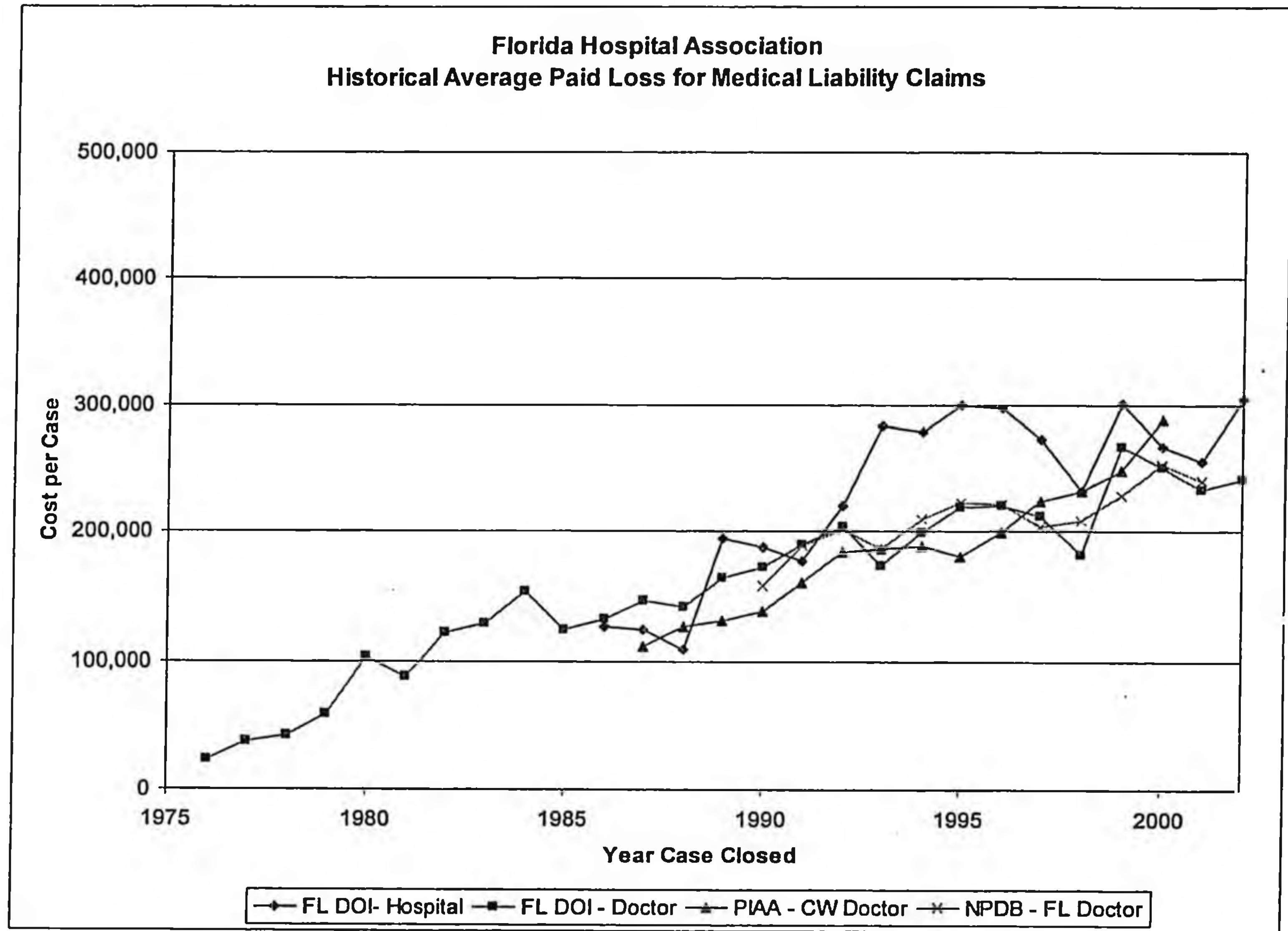
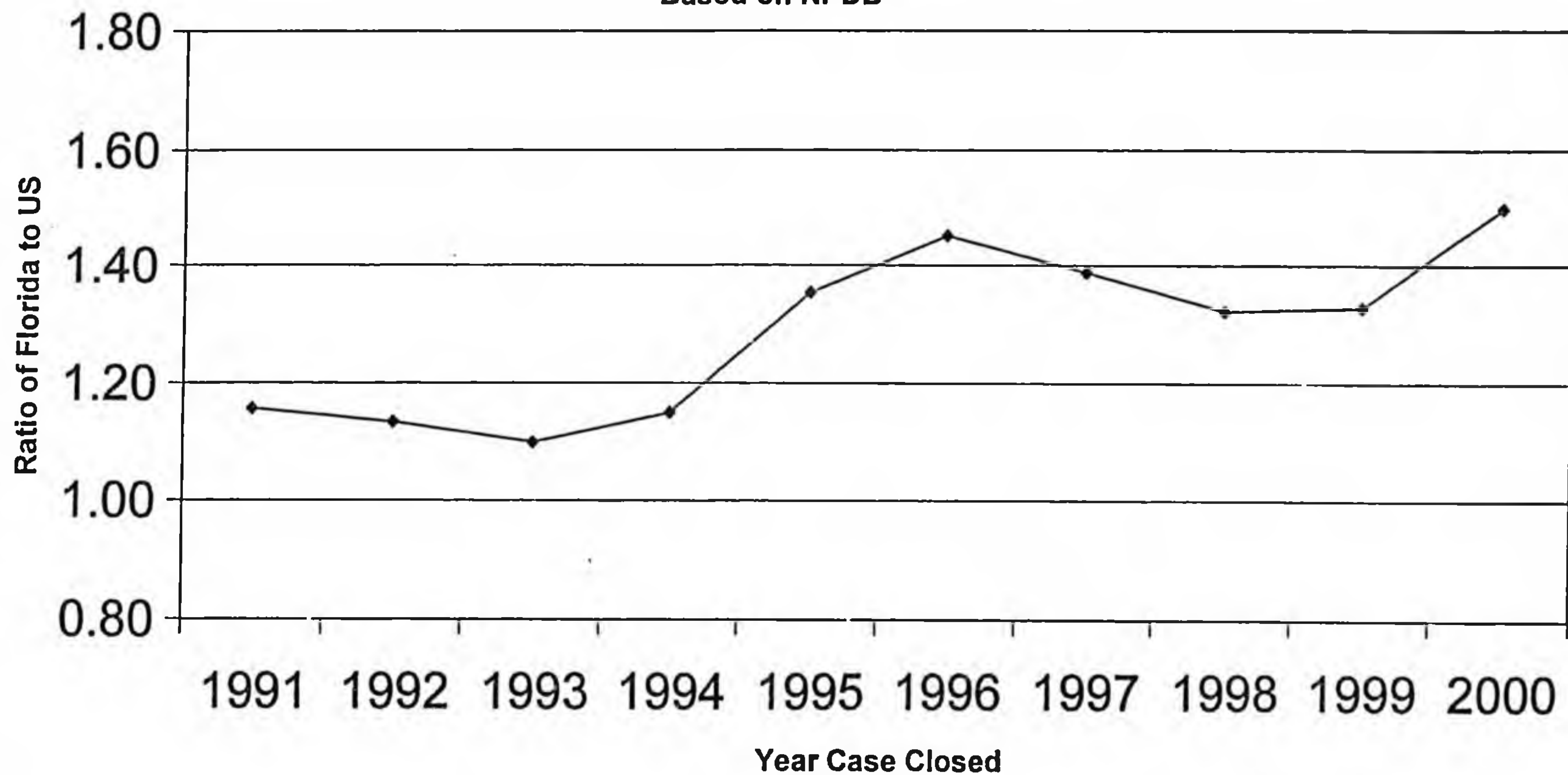
[543] Id., Graph 1.
[544] Id., Graph 2.

Graph 1



Graph 2



- California, Florida, Illinois, Massachusetts, Michigan, New Jersey, New York, Ohio, Pennsylvania, and Texas account for about two-thirds of medical malpractice losses in the United States.[545]

Frequency of claims

- Nationally, the frequency of claims based on number of claims per 100,000/population, has been relatively stable since 1991. The frequency of claims has varied from a low of 5.11 in 1998 to a high of 5.77 in 1994. (Graph 3)[546]
- Florida claims-frequency per 100,000/population increased over the same period with a low of 4.82 in 1991 to a high of 7.56 in 2000. (Graph 3)[547]
- This claims-frequency is only exceeded by Nevada, West Virginia, Pennsylvania, and Montana.[548]

Ratios of economic and non-economic damages

- A review of available[549] data in the Department of Insurance Closed-Claim Database indicated economic damages were approximately 25 percent of awards, and non-economic damages were approximately 77 percent. (Graph 4)[550]

Premium increases

- Since 1996, commercial insurance premiums for Florida have increased 64 percent to $650 million.[551]
- Since 1996, commercial insurance premiums nationally have increased only 26 percent.[552]
- The average malpractice premium, per doctor in Florida, is 55 percent greater than the national average.[553]

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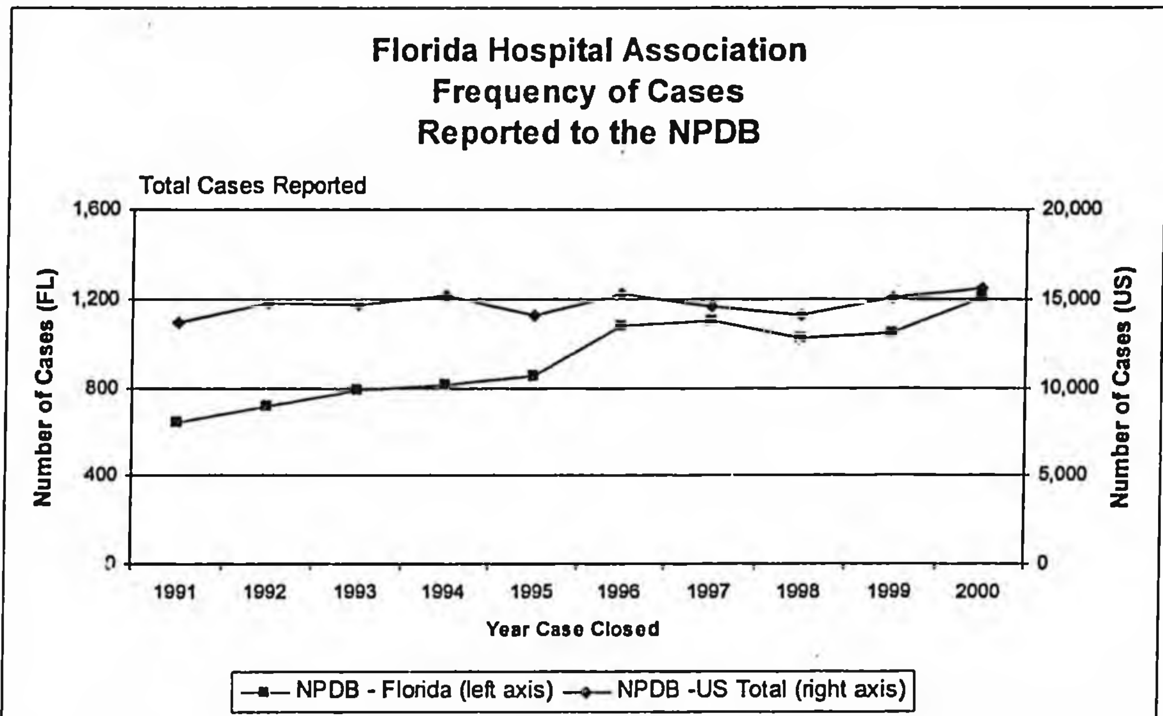
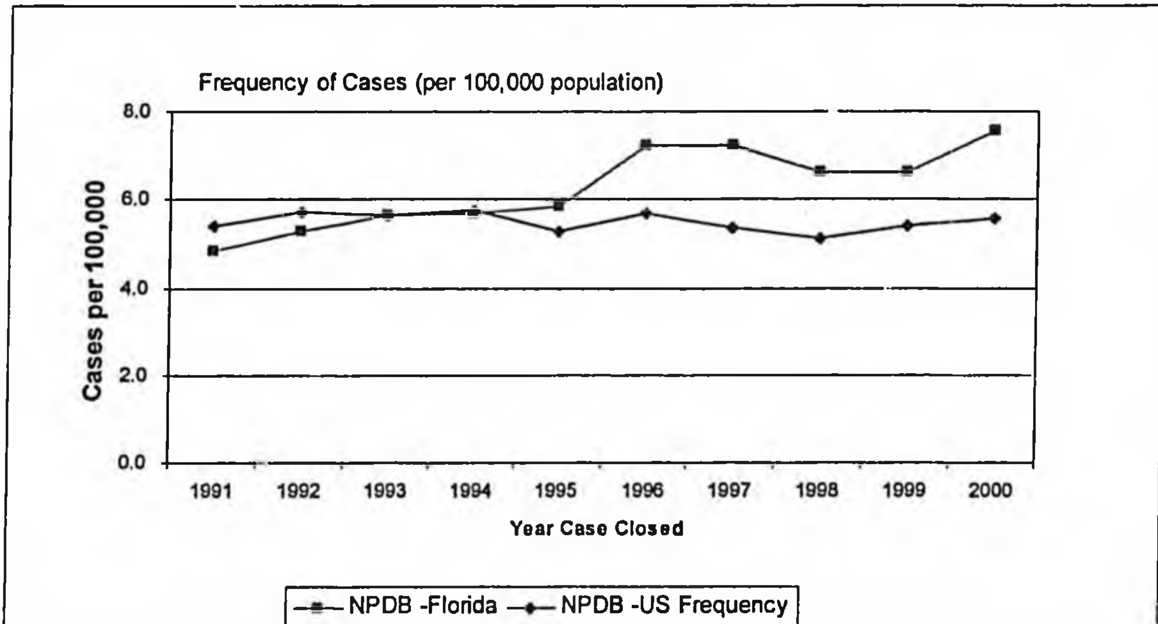
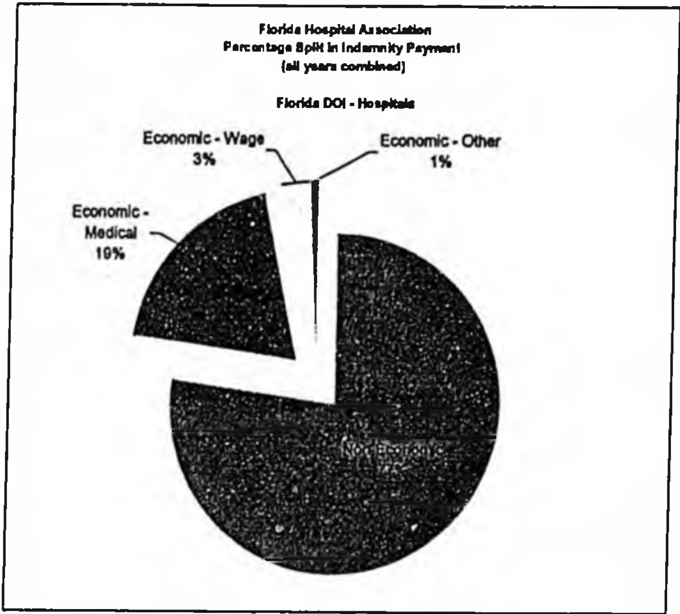
[545] Id. at 20.
[546] Id. at 17.
[547] Id.
[548] Richard S. Biondi et al., Milliman USA, Inc., Florida Hospital Association, Medical Malpractice Analysis 20, Exhibit 7 (Nov. 7, 2002).
[549] In Department of Insurance closed claim data, only about 25 percent of the archive database and about 87 percent of the current database contained a breakout of damages paid.
[550] In only 55 percent of the cases did the non-economic and economic damages stated add to the total of damages paid.
[551] Richard S. Biondi et al., Milliman USA, Inc., Florida Hospital Association, Medical Malpractice Analysis 13, Exhibit 2a. (Nov. 7, 2002).
[552] Id.
[553] Id. at 13, Exhibit 2b.

Graph 3





Graph 4



Florida Academy of Trial Lawyers Medical Malpractice Claims Analysis, Prepared by Lance deHaven-Smith

The Florida Academy of Trial Lawyers retained Dr. Lance deHaven-Smith to perform an analysis of closed-claims data in the Department of Insurance Closed-Claims Database for physicians and surgeons. His analysis did not include hospitals.

Total claims paid

- The claims-paid data for physicians, without an inflation adjustment, showed a 24 percent increase between 1999 and 2001.[554]

- Closed-claims peaked in 1996, dropped in 1997 and 1998, and began increasing again in 1999. (Graph 5)[555]

- When adjusted by medical-care inflation rates, the claims-paid have been down since 1996, and have just now reached the 1991 levels, approximately. (Graph 6)[556]

Average claims paid

- The average claim value, adjusted for medical-care inflation, is down from the levels in 1991, and is even below levels for 1995 and 1996. (Graph 7).[557]
- Severe claims are rare. (Graph 8).[558]

Non-economic damages vs. economic damages

According to Dr. Smith, there is a .110 correlation between economic and non-economic damages. This indicates, "if you get a high economic award, you're more likely to get a higher non-economic award. . . . [I]t is not a strong relationship, but it is statistically significant, and suggests that even those non-economic damages are not unexplainable or irrational."[559]

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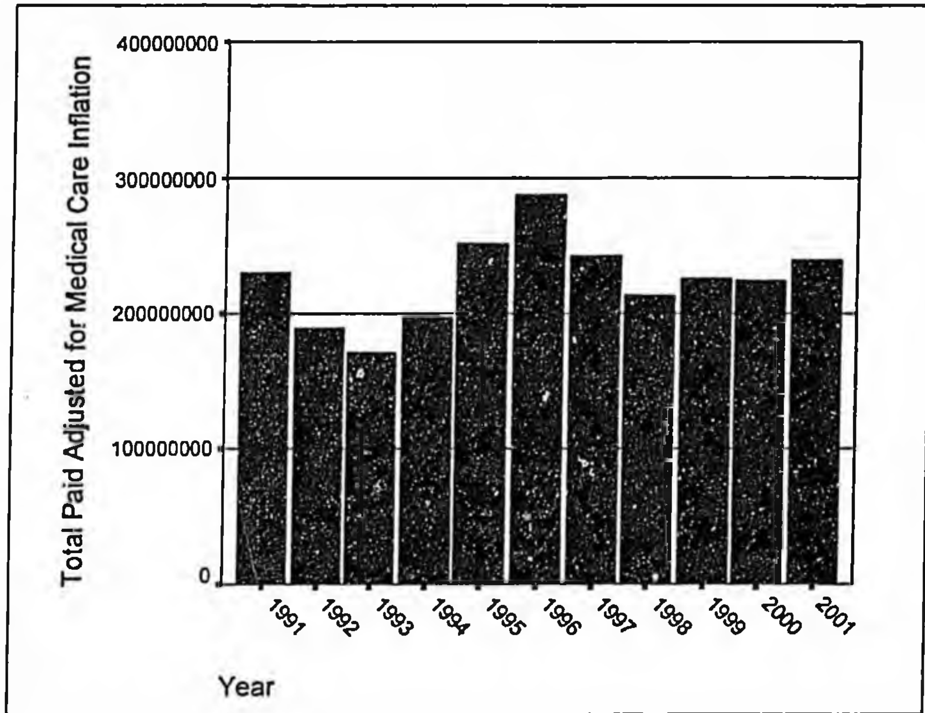
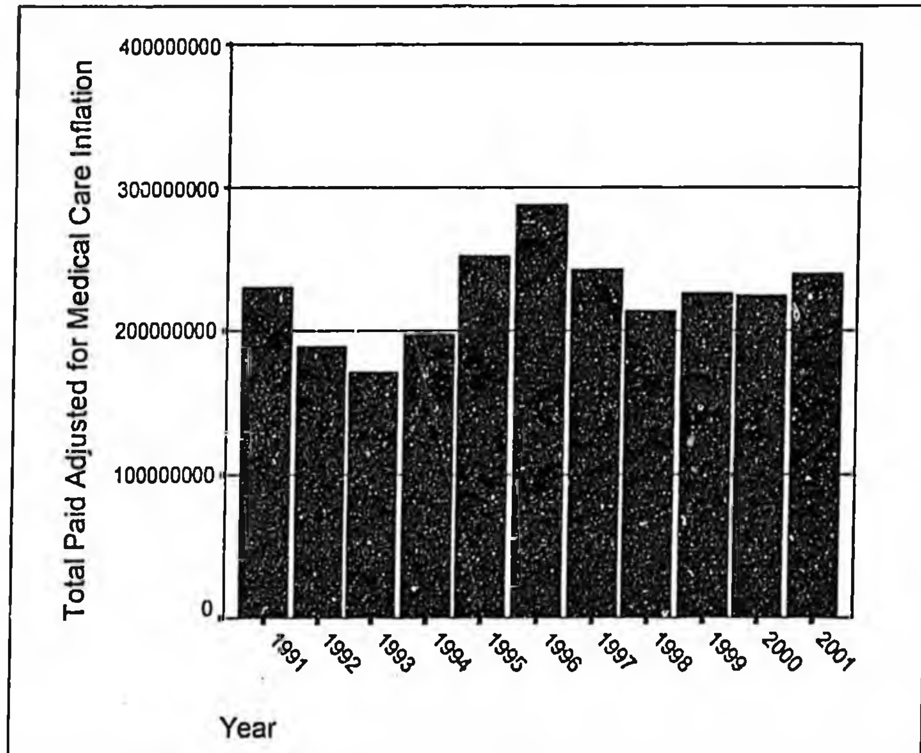
[554] Lance deHaven-Smith, Ph.D., Figure 1, Total Value of Claims 1999-2001.
[555] Lance deHaven-Smith, Ph.D., Figure 2, Claims Adjusted for Inflation Table, and testimony, Nov. 22, 2002, pg. 84.
[556] Id. Figure 3.
[557] Lance deHaven-Smith, Ph.D., Figure 5, Average Claim Value, Adjusted for Inflation.
[558] Lance deHaven-Smith, Ph.D., Figure 2, Outliers.
[559] Lance deHaven-Smith, Ph.D., testimony, Nov. 22, 2002, pg. 89.

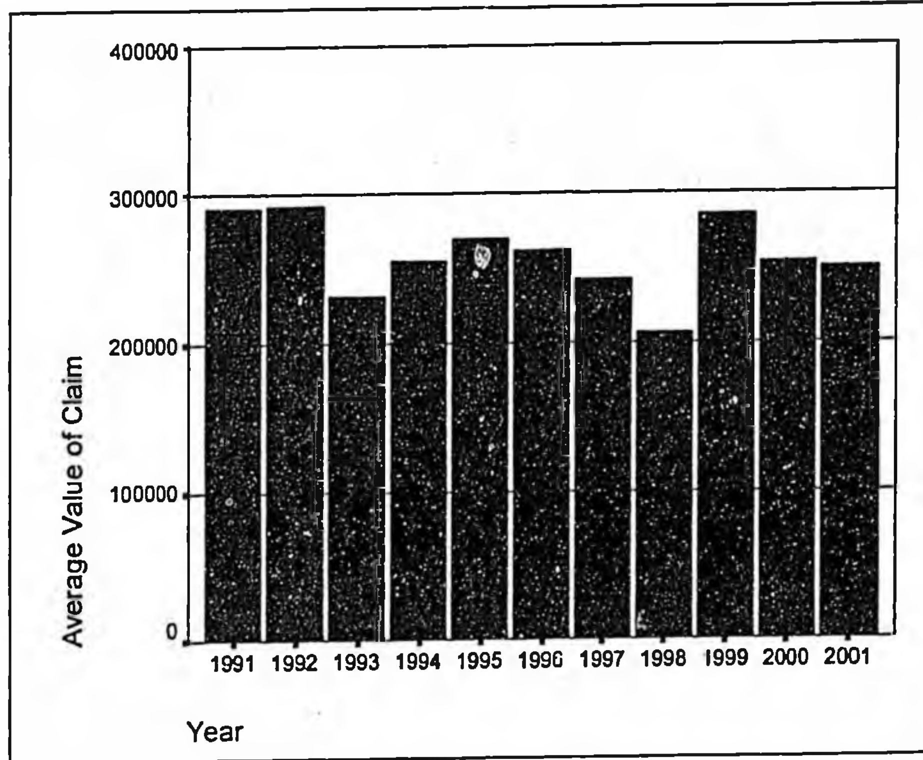
Graph 5: Total Payout per Year, Adjusted for Medical Care Cost Inflation



Graph 6: Total Payout per Year, Adjusted for Medical Care Cost Inflation

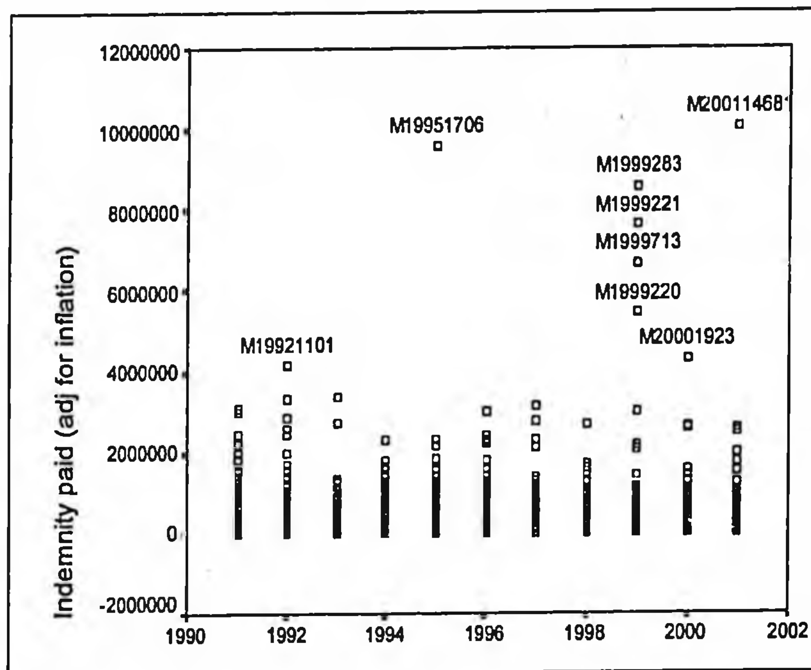


Graph 7: Average Payout Per Claim, Adjusted for Medical Care Cost Inflation



Graph 8

Scatterplot of Individual Payouts, Showing Outliers



Analysis for the Governor's Select Task Force on Healthcare Professional Liability Insurance

This analysis reviews the Florida Hospital Association Report prepared by Milliman USA, Inc., and the Florida Academy of Trial Lawyers Medical Malpractice Analysis prepared by Dr. deHaven-Smith, and independently evaluates the condition of the Florida professional healthcare liability insurance industry.

Comparison of Reports

Databases Used

The study by Dr. deHaven-Smith consists of basic statistical analyses of the Florida Department of Insurance (FLDOI) medical professional liability databases for years 1991 through 2001. Milliman performs similar analyses of the entire FLDOI databases for the years 1974 through 2002. However, limited analysis is done for the year 2002 and the years prior to 1991. Milliman's report is primarily for years 1991 through 2001.

The FLDOI database is composed of two different databases: "Archive" that contains data for claims closed before June 25, 1999 and "Current" that contains data for claims closed between June 25, 1999 and April 30, 2002. Milliman reports some adjustments to the two databases were required. Adjustments were made to the Current database to remove duplicate records in cases involving multiple defendants. The Archive database does not require this adjustment. However, the Archive database includes claims closed without payment while the Current database does not. To account for this discrepancy Milliman confined their analyses to claims closed with indemnity payments. Milliman performed overall analyses of the closed claim databases and they also examined closed claims broken down into physicians and hospitals. deHaven-Smith reports he also analyzed non-zero closed claims for physicians and surgeons. He states "the two datasets were restructured by the author to make them compatible and were then consolidated..." The specific steps taken were not reported.

Milliman's report also included several other analyses including an analysis of closed claims for physicians reported to the National Practitioner Data Bank (NPDB), an analysis of the Texas Department of Insurance Closed Claim Databases (Texas DOI), an analysis of the claim trends of the Physicians Insurers Association of America (PIAA) and analyses of other data obtained from annual statements and rate filings.

Statistical Methods Used

deHaven-Smith Report

deHaven-Smith first computes the raw totals of claim amounts and then adjusts them by the Medical Care Cost Index.[560] He then performs basic statistical analyses based on these adjusted numbers. These analyses include total payout per year, average payout per claim, distribution of claims by severity, average payout for claims broken down by the severity of injury and a scatter plot showing outliers. He also performs analyses based on the number of closed claims per year and runs Pearson Correlations between the payout and other factors as well as between economic and non-economic damages.

deHaven-Smith calculates the medical care cost index has increased 54 percent from 1991 to 2001 and 14 percent since 1997.[561] The Medical Care Price Index (MCPI), a component of the Consumer Price Index, is in Table 12.[562] While claim severity is certainly affected by medical costs, weaknesses in the construction of the MCPI must be considered. Graboyes (1994) writes a price index "measures the average price of a set of goods and services in one period against the average price of the same goods in another period." The index changes proportionally to the price of goods in the basket. Implicit in this calculation is that the basket of goods consumed does not change over time and the satisfaction level of the basket remains the same from period to period. Technological progress in the field of medicine has caused problems with accurately measuring the MCPI. Medical care received in 2001 greatly differs from medical care received in 1950. For example, diseases that were previously untreatable are now almost routine. Advanced techniques such as laparoscopic procedures now replace older ones. Advances such as antibiotics, vaccines, and electronic monitoring of patients have reduced costs. On the other hand the use of defensive medicine has increased costs.[563] In addition, the type and quality of medical care that people use over time changes.

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[560] Although this method is correct for adjusting prior years claims amounts to 2001 levels, one can't help but wonder what the effect would be if premiums were treated in a similar way.

[561] This is an error. The MCPI has actually increased 16 percent since 1997.

[562] Bureau of Labor Statistics, U.S. Department of Labor website (www.bls.gov).

[563] Brostoff (1993) refers to a study by Lewin-VHI, Inc. that estimates costs of $36 billion per year for defensive medicine.

Table 12 A Comparison of the Consumer Price Index and the Medical Care Price Index				
Year	CPI – All Items	YTY % change	MCPI	YTY % change
1991	136.2		177	
1992	140.3	0.03	190.1	0.074
1993	144.5	0.03	201.4	0.059
1994	148.2	0.026	211	0.048
1995	152.4	0.028	220.5	0.045
1996	156.9	0.03	228.2	0.035
1997	160.5	0.023	234.6	0.028
1998	163	0.016	242.1	0.032
1999	166.6	0.022	250.6	0.035
2000	172.2	0.034	260.8	0.041
2001	177.1	0.028	272.8	0.046

Berndt, Griliches, and Rosett (1993) found the Bureau of Labor Statistics (BLS) gives too little weight to new goods. At the same time, new goods tend to have lower price increases compounding the effect and causing the price index to be too high. Prior to January 1995, the CPI did not adequately measure generic drugs. Scherer (1993) found that generic drugs were considered new products in the market basket and the resulting effect of a price decrease for the older drug did not show up. However, since that time, the BLS has implemented changes to more accurately measure the impact of generic drugs on costs to consumers.[564]

Graboyes (1994) notes other problems with the price index. List prices are used instead of actual transaction prices. Prior to January 1997, the list price charged by a hospital was used in the calculation of the MCPI. However, beginning in January 1997 the BLS restructured the hospital portion of the CPI to focus more on treatment outcomes.[565] Now the unit of measure is a hospital visit rather than the individual components making up that visit. The BLS has also improved their data collection procedures and identifies the payor, diagnosis, and reimbursement agreement. Using the reimbursed rate for a hospital rather than the list price for services is a great improvement in the MCPI. There are also other sampling biases that occur. For example, a store may have a product listed at one price but actually sell it at another.

The MCPI practice of measuring payments by non-Medicare and Medicaid patients results in a higher index due to cost shifting. Graboyes

[564] U.S. Department of Labor, Bureau of Labor Statistics, Measuring Price Change for Medical Care in the CPI website (www.bls.gov/cpi/cpifact4.htm).
[565] Id.

notes that the MCPI includes health insurance premiums paid directly by the consumer but not by employers who benefit from group discounts.

In summary, the MCPI most likely overstates the actual cost of medical care. Regardless, it is the best index that we have at this time to measure the cost of medical care.[566]

Milliman Report

Milliman performs many different statistical tests. As in deHaven-Smith, they also compute the raw claims totals. They then use this unadjusted data and perform the following analyses using the FLDOI databases:

- Calculate the historical average annual increase in loss payments.
- Categorize the loss payments between economic and non-economic damages, defense costs, wages, and medical bills.
- Compare the wages and medical increases to the inflation index for wages and healthcare.
- Examine the rate at which economic, non-economic, and defense costs are growing.
- Compute historical trends on claim frequency and that same trend adjusted for population growth.
- Perform a comparison of claims and premium data between South and North Florida.

Milliman also performs several other statistical tests using data other than that provided by the FLDOI. Using this other data they are able to make comparisons between Florida and the rest of the country.

Each study uses vastly different methods. Therefore, only the raw claim totals illustrated in Table 13 are directly comparable between these two reports. Both reports calculate the total unadjusted payout per year and the number of claims closed per year.

[566] Graboyes (1994) notes that some feel the MCPI is understated.

Table 13 Unadjusted Claim Totals

YEAR	DeHaven-Smith Florida DOI Databases		Milliman USA, Inc.			
			Florida DOI Databases		NPDB Database*	
	Total Amount Paid ($)	Claims Closed	Total Amount Paid ($)	Claims Closed	Total Amount Paid ($)	Claims Closed
1991	148,875,447	786	146,534,933	771	121,368,350*	644
1992	131,380,435	643	133,781,196	657	144,527,850	719
1993	126,156,950	736	125,845,187	724	146,440,000	786
1994	152,405,900	769	159,777,554	802	169,668,850	811
1995	203,347,516	933	206,449,199	942	188,983,050	849
1996	241,080,279	1,100	239,875,827	1,087	237,694,550	1,076
1997	208,843,088	1,003	202,750,624	955	223,530,000	1,100
1998	189,263,865	1,032	182,241,758	1,001	214,219,300	1,025
1999	207,541,531	791	220,966,498	828	238,864,100	1,045
2000	214,481,970	881	223,149,549	891	306,424,550	1,209
2001	239,237,089**	958	205,677,297**	882	102,483,600**	427

* National Practitioner Data Bank Public Use File, April 30, 2001, U.S. Department of Health and Human Services, Health Resources and Services Administration, Bureau of Health Professions, Division of Quality Assurance as cited by Milliman USA, Inc. in their report provided to the Governor's Select Task Force on Healthcare Professional Liability Insurance meeting on November 22, 2002.
**1991 was the first complete year that data was collected by the NPDB so the data may be incomplete.
**This data may be incomplete depending on when the data was obtained due to delays in reporting.

An examination of the raw numbers from the two reports reveals some mild to moderate discrepancies. While the total payout amounts appear to be similar in the earlier years appearing to diverge by only $1-2 million dollars from 1991 to 1993, beginning with 1994 the figures become more and more erratic. In 1999 there is a difference of $13 million, $9 million in 2000 and $34 million in 2001. Interestingly, deHaven-Smith's totals are higher in 1991, 1993, 1996, 1997, 1998, and 2001. Milliman's totals are higher in the other years. In 2001, deHaven-Smith's numbers are much larger but he may have had more complete data for 2001 if he obtained the data from the DOI much later in the year 2002 than did Milliman. The number of claims closed per year follows the same pattern as total amount paid. It appears these discrepancies result from different data screening procedures used by the researchers.

Analysis of Findings

deHaven-Smith Report

deHaven-Smith presents a summary of findings in his written report. His main finding is "the annual payout amount after adjusting for inflation has not escalated over the decade." He finds this holds for both annual payout totals and average payouts per claim. Based on the statistics and

adjustments that he performed and the information he provided the Task Force these are reasonable findings.

His second major finding is "payout amounts are quite rational and predictable." He appears to base this statement on the findings that (1) "the amount paid for any given claim is largely a function of the severity of the injury sustained..." and (2) there is a "statistically significant correlation between the payout for economic losses and payouts for non-economic factors."

The most complex statistical test that deHaven-Smith performs is a Pearson Product Moment Coefficient of Correlation. The other tests performed are simple basic statistical calculations of totals, averages, and identification of outliers. He illustrates these figures with histograms. There is no indication that any other tests are performed.

The Pearson correlation is a measure of the strength of the linear relationship between two random variables and ranges between +1 and –1. A value near or equal to 0 indicates there is little or no linear relationship between the two variables. The closer the value gets to 1, the stronger the relationship between the two variables. A –1 indicates a perfect negative relationship between the two variables. As the value of one variable decreases, the value of the other variable increases. A +1 indicates a perfect positive relationship between the two variables.

It should be noted that Pearson correlations are simple correlations and do not calculate or remove any influence that other variables may have. Also, correlations between two variables do not indicate causation. This being said, deHaven-Smith finds the Pearson correlation, r, for economic and non-economic damages is .110. Since r was found to be significant, he states there is a significant correlation between economic and non-economic losses. However, while significant, the value of .110 actually indicates a very weak, positive linear relationship between economic and non-economic damages. In fact, there is very little linear relationship between economic and non-economic damages.

deHaven-Smith finds four payments exceeded $5 million in 1999, one payment exceeded $4 million in 2000, and in 2001 one payment exceeded $10 million dollars and was the highest payment ever. It is common knowledge that once a very high award occurs all parties' expectations regarding the values of future, similar claims are raised accordingly. Therefore, even though the distribution of severity or the probability of the type of injury occurring may be highly predictable, the actual payout required to settle a claim may not be. deHaven-Smith's conclusions that payout amounts are "quite rational and predictable" and "future annual payouts can be predicted with a high degree of accuracy" is not reasonable

based on his findings in his report and on the very weak relationship found between economic and non-economic damages.

Lastly, deHaven-Smith states "payout amounts depend on injury severity." Once again, there is no statistical basis for making that conclusion. The simple correlations calculated between the payout and other variables appear to be the basis for this statement. As previously explained, correlation is not causation and should not be interpreted as such.

Milliman Report

In order to retain a common basis with the deHaven-Smith report the findings by Milliman using data from the Texas DOI, New York, and PIAA will not be discussed. This report will concentrate on those findings that can be obtained from data available from the FLDOI closed claim databases. The unadjusted claim totals referred to below are in Table 14. NPDB data are also discussed since it contains many of the same data items contained in the FLDOI database.

Milliman performed analyses based on FLDOI data and NPDB data. Their observations/conclusions are simply statements of statistical facts calculated by them. Their first conclusion is "Florida medical malpractice paid losses rose over 150 percent between 1991 and 2000" and 28 percent from 1999 to 2000. These figures were obtained from the NPDB. The corresponding analysis using Milliman's figures from the FLDOI closed claim database shows only a 52 percent increase from 1991 to 2000 and a 1 percent increase from 1999 to 2000. deHaven-Smith's unadjusted figures show a 44 percent increase from 1991 to 2000 and a 3 percent increase from 1999 to 2000.

Similarly, using NPDB data, Milliman finds that claim frequency has increased 57 percent from 1991 to 2000 and 14 percent from 1999 to 2000. They adjusted these figures for population growth. Using unadjusted data for 1991 to 2000, Milliman shows an 88 percent increase in NPDB closed claims and a 16 percent increase in FLDOI closed claims. deHaven-Smith's unadjusted figures reveal a 12 percent increase for this time period.

From these figures it appears that the concerns raised by stakeholders at Task Force meetings that the FLDOI closed claim database understates claim amounts, especially in the later years, are valid. In addition, the United States General Accounting Office performed a study of reports received by the NPDB in September 1999. They found 24.4 percent of the malpractice payment reports did not include amounts for damages.

Milliman also concludes non-economic damages account for approximately 77 percent of loss payments for hospitals in Florida. What

they do not point out is that they also find non-economic damages account for a similar large portion of loss payments for Florida physicians. In the last ten years non-economic damages have ranged from a low of 70 percent of total payout in 1998 to a high of 88 percent in 1992. Non-economic damages accounted for 72 percent of total loss payouts in 2001 and 80 percent in 2002.[567] deHaven-Smith did not provide information on this type of analysis so a direct comparison with his study on these figures cannot be made.

Finally, Milliman found that from 1991 to 2000, "medical malpractice paid loss dollars per unit of population increased 8.7 percent per year." deHaven-Smith did not perform this type of analysis so no comparison can be made.

Quality of Databases

Florida Department of Insurance Closed Claim Databases (DOI)

The FLDOI database is available on CD and comes with the following disclaimer.

> "Neither the Department of Insurance nor the State of Florida accepts legal liability or responsibility for the accuracy, completeness or usefulness of this information on closed claim reports filed by insurers. This information is unaudited."

The FLDOI database consists of two databases. "Archive" contains years 1975 up to mid-July 1999 and "Current" contains data from mid-July 1999 to present. The Department of Insurance provides very specific information regarding duplicate records and steps that need to be taken to successfully work with the data.

Concerns have been raised by some stakeholders at Task Force meetings that this database is incomplete due to underreporting of claims. Steve Roddenberry, Deputy Director of the Division of Insurer Services at the Florida Department of Insurance, confirms that some insurers may not report to the FLDOI as required. In addition, self-insurers, off-shore captive companies, risk retention groups, and surplus line companies do not report to the closed claim database.

[567] The 2002 FLDOI database was incomplete at the time Milliman obtained the data.

National Practitioner Data Bank Public Use File (NPDB)[568]

Under Title IV of Public Law 99-660, the Health Care Quality Improvement Act of 1986, each entity that makes a medical malpractice payment for a healthcare practitioner must report to the NPDB. Payments made solely on behalf of entities such as group practices and hospitals as well as clinics are not required to report. Eligible payments must be reported within 30 days of payment date. In contrast to the FLDOI databases, each practitioner's portion of the claim payment is reported. The FLDOI reports the total claim payment for each physician and/or hospital, hence the duplicate records. Therefore, the average claim payment should be lower for NPDB data.

As opposed to the FLDOI, the NPDB requires any entity that makes a payment on behalf of a healthcare practitioner to report that payment. This database should include those entities such as self-insurers, risk retention groups, etc., that are not included in the DOI database. As a result, the total amount paid out per year should be higher for NPDB data than for FLDOI figures. However, as previously mentioned, even the NPDB suffers from underreporting and incomplete filing of reports. In addition, neither database has ever taken legal action against entities that file late reports, do not file reports, or file incorrect or incomplete reports.

In addition to the underreporting problems the General Accounting Office uncovered in their report dated November 2000 and referred to earlier in this report, they also found significant delays between the time payment was made and the data was actually entered into the NPDB. First, it was found that on average 25 percent of the reports received by the NPDB in September 1999 were approximately 85 days late.[569] Second, delays occurred between the time the report reached the NPDB and the information was added into the database. These delays ranged from a low of 5 days to a length of 1 year before the information was added to the database. The median delay was calculated to be 13 days. On the bright side, the NPDB was scheduled to begin Internet-based reporting on October 1, 2000. However, without improved controls this form of reporting may actually worsen the problems of inaccurate and incomplete reports.

In summary, the NPDB requires more entities to report medical malpractice payments paid for healthcare practitioners. The NPDB total claim amount paid is more complete while the FLDOI database has more

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[568] Richard Biondi, Florida Hospital Association Medical Malpractice Analysis, presentation, Nov. 22, 2002, citing National Practitioner Data Bank Public Use File, U.S. Department of Health and Human Services, Health Resources and Services Administration, Bureau of Health Professions, Division of Quality Assurance (April 30, 2001).

[569] Reports are supposed to be filed within 30 days of the initial payment date.

detailed information on specific claim information. For example, the FLDOI contains information on the injuries and types of damages paid including a breakdown of economic, non-economic, incurred, and future damages. The FLDOI also has claim information on hospitals while the NPDB does not. However, from the above information and reviewing Milliman's numbers for the year 2000, it is apparent that these numbers are incomplete.

Analysis of NPDB Data Adjusting for Medical Costs

Due to the very real concerns that more entities report payments to the NPDB and the increase in medical costs caused the increased claim payments, an analysis of the Milliman NPDB figures using deHaven-Smith's MCPI indexing formula is performed.[570] The results of this analysis are in Table 10.

This analysis finds after adjusting for increases in medical care costs from 1991 to 2000, the total amount paid out in medical malpractice payments increased 71.3 percent and the average claim paid decreased by 8.7 percent. Using unadjusted figures for the same time period the total amount paid out increased 152.5 percent while the average claim paid increased 34.5 percent. Further, the number of claims filed increased 87.7 percent from 1991 to 2000 while the total population of Florida increased approximately 23.5 percent from 1990 to 2000.[571] This implies the increase in total claims paid is largely attributed to the increased number of claims filed.

[570] The formula is as follows: *adjusted* $value_t$ = *raw* $value_t$ * *index* $value_{2001}$/*index* $value_t$ where t = the year ranging from 1991 to 2001.
[571] www.state.fl.us/edr/population.

TABLE 14 NPDB Data Using MCPI Indexing Figures Adjusted to 2001 Values*							
Year	Unadjusted Total Amount Paid	MCPI	Adjusted Total Amount Paid	% Change in Adjusted Total Paid	Number of Claims Closed	Adjusted Average Claim Paid	% Change in Adj. Average Claim Paid
1991	121,368,350	177	187,058,112		644	290,463	
1992	144,527,850	190.1	207,402,407	10.9%	719	288,460	-0.7%
1993	146,440,000	201.4	198,355,670	-4.4%	786	252,361	-12.5%
1994	169,668,850	211	219,363,328	10.6%	811	270,485	7.2%
1995	188,983,050	220.5	233,807,601	6.6%	849	275,392	1.8%
1996	237,694,550	228.2	284,150,189	21.5%	1076	264,080	-4.1%
1997	223,530,000	234.6	259,927,468	-8.5%	1100	236,298	-10.5%
1998	214,219,300	242.1	241,383,829	-7.1%	1025	235,496	-0.3%
1999	238,864,100	250.6	260,024,447	7.7%	1045	248,827	5.7%
2000	306,424,550	260.8	320,523,839	23.3%	1209	265,115	6.5%
2001**	102,483,600	272.8	102,483,600	-68.0%	427	240,008	-9.5%

* Using the formula provided by Dr. deHaven-Smith
**Data for this year is incomplete.

Analysis of Florida Department of Insurance Market Performance Reports

Overview of Florida Professional Healthcare Liability Insurance Market

Insurance market performance reports for years 1988 through 2000 were provided to the Task Force by the Florida Department of Insurance. These yearly reports detail the Florida experience of twelve different lines of insurance. Copies of these reports are provided in Appendix 5[572]. The lines of insurance contained in these reports are fire, homeowners, commercial multiple peril, medical malpractice, private passenger physical damage, private passenger auto liability, commercial auto liability, workers' compensation, other liability, product liability and directors and officers liability.[573] Section 627.915, Florida Statutes, requires insurers writing at least 0.5 percent of the Florida market to report this information.

A review of the healthcare professional liability insurance industry's performance reveals some disturbing trends in the Florida market. These trends are outlined in Graph 9. As can be seen, the market was profitable in the late 1980s and early 1990s. However, beginning with 1994 net income went negative and has been negative in 5 of the last 7 years. In fact, with the exception of spikes in years 1996 and 1998, industry profitability has steadily deteriorated. Although the year 2000 produced the largest investment gain for the market since 1988, this increased income was not enough to offset the large increase in direct losses incurred that year and shown in Graph 9.[574]

As seen in Graph 10 direct losses incurred shows an increase in amount over the past 10 years with a large increase observed from 1999 to 2000. Specifically, direct losses incurred have increased 614 percent from 1991 to 2000 and 64 percent from 1999 to 2000. Similarly, direct losses paid have increased 352 percent from 1991 to 2000 and 50 percent from 1999 to 2000.

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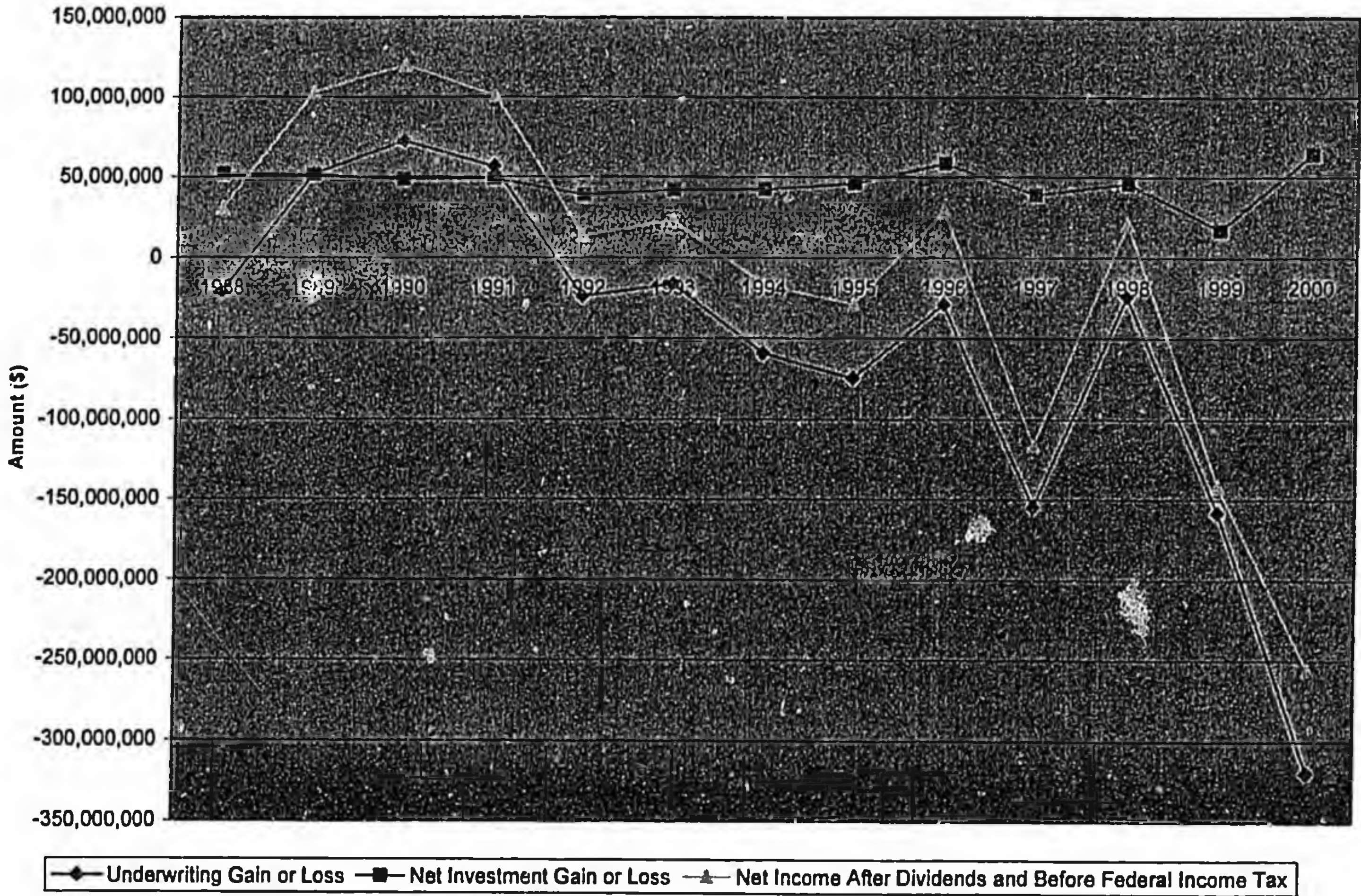
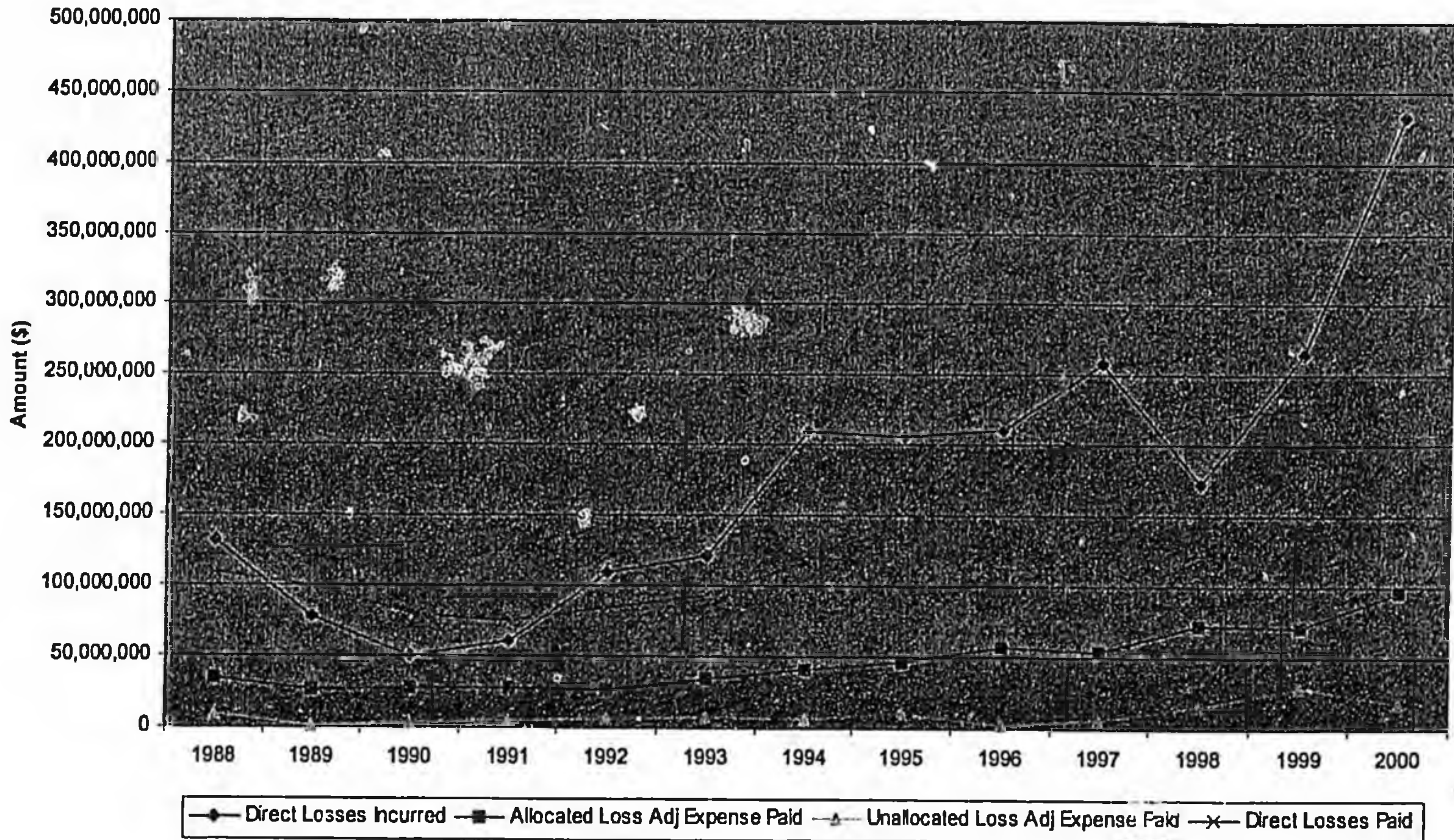
[572] Appendix 5 can be found in Volume 6, Speaker Comments, November 22, 2002 Task Force Meeting.
[573] The Florida Department of Insurance uses the term "medical malpractice." The Task Force prefers the term "healthcare professional liability." They are used interchangeably in this report.
[574] Section 625.305, Florida Statutes restricts insurers' costs of investments "in stock authorized by s. 625.324" to 15 percent of admitted assets, costs of investments in common stock to 10 percent of admitted assets, and costs of investment in "stock of any one corporation" to 3 percent of admitted assets. Regardless, investment income has become more erratic since 1995; see app. 1 for actual figures.

Graph 9



Graph 10



Allocated loss adjustment expense paid has increased over 111 percent in the last 6 years and 254 percent from 1991 to 2000.[575] Unallocated loss adjustment expense paid increased 258 percent from 1991 to 2000 and 85 percent in the past 6 years from 1995 to 2000.[576]

It should be noted these market reports reveal underreporting especially in later years when negative net income for the industry is experienced. Please see Appendix 1[577] for the percentage of total market share of insurers reporting. Therefore, in years with negative net income total amounts are understated relative to years with positive net income. As a result, actual industry experience is most likely worse than reported.

Analysis of Financial Ratios and Rankings of Insurance Lines

The overall performance of the professional healthcare liability insurance market in the state of Florida can be measured by comparing its annual financial ratios realized with the ratios from the other 11 lines sold and referenced above. The use of ratios should mitigate the effects of underreporting by insurers both within and across lines of insurance. The use of ratios should also alleviate concerns regarding the effect of inflation on values.

One measure of insurer performance is the loss ratio. The loss ratio is the ratio of direct losses incurred to premiums earned.[578] A 100 percent loss ratio means that for every $1 in premium earned there is $1 loss incurred. The annual loss ratios and resulting rankings for professional healthcare liability insurance are given in Table 15. The ratio of direct losses incurred to premiums earned and the resulting rankings for all lines is provided in Appendix 2.[579] The results show since 1994, excluding 1998, the professional healthcare liability industry has experienced high losses relative to other lines of insurance. Please see Appendix 3.[580] Interestingly, the cost to adjust these claims has always been relatively high compared to the cost of claims adjustment in other lines.

Underwriting results are measured by calculating the ratio of underwriting gain (loss) to premiums earned. The underwriting results and the resulting rankings are also in Table 15. The ratio of underwriting gain (loss) to premiums earned and the resulting rankings for all lines is provided in

[575] Allocated loss adjustment expenses are specific charges that can be assigned to a claim. For example, defense attorney fees, photographer fees, appraisal fees, and independent physician reports.

[576] Unallocated loss adjustment expenses include charges such as overhead expenses and other expenses not included under allocated loss adjustment expenses.

[577] Appendix 1 can be found in Volume 6 Speaker Comments, November 22, 2002 Task Force Meeting

[578] Direct losses incurred to premiums earned are provided in the market performance reports by the Florida Department of Insurance.

[579] Appendix 2 can be found in Volume 6, Speaker Comments, November 22, 2002 Task Force Meeting.

[580] Appendix 3 can be found in Volume 6, Speaker Comments, November 22, 2002 Task Force Meeting.

Appendix 4.[581] It is clear from these results that underwriting performance for professional healthcare liability insurance has greatly deteriorated in the past few years. This deterioration appears to be due to both increased losses and expenses. From Table 15 the direct loss incurred ratio has increased (worsened) by a large percentage. It is also apparent that this industry ratio is highly variable. The total loss adjustment expense ratio has also worsened over the past years but not as drastically as the direct loss incurred ratio.[582]

TABLE 15
Ratio Analysis of Healthcare Professional Liability Market
Ranked Results with Total Market

Year	Direct Losses Incur / Premiums Earned	Rank	Total LAE Incur / Premiums Earned	Rank	UW Gain / Premiums Earned	Rank
1988	72.2%	10	24.1%	10	-11.6%	11
1989	44.7%	2	12.6%	8	29.8%	1
1990	29.2%	1	17.3%	9	41.7%	1
1991	34.5%	1	19.4%	10	32.0%	1
1992	68%	4	28.7%	8	-15.10%	5
1993	59.7%	5	26.8%	11	-8.0%	8
1994	75.5%	11	28.5%	11	-21.3%	11
1995	87.1%	11	25.6%	11	-31.6%	11
1996	71%	10	24.2%	10	-9.8%	8
1997	113.6%	12	37.4%	10	-68.0%	12
1998	55.6%	5	34.5%	12	-7.8%	9
1999	91.8%	12	38.3%	11	-55.0%	11
2000	136.8%	12	47.4%	12	-100.8%	11

*A rank of 1 means that line had the best ratio (most favorable experience) in the industry for that year.

[581] Appendix 4 can be found in Volume 6, Speaker Comments, November 22, 2002 Task Force Meeting.
[582] Total loss adjustment expense incurred to premiums earned is provided in the market performance reports by the Florida Department of Insurance. It is the sum of the allocated loss adjustment expense incurred and unallocated loss adjustment expense incurred.

TABLE 16

Combined Ratio for Healthcare Professional Liability Insurance

Year	Combined Ratio*
1988	96.3%
1989	57.3%
1990	46.5%
1991	53.9%
1992	96.7%
1993	86.5%
1994	104%
1995	112.7%
1996	95.2%
1997	151%
1998	90.1%
1999	130.1%
2000	184.2%

The combined ratio is the sum of the loss ratio and the expense (LAE) ratio. A ratio of 100 percent means losses and expenses equal the premium earned or, in other words, for every $1 earned there is $1 in loss and expenses.

The combined ratio is simply the sum of the loss and total loss adjustment expense ratios. A combined ratio of 100 percent means losses and expenses equal the premium earned. In Table 16 losses and expenses have exceeded the premium earned in 5 of the last 7 years. The year 2000 was particularly bleak for the industry as a whole with losses and expenses exceeding earned premium by 84.2 percent.

In summary, the last few years have resulted in a marked decrease in profitability for healthcare professional liability insurance in the state of Florida. With an industry-combined ratio of 184.2 percent and a corresponding underwriting ratio of –100.8 percent in 2000, the viability of this market may be threatened if conditions continue to deteriorate.

Chapter 5 - FINDINGS

"Even in a world of perfect experience rating, the deterrent signal would still be blunted by a second problem: the poor fit between instances of negligence and suing. Research has found that most instances of medical negligence never give rise to a malpractice claim, and that many malpractice lawsuits are brought and won by patients even though expert reviewers can identify no evidence of negligent care. . . . A similarly poor fit between negligent injuries and claims was found in the [Harvard Medical Practice Study] sample. The total number of malpractice claims filed was about 14% of the total number of negligent injuries. However, this figure masks the incredibly small overlap between the group of patients injured by negligence and the group who brought suit. Less than 2% of those who were actually injured due to negligence filed a claim, and only about a sixth of the claims that were filed involved both negligence and an injury."

Michelle Mello & Troyen A. Brennan, Deterrence of Medical Errors: Theory and Evidence for Malpractice Reform, 80 Texas Law Review 1595 (June 2002).

Task Force Findings

The Task Force received extensive testimony, documentation and letters related to the current medical malpractice insurance crisis. Based on the information and data received, the Task Force makes the following findings about the crisis:

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

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

Impact of the Underwriting Cycle: The business cycle for medical malpractice insurance companies has exacerbated the increases in medical malpractice insurance rates in Florida but claims paid have had the most significant impact. The late-1990s produced some of the largest investment gains for the market since the mid-1980s, but this increased income was not sufficient to offset the large increase in direct losses for the medical malpractice insurance industry that year. As a result, insurance companies writing medical malpractice suffered a loss ratio of 184 percent.

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

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

Variations Among Medical Specialties: Specialists and other physicians performing high-risk procedures are much more likely to be sued. These specialties, particularly obstetricians and neurosurgeons, also see much higher medical malpractice insurance rates, regardless of whether they have ever been sued.

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

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

<u>Compensation of Victims</u>: As the cost of medical malpractice insurance has increased some healthcare providers carry only minimum insurance of $250,000 or are "going bare." This leaves victims with minimal or no compensation should they be injured.

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

In addition to receiving extensive testimony regarding the existence of a medical malpractice insurance crisis and the current related law, the Task Force requested speakers and participants to offer the Task Force recommendations for addressing the problem. The Task Force requested proposals in the areas of:

- Improving the quality of medical care
- Discipline of healthcare practitioners/providers
- Tort reform
- Alternative dispute resolution
- Insurance reform

Proposals Heard

In total the Task Force heard testimony regarding over 100 proposals for change, which fell into one of the categories below:

(1) Improving healthcare quality
(2) Physician discipline
(3) Tort reform
(4) Insurance reform
(5) Alternative dispute resolution reform

The remainder of this report contains the specific recommendations of the Task Force and the rationale for each recommendation. It is organized according to the above five issue areas. Chapter six contains the healthcare quality issues. Chapter seven contains the physician discipline reform. Chapter eight contains the tort reforms. Chapter nine contains the insurance reforms. Finally, chapter ten contains the alternative

dispute resolution reforms. These recommendations recognize that it is possible to reduce the cost of medical malpractice and the severity and frequency of claims. These recommendations include a comprehensive reform package designed to strengthen quality healthcare in Florida. The Task Force believes that these recommendations constitute a carefully balanced set of ideas, the content of which has been determined by the results of extensive testimony and research. The Task Force recommends that the Florida Legislature adopt these proposals.

Chapter 6 - Improving Healthcare Quality

> *"The culture of medicine creates an expectation of perfection and attributes errors to carelessness or incompetence. Liability concerns discourage the surfacing of errors and communication about how to correct them."*
>
> *"Patient safety is also hindered through the liability system and the threat of malpractice, which discourages the disclosure of errors. The discoverability of data under legal proceedings encourages silence about errors committed or observed. Most errors and safety issues go undetected and unreported, both externally and within health care organizations."*
>
> Institute of Medicine, To Err is Human: Building a Safer Health System 22, 43 (Linda T. Kohn et al. eds., 2000)

Issue

The Task Force voted on December 20, 2002, by a 5-0 vote, to examine the following issues with respect to reducing medical errors and improving healthcare quality:

Should a patient safety authority or patient safety center be created to:

- Require mandatory reporting of serious events or near misses?
  - Should information be confidential?
  - Should information be subject to discovery?
- Analyze and make recommendations directly to medical facilities to improve care?
  - Require retraining or mentors for those with adverse events?
- Require all hospitals to have patient safety plans, patient safety committees, and patient safety officers?
- Require written notice of serious events to impacted patients or their representatives?
- Evaluate objective criteria for evaluating the effectiveness of the current mandatory reporting system?
- Evaluate factors that limit the effectiveness of the current reporting system?
- Implement a system for reporting near miss events?
- Develop objective criteria for evaluating the effectiveness of a near miss reporting system?

- Analyze reported data and make recommendations directly to healthcare facilities and providers to improve care?
- Provide malpractice insurance discounts if a hospital implements a certified patient program?

In addition, the Task Force requested staff to include the recommendations included in the testimony made by Donald Berwick, M.D. Dr. Berwick's recommendations were:

- Implement a safety reporting system, based on the aviation model, which uses "the best people" to analyze medical mistakes. This recommendation is similar to the Patient Safety Authority model in Pennsylvania that is based, in part, on the Institute of Medicine's recommended model described in the To Err is Human and Fostering Rapid Advances in Health Care reports.
- Adopt a strategy to provide all hospitals with a computerized physician order medication system.
- Develop a single inexpensive electronic medical record at the state level that would contain essential information so that all physicians, hospitals, and other facilities would have access to the record.
- Conduct a four-year "no-fault" medical malpractice demonstration project that would use the Workers' Compensation method of compensation for injuries. The system would have five elements: (1) all patients are told when they are injured; (2) an apology to the patient is made; (3) injured patients are compensated just as in the workers' compensation system; (4) the "entity" would be responsible for liability, not the individual; and (5) the demonstration project should have a study component to study injuries to continually reduce risk.
- Include courses on patient safety and safety improvement in medical and nursing school curricula.
- Establish a simulation center for high technology intervention surgery and intensive care for use by all hospitals.

At the January 16 meeting of the Task Force, by a 4-0 vote, staff was directed to prepare a recommendation requiring state government to determine the feasibility of providing information to the public to assist in making better healthcare decisions. The information would not be made available as a "report card."

Current Situation

Florida law requires hospitals, ambulatory surgery centers and nursing homes to have internal risk management programs that are designed to identify and minimize the risk of adverse incidents to patients. Florida law governing risk management programs for hospitals and ambulatory

surgery centers is found in section 395.0197, Florida Statutes.[583] This law was initially enacted in 1975 in response to an earlier crisis in malpractice insurance. In addition, legislation enacted in 1985 amended this statute to require hospitals and ambulatory surgery centers to have licensed healthcare risk managers. In 2001, legislation was passed requiring nursing homes and assisted living facilities to also have risk management programs.[584]

Section 395.0197, Florida Statutes, governs internal risk management programs and requires that adverse incidents be investigated and analyzed, that measures be developed to minimize the risk of adverse incidents to patients, that patient grievances related to patient care and quality be analyzed, and that incident reporting systems be developed. In subsection (16), the Agency for Healthcare Administration (AHCA) is given the responsibility to determine if risk management programs are "...conducted in a manner designed to reduce adverse incidents, and whether the program is appropriately reporting incidents."

Internal risk management programs are confidential pursuant to subsection (15), which states that meetings held solely for the purposes of risk management are not open to the public and the records of meetings are confidential and exempt from public disclosure.

Although section 395.0197, Florida Statutes, requires hospitals and ambulatory surgical centers to annually report to ACHA serious medical injuries and patient deaths that are the result of medical injuries, these reports are confidential and not available to the public. There are three medical injury reports:

(1) the annual report which includes all adverse incidents (patient injuries);

(2) the Code 15 Report which reports serious patient injuries; and

(3) the 24 Hour Report which is a preliminary report on certain serious injuries: death, brain or spinal damage, wrong patient surgery, wrong site surgery, and wrong surgical procedure.

In addition, hospitals and ambulatory surgical centers also report new malpractice claims. AHCA publishes aggregated data for all hospitals and ambulatory surgical centers combined. Under current law, hospitals and ambulatory surgical centers are not required to report "near misses" or to develop strategies to minimize these types of errors. The current system

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[583] See also Tanya Williams, testimony, Nov. 4, 2002, pgs. 38-46.

[584] Sections 400.071(11), section 400.147, Florida Statutes.

also does not assist healthcare providers by using experts to identify ways to prevent errors.

Section 395.0197, Florida Statutes, requires hospitals, ambulatory surgery centers, and nursing homes to have risk management programs to "reduce risk to patients." However, there is no requirement that specific committees be created to foster improvements in patient safety, nor that members of the public be included in the process. Subsection (2) of this section simply states that the internal risk management program "is the responsibility of the governing board." The statutes are silent with regard to how risk management is to be conducted in facilities. In addition, subsection (2) states that a risk manager may be responsible for up to four risk management programs in separately licensed facilities, or more than four separate facilities if the facilities are under the same corporate ownership or are in rural hospitals. A large multi-hospital corporation could, under Florida law, have one risk manager for all of its hospitals

The following table was prepared by AHCA and reports the most recent data available. The table appears on their website. It is important to note that the Legislature changed the definition of "adverse incident" for annual reports and Code 15 reports. Beginning in 1999, adverse incidents resulting from surgical procedures that were described in patient consent forms ceased to be reported. It is also important to note that this chart reflects gross numbers, only, and makes no attempt to analyze these numbers or to relate them to patient days, number of surgical procedures, or any other indicator of volume that could explain fluctuations or provide a relative measure of the rate of occurrence.

Table 17

Annual Report	1996	1997	1998	1999	2000
Annual Report (all adverse incidents)	5,140	5,517	5,113	3,808	4,541
(New) Malpractice Claims	733	718	783	916	949
Code 15 Reports 24 Hour Reports	856	1,102	994	720	920

**Though the number of facilities continually fluctuates, as of January 2001, agency records indicate there were 273 licensed hospitals and 263 licensed ambulatory surgical centers.

As of January 6, 2003, data for 2001 were not available.

Source: Agency for Health Care Administration
http: //www.fdhc.state.fl.us/MCHQ/Health_Facility_Regulation/index.shtml.

The quality of healthcare has received considerable attention since the publication of the Institute of Medicine's (IOM) To Err is Human report in

2000.[585] The report estimated that medical errors in hospitals result in 44,000 to 98,000 patient deaths per year. Although these figures are controversial, there is no doubt that many persons are injured, some of them seriously, by medical errors that could have been prevented.[586] A recent New England Journal of Medicine article reported that large percentages of both physicians and members of the public are aware of medical errors made on members of their own families.[587]

To reduce medical errors, the authors of the IOM study wrote,

> Healthcare organizations must develop a culture of safety such that an organization's care processes and workforce are focused on improving the reliability and safety of care for patients. Safety should be an explicit organizational goal that is demonstrated by the strong direction and involvement of governance, management and clinical leadership. In addition, a meaningful patient safety program should include defined program objectives, personnel, and budget and should be monitored by regular progress reports to governance.[588]

To achieve a culture of safety, the authors recommended that healthcare organizations establish patient safety programs that include non-punitive systems for reporting and analyzing medical errors made within their organizations.

The IOM also recommended that standardized mandatory reporting systems of serious medical errors be established.[589] The mandatory reporting systems would be "linked to systems of accountability," such as professional licensure regulation; the information would be made available to the public and states would have flexibility regarding their implementation.

A recent article in the New England Journal of Medicine reported on the findings of parallel national surveys of 831 practicing physicians and 1,207 members of the public regarding perceptions of medical errors.[590] The findings of these surveys indicate that sizeable proportions of both

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[585] Institute of Medicine, National Academy of Sciences, To Err is Human: Building A Safer Health System (2000).
[586] See Thomas H. Lee, A Broader Concept of Medical Errors, 347(24) New England Journal of Medicine 1965-1966 (Dec. 12, 2002).
[587] Robert J. Blendon et al., Views of Practicing Physicians and the Public on Medical Errors, 347(24) New England Journal of Medicine 1933-1940 (2002).
[588] See Institute of Medicine, To Err is Human: Building A Safer Health System 12.
[589] Id. at 88-89.
[590] See Robert J. Blendon et al., Views of Practicing Physicians and the Public on Medical Errors, 347(24) New England Journal of Medicine 1933-1940 (2002).

physicians (35 percent) and the public (42 percent) report medical errors in either their own care or a family member's care.

The findings also indicate that a large proportion of physicians believe that most medical errors can be prevented; that the understaffing of nurses and the overwork, stress, or fatigue of health professionals are very important causes of preventable medical errors; and that effective recommendations for reducing medical errors that would be very effective include requiring hospitals to develop systems for preventing medical errors and increasing the number of nurses in hospitals.

The following tables excerpt key findings from the surveys.

Table 18

Preventable Medical Errors

(Responses in Percentages)

All Respondents	Physicians (N=831)	Public (N=1207)
Error made in own or family member's care	35	42
Health consequences serious	18	24
Serious consequences		
Severe pain	11	16
Substantial loss of time at work or school or other important activities	12	17
Temporary disability	8	12
Long-term disability	6	11
Death	7	10
Respondents reporting an error*		
Parties who had "a lot" of responsibility for error		
Doctors	70	81
Nurses	25	25
Health professional involved		
Told respondent that error had been made	31	30
Apologized to respondent or family member	34	33
Respondent or family member sued health professional	2	6

*290 physicians (35% of 831) and 507 (42% of 1207) members of the public reported an error either in their own care or in the care of a family member.

Source: Robert J. Blendon et al., Views of Practicing Physicians and the Public on Medical Errors, 347(24) New England Journal of Medicine 1935 (2002).

As the above table indicates, 35 percent of practicing physicians and 42 percent of the general public reported they or someone in their family had experienced a medical error; roughly half of the errors were reported as serious. Seven percent of physicians and 10 percent of the general public stated someone in their families died as a result of medical errors.

Although these survey findings have significant policy implications for improving medical care, only 5 percent of physicians and 6 percent of the

public said medical errors were among the most serious problems in healthcare. Much larger problems reported by physicians were the cost of malpractice insurance and lawsuits (29 percent of physicians), and insurance company and health plan problems (27 percent). The public cited the cost of healthcare as the greatest problem (38 percent), followed by the cost of prescription drugs (31 percent).

It is important to note most physicians believed that medical errors occur infrequently. Only 1 percent indicated preventable medical errors occurred very often and 19 percent indicated they occurred somewhat often. In contrast, 10 percent of the members of the public believed medical errors occurred very often and 39 percent believed they occurred somewhat often.

Table 19

Beliefs About the Frequencies of Medical Errors and Preventable Deaths

(Responses in Percentages)

Question and Response	Physicians (N=831)
How often are preventable medical errors made?	
Very often	1
Somewhat often	19
Not very often	59
Not often at all	21
No response	0
What proportion of (deaths due to medical errors) could realistically have been prevented?	
All of them	8
Three-quarters of them	27
Half of them	41
One-quarter of them	21
None of them	2
No response	1

Source: Robert J. Blendon et al., Views of Practicing Physicians and the Public on Medical Errors, 347 New Eng. J. Med, 24, 1936 (2002).

Table 20

Causes of Preventable Medical Errors (Responses In Percentages)	
Response	Physicians (N=831)
Very important causes	
Understaffing of nurses in hospitals	53
Overwork, stress, or fatigue of health professionals	50
Failure of health professionals to work together or communicate as a team	39
Influence of HMOs and other managed care plans on treatment decisions	39
Complexity of medical care	38
Insufficient time spent by doctors with patients	37
Poor training of health professionals	28
The more important reason for errors	
Mistakes made by individual health professionals	55
Mistakes made by institutions	43
Volume of procedures	
An error is more likely at a low-volume hospital	71
Volume does not make a difference	24

Source: Robert J. Blendon et al., Views of Practicing Physicians and the Public on Medical Errors, 347 New Eng. J. Med, 24, 1937 (2002).

Table 21

Possible Solutions to the Problem of Medical Errors

(Responses in Percentages)

Sclution	Physicians (N=831)	Public (N=1207)
Very effective		
Requiring medical error prevention systems in hospitals	55	74
Increasing the number of nurses in hospitals	51	69
Giving physicians more time to spend with patients	46	78
Limiting certain high-risk procedures to hospitals that perform many of these procedures	40	45
Improving the training of health professionals	36	73
Hospital reports of serious medical errors		
Should be confidential (used only to learn how to prevent future medical errors)	86	34
Should be released to public	14	62

Source: Robert J. Blendon et al., Views of Practicing Physicians and the Public on Medical Errors, 347 New Eng. J. Med, 24, 1938 (2002).

Most physicians surveyed believed the majority of deaths due to medical errors "could have realistically been prevented." A total of 41 percent stated half of the deaths could have been prevented, 27 percent stating three-fourths, and 8 percent stated all. Summing these responses, 76 percent stated half or more of deaths were preventable. Surprisingly, the views of the members of the public were very similar to the views of physicians with regard to the feasibility of preventing errors.

Physicians believed the most important cause of preventable medical error was the understaffing of nurses in hospitals (53 percent of physicians). Nearly as many (50 percent) believed overwork, stress, or fatigue on the part of health professionals was a very important cause of preventable medical errors. Physicians believed other very important causes included the "failure of health professionals to work together or communicate as a team" (39 percent); the "influence of HMOs and other managed-care plans on treatment decisions" (also 39 percent); "the complexity of medical care" (38 percent); and "insufficient time spent by doctors with patients" (37 percent).

When asked about possible solutions to the problem of medical errors, the strategy physicians believed would be most effective was to require hospitals to develop systems for preventing medical errors, with 55 percent of physicians stating this would be a very effective strategy. Increasing the number of nurses in hospitals was believed to be a very effective strategy by 51 percent of physicians, followed by giving physicians more time to spend with patients (46 percent), and limiting

certain high-risk procedures to hospitals that perform many of these procedures (40 percent).

The following table shows responses to a hypothetical situation in a hospital. An antibiotic is ordered by a surgeon to be given to a patient by a nurse despite a notation in the patient's medical record that the patient has an allergy to antibiotic drugs. In one case, the patient has a rash that disappears when the antibiotic is stopped. In the other case the patient dies because of the drug.

Table 22

Responses to Hypothetical Situation Where Patient Is Given a Drug Inappropriately

(Responses in Percentages)

	Outcome without harm (rash)		Outcome with harm (patient dies)	
Response	Physicians (N=404)	Public (N=603)	Physicians (N=427)	Public (N=604)
Party with "a lot" of responsibility for error				
Surgeon	90	89	95	92
Nurse	81	52	82	48
Hospital	42	55	48	57
Should be sued for malpractice				
Surgeon	4	30	55	69
Nurse	3	12	44	21
Hospital	2	22	33	44
Should be fined by a government agency				
Surgeon	5	51	21	65
Nurse	6	26	18	29
Hospital	9	39	21	50
Should have license suspended				
Surgeon	0	23	8	50
Nurse	1	11	8	25
Should be required to report error to patient or family				
Surgeon	85	95	90	95
Nurse	74	67	70	57
Hospital	60	78	71	84
Should be required to undergo training in the prevention of this type of error				
Surgeon	66	80	78	80
Nurse	71	67	81	72
The hospital should be required to develop systems for preventing similar errors	74	79	84	84

Source: Robert J. Blendon et al., Views of Practicing Physicians and the Public on Medical Errors. 347(24) New England Journal of Medicine 1938 (2002).

Finally, the survey found large proportions of both physicians and members of the public believed medical errors should be reported to the patient or family and hospitals should be required to develop systems for preventing errors. In addition, sizeable percentages of both physicians and the public believed physicians and nurses who commit preventable medical errors that do not harm patients but cause a medical problem should be fined or otherwise disciplined. It is also important to point out that the study reflects perceptions from two classes of individuals: those in the medical profession and consumers of medical services. The study does not attempt to prove or disprove the truth of those perceptions.

Information Presented to the Task Force

Ms. Jacqueline Imbertson, representing Floridians for Patient Protection, stated at the October 21 meeting of the Task Force that hospital report cards that contain information pertaining to staffing, services, infection rates, and medical errors by type should be available on the Internet to aid consumers in choosing a hospital.[591]

The Task Force heard testimony from Dr. Robert Muscalas, Physician General, State of Pennsylvania, at the November 4 meeting in Miami, and again at the December 3 meeting in Tallahassee. Dr. Muscalas spoke regarding the establishment of a Patient Safety Authority, based on the aviation model (which analyzes "near misses"), to reduce medical errors and improve the quality of care in hospitals, ambulatory surgical centers, and birth centers.[592] The State of Pennsylvania has adopted legislation creating a Patient Safety Authority that is an independent, advisory, non-regulatory agency. The legislation requires mandatory confidential reporting of serious events and near misses. Serious events and near misses are analyzed and recommendations are made directly to medical facilities to improve care. Information is not subject to discovery in lawsuits. In addition, the legislation requires all hospitals to have patient safety plans, patient safety committees, and patient safety officers and there is a process for hospitals to receive malpractice insurance discounts if they implement certified patient safety programs. Finally, patients who experience serious events must be provided written notice.

The Task Force invited nationally recognized experts to present at the November 4 task force meeting in Miami. Professor Eleanor Kinney, J.D., who has authored numerous articles on medical malpractice in major peer-reviewed journals, stated "the development of systems for ensuring patient

[591] See Jacqueline Imbertson, testimony, Oct. 21, 2002, pgs. 165-166.
[592] See Robert Muscalas, D.O., testimony, Nov. 4, 2002, pgs. 121-126, 135.

safety and improving the quality of care in different patient venues" was a "third-generation" medical malpractice reform that would be part of the concept of "enterprise liability."[593] Professor Kinney, in discussing reducing errors in hospitals, went on to state:

> It's a good thing. And the fewer errors, the fewer frequency of—well, supposedly, you would have fewer malpractice claims. But I think if you really respect the patient safety effort and do it in the right way, I think there is an effort to identify problems and I would imagine opportunities for heading off claims where damage has been done. Ideally, that would be what I would like to see from a really strong patient safety program in a hospital.[594]

In a previous commentary, Ms. Kinney has noted:

> A political basis for second-generation reform in either states or Congress does not exist. Clearly the political power of the medical profession and liability insurers is great as well as focused. On the other hand, the organized power of consumers is diffuse and not focused on malpractice. The only focused advocate for the consumer in the malpractice debate is the trial bar, and it has much at stake in maintaining the common law tort system without reforms. Finally, the third constituency of third-party payers, which cuts across party lines is interested in the issue only as it affects health system costs.... There is simply too much focused opposition to and no political constituency for second-generation reforms in the current debate over health system reform.[595]

Robert G. Brooks, M.D., stated at the November 4 meeting that the Florida Commission on Excellence in Healthcare recommended that a center on patient safety be established to collect, analyze, and distribute information related to adverse incidents and near misses that was similar to recommendations by the Institute of Medicine. Dr. Brooks also stated that legislation (HB 1219 and CS/SB 2294) was introduced in the Florida Legislature in the 2002 session to establish a center on patient safety, based on voluntary reporting, but the legislation was not passed.[596]

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[593] See Eleanor Kinney, J.D., testimony, Nov. 4, 2002, pg. 181. The concept of enterprise liability is included in the design of "no fault" compensation programs, a third-generation reform, which are discussed later in this chapter.

[594] Id. at 187-188.

[595] Eleanor D. Kinney, Learning from Experience, Malpractice Reforms in the 1990s: Past Disappointments, Future Success? 20 Journal of Health Politics, Policy, and Law 99, 124-125 (1995).

[596] See Robert G. Brooks, M.D., testimony, Nov. 4, 2002, pg. 198; Eleanor Kinney, J.D., testimony, Nov. 4, 2002, pgs. 187-188.

Robert Berenson, M.D., who was co-chair of the malpractice reform working group on the Clinton Health Reform Task Force in 1993 and who worked to administer a demonstration grant program in medical malpractice reform for the Robert Wood Johnson Foundation between 1994 to 1998, stated at the November 4 meeting that healthcare quality is a very important component of medical malpractice reform. Dr. Berenson stated:

> ...we now have a new opportunity and, indeed, a new imperative to deal with a malpractice crisis with more than standard tort reform. The Institute of Medicine's two reports on safety and on quality correctly point to the impediment of the current tort system with or without caps on damages places on efforts to actually do something systematically to improve quality and reduce the frequency and magnitude of errors. I agree with those who assert that threat of suit has a chilling effect on creating an environment conducive to efforts to improve patient safety. Further, protecting patient safety activities from discovery is something Congress is now considering, while desirable, misses a unique opportunity we now have of recasting the malpractice liability system into one that itself is a major contributor for improved patient safety. The legal system should be more than permissive to patient safety activities. Properly designed, it can positively promote patient safety.[597]

Randall Bovbjerg, J.D., who has published extensively on the subject of medical malpractice reform, particularly with regard to no-fault compensation models, stated at the November 4 meeting the "big problems" in medical malpractice are "legal performance and patient safety."[598]

Finally, Michelle Mello, J.D., Ph.D., who has also published extensively in peer-reviewed journals on the subject of medical malpractice, stated that the public is very concerned about medical errors and testified:

> ... my own view is that it's imperative that any liability limiting reform in Florida or elsewhere be paired with some accompanying measures to address problems with patient safety, and most importantly, accountability in medicine.[599]

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[597] See Robert Berenson, M.D., testimony, Nov. 4, 2002, pgs. 213-215.
[598] See Randall Bovbjerg, J.D., testimony, Nov. 4, 2002, pg. 267; see also Randall Bovbjerg, J.D., testimony, Nov. 4, 2002, pgs. 273-276.
[599] See Michelle Mello, J.D., Ph.D., testimony, Nov. 4, 2002, pg. 305.

At the December 20 meeting of the Task Force in Tallahassee, Donald Berwick, M.D., M.P.P., Clinical Professor of Pediatrics and Healthcare Policy at the Harvard Medical School, gave a presentation regarding the quality of healthcare. Dr. Berwick has been a member of numerous advisory committees, including the Committee on Quality of Healthcare in America that produced the To Err is Human report by the Institute of Medicine.

Dr. Berwick began his testimony by stating patient safety is a serious problem and the burden on public health is substantial. He stated he believed that the estimates of patient deaths in hospitals due to medical errors reported by the Institute of Medicine (the estimate ranges from 44,000 to 98,000 deaths annually) were sound.[600] Dr. Berwick went on to say the problem does not result from a deficient work force. He said incompetence and carelessness might explain 1 or 2 percent of patient injuries. The remaining 98 or 99 percent result from mistakes made by normal people who try "quite hard to do well" but have complex jobs in work systems which are fragile. Sometimes there are "too many things going on at the same time" in very complicated processes. He next stated there are process failures or system failures due to needed information not being transferred from one part of the system to another. For example, he stated 7 of every 100 people hospitalized experience a major medication error.[601]

To improve patient safety, Dr. Berwick stated four types of changes were needed:

(1) a change in awareness and will to address patient safety;
(2) technical changes to modernize healthcare such as computerized medication ordering systems which have software to check for drug interactions and that dosages are within proper range;
(3) cultural changes to promote effective communication, including communication "against the authority gradient"; training for safety, and the open discussion of mistake; and
(4) environmental changes such as changes in the professional education system to include training for teamwork, safety awareness, and communication in medical student and nurse educational programs, elimination of the fear of lawsuits to promote patient safety communication, and increasing the availability of capital to permit hospitals to invest in patient safety efforts such as computerized medication ordering systems. Dr. Berwick stated one of four patient

[600] See Dr. Donald Berwick, M.D. M.P.P., testimony, Dec. 20, 2002, pg. 5.
[601] Id. at 7-9.

injuries is a medication injury and 80 percent of medication injuries can be eliminated with computerized medication ordering systems.[602]

Dr. Berwick's presentation to the Task Force included six recommendations:

(1) Implement a safety reporting system, based on the aviation model, which uses "the best people" to analyze medical mistakes.[603]

This recommendation is similar to the Patient Safety Authority model in Pennsylvania that is based on the Institute of Medicine's recommended model described, in part, in the To Err is Human and Fostering Rapid Advances in Healthcare reports.

(2) Develop a strategy to generate capital to provide all hospitals with a computerized physician order medication system.[604]

(3) Develop, at the state level, a single inexpensive electronic medical record that contains essential information including "problem list, registry functions, drug medication lists and a few other things."[605] The electronic medical record would be used in both the inpatient and outpatient environments so all physicians, hospitals and other facilities could have access to the record. The November 2002 IOM report states the key components of a computer-based patient record also include laboratory, imaging, and prescription drugs.[606]

(4) Conduct a four-year "no-fault" medical malpractice demonstration project that would use the Workers' Compensation method of compensation for injuries. The system would have five elements:

a. all patients are told when they are injured;
b. an apology to the patient is made;
c. injured patients are compensated just as in the Workers' Compensation system;
d. the "entity" would be responsible for liability, not the individual; and
e. the demonstration project should have a study component to study injuries to continually reduce risk.[607]

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[602] Id. at 9-17.
[603] Id. at 19-20.
[604] Id. at 20.
[605] Id. at 21.
[606] Id. at 63.
[607] Id. at 23-24; see also Albert W. Wu, Handling Hospital Errors: Is Disclosure the Best Defense?, 131(12) Annals of Internal Medicine 970-972 (Dec. 21, 1999) for a discussion of the relationship between informing patients of injuries and malpractice lawsuits.

(5) Include in medical schools and nursing schools curricula courses on patient safety and safety improvement.[608]

(6) Establish a simulation center for high technology intervention surgery and intensive care for use by all hospitals.[609]

In November 2002, the IOM published a study that made recommendations to improve quality in several areas of healthcare. These areas include: (1) information and communications technology (ICT) that includes physician medication order entry and computer-based patient records with clinical information; and (2) demonstration projects that provide for non-judicial ("no-fault") compensation for medical injuries.[610]

The study recommended the enactment of "paperless healthcare system" demonstration projects, administered by public-private partnerships. These demonstration projects should use computer-based patient records to be available in time for use by clinicians and patients on a right- and need-to-know basis. Improvements in patient safety and quality would be expected due to enhanced communications, access to patient information, knowledge management, and decision support.[611] The study stated computer-based patient records should include a summary of current problems, medications, and allergies and also should include results, notes, and disease management guidelines.[612] In addition, clinicians should have access to computer-based clinical information including laboratory and radiology results.[613] Other features would include appointment and billing and "performance measurement data for ongoing assessment of quality and safety improvements."[614] Over time, the system would include functions for disease surveillance, telemedicine, and a public health rapid alert component.[615] The study concluded: "Properly structured ICT also has great potential to reduce some administrative costs and burden."[616]

The study described a web-based patient data system used by twenty-five healthcare organizations, which account for the majority of care provided in Santa Barbara County in California, as the "best-known" example of a data exchange platform for patient information.[617]

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608 Dr. Donald Berwick, M.D. M.P.P., testimony, Dec. 20, 2002, pg. 25.
609 Id. at 26.
610 Institute of Medicine, National Academy of Sciences, Fostering Rapid Advances in Healthcare (Nov. 2002).
611 Id. at 58-59.
612 Id. at 60-61.
613 Id. at 7.
614 Id. at 59.
615 Id. at 63.
616 Id. at 23-24.
617 Id. at 62.

According to the IOM report, the Santa Barbara system has the following features:

- Users (such as clinicians, hospitals and laboratories) need an Internet connection and web browser to access data.

- Patient data resides at original locations (such as a hospital system, imaging center system, etc). Only authorized users can view the data.

- Protocols govern who can have access to patient data. When patient information is requested, the requestor's "digital credentials" are verified by the data exchange.

- Patients do not have unique identifiers; rather, the data exchange maintains a file with patient demographic data and correlates these data with those maintained by the provider organization to produce a validated patient search. The locations of the patient records are then stored with the patient's demographic data as "pointers" or "locators."

- Data is exchanged "peer-to-peer" through a secure portal in the data exchange.

- An audit log is maintained by the data exchange that includes who requested the data, what data was requested, and when the request was made.

Another recommendation made in the November 2002 IOM report was the implementation of systems for "computer-based order entry and prescription writing, with dosage and interaction checking."[618] As discussed earlier, Dr. Berwick also made this recommendation in his presentation to the Task Force at its December 3, 2002 meeting.

Dr. Berwick's recommendation to establish a four-year "no-fault" non-judicial compensation program for avoidable medical injuries parallels recommendations made by the IOM in its November 2002 report. In addition, several of the national experts who gave presentations at the November 4 meeting of the Task Force referenced "no-fault" approaches to improve patient safety and ameliorate many of the problems in the tort system.[619] Two countries, Sweden and New Zealand, have no-fault

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[618] Id. at 61.

[619] See Eleanor Kinney, J.D., testimony, Nov. 4, 2002, pgs. 180-181; Robert Berenson, M.D., testimony, Nov. 4, 2002, pgs. 213, 218-225 (esp. 223); Randall Bovbjerg, J.D., testimony, Nov. 4, 2002, pgs. 285-288; Michelle Mello, J.D. testimony, Nov. 4, 2002, pgs. 307-316. Michelle Mello discussed no-fault in considerable detail. For a discussion of the potential for quality improvement in a no-fault program see

compensation systems for medical injuries. Florida and Virginia have no-fault compensation systems for newborns with neurological impairments. No-fault compensation for medical injuries has been the subject of considerable academic interest and numerous articles have been published in medical and legal journals on this subject since the early 1990s. In a 1998 University of Cincinnati law review article, Randall Bovbjerg and Frank Sloan, both of who presented at meetings of the Task Force, discuss no-fault compensation for medical injuries at length, with particular reference to the Florida and Virginia programs.[620]

According to Bovbjerg and Sloan, there are theoretical advantages and disadvantages of no-fault compensation programs for medical injuries. With respect to advantages, Bovbjerg and Sloan predict in a no-fault program:

- compensation is improved as more people should be compensated because negligence need not be proved;
- costs associated with claims will be lower because "adversarial tension" is reduced;
- the payment of benefits should be faster than in the tort process;
- "more benefits should be paid relative to premiums because the administrative share of spending will decline without a highly formalized and adversarial litigation process [and] as a result claimants will not be forced to compromise on the amount paid in order to get a certain and rapid settlement";
- payments will better meet individual needs because payments are made when needed;
- "payments should be better managed because a unified large-scale program can develop expertise in particular medical services, as well as negotiate for efficacious and cost-effective services from providers"; and
- periodic payments of benefits will improve compensation because there is protection against changes in needs that are not anticipated. In addition, reduced injuries and improved quality are anticipated because there is motivation to "investigate the causes of injury and take cost-effective precautions" and because more information will be available regarding injuries and their causes that will improve quality.[621]

David M. Studdert and Troyen A. Brennan, No-Fault Compensation for Medical Injuries – The Prospect for Error Prevention, 286(2) Journal of the American Medical Association 217-223 (July 11, 2001).

[620] Randall R. Bovbjerg & Frank A. Sloan, No-fault for Medical Injury: Theory and Evidence, 67 University of Cincinnati Law Review 1 (Fall 1998); see also Randall R. Bovbjerg et al., Obstetrics and Malpractice – Evidence on the Performance of a Selective No-Fault System, 265(21) Journal of the American Medical Association 2836-2843 (June 5, 1991).

[621] Randall R. Bovbjerg & Frank A. Sloan, No-fault for Medical Injury: Theory and Evidence, 67 University of Cincinnati Law Review 70-71 (Fall 1998).

Potential disadvantages, according to Bovbjerg and Sloan, include:

- non-economic damages are normally limited, thus reducing compensation to injured persons;
- wage losses (economic damages) would likely not be compensated to the same extent as in the tort system;
- there may be lower quality of representation because attorney's fees may be lower than in the tort system;
- the options of claimants are reduced because of periodic payments are received rather than a lump-sum; and
- no-fault may "succeed too well, by compensating more cases [and this] increased coverage will make it un-affordably more expensive than liability coverage."[622]

The IOM's November 2002 report recommends that "Patient-Centered and Safety-Focused, Non-judicial Compensation" demonstration projects be established by the U.S. Department of Health and Human Services. These demonstration projects would be established as an alternative to the current tort system of compensation for avoidable medical injuries. According to the IOM report, the current liability system, "hampers efforts to identify and learn from errors, and likely encourages 'defensive medicine.'" In addition, the report cited research that has found that:

- "many legal claims do not relate to negligent care";
- "judgments are sometimes inconsistent with the medical evidence base";
- "compensation is highly variable";
- "legal fees and administrative expenses consume upwards of half the cost of liability insurance premiums;" and
- "volatility in liability insurance markets has led to escalating malpractice premiums in certain geographic areas, precipitating closure of practices and shortages of certain types of specialists and services."[623]

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[622] Id. at 72-73. For a discussion of the potential cost-effectiveness of a no-fault compensation system in the United States see David M. Studdert et al., Can the United States Afford a "No Fault System of Compensation for Medical Injury?, 60(2) Law and Contemporary Problems 1-34 (Spring 1997): "We conclude that adoption of a Swedish-style approach could lead to a system that is both affordable and positioned to compensate a considerably larger proportion of medically injured patients than the current malpractice system manages or even allows." However, the authors believe the Swedish system is not "neatly transplantable." Id. at 33.

[623] See Institute of Medicine, National Academy of Sciences, Fostering Rapid Advances in Healthcare 10, 81-83 (Nov. 2002). For discussions of no-fault compensation, see also Michelle M. Mello & Troyen A. Brennan, Deterrence of Medical Errors: Theory and Evidence for Malpractice Reform, 80 Texas Law Review 1595-1637 (June 2002); Randall R. Bovbjerg et al., Administrative Performance of "No-Fault" Compensation for Medical Injury, 60(2) Law and Contemporary Problems 71-115 (Spring 1997).

According to the IOM report, these demonstration projects would:

- "create injury compensation systems outside of the courtroom that would provide timely, fair compensation to injured patients and promote apologies and non-adversarial discussions between patients and clinicians";

- be intended "to create an environment that encourages providers to report and analyze medical errors and to involve patients in safety improvement activities";

- limit financial exposure of providers, "thus contributing to the stabilization of malpractice insurance premiums";

- replace the "existing tort system with an alternative system for compensating patients who have experienced avoidable injuries, allow quicker payments to be made to many more injured patients, and reward providers who put effective programs in place to reduce medical injuries."[624]

The IOM recommends that the Department of Health and Human Services issue a Request for Proposals to states. Four or five states would be selected to receive "modest start-up" funds. States would need to enact appropriate implementing legislation. The IOM projects that within one to two years, benefits should be realized with regard to administrative efficiency. Improvements in patient safety and in stabilizing the medical malpractice insurance premiums would accrue over the longer term. The two types of projects are:

- "Provider-Based Early Payments": This model "offers predetermined limits on non-economic damages including pain and suffering, and federally-subsidized reinsurance to self-insured provider groups that promptly identify and compensate patients for avoidable injuries."[625]

The IOM report states that the "Provider-based Early Payment" model creates incentives for, "...physicians and hospitals to join together to form well-managed clinical entities that bear primary financial responsibility for avoidable errors and have the medical know-how to minimize patient injury."[626]

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[624] Id.
[625] Id. at 10.
[626] Id. at 84.

- "Statewide Administrative Resolution": This model "grants all healthcare professionals and facilities, however organized, immunity from tort liability under most circumstances in exchange for mandatory participation in a state-sponsored, administrative system for compensating avoidable injuries."[627]

According to the IOM, the "Statewide Administrative Resolution" model "gives all healthcare providers equal, immediate access relief from the current liability crisis and does not depend upon particular organizational forms (e.g., integrated group practice) that may not be well developed in many jurisdictions."[628]

The IOM states that both models are compatible with reforms that cap non-economic damages and both support the concept of "early offers." The report states that:

> ...the time is now ripe for successful implementation of [both models] because of two contributions by the emerging science of patient safety.
>
> First, human factors engineers have shown that non-punitive approaches encourage the detection of avoidable injuries and foster systems for continuous improvement, which suggests that resolving malpractice cases without a determination of fault will help rather than harm quality.
>
> Second, as more healthcare providers accept their responsibility to disclose errors to patients, capping liability at defined amounts – an essential attribute of any affordable non-judicial system – will likely result in more rather than fewer patients receiving compensation.[629]

The IOM states that both the Provider-Based Early Payments and Statewide Administrative Resolution models will require four actions by states.

1. **Infrastructure:** States will need to determine which injuries result from "avoidable errors" that patients would be compensated for and also determine "schedules" for calculating economic and non-economic damages.

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[627] Id. at 10.
[628] Id. at 84.
[629] Id. at 85-86.