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Each school receives an approved charter from the district school board that sets out the operations of the charter school in accordance with the terms and conditions set out in law.[974] The approved charter schools receive state and local funding from the district school board based on the same funding standards as other public schools. Approved charter schools are eligible for state capital outlay funds in the same manner as other public schools.[975] Thus, approved charter schools are covered by the same sovereign immunity provisions as any other public school.

- Family foster homes are licensed and regulated by the state pursuant to section 409.175, Florida Statutes. Each home that accepts only children referred by the Department of Families and Children or its agencies enters into a contract with the Department regulating the services to be provided. These family foster homes are provided sovereign immunity as agents of the state.[976]

In reviewing the application of sovereign immunity and the provisions of section 768.28, Florida Statutes, the courts have examined the application to specific entities and types of actions. In these cases, it has been argued that by applying sovereign immunity, the Legislature has violated article I, section 21 of the Florida Constitution by denying access to the courts. In analyzing this issue the courts have applied the test set forth in Kluger v. White.[977] That test provides that "where a right of access to the courts for redress of a particular injury has been provided by statutory law predating the adoption of the Declaration of Rights of the Constitution of the state of Florida, or where such right has become a part of the common law of the state pursuant to section 2.01, Florida Statutes, the Legislature is without power to abolish such a right without providing a reasonable alternative to protect the rights of the people of the state to redress for injuries, unless the Legislature can show an overpowering public necessity for the abolishment of such right, and no alternative method of meeting such public necessity can be shown."

The court, in evaluating the application of section 768.28, Florida Statutes, to municipalities, applied this analysis. In Cauley v. City of Jacksonville,[978] the Florida Supreme Court reversed prior applications of the limitation of sovereign immunity to municipalities and instead applied the provisions of section 768.28, Florida Statutes. The court applied the Kluger test in analyzing the application of sovereign immunity and section 768.28, Florida Statutes, to municipalities and found "[t]here was no

[974] Sections 1002.33(6)(a), 1002.33(6)(g), Florida Statutes.
[975] Section 1002.33, Florida Statutes.
[976] Section 409.175, Florida Statutes.
[977] 281 So. 2d 1 (Fla. 1973).
[978] 403 So. 2d 379 (Fla. 1981).

statutory right to recover for a municipality's negligence predating the adoption of the declaration of rights contained in the Florida constitution nor was there a cause of action at common law as of July 4, 1776, adopted under section 2.01, Florida Statutes."

The Kluger[979] analysis was again argued in White v. Hillsborough County Hospital Authority,[980] regarding the elimination of suit against a government employee. The court stated:

> [s]trong policy reasons support the legislative immunization of state employees from personal liability.[981] Here the right of an injured party to seek redress has not been abolished. Rather, the legislature has merely substituted the state and its agencies, which previously could not be sued because of sovereign immunity, for the individuals who could have been sued.[982] Thus, appellant's cause of action has not been destroyed but has been converted to an action against a state agency.[983]

Subsequently, in interpreting the provisions of section 768.28, Florida Statutes, the courts have covered contractors and agents of the state similarly to employees.

Finally, the courts examined who qualifies as an agent, employee, or contractor of the state within the definitions of section 768.28, Florida Statutes. In Skoblow v. Ameri-Manage, Inc.,[984] the district court of appeals found a state contractor who operated a state mental institution was operating as an agency of the state at the time of the plaintiff's alleged wrongful discharge. This determination was based on the court's examination of the contractual relationship between Ameri-Manage, Inc. and the state. In the case of Stoll v. Noel,[985] the Florida Supreme Court found that physician consultants with Children's Medical Services (CMS) were acting as agents of the state within the provisions of section 768.28(9), Florida Statutes, and thus were immune from suit individually. Here again, the court carefully examined the relationship between the doctors and CMS. The court stated that the determination "turns on the degree of control retained . . . by CMS." In making that determination the court examined the terms of the employment contract.[986] The court found the contract demonstrated that CMS had final authority over all care and

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[979] Kluger v. White, 281 So. 2d 1 (Fla. 1973).
[980] 448 So. 2d 2 (Fla. 1st DCA 1983).
[981] State Department of Transportation v. Knowles, 402 So. 2d 1155 (Fla. 1981).
[982] Id.
[983] White v. Hillsborough County Hospital Authority, 448 So. 2d 2 (Fla. 1st DCA 1983).
[984] 483 So. 2d 809 (Fla. 3rd DCA 1986).
[985] 694 So. 2d 701 (Fla. 1997).
[986] Stoll v. Noel, 694 So. 2d 701, 703 (Fla. 1997).

treatment provided to CMS patients, and it could refuse to allow a physician consultant's recommended source of treatment of any CMS patient for either medical or budgetary reasons.[987]

Hospitals and physicians providing emergency medical care in designated trauma units and hospital emergency rooms are also directed by the state and the Federal governments to provide such care. The federal Emergency Medical Treatment and Active Labor Act (EMTALA) requires that all persons coming into an emergency department must be provided a screening exam to determine whether there is an emergency, and when an emergency is found, the person must be treated to the extent of the emergency room's capability without regard to ability to pay or the type of injury or illness.[988]

Each hospital providing emergency services is required to provide the Agency for Health Care Administration (AHCA) with a list of all emergency services within the service capability of the hospital.[989] Those services are to be listed on the hospital license.[990] The listed services are to be provided by the hospital upon the request of the patient, an emergency medical services provider, or another hospital.[991] Where the hospital is at capacity or does not provide the requested emergency service, the hospital may transfer the patient to the nearest facility with appropriate available services.[992] Each hospital must ensure the services listed on the hospital license can be provided at all times either directly or through another hospital.[993] Through these sections, the state directs and controls the actions and activities of hospitals and physicians providing designated trauma services and emergency services in a designated trauma center or hospital emergency room.

State regulation of designated trauma centers is even more intensive than for emergency rooms. Part II of chapter 395, Florida Statutes, provides for the designation and regulation of designated trauma centers and the filing of trauma center plans to be approved by ACHA.[994] To qualify as a designated trauma center, a hospital must meet the requirements of part II of chapter 395, Florida Statutes, and services must be provided in accordance with that part and rules adopted by ACHA.[995] Section 395.1041, Florida Statutes, requires every hospital with an emergency room to provide services or arrange for services in accordance with the

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[987] Id. at 703.
[988] Emergency Medical Treatment and Active Labor Act (EMTALA), 42 U.S.C. section 1395dd.
[989] Section 395.1041(2), Florida Statutes.
[990] Id.
[991] Section 395.1041(3), Florida Statutes.
[992] Id.
[993] Section 395.1041(3), Florida Statutes.
[994] Section 395.401, Florida Statutes.
[995] Sections 395.401, 395.405, Florida Statutes.

needs of the patient for any patient requesting services. In enacting section 395.1041, Florida Statutes, the Legislature stated its intent as follows:

> It is the intent of the Legislature that the agency vigorously enforce the ability of persons to receive all necessary and appropriate emergency services and care and that the agency act in a thorough and timely manner against hospitals and physicians which deny persons emergency services and care. It is further the intent of the Legislature that hospitals, emergency medical services providers, and other healthcare providers work together in their local communities to enter into agreements or arrangements to ensure access to emergency services and care.[996]

The Emergency Medical Transportation Services Act in chapter 401, Florida Statutes, similarly regulates the services provided by emergency medical technicians, paramedics, and ambulances. This chapter requires that services be provided to all persons requesting transportation to the capacity of the service without regard to ability to pay.[997]

Clearly those facilities and the staff's facilities providing emergency transportation, emergency care, and designated trauma services are providing a necessary and critical public function of care for the most seriously ill or injured. Once a facility and the doctors practicing within the facility agree to provide emergency or trauma care, they must provide that care within the parameters and requirements of state and federal law. In fact, the hospital license granted by the state sets forth the services the hospital has committed to provide and thus must provide on demand. This does not appear to be significantly different from the charter school that has its charter approved by the district school board or the family foster homes granted coverage under section 768.28, Florida Statutes.

While the courts have applied the Kluger test in cases evaluating the application of sovereign immunity to governmental agents, the courts have generally found that there was not an abrogation of a remedy but a substitution of a governmental entity for the agent or employee of that entity. The application of section 768.28, Florida Statutes, to providers of emergency services would be no different. In sum, the courts have extended sovereign immunity on numerous occasions to governmental and quasi-governmental entities. There appears to be a rational basis to extend the protections of section 768.28, Florida Statutes, to those who have the burden of implementing critical state objectives.

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[996] Section 395.1041(1), Florida Statutes.
[997] Section 401.45, Florida Statutes.

Information Presented to the Task Force

At the November 22, 2002, meeting of the Task Force, Mr. George Meros, on behalf of the Florida College of Emergency Physicians, presented the need and rationale for providing limited sovereign immunity to physicians providing services in any state-licensed emergency room.[998] Mr. Meros stated that "emergency care personnel, which includes emergency physicians, . . . hospitals, on-call physicians and others attending emergencies pursuant to the state mandate in chapters 395 and 401, have the burdens of implementing state policy without the benefit of all others who act as arms of the state in implementing state policy."[999] As an example, Mr. Meros discussed the situation where county or state health personnel worked alongside private doctors in addressing a medical emergency such as Anthrax or a hurricane. The medical staffs employed by the state or local governments would have the benefit of sovereign immunity while the private doctors would be subject to full personal liability.[1000] Mr. Meros argued that an extension of sovereign immunity to emergency room physicians would be constitutional, and would not be subject to the Kluger test, because the plaintiff's cause of action is not abolished but the defendant is changed from the healthcare provider to the state.[1001] This is the same position excepted by the court in White.[1002] In the summary of testimony provided to the Task Force, the emergency physicians also stated, "Florida courts have held that the extension of 'sovereign immunity' to persons pursuing state objectives is constitutional."[1003] Further, he stated damages were not capped because the claims bill process would be available to the plaintiff.[1004]

In information provided to the Task Force, Mr. Meros has set forth the following benefits to the public and Florida's emergency care system that could be expected:

- Encouraging specialists to maintain hospital privileges or to provide needed services in a hospital environment, thus making such services available for emergency department patients.[1005]

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[998] George Meros, transcript, Nov. 22, 2002, pgs. 209-211.
[999] Id. at 209.
[1000] Id. at 209-210.
[1001] Id. at 211.
[1002] White v. Hillsborough County Hospital Authority, 448 So. 2d 2 (Fla. 2d DCA 1983).
[1003] Summary of Testimony of the Florida College of Emergency Physicians Before the Select Task Force on Healthcare Professional Liability Insurance (Nov. 22, 2002), citing White v. Hillsborough County Hospital Authority, 448 So. 2d 2 (Fla. 2d DCA 1983) and Campbell v. City of Coral Springs, 538 So. 2d 1373 (Fla. 4th DCA 1989).
[1004] Id.
[1005] Id.

- Enhancing recruitment of physicians to hospitals in Florida, thereby enhancing the availability of such emergency and specialist physicians to serve in Florida's emergency departments.[1006]

- Enabling smoother operation of Florida's EMS system through availability and stabilization of emergency physicians and specialists available to hospital emergency departments.[1007]

- Enhancing the trauma system by encouraging physicians who serve at trauma centers to remain available to the system and by encouraging other physicians to agree to serve at trauma centers.[1008]

- Reducing wait-time for patients needing emergency or specialist physician care through improving the availability of physicians at hospitals. Such improved availability of physicians will also reduce the number of medically-necessary transfers between hospitals and will reduce diversion of ambulances due to lack of specialty availability. The increased availability of prompt medical care will benefit patient care.[1009]

- Ensuring that our first responders (i.e., emergency medicine professionals in and out of the hospital setting) are available in the event of a weapons-of-mass-destruction event.[1010]

Mr. Joel Perwin presented the task force with his reasons why sovereign immunity should not be extended to emergency room physicians or other emergency room healthcare providers.[1011] Mr. Perwin stated that extending the provisions of section 768.28, Florida Statutes, to emergency room physicians created a cap that would be unconstitutional under the case of Smith v. Department of Insurance.[1012] The Smith case found $250,000 caps on non-economic damages in medical malpractice unconstitutional unless the Kluger test, which only allowed a preexisting right of access to the courts to be eliminated when the Legislature can show an overpowering public necessity for the abolishment of such right, and can show no alternative method of meeting such public necessity.[1013] Mr. Perwin stated that for sovereign immunity to apply "either you're an

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[1006] Id.
[1007] Id.
[1008] Id.
[1009] Id.
[1010] George Meros, Florida College of Emergency Physicians, Protecting Access to Emergency Care 7-8 (Dec. 27, 2002).
[1011] Joel Perwin, transcript, Nov. 22, 2002, pgs. 211-217.
[1012] Smith v. Department of Insurance, 507 So. 2d 1080 (Fla. 1987), reh'g denied.
[1013] Kluger v. White, 281 So. 2d 1 (Fla. 1973).

employee of the state in which case you're protected, or an agency, or you are subject to the control of the state in performing a public function."[1014]

Findings and Recommendation

The Task Force finds that to further the public purpose of providing emergency healthcare to citizens and visitors to Florida, healthcare professionals providing services in emergency rooms or trauma centers should be defined as agents of the state.

Recommendation 1. The Legislature should amend section 768.28, Florida Statutes, to define healthcare professionals providing services in emergency rooms or trauma centers as agents of the state for purposes of sovereign immunity.

[1014] Joel Perwin, transcript, Nov. 22, 2002, pg. 212.

Periodic Payment of Damages

Issue

The Task Force voted at its December 20, 2002, meeting by a 4-1 vote, to examine the following issue with respect to periodic payment of damage awards in the context of medical malpractice cases:

- Should the provisions of section 768.78(2) Florida Statutes, and other Florida laws be amended to require the periodic payment of economic and non-economic damages?

Current Situation

The definition of periodic payments for purposes of medical malpractice claims is set out in section 766.202, Florida Statutes. The section authorizes the payment of an award of future economic damages through structured payments over a period of time. The statute is specifically limited to "future economic damages" and does not address non-economic damages in any manner. The total amount of the payments made through the use of periodic payments must equal the amount of the judgment for future economic damages before it is reduced to present value but after collateral sources are deducted. The order or other agreement related to periodic payments must specify who is to receive the payments, the dollar amount of each periodic payment, the interval between payments, and the number of payments or the period of time over which payments must be made.[1015]

For the court to approve periodic payment of future economic damages, the defendant must post a bond or security or must otherwise assure full payment of the damage awards. The bond must be written by a company authorized to do business in Florida and must be from a company rated as an A+ by Best's. When all periodic payments have been made, the amount of the security remaining may be returned to the defendant. The company issuing the bond may not cancel the bond prior to the completion of all payments without 60 days notice to the court and to the claimant.

In implementing the provisions of this statute, the courts have examined whether limitations are placed on the fact finder when establishing the payment schedule and whether the defendant remains liable for the

[1015] Section 766.292(8)(c), Florida Statutes.

payments to the plaintiff when an annuity is purchased to make the future payments. In St. Mary's Hospital, Inc. v. Phillipe,[1016] the district court of appeals held that, based on the provisions of the statute authorizing periodic payments and rules applicable to the arbitration process, the arbitrator (fact finder) had discretion to establish the appropriate period for payment of the economic damages [1017]

In Tallahassee Memorial Regional Medical Center, Inc. v. Kinsey,[1018] the court examined whether the defendant could purchase an annuity to cover future payments and have a final judgment entered and no further obligation to the plaintiff. The defendants argued that when the defendant purchased an annuity with an annuitant qualifying under the statute, that the plaintiff could be required to accept that annuity as discharging the obligation of the defendant and the defendant would be relieved of any further liability for damages.[1019] The court determined there was no expression in the law of the Legislature's intent to relieve the defendant of a future obligation to the plaintiff and had the Legislature wanted such a result, it could have written the law to provide for the relief requested.[1020] Research does not reveal any court that has taken a contrary position to the First District Court of Appeal.

The use of periodic payment of damages varies across states. Ten states have some form of mandatory periodic payment of all damages or just future damages with various thresholds for implementing the provision. Five states mandate periodic payment of some or all of the claimant's economic damages. Thirteen states provide a party may request periodic payment of some or all of the damages or provide for damages to be paid periodically at the discretion of the court.[1021]

For those states including a periodic payment of damages provision, the specifics vary greatly from state to state. In Arkansas,[1022] Delaware,[1023] and Colorado,[1024] some or all of the future payments are terminated at the death of the plaintiff. In California, at the death of the plaintiff, the future payments must be continued only to those to whom the plaintiff owed a duty of care.[1025] The amount of the judgment that triggers periodic

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[1016] 699 So. 2d 1017 (Fla. 1st DCA 1997), reh'g denied (Oct. 22, 1997).
[1017] Id. at 1025
[1018] 655 So. 2d 1191 (Fla. 1st DCA 1995), reh'g denied (June 21, 1995), review denied, 622 So. 2d 344 (Fla. 1995).
[1019] Id. at 1197
[1020] Id. at 1198.
[1021] See National Conference of State Legislatures, State Medical Liability Laws Table.
[1022] See National Conference of State Legislatures, State Medical Liability Laws Table.
[1023] See National Conference of State Legislatures, State Medical Liability Laws Table.
[1024] Section 13-64-306, Colorado Revised Statutes Annotated (West).
[1025] See National Conference of State Legislatures, State Medical Liability Laws Table.

payments can be a judgment of any amount qualifying for periodic payments, to a requirement that the judgment exceed $500,000.[1026]

The method of securing the periodic payments also varies among the states. Some states, such as Florida, require the defendant to remain liable for the periodic payments until the obligation is paid in full.[1027] In other states, such as Colorado, the defendant can be discharged upon complying with requirements to secure funding of the periodic payments through an annuity.[1028] By providing for an annuity, the determination of the present value of an award is shifted from the jury to the market.[1029]

Information Presented to the Task Force

Two speakers presented arguments regarding whether the periodic payment provisions should be expanded to include future non-economic damages. Mr. William Fuller presented the proposal on behalf of the defense bar[1030] and Mr. Neal Roth argued on behalf of the Florida Trial Lawyers Association and plaintiffs.[1031]

Mr. Fuller argued that there should not be a distinction between future economic and future non-economic damages for purposes of allowing periodic payments. He argued that both compensate the plaintiff for damages in the future and should be treated the same. Mr. Fuller raised concerns and made recommendations from the defense bar regarding the current system of periodic payments for economic damages:

- The plaintiff may live longer than the number of years determined by the jury to be used in awarding periodic damages and may not have sufficient funds.[1032]
- Mr. Fuller recommended this be addressed by having the court determine the life expectancy of the plaintiff and an annuity be purchased to provide payment to the plaintiff for future non-economic and economic damages for as long as the plaintiff lives.[1033] When an annuity was purchased by the defendant and approved by the court, the defendant would be discharged from the case and no additional bond would be required.[1034]

[1026] See National Conference of State Legislatures, State Medical Liability Laws Table.
[1027] Section 766.202, Florida Statutes; Tallahassee Memorial Regional Medical Center, Inc. v. Kinsey, 655 So. 2d 1191 (Fla. 1st DCA 1995), reh'g denied (June 21, 1995).
[1028] Section 13-64-312, Colorado Revised Statutes Annotated (West).
[1029] Patricia M. Danzon, Medical Malpractice: Theory, Evidence, and Public Policy 165 (1985).
[1030] William Fuller, J.D., testimony, Dec. 3, 2002, pgs. 28-35.
[1031] Neal Roth, J.D., testimony, Dec. 3, 2002, pgs. 38-43.
[1032] William Fuller, J.D., testimony, Dec. 3, 2002, pg. 29.
[1033] Id. at 30-34.
[1034] Id.

- The plaintiff may die before the term of the periodic damages for medical care and pain and suffering expires, giving the estate a windfall for damages that were not incurred.[1035]
- With payment of periodic damages, the case remains open until the end of the term of the periodic payments or the plaintiff dies and a lump sum payment is made to the estate.[1036]

Mr. Roth did not support periodic payment of non-economic damages. He argued the plaintiff has a right to the money once the judgment is entered and it should be the plaintiff's decision as to whether the money is expended immediately or invested in an annuity or some other investment providing periodic payments. Mr. Roth also questioned how this proposal would further the Task Force goals of reducing insurance rates or providing better access to healthcare. He argued that non-economic damages "are supposed to make an injured medical malpractice victim whole, restore some dignity to their lives, allow them to do some things perhaps that either they can't do because of their disability, disfigurement, inability to lead a normal life, and it really should be up to the injured victim as to what they do, when they do it, how much money they care to spend."[1037] Mr. Roth argued that providing for periodic payment of non-economic damages would be "telling the injured victim what to do with their money by legislative fiat, and they should have the right to make those decisions themselves and for their families."[1038]

Mr. Marshall Criser questioned why a plaintiff should not be protected from bad advice or bad counsel by providing for periodic payment of all damages.[1039] Mr. Roth disagreed and reiterated his belief that the plaintiff should have the right to make the decision on how to spend non-economic damages since the economic damages were protected through periodic payments.[1040]

Findings and Recommendations

The Task Force finds that there is no basic distinction between payments for future economic damages and future non-economic damages. Both awards are intended to compensate the victim for damages that have not accrued as of the date the judgment is entered and are based on the jury's determination of what those future injuries will be. There does not appear to be any policy reason for distinguishing between these two types of future damages for purposes of periodic payments. Further, the use of

[1035] Id. at 29.
[1036] Id.
[1037] Neal Roth, J.D., testimony, Dec. 3, 2002, pg. 40.
[1038] Id. at 41.
[1039] Marshall Criser, J.D., testimony, Dec. 3, 2002, pgs. 41-42.
[1040] Neal Roth, J.D., testimony, Dec. 3, 2002, pg. 42.

periodic payment of damages for the payment of future non-economic damages may reduce the impact of large non-economic damages on the current assets of an insurance company. When the defendant insurance company makes the future payments it mitigates the impact of large verdicts by smoothing the cash needed to cover those verdicts over the years of the periodic payments.

The Task Force finds that termination of periodic payments of future damages related to medical expenditures and future pain and suffering upon the death of the defendant is appropriate.

Recommendation 1. The Legislature should amend the Florida Statutes to allow the periodic payment of future non-economic damages.

Recommendation 2. The Legislature should amend the Florida Statutes to terminate the payment of future economic and non-economic damages upon the death of the plaintiff.

Pre-Suit Reform

Issue

The Task Force voted at its December 20, 2002 meeting, by a 5-0 vote, to examine the following issue with respect to pre-suit reform in the context of medical malpractice cases:

- Should the pre-suit screening process be strengthened to:
  - Improve the quality of information exchanged?
  - Require that the qualifications of the physician providing the affidavit more closely equate with the qualifications of the defendant physician?
  - Require the physician to review all the medical records to the extent available prior to providing an affidavit and to certify that the records have been reviewed?
  - Require an attorney to sign all doctor affidavits prepared for the defendant and the patient?

Current Situation

In 1975, an intensive lobbying effort commenced addressing the medical malpractice crisis that had emerged due to the spiraling increases in insurance premiums, and which threatened to curtail the availability of healthcare services.[1041] The Legislature, in response to this crisis, created the Florida Comprehensive Medical Malpractice Act in 1975, which changed the procedural and substantive aspects of medical malpractice claims.[1042] One significant modification was the requirement that claimants submit their claims to an appropriate medical liability mediation panel before filing a cause of action in court.[1043] This requirement was challenged almost immediately, and in Carter v. Sparkman,[1044] the Florida Supreme Court determined that the mediation panel was not unconstitutionally violative of a plaintiff's rights.[1045] However, in 1980,

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[1041] Jessica Fonseca-Nader, Florida's Comprehensive Medical Malpractice Reform Act: Is it Time for a Change?, 8 St. Thomas Law Review 553 (Spring 1996).
[1042] Id. at 553-554.
[1043] Id. at 554.
[1044] 335 So. 2d 802 (Fla. 1976).
[1045] Jessica Fonseca-Nader, Florida's Comprehensive Medical Malpractice Reform Act: Is it Time for a Change?, 8 St. Thomas Law Review 555 (Spring 1996).

in Aldana v. Holub,[1046] the Florida Supreme Court revisited the issue of mediation panels and overturned the Carter ruling, declaring the statute unconstitutional. The Court found "that the application of the statute and its rigid 'jurisdictional periods . . . [h]as proven intrinsically unfair and arbitrary and capricious,'" under the United States and Florida Constitutions.[1047]

In 1985, amendments to the act substituted mediation panels with a pre-suit screening process.[1048] This pre-suit screening process was created to require both the claimant and the defendant, prior to filing a claim or denying liability, to ensure that the potential suit was not a frivolous action.[1049] Specifically, the Legislature required claimants to certify in their complaints that they had conducted a reasonable investigation resulting in a good faith belief that sufficient grounds existed to support the filing of the action.[1050]

In 1988, the Legislature expanded the pre-suit screening statute in response to criticism that the statutory requirements were not alleviating the medical malpractice litigation crisis.[1051] Amendments were necessary to address the Legislature's conclusion that the "high cost of medical malpractice claims in the state can be substantially alleviated by requiring early determination of the merit of claims . . . thereby reducing delay and attorney's fees . . . while preserving the right of either party to have its case heard by a jury."[1052] Sections 766.201 through 766.206, Florida Statutes, enacted in chapter 88-1, Laws of Florida, established criteria to conduct pre-suit investigations of medical negligence claims and defenses of prospective defendants. Chapter 88-277, section 48, Laws of Florida, creating section 766.106, Florida Statutes,[1053] provides that a prospective plaintiff alleging medical malpractice must wait ninety days before filing a lawsuit against any named defendants. And, during the ninety-day period, informal discovery, including obtaining un-sworn statements from parties and witnesses may occur.[1054] "Because these designations exist today side

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[1046] 381 So. 2d 231 (Fla. 1980).

[1047] Jessica Fonseca-Nader, Florida's Comprehensive Medical Malpractice Reform Act: Is it Time for a Change?, 8 St. Thomas Law Review 556 (Spring 1996).

[1048] Id.

[1049] Id.; section 768.495(1), Florida Statutes (1985) ("[N]o action shall be filed for personal injury or wrongful death arising out of medical negligence...unless the attorney filing the action has made a reasonable investigation as permitted by the circumstances to determine that there are grounds for a good faith belief that there has been negligence in the care or treatment of the claimant").

[1050] Cohen v. Dauphinee, 739 So. 2d 68, 70 (Fla. 1999).

[1051] Id.

[1052] Section 766.201(1)(d), Florida Statutes.

[1053] Chapter 88-277, section 48, Laws of Florida (renumbered sections 768.57-776.106, Florida Statutes); see also Cohen v. Dauphinee, 739 So. 2d 68, 71 (Fla. 1999).

[1054] Edward L. Holloran, III, Medical Malpractice Litigation in Florida: Discussion of Problems and Recommendations, 26 Nova Law Review 333 (Fall 2001).

by side, it is apparent that the Legislature intended to distinguish between pre-suit screening, covering the period up to the serving of the notice of intent, and pre-suit investigation, covering the period between the serving of the notice of intent and the filing of the suit."[1055]

Since 1988, the pre-suit statutes have not been significantly modified. In 1996, the Florida Supreme Court observed: "[W]e agree with the proposition that the medical malpractice statutory scheme must be interpreted liberally so as not to unduly restrict a Florida citizen's constitutionally guaranteed access to the courts, while at the same time carrying out the legislative policy of screening out frivolous lawsuits and defenses.[1056] The Court in Cohen v. Dauphinee[1057] reaffirmed that the Legislature enacted the pre-suit process to "promote the settlement of meritorious claims at an early stage without the necessity of a full adversarial proceeding."

The purpose for having a pre-suit statute is to reduce the overall number of lawsuits either by preventing the filing of frivolous claims or by providing opportunities to settle meritorious cases.[1058] In adopting chapter 766, Florida Statutes, the Legislature attempted to abate the medical malpractice crisis by requiring pre-suit screenings and investigations.

The notice of intent to initiate litigation is a condition precedent to filing a suit. The medical malpractice claimant must first conduct a "reasonable investigation" to determine there are grounds for a good faith belief that there has been malpractice.[1059] This burden to investigate is set forth in section 766.203(2), Florida Statutes, which specifically requires that prior to taking any actions, the claimant and his or her attorney shall conduct an investigation into the reasonable grounds to believe that negligence and resulting injury have occurred.[1060] This investigation must be supported by a verified written expert opinion that shall "corroborate reasonable grounds to support the claim of medical negligence."[1061]

When the claimant's investigation is complete, and the corroborating affidavit is done, section 766.106(2), Florida Statutes, requires the claimant to serve all potential defendants with a notice of intent to initiate litigation.[1062] In Duffy v. Brooker,[1063] the court stated that "[T]he notice

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[1055] Cohen v. Dauphinee, 739 So. 2d 68, 71 (Fla. 1999).
[1056] Kukral v. Mekras, 679 So. 2d 278, 284 (Fla. 1996).
[1057] 739 So. 2d. 68, 70 (Fla. 1999).
[1058] Edward L. Holloran, III, Medical Malpractice Litigation in Florida: Discussion of Problems and Recommendations, 26 Nova Law Review 334 (Fall 2001).
[1059] John A. Grant, Florida's Pre-suit Requirements for Medical Malpractice Actions, Florida Bar Journal 13-14 (Feb. 1994).
[1060] Id. at 14.
[1061] Id.
[1062] Id.

of intent to initiate litigation and the corroborating medical expert opinion, taken together, must sufficiently indicate the manner in which the defendant doctor allegedly deviated from the standard of care, and must provide adequate information for the defendants to evaluate the merits of the claim."[1064]

The defendant, upon the mailing of the notice of intent to litigate, has ninety days to investigate the claim and provide an appropriate response.[1065] Section 766.106(3)(a), Florida Statutes, applies a good faith standard to the defendant to investigate and respond to the claim.[1066] The defendant[1067] is required, pursuant to the statute, to initially undertake a review of the notice and comply with one or more of the four procedures set forth: (1) an internal review by a duly qualified claims adjuster; (2) creation of a panel comprised of an attorney, a healthcare provider, and a duly qualified claims adjuster; (3) a contractual agreement with a state or local professional society which maintains a peer review committee; and/or, (4) any other similar procedure which fairly and promptly evaluates a pending claim.[1068] This review mechanism is only part of the investigation process and is by no means sufficient to satisfy the investigation requirements of chapter 766, Florida Statutes.[1069]

Section 766.106(7), Florida Statutes, provides for a number of informal discovery options available during the ninety-day investigation period, which have sanctions for failure to comply.[1070] For example, the defendant may take un-sworn statements from experts or witnesses that are not discoverable or admissible in any proceeding, propound interrogatories and requests to produce documents, and require the claimant to undergo physical and mental examination.[1071] Failure by the claimant to comply could result in dismissal of the action or waive the requirement of a corroborating medical opinion for the opposing party.[1072]

[1063] 614 So. 2d 539 (Fla. 1st DCA 1993).
[1064] John A. Grant, Florida's Pre-suit Requirements for Medical Malpractice Actions, Florida Bar Journal 14 (Feb. 1994).
[1065] Id.
[1066] Id.
[1067] The statute contemplates that the defendant's insurer or a self-insurer will comply with the pre-suit process.
[1068] Section 766.106(3)(a)1-4, Florida Statutes.
[1069] John A. Grant, Florida's Pre-suit Requirements for Medical Malpractice Actions, Florida Bar Journal 14 (Feb. 1994).
[1070] Section 766.205, Florida Statutes provides grounds for dismissal of an applicable claim or defense asserted in those circumstances where reasonable access to information has not been provided to another party.
[1071] John A. Grant, Florida's Pre-suit Requirements for Medical Malpractice Actions, Florida Bar Journal 15 (Feb. 1994).
[1072] See also section 766.205(3), Florida Statutes.

At or before the conclusion of the ninety-day period, the defendant has four alternatives in response to the complaint. Section 766.106 (3)(b), Florida Statutes, provides that the defendant shall reject the claim; make a settlement offer; make an offer of admission of liability and arbitrate; or do nothing which shall be considered a final rejection of the claim.[1073] Four identified areas of concern have evolved with the creation of the pre-suit process.

Initially, the pre-suit investigations were very informal. Some commentators have indicated that the informal exchange of information does not work because after sharing expert affidavits, un-sworn statements and other discovery tools as set forth in the statutes, none of this information is discoverable or admissible at future proceedings. Time and money is spent pre-filing discovery without yielding any resolution or potential for resolution. In essence, the parties to the lawsuit undergo two discoveries if the matter goes to litigation.[1074]

Second, as a consequence of the pre-suit investigation, the parties will add an additional eight months to the case because the statute of limitation is tolled during this period.[1075]

Third, the statute as written has failed to provide reliability and has failed to satisfy the intent of the pre-suit investigative process. The statute does not require any expert witness to certify that all the medical records have been reviewed prior to rendering an opinion. Moreover, the statute does not obligate an attorney representing the claimant or defendant to sign the doctor affidavits to verify compliance with the statutes. And, section 766.202(5), Florida Statutes, defines the expert witness merely to be "a person duly and regularly engaged in the practice of his or her profession who holds a health care professional degree . . ." thus not requiring that similarly-situated experts are reviewing and rendering decisions about the claim.[1076] A family general practitioner could give a medical expert opinion about a surgical care event, merely because he or she holds a healthcare professional degree.

Finally, the purpose of the pre-suit investigation was to review potential claims, to verify evidence, presented and to provide an opportunity to settle or pursue litigation. What has occurred, however, is that routinely a claimant has two years (the time period for the statute of limitations) to

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[1073] Sections 766.106(3)(b)3, 766.106(3)(c), Florida Statutes.

[1074] Jessica Fonseca-Nader, Florida's Comprehensive Medical Malpractice Reform Act: Is it Time for a Change?, 8 St. Thomas Law Review 558 (Spring 1996).

[1075] Section 766.104, Florida Statutes.

[1076] Section 766.202(5), Florida Statutes.

prepare the pre-suit investigation while the defendant has only ninety days to investigate and respond.[1077]

Information Presented to the Task Force

The stakeholders that testified concurred that strengthening the pre-suit process would improve the quality of the information exchanged. Testimony from the Task Force's November 22, 2002 meeting in Orlando, Florida, concluded that the current pre-suit process was not useful, but could be beneficial with suggested improvements for the early resolution of these type of cases.

First, the expert affidavits that are filed by both the claimant and defendant in the pre-suit process need to be more specific. The intent of the claimant's affidavit is to attest to the fact that there are reasonable grounds to bring a malpractice action against the defendant.[1078] While the content of most affidavits is not very detailed, is very conclusory and does not tell specifically what malpractice event occurred, it is clear that a more detailed affidavit, that sets forth the specifics of the malpractice event would address some of the problems that occur.[1079] Generally, the affidavit is a bare bones document that does not tell anything in terms of what the physician or hospital did that was inappropriate or what the care was that brought about the harm.[1080]

Second, the expert affidavit should be filed by an expert whom the plaintiff is "actually going to use at trial."[1081] During the pre-suit process, the plaintiff can use an affidavit of "somebody . . . they pay a few hundred dollars to" and "you hardly ever see that particular expert witness when it comes to testifying before a jury."[1082] And, that expert, even if used at trial, cannot be cross-examined or impeached with the affidavit that they prepared during the pre-suit process.[1083] Therefore, the proposal is to make the expert "real" by allowing him or her to be called as a witness at trial, which would force the claimants to make a decision about the merits of the case at an earlier stage.[1084]

However, an opposing position suggested that the quality of the expert affidavit may not be the real issue. At the time of the pre-suit evaluation,

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[1077] John A. Grant, Florida's Pre-suit Requirements for Medical Malpractice Actions, Florida Bar Journal 18 (Feb. 1994).
[1078] Bucky Hurt, J.D., testimony, Nov. 22, 2002, pg. 318.
[1079] Id. at 318-319.
[1080] Id. at 319.
[1081] Id. at 320.
[1082] Id.
[1083] Id.
[1084] Id. at 321.

all the facts of the case may not be known to the expert. Generally, it was agreed that the parties want credible experts. However, it was believed that "a credible expert is not going to give you a final opinion under oath without all the facts." And, when a pre-suit affidavit is filed, all the facts are not available yet. "For example, we haven't taken the deposition of the defendant doctor to find out what his defense is going to be. My experts want to know that before they go under oath and say a doctor did something wrong."[1085]

Moreover, the ninety-day period "is simply not enough time for the defendants to figure out whether they have done something wrong. Sometimes you are limited by the medical records that you receive from the plaintiff attorneys. Sometimes he doesn't have all the medical records. You've got to get those medical records off to independent experts" and 90 days is not enough time.[1086] Concerns regarding the ninety-day period in which the parties are suppose to resolve the differences between them, in reality, does not resolve their differences,[1087] because what anecdotally happens is that settlement "almost always [occurs] on the courthouse steps."[1088] One offered proposal was to allow the defendant a minimum of six months from the date the lawsuit is filed to undergo their investigation.[1089]

The informal exchange of information does not bring forth the intended end result.[1090] Every pre-suit involves much work on both sides at a tremendous expense and the vast majority of the information is privileged and cannot be used.[1091] To the extent that there are other procedures that might be used to accomplish a similar result, the practical affect would be to either shore up the pre-suit procedures or investigate the use of alternative dispute options.[1092]

Findings and Recommendations

The Task Force finds the expert affidavits filed in pre-suit proceedings are not sufficient for the parties to make informed decisions regarding the claim.

[1085] Lake Lytal, J.D., testimony, Nov. 22, 2002, pg. 322.
[1086] Bucky Hurt, J.D., testimony, Nov. 22, 2002, pg. 321.
[1087] Id. at 319.
[1088] Lake Lytal, J.D., testimony. Nov. 22, 2002, pg. 324.
[1089] Bucky Hurt, J.D., testimony, Nov. 22, 2002, pg. 321.
[1090] Id. at 322.
[1091] Id.
[1092] Lake Lytal, J.D., testimony, Nov. 22, 2002, pgs. 326-327.

Further, the Task Force finds there is not sufficient incentive for the parties to provide the most complete expert affidavit when the expert completing the affidavit is generally not called as a witness at trial and, even if called at trial, may not be cross-examined regarding the pre-suit affidavit.

The Task Force has reviewed the pre-suit procedures set forth in sections 766.106 and 766.201-206, Florida Statutes, for the purpose of determining what modifications, if any, are needed to improve the quality of information exchanged.

Recommendation 1. The Legislature should require experts reviewing pre-suit claims and defenses and rendering opinions be qualified, in that they possess similar, if not identical, credentials and expertise in the field of healthcare services of the defendant's particular specialty.

Recommendation 2. The Legislature should require the expert who reviews pre-suit claims and defenses and renders opinions be subject to discovery and his or her testimony be admissible in any future proceeding.

Joint and Several Liability

Issue

The Task Force voted at its December 20, 2002 meeting, by a 5-0 vote, to examine the following issues with respect to joint and several liability in the context of medical malpractice cases:

- Should the Fabre[1093] decision be legislatively overturned?
- Should awards in medical malpractice suits be based solely on proportion of fault and not on Florida's structured joint and several liability provisions in section 768.81, Florida Statutes?

Current Situation

Florida is a state that equates fault with liability.[1094] Common sense[1095] dictates that tortfeasors are liable only to the extent of their fault.[1096] Such a conclusion has taken a long time to articulate[1097] and is still incomplete.[1098]

Florida is a state that recognizes the comparative fault of those tortfeasors who caused an injury,[1099] including the plaintiff himself or herself.[1100] Before 1973, Florida adhered to the rule of contributory negligence, which, when present, completely barred relief for a plaintiff found to be

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[1093] Fabre v. Marin, 623 So. 2d 1182 (Fla. 1993).

[1094] See Hoffman v. Jones, 280 So. 2d 431, 436 (Fla. 1973).

[1095] It is a "common sense notion" that liability should be equated with fault and that a defendant should not have to pay more than his fair share of the liability." Chanta G. Hundley & George N. Meros, Jr., Florida's Tort Reform Act: Keeping Faith with the Promise of Hoffman v. Jones, 27 Florida State University Law Review 461 (Winter 2000).

[1096] "The rule of contributory negligence as a complete bar to recovery was imported into the law by judges. Whatever may have been the historical justification for it, today it is almost universally regarded as unjust and inequitable to vest an entire accidental loss on one of the parties whose negligent conduct combined with the negligence of the other party to produce the loss." Hoffman v. Jones, 280 So. 2d 431, 436 (Fla. 1973).

[1097] See Lousiville & Nashville Railroad Co. v. Yniestra, 21 Fla. 700 (1886); see also Smith v. Department of Insurance, 507 So. 2d 1080 (Fla. 1987) (tracing the history of contributory and comparative negligence).

[1098] See Jennings Hurt, Apportionment of Fault, Set-Off and Empty Chair Argument (Oct. 24, 2002); see also Jennings Hurt, testimony, Nov. 22, 2002, pgs. 259-267.

[1099] See Hoffman v. Jones, 280 So. 2d 431, 436 (Fla. 1973).

[1100] See Id.

partly responsible for causing the accident.[1101] By way of contrast, the comparative fault theory is that a plaintiff is only prevented from recovering that portion of the damages that is equal to his or her share of responsibility for the injury.[1102]

Once the amount of fault of the defendant tortfeasors is established, the exercise becomes one of allocating the liability for the damages among the tortfeasors. Florida has a hybrid system of allocating the liability.[1103] The doctrine of joint and several liability has been a part of that system since at least 1914.[1104] Under joint and several liability, all defendant tortfeasors are responsible for the total of the plaintiff's damages, without respect to the extent of each defendant's fault in causing the harm.[1105] For example, in 1987, the Supreme Court of Florida heard a case in which the plaintiff sustained injuries following a bumper car collision at Walt Disney World.[1106] The plaintiff was found to be 14 percent at fault, the other bumper car driver, 85 percent at fault and Disney 1 percent at fault.[1107] Because of joint and several liability, the court entered judgment against Disney for 86 percent of the damages, while Disney was only 1 percent at fault.[1108]

In 1986, the Florida Legislature enacted several changes to the joint and several liability doctrine as part of the Tort Reform and Insurance Act of 1986.[1109] The changes included the following:

- Abolished joint and several liability for non-economic[1110] damages over $25,000.

- Abolished joint and several liability for economic[1111] damages except when a defendant's fault equals or exceeds that of the plaintiff.

[1101] Id.

[1102] Id. "[T]he jury should apportion the negligence of the plaintiff and the negligence of the defendant; then, in reaching the amount due the plaintiff, the jury should give the plaintiff only such an amount proportioned with his negligence and the negligence of the defendant." Id. at 438.

[1103] Walt Disney World Co. v. Wood, 515 So. 2d 198, 201 (Fla. 1987).

[1104] Louisville & Nashville R.R. v. Allen, 67 Fla. 257, 65 So. 8 (1914).

[1105] Fabre v. Marin, 623 So. 2d 1182 (Fla. 1993).

[1106] Walt Disney World Co. v. Wood, 515 So. 2d 198 (Fla. 1987).

[1107] Id. at 199.

[1108] Id.

[1109] See chapter 86-160, section 60, Laws of Florida (codified at section 768.81(3), Florida Statutes). In enacting these provisions, the Florida Legislature found that "there is in Florida a financial crisis in the liability insurance industry" and "that the current tort system has significantly contributed to the insurance availability and affordability crisis." Fabre v. Marin, 623 So. 2d 1182, 1185 (Fla. 1993) (quoting chapter 86-160, Laws of Florida).

[1110] See Issue on Caps for Non-Economic Damages, infra, for definitions of economic and non-economic damages.

[1111] Id.

Following these legislative changes was the Supreme Court of Florida's decision in the Fabre case, which held that, in determining non-economic damages, fault is apportioned among all the responsible entities who contribute to an accident, whether or not they are officially joined as defendants in the lawsuit.[1112]

In 1999, the Florida Legislature further limited joint and several liability by creating a series of damages caps and fault thresholds.[1113] The doctrine of joint and several liability to a particular defendant whose fault equals or exceeds that of a particular plaintiff is determined as follows:

- A defendant whose fault is up to 10 percent is not subject to joint and several liability.[1114]

- With a defendant whose fault is between 10 and 25 percent, there is no joint and several liability for economic damages over $200,000[1115] unless the plaintiff is without fault, then there is no joint and several liability for economic damages over $500,000.[1116]

- With a defendant whose fault is between 25 and 50 percent, there is no joint and several liability for economic damages over $500,000[1117] unless the plaintiff is without fault, then there is no joint and several liability for economic damages over $1,000,000.[1118]

- With a defendant whose fault is over 50 percent, there is no joint and several liability for economic damages over $1,000,000[1119] unless the plaintiff is without fault, then there is no joint and several liability for economic damages over $2,000,000.[1120]

The legislative changes in 1999 also codified the Supreme Court's holding in Fabre.[1121] Accordingly, section 768.81, Florida Statutes, now contains a procedure[1122] and burden of proof[1123] for requesting that a nonparty tortfeasor be placed on the jury verdict form for purposes of allocating

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[1112] Fabre v. Marin, 623 So. 2d 1182 (Fla. 1993); Nash v. Wells Fargo Guard Services, Inc., 678 So. 2d 1262 (Fla. 1996).
[1113] Chapter 99-225, section 27, Laws of Florida (codified at section 768.81, Florida Statutes).
[1114] Sections 768.81(3)(a)(1), (3)(b)(1), Florida Statutes.
[1115] Section 768.81(3)(a)(2), Florida Statutes.
[1116] Section 768.81(3)(b)(2), Florida Statutes.
[1117] Section 768.81(3)(a)(3), Florida Statutes.
[1118] Section 768.81(3)(b)(3), Florida Statutes.
[1119] Section 768.81(3)(a)(4), Florida Statutes.
[1120] Section 768.81(3)(b)(4), Florida Statutes.
[1121] Chapter 99-225, section 27, Laws of Florida.
[1122] Section 768.81(3)(d), Florida Statutes.
[1123] Section 768.81(3)(e), Florida Statutes.

fault among the totality of those who caused the injury, whether party defendants or not.

Based on these most recent legislative changes, a defendant can no longer be held jointly liable for a plaintiff's non-economic damages. Joint and several liability still exists under certain circumstances for economic damages, as outlined above. However, a defendant who is less than 10 percent at fault cannot be held jointly and severally liable for all the damages. Finally, there is no longer joint and several liability against a defendant who is found to be less at fault than the plaintiff.

The seminal case for the issue of whether a party pays its fair share is the Fabre case itself.[1124] In the Fabre case, the plaintiff, Mrs. Marin, was injured in an accident as a passenger in a car that was driven by her husband.[1125] Mrs. Marin sued the Fabres, claiming that their negligent driving caused the accident in which she was injured. During discovery, Mrs. Marin learned that the Fabres' insurance had liability limits of $10,000.[1126] Accordingly, she then also sued State Farm, her uninsured motorist carrier, as a defendant.[1127]

When the case was presented to the jury, the defendants requested that the verdict form be drafted so as to allow the jury to apportion fault for the accident between Mr. Marin, the driver but an unnamed defendant, and Mrs. Fabre. The court denied the request. But Mrs. Marin agreed to have the issue of Mr. Marin's negligence submitted to the jury subject to a posttrial determination of whether any affirmative finding on that issue would result in a reduction of her recovery. The jury returned a verdict finding Mrs. Fabre and Mr. Marin each 50 percent at fault and awarded Mrs. Marin $12,750 in economic damages and $350,000 in non-economic damages. The judge reduced the economic damages by $5000 but refused to reduce the non-economic damages.[1128]

The issue before the Supreme Court was "whether the liability for non-economic damages should be apportioned to the Fabres on the basis of the percentage of fault attributed to them."[1129] The court answered this question affirmatively. In analyzing this issue, the Supreme Court examined the 1988 version of section 768.81(3), Florida Statutes, which stated as follows:

[1124] Fabre v. Marin, 623 So. 2d 1182 (Fla. 1993).
[1125] Id. at 1183.
[1126] Id.
[1127] Id. At the time of this lawsuit, Florida did not allow interspousal claims so Mrs. Marin could not also sue Mr. Marin as the driver of the car.
[1128] Id.
[1129] Id.

> (3) APPORTIONMENT OF DAMAGES – In cases to which this section applies, the court shall enter judgment against each party liable on the basis of such party's percentage of fault and not on the basis of the doctrine of joint and several liability; provided that with respect to any party whose percentage of fault equals or exceeds that of a particular claimant, the court shall enter judgment with respect to economic damages against that party on the basis of the doctrine of joint and several liability.[1130]

In construing this statutory language, the Third District Court of Appeal, the lower appellate court in Fabre, concluded that Mrs. Marin could not recover damages from her husband because of the doctrine of inter-spousal tort immunity.[1131] Accordingly, the Third District Court concluded that in discarding joint and several liability in section 768.81, Florida Statutes, the Florida Legislature did not intend to thwart a fault-free plaintiff's ability to recover her total damages.[1132] Rather, according to the Third District, the Legislature intended only to apportion liability among the tortfeasors who were defendants in the lawsuit.[1133]

Based on this case law history and the legislative intent[1134] of section 768.81, Florida Statutes, the Supreme Court in Fabre concluded that "[b]y [the] clear terms [of the statute], judgment should be entered against each party liable on the basis of that party's percentage of fault."[1135] The court reasoned that "[t]he 'fault' which gives rise to the accident is the 'whole' from which the fact-finder determines the party-defendant's percentage of liability. Clearly, the only means of determining a party's percentage of fault is to compare that party's percentage to all of the other entities who contributed to the accident, regardless of whether they have been or could have been joined as defendants."[1136] Furthermore, the court declared that "[l]iability is to be determined on the basis of the percentage of fault of each participant to the accident and not on the basis of solvency or amenability to suit of other potential defendants."[1137]

[1130] Section 768.81(3), Florida Statutes (Supp. 1988). The constitutionality of this statue was upheld by the Supreme Court. See Smith v. Department of Insurance, 507 So. 2d 1080, 1091 (Fla. 1987) (noting that the right of access to courts "does not include the right to recover for injuries beyond those caused by the particular defendant").

[1131] Fabre v. Marin, 623 So. 2d 1182, 1186 (Fla. 1993).

[1132] Id.

[1133] Id. at 1184.

[1134] The term "party" was not defined by the statute. At the time the Supreme Court decided the Fabre case, there were three judicial theories as to what was meant by "party." The term could refer to: 1) persons involved in the injury; 2) defendants in the lawsuit; or 3) all litigants in the lawsuit. See 6 Fla. Prac., Personal Injury & Wrongful Death Actions, section 5.5 (2002-03 ed.).

[1135] Id.

[1136] Id.

[1137] Id. at 1186.

The result, then, in Fabre was that the court reduced Mrs. Marin's judgment by half of her non-economic damages. There was no reduction in the economic damages because under section 768.81(3), Florida Statutes (Supp. 1988), joint and several liability continued to apply when a defendant's fault equaled or exceeded that of the plaintiff.[1138]

Following the Fabre case, the Supreme Court in Nash v. Wells Fargo Guard Services, Inc.,[1139] outlined the pleading and proof requirements with which a defendant must comply to submit the issue of a nonparty's negligence to the jury.[1140] In order to include a nonparty on the verdict form under Fabre, the party defendant must plead, as an affirmative defense, the negligence of the nonparty and specifically identify the nonparty.[1141] The party defendant can move to amend the pleading to assert the negligence of a nonparty, subject to the requirements of Florida Rule of Civil Procedure 1.190. However, because the argument that non-economic damages should be apportioned against a nonparty affects both the presentation of the case and the trial court's rulings on evidence, notice before trial is necessary.[1142] In addition to these pleadings requirements, the party defendant also has the burden of proving that the nonparty's fault contributed to the injury in order to include the nonparty's name on the jury verdict form.[1143]

The rule adopted by the Supreme Court in Fabre is premised on an application of the comparative fault statute of section 768.81, Florida Statutes. If this statute does not apply, then Fabre does not apply. Accordingly, Fabre does not apply to actions in which the doctrine of joint and several liability applies.[1144]

Information Presented to the Task Force

The problem, as presented to the Task Force, is with deep pocket defendants, like hospitals or physicians with significant amounts of insurance coverage who are minimally liable for the harm to the plaintiff. An example might be if a plaintiff with significant long-term care issues sues the doctor, nurse, and the hospital. The hospital is often the least liable (assume 1 percent) but provides the deepest pocket for the payment of damages. Under the current state of the law, the hospital is still jointly

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[1138] Id. at 1187.
[1139] Nash v. Wells Fargo Guard Services, Inc., 678 So. 2d 1262 (Fla. 1996).
[1140] See 6 Fla. Prac., Personal Injury & Wrongful Death Actions, section 5.5 (2002-03 ed.).
[1141] Nash v. Wells Fargo Guard Services, Inc., 678 So. 2d 1262, 1264.
[1142] Id.
[1143] Id.
[1144] See 6 Fla. Prac., Personal Injury & Wrongful Death Actions, section 5.5 (2002-03 ed.).

and severally liable for all the economic damages to the plaintiff.[1145] Those damages can, in a long-term care situation, amount to $15,000,000. The hospital, while only 1 percent responsible for the injury is jointly liable for $15,000,000.[1146] The recommended solution is to repeal joint and several liability for economic and non-economic damages for all medical malpractice suits.

The Task Force heard testimony in response to the claim that joint liability has been sufficiently limited in Florida.[1147] It also heard testimony regarding the claim that tort law favors a plaintiff receiving compensation for the injury caused, so that in the event one of the defendants is insolvent the plaintiff should be able to collect the entire amount of damages from a solvent defendant.[1148]

Findings and Recommendations

The Task Force finds that there is a problem with joint liability in the State of Florida and that modern times and fundamental fairness dictate the apportionment of fault among all parties who caused the harm to the plaintiff for both economic and non-economic damages. The fact that one defendant may be insolvent or for other reasons immune from payment of damages should not shift the burden to another defendant to fund the total amount of damages, beyond the degree of fault for that defendant.

Recommendation 1. Joint liability has a negative impact on a medical malpractice insurer's ability to forecast future losses and contributes to the insurer's paid losses. Accordingly, the Legislature should amend section 768.81, Florida Statutes, to provide that a defendant's liability for both economic and non-economic damages be several only.

[1145] This is the law pre-1999 passage of chapter 99-225, Laws of Florida.
[1146] See Gail Parenti, testimony, Nov. 22, 2002, pgs. 267-68.
[1147] See Joel Perwin, testimony, Nov. 22, 2002, pg. 276.
[1148] Fabre v. Marin, 623 So. 2d 1182, 1186 (Fla. 1993).

Set Off of Settlement Proceeds

Issue

The Task Force voted at its December 20, 2002 meeting, by a 5-0 vote, to examine the following issues with respect to set off of settlement proceeds in the context of medical malpractice cases:

- Should the collateral source rule be re-examined to ensure that payments received by the plaintiff that are not required to be repaid from a settlement or judgment are deducted from the award or are considered by the jury?

Current Situation

Under certain conditions, money received by a plaintiff under a settlement agreement with another defendant may be set off from the total damages awarded by a jury. The purpose of these set off laws is to prevent the plaintiff from receiving a windfall by recovering damages in excess of those awarded by the jury. However, these statutes predate Florida's partial abrogation of joint liability. Current case law interpreting these statutes forbids the setting off of the settlement dollars to non-economic damages in any tort action.

Florida law provides that settlement proceeds received by a plaintiff may, in certain circumstances, be credited toward or "set off" from the total damages awarded by a jury at trial.[1149] However, such set off allowances only apply to economic damages in a tort action, including a medical malpractice case; they do not apply to non-economic damages.[1150]

Florida's jurisprudence contains two cases that directly impact the issue of set offs. The first was decided by the Supreme Court in 1995.[1151] In Wells v. Tallahassee Memorial Regional Medical Center, Mrs. Wells sued TMRMC, Dr. Alford, and Anesthesiology Associates and its employees Raymond Johns and Dr. Sell, for the wrongful death of her husband.[1152] Before trial, Mrs. Wells settled with Dr. Alford for $250,000, $50,000 of

[1149] See sections 46.015(2), 768.041(2), 768.31(5), Florida Statutes.
[1150] See Wells v. Tallahassee Memorial Regional Medical Center, Inc., 659 So. 2d 249 (Fla. 1995); Gouty v. Schnepel, 795 So. 2d 959 (Fla. 2001).
[1151] Wells v. Tallahassee Memorial Regional Medical Center, Inc., 659 So. 2d 249 (Fla. 1995).
[1152] Id. at 250.

which were economic damages and $200,000 of which were non-economic damages. Mrs. Wells also settled with Anesthesiology Associates and its employees for $50,000, without apportionment between economic and non-economic damages. Accordingly, TMRMC was the sole defendant at trial.[1153]

The trial court instructed the jury to apportion fault, if any, among all the defendants, including those that had settled before trial. The jury returned the following verdict: TMRMC 90 percent at fault, Dr. Alford 5 percent at fault, and Anesthesiology Associates 5 percent at fault. The jury assessed the damages at $575,853: $202,853 in economic damages, and $371,000 in non-economic damages. The court awarded Mrs. Wells $508,467.70 in damages; 90 percent of $573,852, plus $9,000 in costs, less $17,000 social security benefits.[1154]

After the award was announced, TMRMC asked the court to reduce the judgment. TMRMC argued that the judgment should be reduced by $300,000. This was the total amount paid by the settling defendants to Mrs. Wells before trial. The court denied the request.[1155]

One question that was presented to the Supreme Court was whether a non-settling defendant, in a case tried under section 768.81(3), Florida Statutes, is entitled to a set off of his or her apportioned share of the damages based on amounts paid by settling defendants in excess of their apportioned liability as determined by the jury. The Supreme Court was also asked to determine whether the rule of set off applied equally to economic and non-economic damages.[1156]

Mrs. Wells argued to the court that with respect to non-economic damages, "the notion that each party is only responsible for his or her share of the damages dictates that payment by one tortfeasor should only extinguish that tortfeasor's liability and have no effect on another tortfeasor's liability."[1157] She further argued that the set off statutes[1158] apply only when there is common (i.e., joint) liability, like with economic damages.[1159] Therefore, Mrs. Wells argued, when a jury determined liability is a percentage of fault, section 768.81(3), Florida Statutes, the comparative fault statute, applied and there is no set off.[1160] In response, TMRMC argued that the purpose of set off is to "prevent duplicate or

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[1153] Id.
[1154] Id.
[1155] Id.
[1156] Id.
[1157] Id. at 251.
[1158] See sections 768.041(2), 46.015(2), 768.31(5)(a), Florida Statutes.
[1159] Wells v. Tallahassee Memorial Regional Medical Center, Inc., 659 So. 2d 249, 251 (Fla. 1995).
[1160] Id.

overlapping compensation for identical damages."[1161] Without set off, Mrs. Wells would recover a monetary amount in excess of her damages, as determined by the jury.[1162]

The Supreme Court was persuaded by other states that had abolished joint and several liability but had not legislatively extended set off requirements to the proportional liability setting.[1163] The court also examined the statutory language of sections 768.81(3), 46.015, and 768.041, Florida Statutes (1989), and concluded that the set off statutes did not apply to non-economic damages.[1164] However, the court held that the set off statutes do apply to economic damages for which parties continue to be subject to joint and several liability.[1165]

Once the Supreme Court determined set off did not apply to non-economic damages, the court had to determine how to divide the settlement proceeds between economic and non-economic damages.[1166] The court decided to divide the damages in the same proportion as the jury award.[1167] Accordingly, the economic damages were 35.349 percent of the total award. Applying this percentage to the total of the settlement resulted in $106,047 of the $300,000 in settlement proceeds being designated as economic damages. Thus, $106,047 was set off against the $202,953 award of economic damages. Because of collateral sources related to economic damages, the hospital received an additional set off of $17,000. This made the resulting award for economic damages to be $79,806. In addition, Mrs. Wells was entitled to recover the full non-economic damages, less 10 percent, for her comparative fault, which amounted to $333,900, as well at $9,000 in costs. Therefore, the total judgment entered in favor of the plaintiff was $422,706.[1168]

This formula for determining the non-settling defendant's right to a set off allows for a double recovery by the plaintiff. Both the settlement and the damages awarded by the jury were for the same harm (i.e., the wrongful death of Mrs. Wells' husband). The jury determined that the full value of damages for the wrongful death was $573,853. However, because the court only allowed that portion of the settlement attributable to economic damages to be used as a set off, Mrs. Wells' total recovery (settlement plus jury award) was $722,706 ($422,706 + $300,000). This amount was

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[1161] Id.
[1162] Id.
[1163] Id. at 252.
[1164] Id. at 252-253.
[1165] Id. at 253.
[1166] Id.
[1167] Id. at 254.
[1168] Id.

$180,892 more than the full value of the wrongful death as determined by the jury.[1169]

After this decision was issued, the question remained as to whether a defendant would be entitled to a set off against both economic and non-economic damages if that defendant essentially waived section 768.81, Florida Statutes, and did not ask the jury to apportion fault among nonparties. The reason for this question was that if there was no apportionment of fault to the settling defendant, then section 768.81, Florida Statutes, and the set off formula in Wells arguably would not apply.[1170] Instead, the set off statutes (sections 46.105(2), 768.31(5)(a), and 768.041(2), Florida Statutes) would control. These statutes authorized a dollar-for-dollar set off for settlements entered into before the enactment of section 768.81, Florida Statutes. The Fourth District Court of Appeal hinted that such an outcome might be possible.[1171]

However, in September 2001, the Supreme Court issued its opinion in Gouty v. Schnepel,[1172] which had the effect of requiring a defendant to place all settling defendants on the jury verdict form and request an apportionment of fault by the jury before any set off for economic damages would be allowed based on an earlier settlement.[1173]

In Gouty v. Schnepel, the plaintiff, Gouty, was shot and injured by a gun owned and operated by Schnepel and manufactured by Glock, Inc.[1174] Gouty sued both Schnepel and Glock. Before trial, Glock settled Gouty's claim, paying Gouty $137,500 in exchange for a release and dismissal of its claim. However, Glock was listed on the jury verdict form for the purpose of apportioning fault among the parties. The jury returned a verdict, finding Schnepel 100 percent liable, exonerating Glock altogether. The jury awarded damages of $250,000 total, $125,000 economic damages, $125,000 non-economic damages. Schnepel asked the court to reduce the verdict by the settlement amount, but the request was denied.[1175]

On appeal to the Supreme Court, the question was whether the set off statutes can be used in circumstances when a jury finds a non-settling defendant liable for economic damages but finds that the settling defendant is not liable.[1176] The court decided that without joint and several liability, the set off statutes do not apply to reduce a non-settling

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[1169] Jennings Hurt, Apportionment of Fault, Set-Off and Empty Chair Argument (Oct. 24, 2002).
[1170] Id.
[1171] Id.; see also Anderson v. Ewing, 768 So. 2d 1161 (Fla. 4th DCA 2000).
[1172] Gouty v. Schnepel, 795 So. 2d 959 (Fla. 2001).
[1173] See Jennings Hurt, Apportionment of Fault, Set-Off and Empty Chair Argument (Oct. 24, 2002).
[1174] Id. at 960.
[1175] Id.
[1176] Id. at 961.

defendant's payment for liability.[1177] In so concluding, the court noted "as long as a defendant does not pay more than his or her percent of fault, that defendant is not entitled to contribution from another tortfeasor or entitled to a set off from a settling defendant."[1178] "However, if the defendant is required to pay damages on the basis of joint and several liability, that defendant's rights of contribution and set off remain unchanged."[1179]

The court essentially viewed this issue of set off vis-a-vis joint and several liability as an issue to be decided by the Florida Legislature. The court reasoned "the applicability of the set off statutes is predicated on the existence of other tortfeasors who are liable for the same injury as the settling party."[1180] The court recognized that the Legislature amended section 768.81(3), Florida Statutes, in 1999, but that the Legislature enacted the set off statutes before it enacted the comparative fault statute and the language of the set off statutes has not changed since Wells.[1181]

In conclusion, then, the court confirmed that Schnepel was 100 percent liable for Gouty's injuries and the jury expressly found that Glock was not liable at all (i.e., it was not a joint tortfeasor). Thus, the judgment against Schnepel for both economic and non-economic damages was not based upon joint and several liability, but on Schnepel's percentage of fault, which was found to be 100 percent. Accordingly, Schnepel was not entitled to the benefit of a set off from the award of economic damages.[1182]

As a result of the statutory scheme on set off, the partial legislative abrogation of joint and several liability in section 768.81, Florida Statutes, and the pronouncements of the Supreme Court of no set offs where there is no joint liability, plaintiffs are in the position to receive a double recovery for the same injury.[1183] Most medical malpractice cases involve plaintiffs suing multiple healthcare providers.[1184] At least some of the defendants in that suit will settle with the plaintiffs prior to trial.[1185] Assuming for example that $2,000,000 is paid in settlement dollars to the plaintiffs by other defendant doctors and the least culpable defendant doctor proceeds to trial, loses, and the plaintiff is awarded $2,000,000 for the same injury, for which he has already received $2,000,000, the plaintiff has received a double recovery.[1186] According to testimony

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[1177] Id.
[1178] Id. at 964.
[1179] Id.
[1180] Id. at 965.
[1181] Id. at 965-966.
[1182] Id. at 966.
[1183] See Jennings Hurt, Apportionment of Fault, Set-Off and Empty Chair Argument (Oct. 24, 2002); see also Jennings Hurt, testimony, Nov. 22, 2002, pgs. 259-267.
[1184] Id.
[1185] Id.
[1186] See Jennings Hurt, testimony, Nov. 22, 2002, pgs. 259-267.

provided to the Task Force, the only way to avoid that result is to place the settling defendants on the jury verdict form. The remaining, non-settling defendant does not get to tell the jury that the others have settled but that defendant must prove that the settling defendants were negligent.[1187] Essentially, the defense is turned into a plaintiff at this point: the doctor in the courtroom is forced to prove that the injury was caused by a nurse who is not there to defend himself or herself.[1188]

Information Presented to the Task Force

The Task Force heard testimony that plaintiffs are currently in a position to receive a double recovery for a single injury when a defendant settles prior to trial and no set off is allowed by the court to the ultimate jury award of damages for the previous settlement amount paid.[1189] Other testimony to the Task Force also highlighted practical defense problems because of the set off law in Florida. A remaining, non-settling defendant can often find himself or herself on the eve of trial having to "blame" another defendant who is no longer part of the litigation and not present in the courtroom because of a last minute settlement.[1190] The recommended solutions were legislative changes to the current set off statutes to allow set off of settlement proceeds from a jury verdict of damages for both economic and non-economic damages.[1191]

According to testimony provided to the Task Force, under the evolving hybrid system of apportionment of fault in the State of Florida, a defendant more closely pays according to his or her fault than was the case years ago. The plaintiffs' bar testified that when joint and several liability was in full force, set offs were allowed because each defendant, regardless of fault, was jointly liable for all other defendants' harm as well. Therefore, any payment received by the plaintiff from a defendant was set off against the ultimate award of damages because the damages were not assigned to any particular defendant. When joint liability is removed, each defendant is, in theory, paying only for his or her own fault. The payment, by another defendant, does not lessen the damages that should be paid by a remaining defendant.[1192]

[1187] Id.
[1188] Id.
[1189] See Jennings Hurt, Apportionment of Fault, Set-Off and Empty Chair Argument (Oct. 24, 2002); see also Jennings Hurt, testimony, Nov. 22, 2002, pgs. 259-267, 286-291; see also Gail Parenti, testimony, Nov. 22, 2002, pgs. 267-269.
[1190] See Jennings Hurt, Apportionment of Fault, Set-Off and Empty Chair Argument (Oct. 24, 2002); see also Jennings Hurt, testimony, Nov. 22, 2002, pgs. 266-67.
[1191] See Jennings Hurt, Apportionment of Fault, Set-Off and Empty Chair Argument (Oct. 24, 2002); see also Jennings Hurt, testimony, Nov. 22, 2002, pgs. 259-267, 286-291; see also Gail Parenti, testimony, Nov. 22, 2002, pgs. 269-70.
[1192] See Joel Perwin, testimony, Nov. 22, 2002, pgs. 274-282.

Findings and Recommendation

The Task Force finds that there is fundamental unfairness in a system that allows the possibility of a double recovery to a plaintiff for the same harm when there has to be a good faith belief on the part of the plaintiff that all named defendants participated in causing the harm. The Task Force further finds that it is not inconsistent to have a system that allows for several liability only and permits set off for settlement moneys received for the same harm that is also compensated by a jury.

Chief Justice Anstead has even recognized the Legislature's role on this issue. "It would be far better, however, since this is an area in which the legislature has broad discretion and authority, and has been very active, for the legislature to expressly indicate the limitations on the continuing use of the contribution scheme, including the set off provisions of sections 46.015(2), 768.31(5)(a), and 768.041(2)," he stated.[1193]

Recommendation 1. The Legislature should amend the set off statutes, sections 46.015 and 768.041, Florida Statutes, to clarify that set off amounts should be applied to jury damage awards, including both economic and non-economic damages, even when fault is several only.

[1193] Wells v. Tallahassee Memorial Regional Medical Center, Inc., 659 So. 2d 249, 256 (Fla. 1995) (Anstead, J., specially concurring).

Chapter 9 - Alternative Dispute Resolution

"[C]hange is difficult. Even with the most enlightened leadership, creating a non-punitive atmosphere is a major challenge. The urge to punish is deeply entrenched. . . . If there is any lesson to be learned, it is that fear of reprisal and punishment produce not safety but defensiveness, secrecy and personal anguish."

Lucien L. Leape, M.D., Can We Make Health Care Safe?, (2000)

Mandatory Mediation

Issue

The Task Force voted at its December 20, 2002 meeting, by a 5-0 vote, to examine the following issues with respect to mandatory mediation in the context of medical malpractice cases:

- Should medical mediation panels be established to divert medical malpractice cases to either mediation or arbitration?
- Should the mediation panel be in addition to the current pre-suit process, or in lieu of the current process?
- If created, should the panel consist of one attorney and three physicians?

Current Situation

Medical malpractice litigants have several options set out in law for settling the law suit prior to litigation. Section 766.108, Florida Statutes, establishes a mandatory pre-trial settlement conference for medical malpractice cases and section 768.79, Florida Statutes, sets out the process for offers of judgment available in any civil action for damages.

Section 766.108, Florida Statutes, provides the court must require a settlement conference at least three weeks before the date set for trial in all medical malpractice cases. The attorneys who will conduct the trial, the parties and any person having the authority to settle the case must attend

this conference and must be excused by the court, for good cause shown, if they will not attend.

Section 768.79, Florida Statutes, sets out the procedures for either party to make an offer of judgment to settle the litigation. Either party may make an offer of settlement to the opposing party, which if not accepted within thirty days can result in the party not accepting the offer paying the offering parties attorney fees and costs from the date of the offer. If the plaintiff makes the offer that is not accepted then the defendant will owe the plaintiff's attorney fees and costs from the date of the offer if the final judgment obtained by the plaintiff is 25 percent higher than the offer. If the defendant makes the offer and the plaintiff rejects it then the defendant will be entitled to attorney fees and costs from the date of the offer if the judgment is one of no liability or is at least 25 percent lower than the offer. The amount of the offer is not admissible at trial but may be admitted for purposes of enforcing this section within thirty days after the entry of the judgment or voluntary or involuntary dismissal of the case. In making the determination as to the amount of the attorney fees and costs to be awarded, the statute provides specific criteria to be considered by the court, in addition to the standards generally considered by the court in awarding fees and costs. These criteria include:

- The apparent merit or lack of merit in the claim.
- The number and nature of offers made by the parties.
- The closeness of questions of fact and law at issue.
- Whether the person making the offer had unreasonably refused to furnish information necessary to evaluate the reasonableness of such offer.
- Whether the suit was in the nature of a test case presenting questions of far-reaching importance affecting nonparties.
- The amount of the additional delay cost and expense that the person making the offer reasonably would be expected to incur if the litigation should be prolonged.
- Evidence of an offer is admissible only in proceedings to enforce an accepted offer or to determine the imposition of sanctions under this section.[1194]

Information Provided to the Task Force

Mr. Perry Odom[1195] testified to the Task Force regarding his experience with mediation and its use early in the litigation process. He testified that the advantage of mediation over other dispute resolution processes is that

[1194] Section 768.79 (7)(b), Florida Statutes.
[1195] Perry Odom, J.D., North Florida Mediation and Arbitration Services.

the decision rests with the parties not with a third party.[1196] The purpose of the mediator is to assist the parties in narrowing the issues and understanding the strengths and weaknesses of the case.[1197] Early mediation can serve to substantially reduce the cost of the case and can allow the parties to meet and discuss settlement before "acrimony" between the parties has built.[1198] While some object to early mediation because of a lack of information about the case, Mr. Odom stated even at an early point, the plaintiff has a lot of information about the case and the insurance companies have a lot of experience on which to base an early assessment of the worth of the case.[1199]

Mr. Odom proposed a pre-suit mediation process as follows:[1200]

At the conclusion of the pre-suit screening period and any pre-suit informal discovery, but before the claimant files suit, the parties shall submit the matter to pre-suit mediation as follows:

- A certified circuit court mediator to be selected by mutual agreement of the parties shall conduct the pre-suit mediation. If the parties are unable to agree on a mediator within fifteen days after the claimant requests pre-suit mediation, a mediator shall be appointed by the general counsel of the Department of Health from the list of certified circuit court mediators maintained by the chief judge of the circuit in which the suit may be filed.

- Within thirty days after the mediator is selected, the mediation conference shall be scheduled by the mediator after conferring with the parties or their attorneys to determine a mutually acceptable date, time, and place, whereupon the mediator shall promptly give written notice to all parties of the date, time, and place of the mediation conference at least fifteen days prior to the scheduled mediation conference. Unless otherwise agreed by all of the parties, the pre-suit mediation shall be concluded within sixty days after the mediator is selected.

- The personal attendance of all parties at the pre-suit mediation conference is essential and required, unless excused by mutual agreement of all of the parties. Parties shall have absolute authority to settle the matter. If a party is a corporation, the corporate representative shall be either an officer of the corporation or a delegated representative, either of whom must have authority to bind the corporation to a settlement agreement. In the case of an insurance

[1196] Perry Odom, J.D., testimony, Dec. 3, 2002, pg. 234.
[1197] Id.
[1198] Id. at 235.
[1199] Id. at 236.
[1200] Language provided to Task Force by Perry Odom, J.D.

carrier or self-insurer, the representative of the insurance carrier or self-insurer shall be empowered to resolve the matter for the lower of the demand of the claimant or the limits of coverage.

- Section 44.107, Florida Statutes, regarding judicial immunity for the mediator and Rule 1.700, et seq., Florida Rules of Civil Procedure shall apply to the pre-suit mediation.

- Each party involved in the pre-suit mediation process has a privilege to refuse to disclose, and to prevent any person present at the pre-suit mediation conference from disclosing, communications made during the pre-suit mediation conference. All oral or written communications in the pre-suit mediation proceedings, other than an executed settlement agreement, shall be exempt from the requirements of chapter 119 and shall be confidential and inadmissible in any subsequent legal proceedings, unless all parties agree otherwise.

- The statute of limitations is tolled as to all possible defendants until conclusion of the pre-suit mediation proceedings.

- Unless all parties agree otherwise, the parties shall share the fee or other costs charged by the mediator equally.

- If pre-suit mediation terminates in an impasse declared by the mediator, and the claimant thereafter files suit, nothing contained herein shall prevent the court from ordering the parties to submit to court-ordered mediation pursuant to chapter 44, Florida Statutes.

The Academy of Florida Trail Lawyers, in response to the discussion at the December 3, 2002 Task Force meeting, proposed the following language to provide for early mandatory mediation with sanctions but not pre-suit mediation.[1201]

- Within 120 days of suit being filed, the parties shall conduct mandatory mediation in accordance with section 44.102, Florida Statutes, if binding arbitration under sections 766.106 or 766.207, Florida Statutes, has not been agreed to by the parties. The Florida Rules of Civil Procedure shall apply to mediation held pursuant to this section. During the mediation, each party shall make a demand for judgment or an offer of settlement. At the conclusion of the mediation, the mediator shall record the final demand and final offer to provide to the court upon the rendering of a judgment.

[1201] Id.

- If a claimant rejecting the final offer of settlement made during the mediation does not obtain a judgment more favorable than the offer, the court shall assess the mediation costs and reasonable costs, expenses, and attorneys fees which were incurred after the date of mediation. The assessment shall attach to the proceeds of the claimant and attributable to any defendant whose final offer was more favorable than the judgment.

- If the judgment obtained at trial is not more favorable to a defendant than the final demand for judgment made by the claimant to the defendant during mediation, the court shall assess the mediation costs, and reasonable costs, expenses, and attorneys fees that were incurred after the date of mediation. Prejudgment interest at the rate established in section 55.03, Florida Statutes, from the date of the final demand shall also be assessed. The defendant and the insurer of the defendant, if any, shall be liable for the costs, fees, and interest awardable under this section.

- The final offer and final demand made during the mediation required in this section shall be the only offer and demand considered by the court in assessing costs, expenses, attorneys fees, and prejudgment interest under this section. No subsequent offer or demand by either party shall apply in the determination of whether sanctions will be assessed by the court under this section.

- Notwithstanding any law to the contrary, sections 45.061 and 768.79, Florida Statutes, shall not be applicable to medial negligence or to wrongful death cases arising out of medial negligence causes of action.

Findings and Recommendations

The Task Force finds encouraging the parties to seriously provide for early case evaluation and to mediate the case as soon as possible in the litigation process will reduce the litigation costs related to medical malpractice suits, thus reducing some of the medical malpractice litigation costs.

The Task Force finds the parties are currently free to mediate a case at any point but the confidentiality provisions currently available in chapter 44, Florida Statutes, do not cover any pre-suit mediation.

The Task Force finds mandatory mediation does not occur early enough in the litigation process to significantly reduce litigation costs and without sanctions for failure to mediate in good faith early mediation can be useless if the parties appear but are not ready or willing to work toward a settlement of the case.

Recommendation 1. The Legislature should encourage pre-suit mediation by providing for confidentiality of any pre-suit mediation in a medical malpractice case in the same manner as is provided for mediation occurring after suit is filed.

Recommendation 2. The Legislature should amend the mandatory mediation provisions of section 766.108, Florida Statutes, to require mediation within 120 days of filing suit and to provide sanctions if a good faith offer of settlement is refused.

Recommendation 3. The Legislature should not make admissible at trial the fact that mandatory mediation occurred or that offers of settlement were made, but should make this fact admissible for purposes of enforcing the attorney fees and costs. The mediator should maintain a report of the issues and facts presented at the mediation and the final settlement offers of each party at the mandatory mediation.

Recommendation 4. The Legislature should enact specific criteria similar to those in the offer of judgment statute to be considered by the court in making the determination as to how close in amount the judgment must be to the offer and the criteria to be used in evaluating the amount of the attorney fees and costs to be awarded in addition to the standards generally considered in awarding fees and costs.

Recommendation 5. The Legislature should require the court to consider, in addition to all other criteria, whether the issues and facts presented at mediation were significantly the same issues presented at trial.

Voluntary Binding Arbitration

Issue

The Task Force voted at its January 8, 2003 meeting, by a 5-0 vote, to examine the following issues with respect to voluntary binding arbitration in the context of medical malpractice cases:

- Should the optional arbitration program be eliminated?
- Should the definition of the caps established in the voluntary arbitration process be clarified to apply a cap of $250,000 per incident regardless of the number of survivors (claimants)?

Current Situation

Chapter 766, contains two separate arbitration provisions: (1) section 766.106, Florida Statutes, and (2) sections 766.207-766.212, Florida Statutes. While both section 766.106, Florida Statutes, and sections 766.207 through 766.212, Florida Statutes, concern arbitration, they are two separate and distinct arbitration procedures. Parties cannot employ some of the provisions of section 766.106, Florida Statutes, and some of the provisions of section 766.207, Florida Statutes, to create a hybrid of arbitration.[1202]

Section 766.106, Florida Statutes

Section 766.106, Florida Statutes, was enacted as part of the Medical Malpractice Reform Act of 1985.[1203] Under this statute, the defendant may make an offer to arbitrate and the statute expressly contemplates an admission of liability with arbitration being conducted on the damages issue. More specifically, its provisions permit "an offer of admission of liability and for arbitration on the issue of damages" in response to a notice of intent to initiate medical malpractice litigation.[1204]

According to Gail Parenti, whose Coral Gables firm primarily represents hospitals, "I have never seen an arbitration proceed under 766.106 because there, frankly, is no reason to. It has done nothing but generate confusion

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[1202] Platman v. Holmes Regional Medical Center, Inc., 683 So. 2d. 671 (Fla. 5th DCA 1996), rev. denied, 687 So. 2d. 1305 (Fla. 1997); see also Tallahassee Memorial Regional Medical Center, Inc. v. Kinsey, 655 So. 2d 1191 (Fla. 1st DCA 1995), rev. denied, 662 So. 2d. 344 (Fla. 1995).

[1203] Chapter 85-175, section 14, at 1199-1202, Laws of Florida.

[1204] See section 766.106(3)(b)3, Florida Statutes.

because it gives rise to arguments that an attempt to make an offer under 766.207 is somehow invalid because it's confusing."[1205]

Sections 766.207 through 766.212, Florida Statutes

In 1988, the Legislature was again asked to turn its attention to medical malpractice, enacting what is now chapter 766, Florida Statutes.[1206] While amendments changed some of what is now section 766.106, Florida Statutes, and added additional subsections, the substance of the provisions relating to admission of liability and voluntary binding arbitration of damages remained unchanged.

Instead, the Legislature adopted a completely separate set of procedures for admission of liability and binding arbitration of damages.[1207] Those provisions were subsequently codified as sections 766.207 through 766.212, Florida Statutes. While the motivation for enactment of those provisions is explained in section 766.201(2)(b), Florida Statutes, no reference is made to the provisions regarding admission of liability and voluntary binding arbitration of damages already set forth in section 766.106, Florida Statutes, or to the intended interplay between section 766.106, Florida Statutes, and sections 766.207 through 766.212, Florida Statutes.

Section 766.201(1), Florida Statutes, expressly sets forth the Legislature's intent to provide a mechanism for the prompt resolution of medical malpractice claims through mandatory pre-suit investigation and voluntary binding arbitration of damages.

Sections 766.203 through 766.206, Florida Statutes, set out the pre-suit investigation procedure that both the claimant and defendant must follow before a medical negligence case may be filed in circuit court. The first step in the pre-suit investigation is for the claimant to determine whether reasonable grounds exist to believe that a defendant acted negligently in the claimant's care or treatment, and to determine whether this negligence caused the claimant's injury.[1208] This section also requires that the medical negligence claim be corroborated by a "verified written medical expert opinion" from a medical expert as defined in section 766.202(5), Florida Statutes. Copies of any medical records relevant to the litigation must be provided to the claimant or defendant.[1209] From there, each party shall provide to the other party reasonable access to information within its

[1205] Gail Parenti, J.D., testimony, Nov. 22, 2002, pg. 206; but see Neal Roth, J.D., testimony, Nov. 22, 2002, pg. 207 (recalling an offer, later revoked, to arbitrate under section 766.106, Florida Statutes).
[1206] Chapter 88-1, sections 48-87, at 164-186, Laws of Florida; chapter 88-277, sections 26-49, at 1473-1495, Laws of Florida.
[1207] Chapter 88-1, sections 54-59, at 169-173, Laws of Florida; chapter 88-277, sections 30-35, at 1476-1482, Laws of Florida.
[1208] Section 766.203(2), Florida Statutes.
[1209] Section 766.204(1), Florida Statutes.

possession or control in order to facilitate evaluation of the claim[1210] before giving notice to a defendant. After the completion of the pre-suit investigation by the parties pursuant to sections 766.203 through 205, Florida Statutes, with preliminary reasonable grounds for a medical negligence claim intact, the parties may elect to have damages determined by arbitration.

This arbitration mechanism is found in sections 766.207 through 766.212, Florida Statutes. If the claimant's reasonable grounds for the medical negligence claim are intact at the completion of the pre-suit investigation, either party may request that a medical arbitration panel determine the amount of damages.[1211]

The 1988 Legislature initially contemplated that these provisions would provide benefits to both a claimant and a defendant, the logic being that the claimant benefits from the requirement that a defendant quickly determine the merit of any defenses and the extent of its liability. The claimant also saves the costs of attorney and expert witness fees, which would be required to prevail in a civil trial. Moreover, a claimant who accepts a defendant's offer of voluntary binding arbitration receives the following additional benefits: (1) a relaxed evidentiary standard for arbitration proceedings; (2) joint and several liability of multiple defendants in arbitration; (3) prompt payment of damages after the determination by the arbitration panel; (4) interest penalties against the defendant for failure to promptly pay the arbitration award; and (5) limited appellate review of the arbitration award.

Likewise, a defendant benefits in that he or she is relieved of punitive damages and is assured that there will not be an award greater than $250,000 in non-economic damages. This limitation was intended to provide liability insurers with the ability to improve the predictability of the outcome of claims for the purpose of loss planning in risk assessment of medical malpractice premiums. At the same time, the arbitration mechanism forces parties to settle their disputes.

During the course of testimony, this Task Force heard from Gail Leverett Parenti. Ms. Parenti noted that at the time of the Echarte decision (to be discussed below), the Division of Administrative Hearings (DOAH) reported a total of 132 medical arbitration cases had been filed in the fourteen years since the enactment of the voluntary binding arbitration provisions. Of these cases, 106 had been resolved without a hearing.[1212] In other words, they had been settled. Ms. Parenti explained that voluntary binding arbitration was a highly-effective means of achieving the

[1210] Section 766.205(1), Florida Statutes.
[1211] Section 766.207, Florida Statutes.
[1212] Gail Parenti, J.D., testimony, Nov. 22, 2002, pg. 184.

Legislature's stated goal of early settlement of medical malpractice cases. However, Ms. Parenti went on to further note that these statistics cannot capture the number of cases in which an offer to arbitrate has resulted in a settlement before the parties actually initiated arbitration proceedings, or those in which a credible threat to offer to arbitrate resulted in a settlement before the conclusion of the pre-suit period.[1213]

The Task Force heard conflicting testimony from defense and plaintiff's attorneys regarding the extent to which arbitration under sections 766.207 through 766. 212, Florida Statutes, is actually used. Ms. Parenti, citing the above-mentioned figures, stated that although settlements are actually taking place, the number of these settlements is lower than it should be because too few parties are taking advantage of the offer to arbitrate.[1214] Tommy Dukes, who is with the Florida Defense Lawyers Association, stated that, of the hundreds of malpractice cases he has handled, he has recommended arbitration in just two instances. Mr. Dukes explained that because the statute has been interpreted as allowing $250,000 per claimant (rather than per claim), and because the defendant must, in essence, admit liability to participate, arbitration under this section is simply not a viable option.[1215] However, Neal Roth, representing the Academy of Florida Trial Lawyers, countered the above testimony, stating he and his colleagues were seeing more and more offers to arbitrate.[1216] He also cited a recent survey of his group, which indicates that, in fact, arbitration was offered in at least fifty cases in the last two years.[1217]

University of Miami v. Echarte

The constitutionality of the voluntary binding arbitration provisions was ruled on in the seminal case of University of Miami v. Echarte.[1218] In Echarte, the claimants argued the voluntary binding arbitration provision had the effect of limiting the amount of non-economic damages they may recover for the defendant's neglect. The claimants argued the arbitration provision replaced their common law remedy of all damages proximately flowing from the neglect of the defendant. After reviewing the legislative history as well as the findings of the 1988 task force, the Florida Supreme Court expressly upheld the statutory scheme against an attack that the arbitration provision was an insufficient substitute for the common law right of an ordinary damages action. In so doing, the Florida Supreme Court explained:

[1213] Id. at 184-185.
[1214] Id. at 184.
[1215] Tommy Dukes, J.D., testimony, Oct. 21, 2002, pgs. 240-242.
[1216] Neal Roth, J.D., testimony, Nov. 22, 2002, pg. 195.
[1217] Neal Roth, J.D., testimony, Oct. 21, 2002, pg. 272.
[1218] 618 So. 2d 189, 196 (Fla. 1993), cert. denied, 510 U.S. 915, 114 Sup. Ct. 304 (1993).

> The initial question in the instant case is whether the arbitration statutes, which include the non-economic damage caps found in sections 766.207 and 766.209, provide claimants with a "commensurate benefit" for the loss of the right to fully recover non-economic damages. Sections 766.207 and 766.209 only limit a claimant's right to recover non-economic damages after a defendant agrees to submit the claimant's action to arbitration. The defendant's offer to have damages determined by an arbitration panel provides the claimant with the opportunity to receive prompt recovery without the risk and uncertainty of litigation or having to prove fault in a civil trial. A defendant or the defendant's insurer is required to conduct an investigation to determine the defendant's liability within ninety days of receiving the claimant's notice to initiate a malpractice claim.
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> Before the defendant may deny the claimant's reasonable grounds for finding medical negligence, the defendant must provide a verified written medical expert opinion corroborating a lack of reasonable grounds to show a negligent injury. § 766.203(3)(b). The claimant benefits from the requirement that a defendant quickly determine the merit of any defenses and the extent of its liability. The claimant also saves the costs of attorney and expert witness fees which would be required to prove liability. Further, a claimant who accepts a defendant's offer to have damages determined by an arbitration panel receives the additional benefits of:
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> - the relaxed evidentiary standard for arbitration proceedings as set out by section 120.58, Florida Statutes (1989);
> - joint and several liability of multiple defendants in arbitration;
> - prompt payment of damages after the determination by the arbitration panel;
> - interest penalties against the defendant for failure to promptly pay the arbitration award; and
> - limited appellate review of the arbitration award requiring a showing of "manifest injustice."[1219]

The court went on to reject the claimant's assertion that the medical malpractice arbitration statute did not provide the claimant with a

[1219] University of Miami v. Echarte, 618 So. 2d 189, 194 (Fla. 1993).

commensurate benefit.[1220] After the holding in Echarte, it appeared the intent of the voluntary binding arbitration statute would be implemented.

However, after the Florida Supreme Court's decision in St. Mary's Hospital, Inc. v. Phillipe,[1221] it appears there is no future for voluntary binding arbitration. The Task Force heard testimony that most defendants will not consider voluntary binding arbitration in light of the St. Mary's decision.[1222] As Ms. Parenti noted, "Because I've been talking to defense lawyers for the last seven years about arbitration and they come to me and say, 'Gail, after [the Supreme Court rulings], I just can't do it. I cannot recommend to my client that they go to a forum where there's that risk.'"[1223]

St. Mary's Hospital, Inc. v. Phillipe

The St. Mary's decision was actually two separate cases that were consolidated for review: (1) St. Mary's Hospital, Inc. v. Phillipe,[1224] and (2) Frazen v. Mogler.[1225] Both were medical malpractice wrongful death cases in which the defendants conceded liability.

The facts of St. Mary's Hospital v. Phillipe were as follows: Juslin Phillipe died while giving birth to her daughter, Ecclesianne. Ecclesianne was born severely brain damaged. Charles Phillipe, Juslin's husband and the personal representative of her estate, brought a medical malpractice wrongful death action against St. Mary's Hospital on behalf of himself and the decedent's four surviving children.[1226]

St. Mary's conceded liability and the case proceeded under that arbitration process on the issue of damages. The independent personal injury action of the brain-damaged child, Ecclesianne, was not part of the arbitration process.[1227]

After a hearing, the arbitrators awarded the following damages: $250,000 in non-economic damages to both Charles, the husband, and Ecclesianne, the daughter; $175,000 in non-economic damages to each of the remaining children; $2,284,804 to the family in economic damages for loss of services; $943,000 in economic damages for loss of special services to Ecclesianne; $3,398 in funeral expenses; and $510,632 in

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[1220] Id. at 197.
[1221] 769 So. 2d 961 (Fla. 2000).
[1222] Gail Parenti, J.D., testimony, Nov. 22, 2002, pg. 184.
[1223] Id.
[1224] 699 So. 2d 1017 (Fla. 4th DCA 1997).
[1225] 699 So. 2d 1026 (Fla. 4th DCA 1997).
[1226] St. Mary's Hospital v. Phillipe, 769 So. 2d 961, 963 (Fla. 2000).
[1227] Id.

attorneys' fees. The total amount of the arbitration award was $4,766,834.[1228]

St. Mary's argued that the arbitrators' total award of non-economic damages in the amount of $1,025,000 exceeded the $250,000 cap. That provision provides that "[n]on-economic damages shall be limited to a maximum of $250,000 per incident." St. Mary's asserted that the term "per incident" reflected that the limit applies in the aggregate to all claimants, rather than separately to each wrongful death beneficiary.[1229] The district court agreed with St. Mary's. The court concluded the plain language of the statute indicates "there can be no more than $250,000 in non-economic damages awarded by the arbitrators under section 766.207, Florida Statutes, no matter how many different people may have a direct benefit in the award, or the source of their entitlement to share in the award."[1230] The district court reversed the arbitration award of non-economic damages, and remanded for the reduction of such damages to $250,000.[1231]

St. Mary's also argued that the award of economic damages for the decedent's loss of earning capacity was improper because such damages are not available under the Wrongful Death Act. The district court disagreed, however, holding that the elements of economic damages available in a voluntary binding arbitration of a medical malpractice claim are controlled by the voluntary binding arbitration statute.[1232]

The facts of Franzen v. Mogler were as follows: Michael Mogler, a minor, died following treatment from Dr. Dirk Franzen. The parents of Michael Mogler brought a medical malpractice wrongful death claim on behalf of themselves and their son's estate against Dr. Franzen.[1233] As in Phillipe, the parties voluntarily chose to proceed under the voluntary statutory arbitration process. Dr. Franzen conceded liability, and the issue of damages proceeded to arbitration. After a hearing, the arbitrators awarded the following damages to Henry Mogler: $250,000 in past and future non-economic damages; $9,125 for past medical expenses; $29,750 for future medical expenses; and $7,950 for past and future loss of services.[1234] The arbitrators awarded the following damages to Donna Mogler: $250,000 in past and future non-economic damages; $46,593 for past medical expenses; $46,000 for future medical expenses; $57,636 for past wage loss; $304,189 for future wage loss; and $7,950 for past and future loss of

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[1228] Id.
[1229] Id. at 964.
[1230] Id.
[1231] Id.
[1232] Id.
[1233] Id.
[1234] Id.

services.[1235] The Estate of Michael Mogler was awarded the following damages: $3,078 for funeral expenses; $5,084 for medical expenses; and $388,272 for lost wages.[1236] The arbitrators also awarded attorneys' fees and costs in the amount of $210,844.[1237]

The total amount of the arbitration award was $1,616,471.[1238] Following its decision in Phillipe, the district court reversed the award of non-economic damages and affirmed the award of eccnomic damages.[1239]

In the consolidated appeal, the Florida Supreme Court framed the controversy in terms of three separate issues:

ISSUE I: Stay pending review of medical malpractice arbitration award.[1240] The court disposed of this issue by rejecting the claim of unconstitutionality, and reasoned that both parties agreed to participate in voluntary binding arbitration. The court noted: "When a party voluntarily agrees to enter binding arbitration under this statutory alternative process, the party has bound itself to the statutory terms of that process."[1241]

The Task Force does not take issue with this particular finding. Instead, this Task Force is of the opinion that the results of the next two issues were much more troubling.

ISSUE II: Meaning of the clause "non-economic damages shall be limited to a maximum of $250,000 per incident." The second issue involved whether the $250,000 "per incident" limitation of non-economic damages in the arbitration provision limits the total recovery of all claimants in the aggregate to $250,000 or limits the recovery of each claimant individually to $250,000.[1242] The court reasoned that the legislative intent behind the statute should be gathered from consideration of the statute as a whole rather than from any one section.[1243] The court noted that for purposes of the statute, "claimant" was clearly defined as "any person who has a cause of action arising from medical negligence.[1244] The court further noted that the statute was perfectly clear when it referred to multiple parties.[1245] Likewise, the court noted that the Legislature had previously been clear when it intended to limit claimants' damages in the aggregate in other

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[1235] Id.
[1236] Id.
[1237] Id.
[1238] Id.
[1239] Id.
[1240] Id. at 964.
[1241] Id. at 967.
[1242] Id. at 965.
[1243] Id. at 967-968.
[1244] Id. at 968.
[1245] Id. at 969.

contexts.[1246] For example, The court reasoned that in the Wrongful Death Act, the limitation read as follows: "Neither the state nor its agencies or subdivisions shall be liable to pay a claim or a judgment by any one person which exceeds the sum of $100,000 or any claim or judgment, or portions thereof, which, when totaled with all other claims or judgments paid by the state or its agencies . . . "[1247] Thus, the court concluded section 766.207(b), Florida Statutes, was neither unclear nor unambiguous.[1248]

The court concluded, that each claimant's non-economic damages must be independently determined.[1249] "Differentiating between a single claimant and multiple claimants bears no rational relationship to the Legislature's stated goal of alleviating the financial crisis in the medical liability insurance industry."[1250] As a final caveat, the court concluded that were it to interpret the non-economic damages cap to apply to all claimants in the aggregate, such an interpretation would create an equal protection problem.[1251]

ISSUE III: Economic Damages. The final issue involved the question of whether the elements of economic damages awardable in the voluntary binding arbitration or a medical malpractice wrongful death claim are controlled by the Wrongful Death Act.[1252] Unlike the voluntary binding arbitration statute, the Wrongful Death Act does not provide claimants with a full range of economic damages.[1253] The court ruled that the arbitration provisions of the voluntary binding arbitration statute expressly specify the elements of all the damages available when the parties agree to binding arbitration, regardless of whether the medical malpractice action involves a wrongful death.[1254] The court reasoned that the legislative intent of the voluntary binding arbitration statute was to enact reforms to prevent soaring non-economic damage awards, rather than the more predictable economic damage awards.[1255] The court concluded: "If the Legislature intended for the Wrongful Death Act to control the elements of damages available in a medical malpractice arbitration, it could have specifically provided for the application of the provisions of the Act in the [voluntary binding arbitration statute]. It has not done so."[1256]

[1246] Id.
[1247] Id.
[1248] Id.
[1249] Id. at 971.
[1250] Id.
[1251] Id.
[1252] Id.
[1253] Id. at 973.
[1254] Id.
[1255] Id.
[1256] Id.

Findings and Recommendations

As a result of the St. Mary's decision, the Task Force has found that defendants are no longer using arbitration as a means of resolving claims.[1257] In sum, the St. Mary's opinion has made it impossible for defendants to offer to arbitrate in wrongful death cases.[1258] Those defendants that agree to arbitrate now find themselves at risk of arbitrators awarding damages that are not compensable under Florida law. One speaker to the Task Force cogently noted: "As a result of the St. Mary's decision, the universe of claims in which an offer to arbitrate can reasonably be considered will be limited to these cases with a single claimant, or a decedent with no statutory survivors; with little or no economic damages; ironically, the cases which should not need the assistance of the arbitration mechanism to settle."[1259] The Task Force finds that voluntary binding arbitration in Florida is effectively dead as a result of the St. Mary's case.

Recommendation 1. The Legislature should amend the definitions of "economic damages" and "non-economic damages" as provided in sections 766.202 and 766.207, Florida Statutes, to provide that such damages are recoverable in voluntary binding arbitration only if the claimant has the right to recover such damages under general law, including the Wrongful Death Act.

Recommendation 2. The Legislature should provide for an aggregate cap on non-economic damages in arbitrated cases of multiple defendants.

[1257] Gail Parenti, J.D., testimony, Nov. 22, 2002, pg. 191.

[1258] Gail Parenti, The Bells of St. Mary: Tolling the End of Voluntary Binding Arbitration of Medical Malpractice Claims, 19(4) Trial Advocate Quarterly 11 (Fall 2000).

[1259] Id.

Chapter 10 - Insurance Reform

"Malpractice fears and high premiums can contribute to 'excessive' service (such as unnecessary cesarean sections and diagnostic tests) or insufficient service (such as physicians no longer assisting in the birth of babies, especially to mothers who are uninsured or have only Medicaid coverage)."

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

Florida Birth-Related Neurological Injury Compensation Act

Issue

The Task Force voted at its January 8, 2003 meeting, by a 5-0 vote, to examine the following issues with respect to the Florida Birth-Related Neurological Injury Compensation Act (NICA) in the context of medical malpractice cases:

- Should the criteria for a claim to qualify for referral to NICA be expanded to include lower birth weights?
- Should the criteria for a claim to qualify for referral to NICA be expanded to allow claims for mental and physical impairment rather than requiring both?

Current Situation

Two issues arise from the historical operation of the Florida No-Fault Compensation Plan created by the Florida Legislature in sections 766.301-316, Florida Statutes. First, whether the act has met its original purpose and continues to have value for that purpose. Second, whether the operation of the act is satisfactory, or whether changes are needed to enhance the purpose of the act.

Throughout the 1980s, a serious and highly-publicized crisis evolved regarding the costs of medical malpractice insurance for physicians. In 1987, the problem was specifically determined to be most serious for obstetricians, who were experiencing some of the highest insurance premium rates in the country.[1260]

Newspapers reported rising costs for malpractice insurance and the devastating effects these costs were having on physicians in their daily practices and on the patients who were unable to secure adequate medical attention. For example, a sample of the antidotal evidence reported clearly illustrates the scope of this crisis. One article appearing in the Sun-Sentinel written by the United Press International, stated that "most doctors are paying 81 percent more for medical malpractice insurance between 1982 and 1985, but that obstetrics and gynecologists paid as much as 113 percent more."[1261] A reporter for the St. Petersburg Times, noted that in "Broward and Dade County obstetricians' premiums will jump from $113,631 to $166,355 as of July 1."[1262] Another article in the St. Petersburg Times declared that the only one in 55 obstetricians in Palm Beach County was still accepting new patients.[1263] And, in Florida, two maternity wards were closed, one in Collier County and the other in Lake County.[1264]

In the State of Florida alone, the malpractice premium rates for obstetrics and gynecology rose 395 percent from 1980 to 1986.[1265] Florida experienced the effects of the problem more severely than most other states.

In an effort to address the mounting malpractice crisis, the Tort and Insurance Act of 1986 created the 1987 Academic Task Force for Review of the Insurance and Tort Systems, a task force to evaluate the state's tort and insurance laws.[1266] This task force was asked to examine the emergent problems facing the healthcare delivery systems, including

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[1260] House of Representatives, Council for Healthy Communities, Committee on Health Promotion, A Review of the Legislative History and Financial Status of the Florida Birth-Related Neurological Injury Compensation Association (NICA) 2 (Apr. 2001).

[1261] Malpractice Rates Still Skyrocketing: Insurance Premiums Up 81% for Most Doctors, Sun-Sentinel, Aug. 1987.

[1262] Mark Journey, Malpractice Insurer Raises Rates, St. Petersburg Times, June 27, 1987, at 3B.

[1263] Patients Get Left Behind as Costs Push Doctors Out of the Delivery Rooms, St. Petersburg Times, June 9, 1987, at 4B.

[1264] Elizabeth Wasserman, Lake County Obstetrics Crisis Reaches Critical Condition, Orlando Sentinel, Dec. 23, 1987, at 3.

[1265] House of Representatives, Council for Healthy Communities, Committee on Health Promotion, A Review of the Legislative History and Financial Status of the Florida Birth-Related Neurological Injury Compensation Association (NICA) app. 1 (Apr. 2001).

[1266] Academic Task Force for Review of the Insurance and Tort Systems, Preliminary Fact-Finding Report on Medical Malpractice 1 (Aug. 6, 1987).

physicians, hospitals, and other medical personnel and to make recommendations for reforms, where appropriate. The task force noted that the impact of the medical malpractice problems varied considerably among medical specialties.[1267] As a case in point, the task force found that:

- Obstetricians were more likely than other physicians to have claims filed against them;
- Obstetricians' malpractice premiums were among the highest; and
- The recent increases in malpractice premiums for obstetricians were much greater than for other physicians.[1268]

The task force noted that a generation ago abnormal births were regarded as an inherent risk of childbirth. They observed in 1986, most childbirth injuries resulted in increased claims against the obstetrician.[1269] Thus, the task force determined that, for birth related neurological injuries, distinctive treatment was warranted.[1270]

That 1987 task force was the first to propose the Florida Birth-Related Neurological Injury Compensation Act. Its November 6, 1987 report recommended the adoption of a no-fault compensation plan for birth-related neurological injuries.[1271] Accordingly, in 1988, the Legislature enacted section 766.301, Florida Statutes,[1272] (entitled Legislative Findings and Intent), and determined that physicians practicing obstetrics were high-risk medical specialists for whom malpractice insurance premiums were escalating.[1273] These medical specialists were found to be the most-severely affected group in the medical malpractice arena.[1274] Moreover, the costs of birth-related neurological injury claims for custodial care and rehabilitation were determined to be particularly high, thus warranting the establishment of a limited system of compensation that was irrespective of fault.[1275] The Florida Birth-Related Neurological Injury Compensation Plan was instituted with the intent to provide compensation to a limited class of catastrophically-injured infants on a no-fault basis to help alleviate the malpractice insurance crisis facing

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[1267] Id. at 12.
[1268] Id.
[1269] Id.
[1270] Id.
[1271] Academic Task Force for Review of the Insurance and Tort Systems, Medical Malpractice Recommendations (Nov. 6, 1987); see Galen of Florida, Inc. v. Braniff, 696 So. 2d 308, 310 (Fla. 1997).
[1272] Chapter 88-1, section 60, Laws of Florida.
[1273] Section 766.301(1)(a), Florida Statutes.
[1274] Section 766.301(1)(b), Florida Statutes.
[1275] Section 766.301(1)(d), Florida Statutes.

physicians practicing obstetrics. This no-fault compensation plan also provided participating physicians finite liability.[1276]

Sections 766.301 through 766.316, Florida Statutes, outline the components necessary to implement the no-fault compensation structure for participating physicians and eligible claimants.[1277]

The terms that are applicable to sections 766.301 through 766.316, Florida Statutes, are defined in section 766.302, Florida Statutes. The terms define the limitations expressed in this narrow compensation plan.

The critical definition as to "eligibility" for participation in the act is provided in section 766.302(2), Florida Statutes. This section defines "birth-related neurological injury" as an injury to the brain or spinal cord of a live infant weighing at least 2500 grams for a single gestation or, in a multiple gestation, a live infant weighing at least 2000 grams at birth caused by oxygen deprivation or mechanical injury occurring in the course of labor, delivery, or resuscitation in the immediate post-delivery period in a hospital, which renders the infant permanently and substantially mentally and physically impaired.[1278]

Section 766.302(3), Florida Statutes, identifies the persons who are authorized to file a claim on behalf of the infant. The claimant is a person who files a claim pursuant to section 766.305, Florida Statutes, for compensation for a birth-related neurological injury to an infant. Such a claim may be filed by any legal representative on behalf of an injured infant; and, in the case of a deceased infant, the claim may be filed by an administrator or personal representative, or legal representative.[1279]

A "participating physician" is a Florida physician who practices obstetrics or performs obstetrical services and who had paid or was exempted from payment at the time of the injury the assessment required for participation in the birth related neurological injury compensation plan for the year in which the injury occurred.[1280] This definition is found in section 766.302(7), Florida Statutes.

[1276] Historically, since the establishment of NICA, some medical malpractice insurers have offered discounts on premiums for obstetricians who participated in the program. House of Representatives, Council for Healthy Communities, Committee on Health Promotion, A Review of the Legislative History and Financial Status of the Florida Birth-Related Neurological Injury Compensation Association (NICA) (Apr. 2001).

[1277] Several revisions to the 1988 statute have been made since the inception of NICA. For a historical evolutionary discussion on the changes, see House of Representatives, Council for Healthy Communities, Committee on Health Promotion, A Review of the Legislative History and Financial Status of the Florida Birth-Related Neurological Injury Compensation Association (NICA) (Apr. 2001).

[1278] Section 766.302(2), Florida Statutes.

[1279] Section 766.302(3), Florida Statutes.

[1280] Section 766.302(7), Florida Statutes.

Section 766.303, Florida Statutes, provides for the exclusiveness of remedies for the eligible claimants through administrative procedures except where there is evidence of bad faith, malicious purpose, or a willful and wanton disregard.[1281]

Exclusive jurisdiction vests with an administrative law judge. Section 766.304, Florida Statutes, provides that a claimant can no longer bring a civil action against a participating physician unless an administrative law judge from the Division of Administrative Hearings determines that the birth-related injury does not fall within the no-fault compensation plan.[1282]

Determination of the claims and the nature of the findings that may result are set forth in section 766.309, Florida Statutes. Subsections (1)(a), (b), and (c) provide the findings that shall be made as to: (a) whether the injury is birth-related neurological injury; (b) the obstetrical service is delivered by a participating physician in the course of labor; and (c) how much compensation, if any, is awardable.[1283]

For a determination that the infant has been found to have sustained a birth-related neurological injury, such an award to the parents or legal guardian shall not exceed $100,000; funeral expenses shall not exceed $1,500; and attorney fees shall be assessed per the criteria set forth in section 766.309(1)(c), Florida Statutes. Section 766.31(1)(b), Florida Statutes, set forth the maximum awards.[1284]

No claim may be filed more than five years after the birth of the injured infant, under section 766.313, Florida Statutes.

Terminally, section 766.316, Florida Statutes, requires that each hospital with a participating physician and all participating physicians must provide notice on the forms, furnished by the Association, to the obstetrical patients as to the limited no-fault alternative for birth-related neurological injuries.[1285]

The Florida Legislature, in creating an assessment formula, has set forth requirements that initial assessments into the program and yearly

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[1281] Barden v. Haddox, 695 So. 2d 1271 (5th DCA 1997) (right to receive compensation under NICA, exclusive relief available to victims, is a substitute for common law rights which are otherwise available and as a result forecloses civil lawsuit against a doctor in the plan).

[1282] Since O'Leary v. Florida Birth-Related Neurological Injury Compensation Association, 757 So. 2d 624 (Fla. 5th DCA 2000), following the Florida Legislature amendment of section 766.304, Florida Statutes, correcting any confusion resulting from the decision in Florida Birth-Related Neurological Injury Compensation Association v. McKaughan, 668 So. 2d 974 (Fla. 1996), as to where jurisdiction reposed.

[1283] Section 766.309(1)(a-c), Florida Statutes.

[1284] Section 766.31(1)(b), Florida Statutes.

[1285] Galen of Florida V. Braniff, 696 So. 2d 308 (Fla. 1997).

assessments to remain in the program be made. Section 766.314, Florida Statutes, sets out monetary obligations for such assessments and provides for additional assessments when, under subsection (7)(b), the Department of Insurance finds that the plan cannot be maintained on an "actuarially sound basis".[1286]

Information Presented to the Task Force

Complaints about insurance costs are not new, however, increases since 1999 have shown that the availability of a million or more dollar of coverage has escalated premium costs so high that the dollar insurance amounts are beyond the reach of many physicians.[1287] The Professional Medical Insurance Services, Inc., underwriters for Florida physicians, estimates that, in 2003, for OB/GYNs who presently have coverage, costs for $1 million dollar of coverage will average between $70,000 and $110,000 per year; $250,000 of coverage will cost between $50,000 and $60,000 per year. For OB/GYNs seeking new insurance in 2003, estimates show that $1 million dollars in coverage will cost $150,000 per years and $250,000 in coverage will cost between $90,000 and $107,000 per year.[1288] As a result of these escalating costs, physicians are simply either under insuring or becoming uninsured with regard to their practices.[1289] Indeed, some experts suggest that Florida has reached a crisis status and some obstetricians and surgeons will be paying over $200,000 annually for premiums.[1290]

Evidence shows for example that OB/GYN physicians in areas such as Jacksonville are either retiring early, becoming college faculty members to obtaining sovereign immunity, or operating without insurance instead of meeting high premiums for adequate coverage. In Orlando, 20-25 percent of the OB/GYNs will operate without insurance and similar numbers exist in Tampa. In Miami, evidence reflects that 80 percent of the OB/GYNs carry no insurance and those who do are paying over $207,000 per year for $1 million dollars worth of coverage. Tallahassee's Neonatology

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[1286] Section 766.314 (5)(b), Florida Statutes, authorizes the transfer of no more than $20 million from the Department of Insurance, Insurance Commissioner's Regulatory Trust Fund if the assessments collected are insufficient to maintain the plan on an actuarially-sound basis. In 1988, The Florida Legislature appropriated $40 million of the Insurance Commissioner's Regulatory Trust Fund in the Department of Insurance for NICA. Twenty million dollars of this appropriation has been set aside in case of actuarial need and the other twenty million dollars funded NICA's establishment. See House of Representatives, Council for Healthy Communities, Committee on Health Promotion, A Review of the Legislative History and Financial Status of the Florida Birth-Related Neurological Injury Compensation Association (NICA) 5 (Apr. 2001).

[1287] Robert W. Yelverton, M.D., testimony, Oct. 21, 2002, pgs. 55-56.

[1288] Robert W. Yelverton, M.D., PowerPoint presentation, Oct. 21,2002.

[1289] C. Howard Hunter, testimony, Nov. 22, 2002, pg. 139.

[1290] Eleanor Kinney, J.D., testimony, Nov. 4, 2002; Eleanor Kinney, J.D, written statement, Legal Reforms Addressing Affordability and Availability of Medical Liability Insurance: Past Experience and Future Directions, Nov. 4, 2002.

Group at the local hospital has been unable to find insurance and is considering closing the neonatal intensive care unit.[1291]

Experts acknowledge that NICA, a second-generation level reform of the insurance liability issue, functions as intended according to empirical evidence. It was, however, never intended to be a cure to insurance rates, but rather, was intended to maintain lower insurance premiums.[1292] Based upon its intended purpose, NICA has been a success, however, adoption of no-fault returns has been limited to Florida and Virginia and other countries like Sweden and New Zealand where it has been more fully developed.[1293] Because the exposure of these no-fault compensation plans is limited to a very few states, any empirical data may be skewed and therefore the total success of a no-fault compensation plan has not been embraced.[1294]

Clearly, attempts to reduce or maintain reasonable liability insurance costs may not stop doctor-flight without global reform or adoption of uniform insurance policies from state to state. The insurance liability crisis is not unique to Florida and the causes as well as solutions will likewise not be unique to Florida. Unavailable and unaffordable insurance will result in under-insured or uninsured practitioners and those who are injured will seek deeper pockets, because when liability is without restraints, it becomes unpredictable and can result in excessive payouts.[1295]

NICA provides for no-fault compensation that results in most stakeholders gaining some benefit.[1296] Instead of almost half of a settlement award going to attorney's fees, reports reflect that, under NICA, less than 1 percent is distributed to plaintiff's attorneys. As a result, a greater percentage of resources are distributed to the child in need of care.[1297]

In the fourteen years NICA has been in place, 161 cases have been accepted and there are presently eighty-seven current open cases. Reports reflect an average of $3 million dollars per case is set aside based on actuarial data evaluating the lifetime care of the child, the medical fragility of a child, and the premise that as the child ages, care becomes more expensive.[1298]

[1291] Robert W. Yelverton, M.D., PowerPoint presentation, Oct. 21, 2002.
[1292] Eleanor Kinney, J.D., testimony, Nov. 4, 2002, pg. 180.
[1293] Robert Berenson, M.D., testimony, Nov. 4, 2002, pg. 219.
[1294] Eleanor Kinney, J.D., testimony, Nov. 4, 2002, pg. 180.
[1295] C. Howard Hunter, PowerPoint presentation, Nov. 22, 2002.
[1296] Kenney Shipley, testimony, Nov. 22, 2002, pgs. 20-21.
[1297] Id.
[1298] Id. at 21.

Findings and Recommendation

To suggest that the current structure of the NICA program should remain unchanged[1299] is not uniformly embraced by all stakeholders.[1300] Indeed, modifications as to eligibility requirements, including birth weight and changes to proof of "mental and physical impairment" to "mental or physical impairment,"[1301] may quiet many of the concerns expressed with regard to the willingness to participate.[1302] The broadening of the definition of eligible claimants[1303] may provide a reasonable alternative and likewise create a stopgap to the insurance crisis facing physicians providing obstetrical services.

As a potential consequence of any changes made to NICA, financial assessments of hospitals and all physicians may need to be evaluated.[1304] However, at some time in the future, it is reasonable to assume that escalation of costs may level off for obstetricians as well as all physicians because of this no-fault system and the fact that other medical disciplines may be encouraged to urge passage of other no-fault compensation plans.

The Task Force, after hearing extensive input from a variety of experts, believes that the issues relating to the NICA program warrants further consideration and study. Additional hearings and testimony from experts are necessary for this worthy program.

Recommendation 1. The Legislature should maintain the NICA program because of its success and should further consider and study the issues for broadening the NICA program, as discussed in this report.

[1299] William Brewster, testimony, Dec. 3, 2002, pgs. 134-136.

[1300] Theodore Babbitt, J.D., testimony, Dec. 3, 2002, pgs. 120-125.

[1301] Only when the infant meets the definitional criteria established by this section, will the exclusive remedies provided for by this limited no-fault compensation plan be available. The Florida Supreme Court in Florida Birth-Related Neurological Injury Compensation Association v. Florida Division of Administrative Hearings, 686 So. 2d 1349, 1355 (Fla. 1997), stated that because the NICA plan is a statutory substitute for common law right and liabilities, it should be strictly construed to include only those subjects that clearly embrace in its terms. Additionally, the court further narrowed the application of this statute by affirming the well-settled rules of statutory construction concluding that the word "and" in the phrase "permanently and substantially mental and physically impaired" should be read in the conjunctive. To do so does not lead to either an absurd result nor does it undermine the legislative policy of limiting the class. Therefore, an eligible infant to avail themselves of the no-fault compensation system must be at least 2500 grams weight and permanently and substantially mentally and physically impaired.

[1302] Tommy Dukes, J.D., testimony, Dec. 3, 2002, pgs. 108-113.

[1303] Mr. Dukes' proposal that modification to the definition of the "birth-related neurological injury" to allow the birth weight to be lowered to some number other than 2500 grams, would increase the number of infants eligible for NICA. Id. at 108-110.

[1304] William Brewster, J.D., testimony, Dec. 3, 2002, pgs. 139-143.

Bad Faith

Issue

The Task Force voted at its December 20, 2002 meeting, by a vote of 5-0, to examine the following issues with respect to bad faith claims in the context of medical malpractice cases:

- Should a bad faith cause of action be limited to a right of the insured and not extend to third-party claimants?

- Should criteria or standards be established for insurer conduct that constitutes bad faith and the duty of good faith when dealing with an insured and limited to protect the assets of the insured from judgment?

Current Situation

In Florida, there are two causes of action for bad faith claims by third parties to the insured/insurer relationship (e.g., injured plaintiffs). One of these causes of action arises out of common law and is therefore a creation of judicial case law. The other cause of action arises out of judicial interpretation of statute. At its fundamental core, the bad faith cause of action is intended to promote the following purposes:[1305]

- To economically protect the defendant insured from an excess judgment when the insurer has control of the defense and settlement;

- To make available to injured persons specified dollar limits that are available as compensation; and

- To encourage insurers to behave responsibly by making them liable for the financial damage that is caused by their breach of good faith duties.

By judicial interpretation of both the common law bad faith cause of action and the statutory law bad faith cause of action, "any person aggrieved" may sue an insurer for the insurer's alleged improper conduct in medical malpractice cases. Accordingly, in Florida, an insurer can be held liable to pay an entire judgment against its insured even when the

[1305] See Vincent Rio, J.D., testimony, Nov. 22, 2002, pgs., 116-117.

judgment exceeds the limits of the insurance for which the insured has contracted.

In Thompson v. Commercial Union Ins. Co. of New York, the Supreme Court of Florida declared: "It is established in Florida that an insured has the right to sue and recover damages against his own insurer for an excess judgment on the basis of fraud or bad faith in the conduct of the insured's defense by the insurer."[1306] The Thompson court also extended the third-party beneficiary doctrine to allow injured plaintiffs to directly sue a defendant's insurer "for recovery of the judgment in excess of the policy limits, based upon the alleged fraud or bad faith of the insurer in the conduct or handling of the suit."[1307] This extension had the effect of enlarging the limits of liability of the insurer beyond those in the stated insurance policy at issue.[1308] Since Thompson, the law in Florida has placed very few limits on that liability.

In 1980, the Supreme Court of Florida decided the case of Boston Old Colony Ins. Co. v. Gutierrez.[1309] That case explains many of the principles on which the cause of action by a third party against an insurer for bad faith exists and outlines the Court's understanding of the problems raised thereby. In Boston Old Colony, the plaintiff and defendant were involved in a head-on collision. Both men claimed that the accident was the other's fault. Brown, the defendant in the original case, had a liability policy that covered him up to a limit of $10,000 in damages. However, because of Brown's recollection of the accident and some corroborating evidence, Boston Old Colony hired an accident reconstruction expert to further investigate the cause of the accident. That expert determined that Gutierrez, the plaintiff in the original suit, was on the wrong side of the road at the time of accident impact. Despite this evidence, Boston Old Colony's adjuster knew that there was still a question of Brown's liability and that Gutierrez's injuries were extensive. Therefore, there was a possibility of an excess judgment in the case. The adjuster warned Brown of these matters and suggested that an offer to settle the case be made. Brown refused. He had counterclaimed against Gutierrez for his own injuries and did not want to make the admission of fault that is implied in an offer to settle. Boston Old Colony then had Brown execute a "hold harmless" agreement, in which Brown assumed responsibility for any excess judgment.[1310]

[1306] Thompson v. Commercial Union Ins. Co. of New York, 250 So. 2d 259, 260 (Fla. 1971); see also Auto Mutual Indemnity Co. v. Shaw, 184 So. 2d 713 (Fla. 1969).
[1307] Id. at 264.
[1308] Id. at 260 (quoting Shingleton v. Bussey, 223 So. 2d 713 (Fla. 1969)).
[1309] Boston Old Colony Ins. Co. v. Gutierrez, 386 So. 2d 783 (Fla. 1980).
[1310] Id. at 784.

Before the trial, Gutierrez offered to take the policy limits of $10,000 in settlement of his claim against Brown. Boston Old Colony responded by denying liability. Then, Brown settled his counterclaim against Gutierrez and his insurer. Boston Old Colony offered Gutierrez the policy limits as settlement of the claim. Gutierrez refused. The trial resulted in a judgment against Brown for $1,400,000. Gutierrez then sued Boston Old Colony, alleging bad faith on its part because of its failure to settle the claim for policy limits when it had the opportunity. Gutierrez prevailed and obtained a judgment against Boston Old Colony for $1,400,000.[1311]

The question before the Supreme Court was whether the common law in Florida[1312] authorized "a bad faith action against an insurance company when that company [had] refused to settle a claim at the express direction of its own insured who obtains a settlement of his claim and the insurance company thereafter offers to settle for its policy limits before trial?"[1313] The court answered "no."

In analyzing this issue, the court noted that "[a]n insurer, in handling the defense of claims against its insured, has a duty to use the same degree of care and diligence as a person of ordinary care and prudence should exercise in the management of his own business."[1314] The insurer assumes a duty to exercise "such control and made such decisions in good faith and with due regard for the interests of the insured" when the insured surrenders all control over the handling of the claim, including all decisions in the litigation and settlement to the insurer.[1315]

This good faith duty obligates the insurer to advise the insured of settlement opportunities, of the probable outcome of the litigation, of the possibility of an excess judgment, and of any steps the insured might take to avoid such a judgment. The insurer "must investigate the facts, give fair consideration to a settlement offer that is not unreasonable under the facts, and settle, if possible, where a reasonably prudent person, faced with the prospect of paying the total recovery, would do so."[1316]

Justice Alderman wrote specially to voice his opinion on the issues of the bad faith cause of action in the Boston Old Colony case. He opined that an injured plaintiff should not be allowed to sue the defendant's insurer for bad faith failure to settle a claim. According to Justice Alderman, the good faith duty to settle is between the insurer and insured. "In the 'Alice-in-Wonderland' world created by the [common law] rule, it is to the

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[1311] Id. at 784-785.
[1312] See Thompson v. Commercial Union Ins. Co. of New York, 250 So. 2d 259 (Fla. 1971).
[1313] Boston Old Colony Ins. Co. v. Gutierrez, 386 So. 2d 783, 784 (Fla. 1980).
[1314] Id. at 785.
[1315] Id.
[1316] Id.

injured party's benefit if the insurer breaches its duty to its insured and to his detriment if there is no breach."[1317] This result exists because "if the insurer settles, the plaintiff will receive no more than the policy limits, but if it does not, the plaintiff may end up with both the policy limits and an excess judgment."[1318] Accordingly, the common law rule induces a plaintiff not to settle.[1319]

While in Boston Old Colony, the Supreme Court found that the third party (Gutierrez) had failed to prove bad faith on the part of the insurer (Boston Old Colony), the Court continued to extend the common law cause of action itself to persons beyond the insured/insurer contract relationship. Furthermore, the same result has been reached by the courts with respect to the statutory cause of action for bad faith by an insurer.[1320]

Section 624.155, Florida Statutes, describes who may bring a civil action for bad faith and outlines the Insurance Code violations that subject the insurer to such suits. This section states that "[a]ny person may bring a civil action against an insurer when such person is damaged [by the enumerated provisions of the Insurance Code]."[1321] In 1995, the Supreme Court had the opportunity to interpret the phrase, "any person" in the context of a third-party bad faith claim against an insurer.[1322] The court concluded that these words were "precise and their meaning unequivocal. By choosing this wording the legislature has evidenced its desire that all persons be allowed to bring civil suit when they have been damaged by [statutorily] enumerated acts of the insurer."[1323]

Even though the Supreme Court interpreted "any person" to include those people beyond the insured/insurer contractual relationship, the court recognized the premonition of other courts that such an interpretation of this phrase would achieve an unreasonable result. Permitting a third party such a cause of action against the insurer any time the insurer allegedly

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[1317] Id. at 786 (Alderman, J., concurring specially).

[1318] Id.

[1319] Id.; see also Judge Carroll, in Canal Insurance Company of Greenville, South Carolina v. Sturgis, 114 So. 2d 469 (Fla. 1st DCA 1959), aff'd, 122 So. 2d 313 (Fla. 1960):

> No one can today question the legal right of the insured to sue the insurer for negligence or bad faith in failing to settle a claim within the policy limits for, if he has had to pay a part of the judgment, he had indeed suffered damages because of such failure of the insurer; but, when the judgment creditor directly so sues the insurer for an amount above such limits, a vastly different situation exists in the eyes of the law. The judgment creditor has not suffered because of the insurer's failure, but has, if anything, gained thereby. The judgment creditor would be in an anomalous position, for typically he would be claiming damages for the insurer's failure to settle the case for much less than the verdict he himself actually won.

[1320] See, e.g., Auto-Owners Ins. Co. v. Conquest, 658 So. 2d 928 (Fla. 1995), State Farm Fire & Casualty Co. v. Zebrowski, 706 So. 2d 275 (Fla. 1997).

[1321] Section 624.155(1)(a)(1), Florida Statutes.

[1322] See Auto-Owners Ins. Co. v. Conquest, 658 So. 2d 928 (Fla. 1995).

[1323] Id. at 929.

failed to settle in good faith could result in undesirable social and economic effects (such as multiple litigation, unwarranted bad faith claims, coercive settlements, excessive jury awards, and escalating insurance, legal, and other transaction costs).[1324]

In addition to a cause of action under section 624.155(1)(a), Florida Statutes, as interpreted in Auto-Owners Ins. Co. v. Conquest,[1325] a bad faith cause of action also exists under section 624.155(1)(b), Florida Statutes. This provision states, in pertinent part, as follows:

(1) Any person may bring a civil action against an insurer when such person is damaged:

(b) By the commission of any of the following acts by the insurer:

1) Not attempting in good faith to settle claims when, under all the circumstances, it could and should have done so, had it acted fairly and honestly toward its insured and with due regard for her or his interests;

2) Making claims payments to insureds or beneficiaries not accompanied by a statement setting forth the coverage under which payments are being made; or

3) Except as to liability coverages, failing to promptly settle claims, when the obligation to settle a claim has become reasonably clear, under one portion of the insurance policy coverage in order to influence settlements under other portions of the insurance policy coverage.

In 1997, the Supreme Court interpreted this additional cause of action in section 624.155(1)(b), Florida Statutes, and reasoned as follows:

> In subsection (1)(a) there are no specified limitations upon claims for violation of any of the enumerated statutes. However, in subsection (b), the cause of action is predicated on the failure of the insurer to act "fairly and honestly toward its insured and with due regard for his interest." The duty runs only to the insured. Therefore, in the absence of any excess judgment, a third-party plaintiff cannot demonstrate that the insurer breached a duty toward its insured.[1326]

[1324] Id. at 930 (quoting Cardenas v. Miami-Dade Yellow Cab Co., 538 So. 2d 491, 496 (Fla. 3d DCA 1989)).

[1325] Auto-Owners Ins. Co. v. Conquest, 658 So. 2d 928 (Fla. 1995)

[1326] State Farm Fire & Casualty Co. v. Zbrowski, 706 So. 2d 275, 277 (Fla. 1997).

Accordingly, section 624,155(1)(b), Florida Statues, allows a third party to sue a liability insurer for bad faith, without an assignment by the insured when the third party obtains a judgment in excess of the insured's policy limits. This result provides the basis for alleging a breach of duty to the insured.

While the Boston Old Colony case discussed above was decided in favor of the defendant insurer, the case demonstrates various issues facing insurers in fulfilling their obligations to defend their insureds.

First, insurers must remember that, despite their best efforts on behalf of their insured, they are still subject to a bad faith claim brought by the injured third party. Because the claim is brought after the jury returns a verdict in excess of policy limits against the insured, and given the inherent sympathy afforded to the injured plaintiff in a medical malpractice suit, the insurer faces a rather daunting obstacle in defending a bad faith action. Such a defense can require the insurer to maintain that, despite the plaintiff's serious injuries, and with the hindsight knowledge that the underlying suit resulted in a large jury award that exceeded the insured's policy limits, the insurer not only acted reasonably in not settling the underlying medical malpractice suit, but continues to act appropriately in refusing to pay the jury's award.

Second, the insurer has a duty to try to settle the case where a reasonably prudent person facing the prospect of paying the total judgment would do so. This is the simple negligence standard and makes the insurer's position more untenable. At least two standard jury instructions used by Florida judges[1327] charge the jury with the task of determining whether, under the totality of the circumstances, the insurer was reasonable in deciding to proceed to trial, rather than settle the claim. This standard, combined with the statutory "reasonable person" standard, seems to guarantee the success of a bad faith claim[1328] submitted to a jury, given its hindsight regarding the outcome of the already-decided underlying case.

The third issue from Boston Old Colony comes from language at the close of the Supreme Court's opinion there:

> By way of caveat, we point out that the "hold harmless" agreement in this case was not a determining factor in our

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[1327] See Fla. Std. Jury Instr. MI 3.1, 3.2.

[1328] Originally in Florida, bad faith cases fell within the same category of wrongs as frauds. See, e.g., Thompson v. Commercial Union Ins. Co. of New York, 250 So. 2d 259, 264 (Fla. 1971) (holding that a third-party plaintiff could directly sue an insurer for "alleged fraud or bad faith of the insurer in the conduct or handling of the suit"). By way of contrast, reasonable person standards are those that govern innocent (without malice) mistakes (i.e., basic negligence).

> decision. An insurer with control over defense and settlement must at all times act in good faith, and it may not insulate itself from a bad faith excess judgment by simply obtaining a hold harmless agreement from its insured.[1329]

Accordingly, even when an insurer acts at the insistence of the insured in refusing to settle the claim, an insurer is still susceptible to a bad faith judgment against it. An insurer must operate as a fiduciary in the insured's best interest but the insurer cannot defer to the insured's wishes regarding settlement of the case.[1330]

An insurer can also be liable in bad faith for delays in offering policy limits, failing to disclose policy limits, and failing to inform the insured of settlement overtures. Liability still attaches for these omissions when the third-party plaintiff refuses settlement offers so long as there was an opportunity to settle the case at some point in the claim process.[1331] For example, the Third District Court of Appeal decided a case in which an insured's daughter seriously injured a pedestrian in a car accident. The pedestrian's attorney contacted the insurer and requested disclosure of the insured's policy limit. But, the attorney never made a specific monetary demand. Ultimately, the insurer tendered an offer of policy limits, despite the injured pedestrian's lack of demand. The offer was rejected. At trial, the jury returned a verdict against the insured for $250,000. The insured filed suit against his insurer, alleging bad faith.[1332] The Third District Court found bad faith and noted:

> Any question about the possible outcome of a settlement effort should be resolved in favor of the insured; the insurer has the burden to show not only that there was no realistic possibility of settlement within policy limits, but also that the insured was without the ability to contribute to whatever settlement figure that the parties could have reached. [citations omitted]. Whether the insurer's delay in disclosing the policy limits foreclosed settlement negotiations and prevented an offer to settle is a relevant and material fact.[1333]

Thus, there is an affirmative duty on the part of the insurer to seek settlement of a claim against the insured within the policy limits. When

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[1329] Boston Old Colony Ins. Co. v. Gutierrez, 386 So. 2d 783, 786 (Fla. 1980).

[1330] See Vincent Rio, J.D., testimony, Nov. 22, 2002, pgs. 120-121.

[1331] See Powell v. Prudential Property & Casualty Ins. Co., 584 So. 2d 12 (Fla. 3d DCA 1991), rev. denied, 598 So. 2d 77 (Fla. 1992).

[1332] While the Powell v. Prudential Property & Casualty Ins. Co. case arose in a general tort context, the same result would have existed in the medical malpractice context, substituting in the fact pattern a doctor for the car driver and an injured patient for the pedestrian.

[1333] Id. at 14-15.

the insurer fails to obtain a settlement, it then has the burden of demonstrating that the plaintiff would not have accepted a settlement offer within policy limits at any time.

Furthermore, under section 627.4147, Florida Statutes, all medical malpractice insurance policies must contain a clause authorizing the insurer "to determine, to make, and to conclude, without the permission of the insured, any . . . settlement offer . . . if the offer is within the policy limits."[1334] This statute further proclaims that it "is against public policy for any insurance . . . policy to contain a clause giving the insured the exclusive right to veto any . . . settlement offer . . . when such offer is within the policy limits."[1335] The result of this provision is that the insurance carrier is expected to make an independent evaluation of the claim and to act accordingly, including settling the case, regardless of the insured's position as to whether settlement is appropriate. These statutory provisions place pressure on the insurer to settle claims filed against their insureds, at the risk of being liable to either the insured or a third-party plaintiff for the entire judgment rendered against the insured, and irrespective of the coverage limits of the insured's policy.

Despite this pressure to settle claims, however, the statutes also place a constraint on the insurer's ability to settle when the insured objects to the settlement. Section 627.4147(1)(b), Florida Statutes, also contains the following language: "any offer of admission of liability, settlement offer, or offer of judgment made by an insurer or self-insurer shall be made in good faith and in the best interest of the insured." This standard is open to many interpretations, including the insured's out-of-pocket expense, financial position, and the impact settlement may have on future employment possibilities or the insured's professional reputation.

The damages recoverable in bad faith actions under present law in Florida, as well as the other standards discussed above, have little relationship to the public purposes of asset protection, making specified coverage available, or encouraging reasonable behavior.[1336] When a $5,000,000 judgment is entered against an insured because of the insurer's failure to settle, the implication is that the "real" amount of the insured's damages is $5,000,000, when the insured may never have such an amount of reachable assets. Accordingly, the insurer is required to pay beyond the combination of its policy limits and the accumulated and future assets of the insured, with no rational basis. The conclusion is that the plaintiff is financially better off if the insurer behaves badly than if the insurer behaves properly.

[1334] Section 627.4147(1)(b), Florida Statutes. This mandate does not apply to all liability insurance contracts but almost all contracts give the insurer the exclusive right to settle.

[1335] Section 627.4147(1)(b)1, Florida Statutes.

[1336] See Vincent Rio, I.D., Summary of Comments to Medical Malpractice Task Force 1.

Like Florida, California allows bad faith causes of action when an insurer breaches its duty to attempt to settle meritorious claims.[1337] However, California does not require that the insured contract away his right to trial when the insurer feels that the case should be settled. Thus, when an insured refuses to consent to settle and the insurance contract allows the insured to veto settlement, the insurer cannot be held liable in fad faith for refusing to settle the plaintiff's claim against the insured's consent.[1338]

Other states also expressly articulate the standards that constitute bad faith acts. For example, Illinois law provides that seven factors should be considered in determining whether the insurer has failed to act in the good faith interests of the insured. These factors include:

- whether the insurer has considered the advice of the insurer's own adjuster;
- whether the insurer refuses to negotiate a settlement;
- what advice the insurer receives from its defense counsel;
- whether the insurer keeps the insured fully aware of the claimant's willingness to settle;
- whether the insurer conducts an adequate investigation into the claim;
- whether there exists a substantial prospect of an adverse verdict; and
- the potential for damages that exceed the policy limits.[1339]

Finally, Michigan is instructive as to an example in limiting damages in bad faith cases. In Michigan, the relationship with the insured is not a fiduciary relationship.[1340] On the other hand, the duty is greater than that of a buyer and seller of products and services. The duty of using good faith in settlement negotiations is a duty to protect the insured—it is of a fiduciary nature.[1341] The insurer must fulfill its policy-contracted obligation with the utmost loyalty to its insured.[1342]

Michigan law provides that bad faith may exist if the defense attorney advises the insurer that defense of the case is hopeless, recommends settlement, the insurer refuses to settle, and the jury returns a judgment in excess of policy limits.[1343] Arbitrary, reckless, indifferent, or intentional disregard of the interest of the insured amounts to bad faith.[1344]

[1337] See section 790.03, California Statutes.
[1338] See Carlile v. Farmers Ins. Exchange, 219 Cal. Rptr. 773 (Cal 3d DCA 1985).
[1339] See O'Neill v. Gallant Ins. Co., 769 N.E.2d 100 (Ill. 5th DCA 2002).
[1340] Drouillard V. Metropolitan Life Ins. Co., 107 Mich. App. 608, 621 (1981).
[1341] Lisiewski v. Countrywide Ins. Co., 75 Mich. App. 631, 637 (1977).
[1342] Meirthew v. Last, 376 Mich. 33, 38 (1965).
[1343] City of Wakefield v. Globe Indemnity Co., 246 Mich. 645 (1929).
[1344] Commercial Union Ins. Co. v. Liberty Mutual Ins. Co., 426 Mich. 127 (1986). This case outlines twelve factors that the "factfinder may take into account . . . in deciding whether or not the defendant

The most unique principle of Michigan's bad faith law is the insurer's liability for bad faith in the case of excess judgments. Michigan law limits the bad faith exposure of an insurer "by precluding collection on the judgment from the insurer beyond what is or would actually be collectable from the insured."[1345] In Frankenmuth Mutual Ins. Co. v. Keeley, Charles Keeley, the son of the insured, shot the plaintiff, Boone, rendering Boone a quadriplegic.[1346] The plaintiff demanded policy limits of $50,000, but the insurer initially offered to settle for $20,000 on the basis that the policy excluded intentional acts. Within the month and after the plaintiff filed his lawsuit, the insurer offered to settle for $25,000. Two and one-half years later, after much litigation over the claim and the coverage, the insurer tendered policy limits. Boone rejected this offer. The case proceeded to trial and the jury determined the damages to be $500,000, but found that the plaintiff, Boone, was 50 percent at fault. Judgment was entered against Keeley for $250,000. Boone agreed to forbear any action against Keeley for the excess judgment, and Keeley agreed to pursue action against the insurer for the excess judgment and to pay any sums recovered from the insurer to the plaintiff.[1347]

On first hearing, the majority of the Michigan Supreme Court held that "the insurer is liable for the excess without regard to whether the insured has the capacity to pay."[1348] On rehearing, the Michigan Supreme Court essentially reversed itself and limited the bad faith liability of the insurer to the amount that can actually be collected from the insured.[1349]

The reasoning behind the Michigan rule on bad faith liability rests on the issue of causal relationship to damages. The question was "whether . . . there was a causal relationship between the bad-faith conduct that the [judge] found in the handling of the claim and the loss claimed by Keeley resulting from the entry of the judgment in the amount of $250,000."[1350] Accordingly, the question should be whether the insurer caused damage to

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[insurer] acted in bad faith . . ." Id. at 137-139. The Florida Legislature may want to consider adopting some or all of these factors.

[1345] Frankenmuth Mutual Ins. Co. v. Keeley, 433 Mich. 525, 565 (1989). The quoted language is from the dissenting opinion of Justice Levin; however, Justice Levin's dissent was adopted by the majority in Frankenmuth Mutual Ins. Co. v. Keeley (on rehearing), 436 Mich. 372, 376 (1990).

[1346] Id. at 547.

[1347] See id. at 547-549.

[1348] Id. at 528. The court also adopted what is known as the "judgment rule," as contrasted with the "prepayment rule." The "prepayment rule" requires that the insured make some payment on the judgment before pursuing an action for bad faith against the insurer, while the judgment rule simply requires the entry of a judgment. Id. at 553. This portion of the majority opinion was adopted by the dissent on first hearing and then by the majority on rehearing. See Frankenmuth Mutual Ins. Co. v. Keeley (on rehearing), 436 Mich. 372 (1990).

[1349] Id. at 565.

[1350] Id. at 551.

the insured, and if so, what actual damage the insurer sustained. In reaching the decision that the Michigan law should be that the insurer is not required to pay more than the insured is able to pay on the judgment, the Michigan Supreme Court quoted extensively from a New York Court of Appeals case and from Judge Keeton:

> I do not suggest—although there are a number of decisions so holding—that an insured must pay the judgment before he, or another on his behalf, is able to proceed against a bad faith insurer. However, there must be some showing that he has been damaged. In the case before us, there is not the slightest evidence, or even intimation, that the insured was harmed by the judgment, that he had any assets which were imperiled or that either his reputation or credit was impaired.
>
> In short, the complaint in this case should be dismissed not only because there is no evidence that the insurer acted in bad faith but also because there is no evidence that the insured suffered any damaged.[1351]

Judge Keeton has expressed the following view:

> When it seems almost certain the insured will never pay anything at all on the excess judgment if the claim against the insurer is denied, arguments that the insured has been damaged by the increase in debts are rather weak support for any cause of action at all, much less for a measure of damages equal to the amount of the increase in the insured's debts. However, other courts have concluded that the entry of judgment against a person constitutes a loss and that the insured's "loss does not turn on whether the judgment has been satisfied." Since, absent a discharge of the obligation through a bankruptcy proceeding, the third party's judgment can remain as an outstanding obligation for extended periods of time, in many circumstances there is considerable uncertainty in regard to predicting whether the insured may ultimately have resources or assets that may be taken to satisfy some portion of the judgment.
>
> Third party claimants are not in a position to assert that they were harmed as a result of the insurer's conduct in regard to having not settled the tort claim. The insurer's duty was to the insured, not to the claimant. Furthermore,

[1351] Gordon v. Nationwide Mutual Ins. Co., 30 N.Y. 2d 427, 441, 285 N.E 2d 849 (1972).

> in one sense, a third party benefits from the insurer's refusal to settle because the insurer's refusal to settle resulted in the claimant's obtaining a judgment in excess of the amount the claimant had offered to accept in settlement. Thus, although the third party claimant deserves further compensation, the theoretical justification for imposing liability on the insurer does not warrant a recovery by such a claimant any more than the innocent victims of an under-insured tortfeasor would be entitled to indemnification beyond the amount of the applicable coverage from a liability insurer who had not refused a settlement.[1352]

The Task Force finds that the Michigan law that precludes the collection on the judgment from the insurer beyond what is or would actually be collected from the insured is sound in principle, public policy, and reasoning.

Information Presented to the Task Force

The Task Force heard testimony that certain aspects of bad faith law have resulted in costing consumers more than it benefits them.[1353] According to testimony, one of the most frequent complaints of defendant medical providers is that they are not responsible for the plaintiff's injury and that they do not want to settle the case because they want to prove their "innocence" in court.[1354] However, insureds with low policy limits, as compared to the possible amount of a jury verdict, are often required by the law of bad faith to accept settlement offers that otherwise would be rejected.[1355]

For example, a physician is sued for $5,000,000 by a plaintiff who alleges medical malpractice on the part of the physician. The physician has $300,000 in liability coverage and $100,000 of reachable assets. The physician, based on evaluation of the case, appears to be innocent and when this insurer refuses to settle based on such an evaluation, he or she prevails 90 percent of the time. Under current law, if this case is lost at trial, the insurer would be liable for the $5,000,000 verdict. The difference of $4,600,000 was not caused by the insurer's bad faith but the plaintiff is the recipient of the windfall anyway.[1356] This scenario is the environment in which cases are litigated and it forces insurers to settle

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[1352] Frankenmuth Mutual Ins. Co. v. Keeley, 433 Mich. 525, 554-556 (1989).
[1353] See Vincent Rio, J.D., Summary of Comments to Medical Malpractice Task Force 2.
[1354] See Tommy Dukes, J.D., testimony, Oct. 21, 2002, pg. 239.
[1355] See Vincent Rio, J.D., testimony, Nov. 22, 2002, pg. 121.
[1356] See Vincent Rio, J.D., Summary of Comments to Medical Malpractice Task Force 1-2.

cases at, near, or even somewhat above policy limits to avoid bad-faith claims.[1357]

The following solutions were provided to the Task Force:

- Restore the insured as the owner of the bad faith cause of action.[1358]

- The common law cause of action, as outlined by the Supreme Court in 1980[1359] should be preempted by the Florida Legislature so that only insureds, not third-party plaintiffs, can bring a bad faith cause of action against its insurer.[1360] In addition, section 624.155, Florida Statutes, should be amended to limit the proper party in a bad faith cause of action to the insured only.

- Legislatively identify common sense standards of what constitutes bad faith.[1361]

- The current law is vague as to what defines bad faith. Examples of some standards that were presented to the Task Force, include: (1) the insurer's proper investigation of a claim, providing an insurer with a reasonable period in which to investigate all aspects of potential liability of the insured and of the plaintiff's potential damages without being in bad faith; (2) no bad faith if the insurer tenders its policy limits sixty days before trial; (3) the insurer's willingness to negotiate, allowing the insurer to consider the interest of all its insureds in defending claims that it believes to be overstated; (4) clarify that an insurer has no affirmative duty to initiate settlement negotiations when it believes such an action would be detrimental to the ultimate settlement; (5) disallow bad faith claims when an insured refuses to consent to a proposed settlement and/or when the insurer agrees to indemnify the insured for excess judgments collectible from the insured's reachable assets; (6) the insurer's consideration of the advice of its defense counsel; and (7) whether the insurer informed the insured of the offer to settle within the limits of coverage, the right to retain personal counsel and the risks of litigation.[1362]

[1357] Id. at 2.

[1358] See Vincent Rio, J.D., testimony, Nov. 22, 2002, pgs. 117-118.

[1359] See Boston Old Colony Ins. Co. v. Gutierrez, 386 So. 2d 783 (Fla. 1980).

[1360] Section 624.155(7), Florida Statutes, currently provides that "[t]he civil remedy specified in this section does not preempt any other remedy or cause of action provided for pursuant to any other statute or pursuant to the common law of this state." Id.

[1361] See Vincent Rio, J.D., testimony, Nov. 22, 2002, pgs. 117-118.

[1362] See Vincent Rio, J.D., Summary of Comments to Medical Malpractice Task Force 3.

- Calculate the maximum liability for bad faith as the amount of damages that were actually caused by the acts of bad faith, limited by the amount of the reachable assets of the insured.[1363]

- The bad faith claimant should be required to prove that he has sustained actual financial damage as a result of the bad faith of the insurer and the claim of bad faith should be limited to such actual damage. In addition, the insured should be entitled to retain his assets while the insurer pays any excess judgment, up to the amount of the reachable assets of the insured. If the financial circumstances of the insured improved over the life of the judgment, the insurer should be responsible for such excess payments.[1364]

In response, the Task Force heard testimony that the current state of the law in Florida adequately protects insured and ensures that insurers protect insureds' assets.[1365] Insurers control the defense of the case and decide when and if to settle.[1366] The plaintiffs' bar testified that because judgments in Florida are effective for twenty years, a proposal to limit the bad faith exposure of an insurer to the reachable assets of the insured at the time of judgment may expose the insured's future assets.[1367]

Findings and Recommendations

The Task Force finds that there is a problem with the state of the law in Florida on the issue of bad faith. The problem is that the cost of settlement made under the veil of the bad faith law in Florida is a major factor in raising loss costs that insurers must pay and, in turn, in raising malpractice insurance premiums. The problem stems from the fact that third parties can sue the insurer for bad faith, when the good-faith duty is owed by the insurer to the insured. There is no corresponding good faith duty that extends from the insurer to injured plaintiffs who are not part of the insured/insurer contractual relationship. The law on bad faith is lacking in logical standards that constitute (or at least evidence) bad faith on the part of an insurer. Finally, a limitation on the amount of damages for which an insurer would be liable would promote consistency and predictability in the market.

The Task Force finds calculating the damages recoverable in an action for bad faith based on the actual damages caused by the insurer would have several beneficial effects. First, this calculation would allow insurers to

[1363] See Vincent Rio, J.D., testimony, Nov. 22, 2002, pgs. 123-124.
[1364] Id. at 121.
[1365] See Lake Lytal, J.D., testimony, Nov. 22, 2002, pgs. 123-124.
[1366] Id. at 124.
[1367] Id. at 126.

honor requests from well-informed insureds who prefer that actions be defended rather than settled because of the threat now posed by Florida bad faith standards and calculations of damages. Second, this calculation would enable insurers to more effectively resist the coercive effect of these standards and measurements of damage, which raise the costs of settlements and premiums. The assets of insureds would remain fully protected. The protection of assets that are replaced by insurance may logically be expected to encourage the purchase of insurance.

The Task Force recommends the following legislative solutions:

Recommendation 1. The Legislature should restore the insured as the owner of the bad faith cause of action. The common law cause of action, as outlined by the Supreme Court in 1980[1368] should be legislatively cured so that the Florida Legislature preempts that rule and only insureds, not third-party plaintiffs, can bring a bad faith cause of action against its insurer.[1369] In addition, section 624.155, Florida Statutes, should be amended to also limit the proper party in a bad faith cause of action to the insured only.

Recommendation 2. The Legislature should articulate standards of what constitutes bad faith on the part of an insurer.

Recommendation 3. The Legislature should require that the maximum liability for bad faith be calculated as the amount of damages that were actually caused by the acts of bad faith, limited by the amount of the reachable assets of the insured.

Recommendation 4. The Legislature should require that, if an insurer is found to be in bad faith or settles a case for bad faith, the Department of Insurance be notified of such finding.

Recommendation 5. The Department of Insurance should conduct an investigation into the specific allegations of the insurer and into the insurer's general practices and should take necessary action against the insurer to punish and prevent future bad faith practices.

[1368] See Boston Old Colony Ins. Co. v. Gutierrez, 386 So. 2d 783 (Fla. 1980).

[1369] Section 624.155(7), Florida Statutes, currently provides that "[t]he civil remedy specified in this section does not preempt any other remedy or cause of action provided for pursuant to any other statute or pursuant to the common law of this state." Id.

Alternative Insurance Products

Issue

The Task Force voted at its January 8, 2003 meeting, by a 5-0 vote, to examine the following issues with respect to alternative insurance products in the context of medical malpractice cases:

- Should the Department of Insurance be directed to work with physicians and hospitals to expand self-insurance options?
- Should the Legislature create tax and other regulatory incentives for the creation of mutual, trust, and other physician-owned insurance companies to provide coverage?
- Should the patient compensation fund be reactivated?
  - Should there be mandatory participation by physicians and hospitals?
  - Should there be caps on payments?

Current Situation

The Florida Insurance Code provides several alternative insurance products that can be used by healthcare providers to provide medical malpractice insurance coverage. These include commercial Self-Insurance Funds in section 624.462, Florida Statutes, Risk Retention Groups in section 627.942, Florida Statutes, and Medical Malpractice Risk Management Trust Funds in section 627.357, Florida Statutes.

Only the Medical Malpractice Risk Management Trust Fund statute is a specific alternative for commercial medical malpractice insurance; the other forms of self-insurance are available to any group providing self-insurance. A Medical Malpractice Risk Management Trust Fund is authorized to purchase insurance, specific excess insurance, and aggregate excess insurance. The fund is authorized to hire consultants for loss prevention and claims management coordination, and pay claims; the "prudent" investment of trust funds is also authorized. The Department of Insurance is directed to adopt rules to implement the section including ensuring the funds meet a requirement that a trust fund created pursuant to the act maintain sufficient reserve to cover contingent liabilities in the event of a dissolution.

The funding of a trust fund created pursuant to the section is provided by premiums paid by members. Additionally, each member has a contingent

assessment liability to pay actual losses when there is a deficiency due to claims or liquidation. A member's share of any deficiency is to be computed by applying against the member's premium the ratio of the total deficiency to the total premiums earned. If a member fails to pay the assessment, the other members are proportionately liable for that amount. This assessment must be made if assets of the trust fund are insufficient to discharge the funds liabilities and meet the requirements of law or if a judgment remains unpaid for thirty days.

The Department of Insurance must review and approve all expense factors related to rates before a new rate can be implemented. For the Department to approve rates and the associated expense factors, the rates must be justified and reasonable for the benefits and services provided.

The statute provides that the premiums, contributions, and assessments are subject to taxation at 1.6 percent instead of the 1.75 percent provided in section 624.509(1) and (2), Florida Statutes, for insurance premiums and assessments generally.

In 1992, the statute was amended to provide that no Medical Malpractice Risk Management Trust Fund could be formed after October 1, 1992. Currently there are only two trust funds in existence: the South Pinellas Medical Malpractice Risk Management Trust Fund, and the Central Dade Medical Malpractice Risk Management Trust Fund.

Information Presented to the Task Force

Speakers on both sides of the medical malpractice issue discussed the need to reactivate the provisions of section 627.357, Florida Statutes, to again allow physicians and hospitals to create self-insurance funds. Speakers agreed that making this alternative form of insurance available would provide a viable insurance option to healthcare providers.

Mr. Neal Roth indicated physicians and hospitals needed the authority to create the self-insurance trust funds.[1370] To encourage the creation of these trust funds, Mr. Roth suggested the Legislature should provide tax incentives such as exemption from the tax on premiums and exemption of the companies from payment to the guarantee fund. He also suggested the Department of Insurance should be given additional authority to review the capitalization requirements for these trust funds.

Mr. Bruce Hill, an Orlando attorney who represents hospitals, also recommended removing the prohibition on creation of self-insured trust

[1370] Neal Roth, J.D., testimony, Nov. 22, 2002, pgs. 129-130.

funds.[1371] Mr. Hill was general counsel and chief trial counsel for the Florida Hospital Trust Fund created in the 1970s in response to that medical malpractice insurance crisis. Mr. Hill testified that the fund worked well until 1995, when the insurance companies under-cut the rates to the point it was more cost effective for the hospitals to purchase commercial insurance.[1372] At that point, the trust fund stopped selling insurance. Currently, all of the claims against the fund have been paid and an excess $30 million is to be refunded to the member hospitals.[1373] Mr. Hill testified that the fund was heavily regulated by the Department of Insurance to ensure the rates were actuarially sound and the investments were secure. He explained that the reason the fund worked was a low expense ratio resulting from no advertising and no agents. Additionally, the members who ran the trust fund had an interest in ensuring that the fund operated cost effectively because they had to pay part of the bill if assessments became necessary. Finally, the member-run trust fund encouraged the participating hospitals to maintain better risk management programs to reduce claims.[1374]

David McKinney, an executive with Pro National Assurance Company, pointed out some of the concerns with newly-formed alternative risk groups.[1375] First, they face the same uncertainty in claims experience that the insurance companies are facing and the managers often do not have the experience to assess those risks. This allows mistakes in underwriting and claims evaluation.[1376] Because of the significant lag time for claims to be made these problems can be long term in nature. Additionally, the physician-run operations are subject to losing members when the insurance market softens and commercial insurance rates decrease.[1377] His last major point was the fact that under these funds, the members are jointly and severally liable for all claims. He stated the key to a strong fund was having "good people" running the insurance program who know what they are doing.[1378]

Mr. Steve Roddenberry[1379] discussed the regulation of risk retention groups with the Task Force. After an extensive discussion of commercial insurance, Mr. Roddenberry brought up concerns regarding the regulation of risk retention groups.[1380] The rates and forms of risk retention groups domiciled outside of Florida are not subject to review by the Department

[1371] Bruce Hill, J.D., testimony, Nov. 22, 2002, pgs. 143, 146-150.
[1372] Id.
[1373] Id.
[1374] Id.
[1375] David McKinney, testimony, Nov. 22, 2002, pgs. 151-155.
[1376] Id.
[1377] Id.
[1378] Id.
[1379] Steve Roddenberry, Director, Department of Insurance.
[1380] Steve Roddenberry, testimony, Nov. 4, 2002, pg. 401.

of Insurance.[1381] Further, they do not have the same minimum capital or surplus requirements as insurance companies and they are not eligible for the guarantee fund if a failure should occur.[1382]

Findings and Recommendations

The Task Force finds the healthcare community has an option to address medical malpractice self-insurance programs. Further, the Task Force finds that the Department of Insurance does not have sufficient rule-making authority to provide protection to the healthcare professionals and the victims of medical malpractice utilizing or making claims against self-insurance funds.

The Task Force recommends the Legislature encourage the use of self-insurance funds by healthcare providers and expand the rulemaking authority of the Department of Insurance to adopt rules providing for better regulation of the self-insurance programs to ensure they remain solvent and provide the insurance coverage purchased by participants.

The Task Force finds that removing the limitation on the creation of Medical Malpractice Risk Management Trust Funds would provide an additional opportunity for medical facilities and providers to have insurance rather than "go bare," quit practicing medicine, or reduce services provided. Additionally, the creation of these funds would increase the opportunities to ensure that injured parties are compensated.

Recommendation 1. The Legislature should repeal the prohibition against creating Medical Malpractice Risk Management Trust Funds in section 627.357, Florida Statutes.

Recommendation 2. The Legislature should encourage the creation of self-insured options for healthcare providers.

Recommendation 3. The Legislature should expand the rulemaking authority of the Department of Insurance for self-insurance programs to ensure they remain solvent and provide the insurance coverage purchased by participants.

[1381] Id.
[1382] Id.

Insurance Code Reform

Issue

The Task Force voted at its January 16, 2003 meeting, by a 5-0 vote, to examine the following issues with respect to insurance code reform:

- Should the Department of Insurance be authorized to require insurers to provide:
  - How much insurers pay for the different categories of damages;
  - How much claimants actually received in settlements or verdicts that are reduced post trial; and,
  - How much insurers pay in cases involving multiple defendants?

- Should the Department of Insurance prohibit punitive damages or bad faith judgments from being included in the rate base?

Current Situation

Section 627.912, Florida Statutes, requires all insurance companies, self-insurers, and joint underwriting associations providing professional liability insurance to a healthcare practitioner[1383] to report any claim or action for damages for personal injuries claimed to have been caused by error, omission, or negligence in the performance of the insured's professional services, or based on a claim the services were performed without consent. These reports must be made only if the claim resulted in a final judgment or a settlement in any amount.[1384] The reports must contain the following specific information:

> (2) The reports required by subsection (1) shall contain:
> (a) The name, address, and specialty coverage of the insured.
> (b) The insured's policy number.
> (c) The date of the occurrence with created the claim.
> (d) The date the claim was reported to the insurer or self-insurer.
> (e) The name and address of the injured person. This information is confidential and exempt from the provisions

[1383] Section 627.912 (1), Florida Statutes, provides the reports must be made for any practitioner of medicine licensed under chapter 458, any practitioner of osteopathic medicine licensed under chapter 459, any podiatric physician licensed under chapter 461, any dentist licensed under chapter 466, any hospital licensed under chapter 395, any crisis stabilization unit licensed under part IV of chapter 394, any health maintenance organization certificated under part I of chapter 641, any clinics included in chapter 390, any ambulatory surgical center defined in section 395.002, and any member of the Florida Bar.
[1384] Section 627.912(1), Florida Statutes.

of s. 119.07(1), and must not be disclosed by the department without the injured person's consent, except for disclosure by the department to the Department of Health. This information may be used by the department for purposes of identifying multiple or duplicate claims arising out of the same occurrence.

(f) The date of suit, if filed.

(g) The injured person's age and sex.

(h) The total number and names of all defendants involved in the claim.

(i) The date and amount of judgment or settlement, if any, including the itemization of the verdict, together with a copy of the settlement or judgment.

(j) In the case of a settlement, such information as the department may require with regard to the injured person's incurred and anticipated medical expense, wage loss, and other expenses.

(k) The loss adjustment expense paid to defense counsel, and all other allocated loss adjustment expense paid.

(l) The date and reason for final disposition, if no judgment or settlement.

(m) A summary of the occurrence which created the claim, which shall include:

1. The name of the institution, if any, and the location within the institution at which the injury occurred.

2. The final diagnosis for which treatment was sought or rendered, including the patient's actual condition.

3. A description of the misdiagnosis made, if any, of the patient's actual condition.

4. The operation, diagnostic, or treatment procedure causing the injury.

5. A description of the principal injury giving rise to the claim.

6. The safety management steps that have been taken by the insured to make similar occurrences or injuries less likely in the future.

(n) Any other information required by the department to analyze and evaluate the nature, causes, location, costs, and damages involved in professional liability cases.

Subsection (4)[1385] provides that the entity making the report is not liable for any action taken in reporting to the Department of Insurance. However, the department may impose a fine of $250 per day per case, up

[1385] Section 627.912, Florida Statutes.

to $1,000 per case for violations of the requirements of the section. The subsection related to fines only applies to claims accruing on or after October 1, 1997.[1386]

According to the Department of Insurance, some insurers may not report as required and others, such as self-insurers, off-shore captive companies, risk retention groups, and surplus lines companies do not report at all.[1387]

Section 456.049, Florida Statutes, requires medical professionals to report any claim or action for damages for personal injury if the claim was not covered by an insurer required to report under section 627.912, Florida Statutes, where the claim resulted in a final judgment or settlement in any amount or a final disposition with no payment on behalf of the licensee.[1388]

The report is to be filed with the Department of Health no later than sixty days after the occurrence of the judgment, settlement, or determination of no payment. The report must contain the following:

(a) The name and address of the licensee.
(b) The date of the occurrence which created the claim.
(c) The date the claim was reported to the licensee.
(d) The name and address of the injured person. This information is confidential and exempt from s. 119.07(1) and shall not be disclosed by the department without the injured person's consent. This information may be used by the department for purposes of identifying multiple or duplicate claims arising out of the same occurrence.
(e) The date of suit, if filed.
(f) The injured person's age and sex.
(g) The total number and names of all defendants involved in the claim.
(h) The date and amount of judgment or settlement, if any, including the itemization of the verdict, together with a copy of the settlement or judgment.
(i) In the case of a settlement, such information as the department may required with regard to the injured person's incurred and anticipated medical expense, wage loss, and other expenses.

[1386] Section 627.912(4), Florida Statutes.
[1387] Steve Roddenberry, Deputy Director of the Division of Insurer Services at the Florida Department of Insurance.
[1388] This includes injuries alleged to have been caused by error, omission, or negligence in the performance of the licensee's professional services or based on a claimed performance of professional services without consent.

(j) The loss adjustment expense paid to defense counsel, and all other allocated loss adjustment expense paid.

(k) The date and reason for final disposition, if no judgment or settlement.

(l) A summary of the occurrence which created the claim, which shall include:

1. The name of the institution, if any, and the location within such institution, at which the injury occurred.

2. The final diagnosis for which treatment was sought or rendered, including the patient's actual condition.

3. A description of the misdiagnosis made, if any, of the patient's actual condition.

4. The operation or the diagnostic or treatment procedure causing the injury.

5. A description of the principal injury giving rise to the claim.

6. The safety management steps that have been taken by the licensee to make similar occurrences or injuries less likely in the future.

(m) Any other information required by the department to analyze and evaluate the nature, causes, location, cost and damages involved in professional liability cases.

On a national level, each entity making a medical malpractice payment under a policy of insurance, self-insurance, or otherwise in settlement of or to satisfy a judgment related to medical malpractice on behalf of a healthcare provider must, report to the National Practitioner Data Bank.[1389] The information to be reported includes:

(1) the name of any physician or licensed health care practitioner for whose benefit the payment is made,

(2) the amount of the payment,

(3) the name (if known) of any hospital with which the physician or practitioner is affiliated or associated,

(4) a description of the acts or omissions and injuries or illnesses upon which the action or claim was based, and

(5) such other information as the Secretary determines is required for appropriate interpretation of information reported under this section.

[1389] 42 U.S.C. section 11131.