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IN THE FLORIDA SUPREME COURT

JAMES F. COY, M.D., SIDNEY R. STEINBERG, M.D., and CLAUDE A. BOYD, M.D., on behalf of themselves and all others similarly situated,

Appellants,

CASE NO. 76,565

vs.

FLORIDA BIRTH-RELATED NEUROLOGICAL INJURY COMPENSATION PLAN, FLORIDA BIRTH-RELATED NEUROLOGICAL INJURY COMPENSATION ASSOCIATION, TOM GALLAGHER, in his official capacity as the head of THE FLORIDA DEPARTMENT OF INSURANCE and LAURENCE GONZALEZ, in his official capacity as the head of THE FLORIDA DEPARTMENT OF PROFESSIONAL REGULATION,

Appellees.

REPLY BRIEF OF AMICUS CURIAE, DR. JAMES T. MCGIBONY, DR. JOSEPH VON THRON, DR. MARK D. ZIFFER AND DR. WILLIAM BARFIELD, IN SUPPORT OF APPELLANTS

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I. IN THE ABSENCE OF ANY ADMISSIBLE EVIDENCE OF A RATIONAL BASIS FOR THE LEGISLATURE TO SINGLE OUT THE APPELLANTS TO BEAR THE BURDEN OF RESOLVING THE OBSTETRICIANS' MALPRACTICE INSURANCE PROBLEMS, THE TRIAL COURT'S ORDER MUST BE REVERSED.

The appellees' answer brief abounds with conclusory statements that the assessment is constitutionally valid. For example, the appellees assert that the assessment "was not so far afield or so infirm as to overcome the presumption in favor of constitutionality", "is not overburdensome", "is not unreasonable or arbitrary", "is not so great, nor is the classification so palpably arbitrary, as to be beyond necessity for the legislation", "is [not] grossly unequal or discriminatory", "is not equal to an impairment of the constitutional rights of property." Appellees' Answer Brief at 15, 16, 18. All of above-quoted statements contained in the appellees' brief are nothing more than legal conclusions. These legal conclusions do not provide an explanation as to how the imposition of the assessment on the appellants is based upon a rational relationship or why it does not arbitrarily discriminate against appellants' class without a reasonable distinction or difference.

The only purported explanation of a rational basis for the imposition of the assessment on the appellants was provided by the testimony of Mr. Jay Weinstein at trial. The appellees concede as much in their brief when they state: "Mr. Jay Weinstein, an expert in hospital administration and found so qualified by the lower court, provided unrefuted testimony regarding the extent and effects of the disruption of obstetrical services and the delivery of healthcare services." Appellees' Answer Brief at 22 (emphasis added). The appellees then quote from and cite to the testimony of

Mr. Weinstein regarding the purported impact of the absence of obstetrical services. Id. at 23. The appellees set forth the purpose of having Mr. Weinstein testify in the trial court:

> The obvious purpose of Mr. Weinstein's testimony was to advise the court of the importance of obstetrical services within the hospital setting in the public health area and the overall effect of the disruption of the delivery of obstetrical services at hospitals or other healthcare facilities.
>
> Mr. Weinstein was clearly qualified to advise the court in that area.

Id. at 40-41 (emphasis added).

The appellees in an attempt to buttress Mr. Weinstein's testimony regarding obstetrics make a number of conclusionary statements regarding his expertise. These statements are completely unsupported by Mr. Weinstein's qualifications. The appellees assert:

> Mr. Weinstein was specifically qualified by NICA as an expert to discuss and offer his opinion regarding the effects of the malpractice crisis and the delivery of obstetrical services in Florida and the effects of this disruption on the healthcare system in Florida. Mr. Weinstein was clearly qualified because of his years of experience as a hospital administrator and, as a result of that experience, had obtained a detailed knowledge and understanding of the healthcare system in Florida. Further, Mr. Weinstein's experience has given him knowledge regarding the overall and general effects of the malpractice crisis on the delivery of obstetrical services and effect of the disruption of obstetrical services on the healthcare system of Florida.

Id. at 38 (emphasis added).

The appellees go on to state:

> Mr. Weinstein specifically testified that he is familiar with all aspects regarding the delivery of healthcare services in a hospital. He was particularly familiar with the way in which obstetrical services are

delivered in a hospital from an administrative point of view, not a medical point of view.

Id. at 40 (emphasis added).

Mr. Weinstein had absolutely no expertise in the area "of the importance of obstetrical services" or "the effect of the disruption of the delivery of obstetrical services." During the past nine years, Mr. Weinstein has not been involved with a hospital that delivered babies. Hearing Transcript at 69-70 (R. at 247-48). In fact, the hospital which employs Mr. Weinstein has not paid a penny into the Plan because it does not deliver babies. Id.[1] Finally, Mr. Weinstein admitted that the hospitals that he has been involved with during the past nine years, which do not deliver babies and do not pay anything into the Plan, "have all gotten along perfectly fine without delivering babies." Id. at 88-89 (R. at 266-67). If the recent malpractice crisis disrupted the delivery of obstetrical services, then according to Mr. Weinstein, none of the hospitals he has been involved with were adversely affected.

Mr. Weinstein knew absolutely nothing about the "delivery of obstetrical services" or the "effect of the disruption of obstetrical services on the health care system in Florida." Mr.

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[1] Under the legislation, hospitals are required to pay $50 per baby delivered. If a hospital has no deliveries, then it pays nothing into the Fund. § 766.314(4)(a), Fla. Stat. (1988 Supp.).

It should be noted that appellees' brief on page 5 in its statement of the facts erroneously states: "All hospitals in the state of Florida . . . pay certain defined assessments for purposes of funding the Plan." This statement is true only to the extent that the hospital delivers babies. If no babies are delivered, then the hospital pays nothing into the Fund.

Weinstein should not have been qualified as an expert and allowed to advise the trial court.

The only other testimony on the issue of the disruption of healthcare services relating to obstetrics came in response to a misleading and incomplete hypothetical question addressed to appellants' expert, Dr. Masterson, the chairman of the Department of Obstetrics and Gynecology at the University of Florida. Dr. Masterson was asked hypothetically and based on his "small knowledge of Jackson" what would happen to the hospital if all of the obstetricians at Jackson Memorial Hospital were to stop practicing. Dr. Masterson replied that it would be "disastrous." The hypothetical did not ask what would happen if the obstetricians at Jackson Memorial Hospital were unable to obtain malpractice insurance at lower rates. Instead, the hypothetical assumed that the obstetricians would stop practicing. There was no testimony or predicate for the assumption that all obstetricians at Jackson Memorial would stop practicing because of high insurance rates or the malpractice crisis. "An expert's opinion which is based on an incorrect or incomplete hypothetical cannot constitute competent substantial evidence." Sabre Marine v. Feliciano, 461 So.2d 985, 987-88 (Fla. 1st DCA 1984).

Even if the misleading, incomplete, and inaccurate hypothetical question asked on cross-examination were a proper one, it dealt only with the "affect on the hospital's operations" and not on physicians in the appellants' class. As noted previously, see supra at note 1, the Legislature saw fit not to impose an

assessment on hospitals, such as the one employing Mr. Weinstein, that do not deliver babies. Those hospitals which are delivering babies are assessed on the basis of the number of babies delivered, which has a rational basis.

Disregarding Mr. Weinstein's testimony, there was no evidence presented in the trial court which attempted to provide an explanation of how the assessment on the appellants was based upon a rational relationship or why it did not arbitrarily discriminate against their class without a reasonable distinction or difference.

II. THE ASSOCIATION'S POWER TO DETERMINE THE AMOUNT OF ADDITIONAL ASSESSMENTS OF APPELLANTS IS AN UNCONSTITUTIONAL DELEGATION OF THE POWER TO TAX.

The appellees state on page 40 of their brief that "it is the DOI [Department of Insurance] that determines the amount of any increased assessments. NICA [the Association], when performing its responsibility to administer the Plan assessments, and appropriations, would simply 'bill' the physicians for the assessments." This statement is inaccurate. "The association shall make all assessments required by this section, . . . except assessments of casualty insurers pursuant to subparagraph (5)(c)1." § 766.314(6)(a), Fla. Stat. (1989) (emphasis added). The Department only determines the rate for insurance companies under section 766.314(7)(a).

The plain language of section 766.314(5)(a) provides:

> Beginning January 1, 1990, the persons and entities listed in paragraphs (4)(b) and (c) [participating and non-participating physicians], except those persons or entities who are specifically excluded from said provisions, as of the date determined in accordance with the plan of operation, taking into account persons licensed subsequent to the payment of the initial assessment, shall pay an annual assessment in the amount equal to the initial assessments provided in paragraphs (4)(b) and (c). On January 1, and on each January 1 thereafter, the association shall determine the amount of additional assessments necessary pursuant to subsection (7), in the manner required by the plan of operation, subject to any increase determined to be necessary by the Department of Insurance pursuant to paragraph (7)(b). On July 1, and one each July 1 thereafter, the persons and entities listed in paragraphs (4)(b) and (c), except those persons or entities who are specifically excluded from said provisions, shall pay the additional assessments which were determined on January 1. Beginning January 1, 1990, the entities listed in paragraph (4)(a) [hospitals], including those licensed on or after October 1, 1988, shall pay an annual assessment of $50 per infant delivered during the prior calendar

year. The additional assessments which were determined on January 1, 1991, pursuant to the provisions of subsection (7) shall not be due and payable by the entities listed in paragraph (4)(a) until July 1.

§ 766.314(5)(a), Fla. Stat. (1989) (emphasis added).

The Association, not the Department, determines the level of assessments for both the participating and non-participating physicians (i.e. the "persons and entities listed in paragraphs (4)(b) and (c)") in the "manner required by the plan of operation." Section 766.314(2)(a) requires that the plan of operation shall include provision for:

3. Processing of claims against the plan.

4. Assessments of the persons and entities listed in subsections (4) and (5) to pay awards and expenses, which assessments shall be on an actuarially sound basis subject to the limits set forth in subsections (4) and (5).

§ 766.314(2)(a), Fla. Stat. (1989) (emphasis added).

The Association, not the Department, sets the assessments on the appellants, subject to the limits contained in section 766.314(5)(a). The only limit on non-participating physicians[2] in subparagraph 5(a) is "any increase determined to be necessary by the Department of Insurance pursuant to paragraph (7)(b)." Subsection 766.314(7)(b) requires the appellants' assessments to be increased by the Association by the amount required by the Department if the Department found the Plan could not be maintained

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[2] On the other hand, hospitals cannot have their $50 per baby assessment increased, unless the Department determines the Plan not to be actuarially sound. § 766.314(5)(a)-(7)(b).

at an actuarially sound level at the then current level of assessment.

If the Association were limited to increasing its assessments on the appellants to the situation when the Department found such an increase required under section 766.314(7)(b), then there would be no need for the first phrase in the second sentence of section 766.314(5)(a). If the appellees are correct, that sentence would read: "The Association shall bill non-participating physicians for any additional assessment determined to be necessary by the Department of Insurance pursuant to paragraph (7)(b)." It does not so read. Instead, the sentence grants to the Association the power to determine the appropriate level of assessments in the manner required by the plan of operation, subject to mandating that it be at least in an amount sufficient to maintain an actuarially sound basis if the Department of Insurance determines the Plan to be unsound. In essence, the Department steps in only if the Association is failing to set assessments at a level sufficient to maintain the Plan on an actuarially sound basis.

This is consistent with the Association's role in controlling the factors that determine the soundness of the Plan. The soundness of the Plan is directly dependent upon its assets and liabilities, namely the claims accepted, the amount of the previous years' assessments, and the management (or investment) of funds collected on behalf of the Plan, all of which are in the control of the Association under the plan of operation, not the Department of Insurance. In other words, the claims accepted and the assessments

made by the Association determine actuarial soundness and not the other way around.

The problem with the delegation to the Association of the power to make the assessments is that it involves delegating the taxing power to a non-state agency which effectively determines the amount of the assessment by the claims it accepts. The Association accepts claims and then raises taxes to pay for the claims it has accepted. The Legislature cannot delegate the power to tax, including determining the appropriate level, to a non-state entity.

Respectfully submitted,

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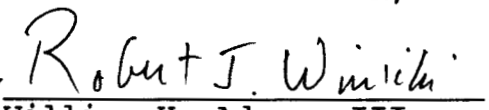
By 

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