Qt 7 O/A 4/10/91

IN THE SUPREME COURT OF FLORIDA

CASE NUMBER 76,565

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,

Petitioners,

vs.

FLORIDA BIRTH-RELATED NEUROLOGICAL INJURY COMPENSATION PLAN, FLORIDA BIRTH-RELATED NEUROLOGICAL INJURY COMPENSATION ASSOCIATION, TOM GALLAGHER, in his official capacity as head of THE FLORIDA DEPARTMENT OF INSURANCE,

Respondents.

FILED
SID J. WHITE
JAN 14 1991
CLERK, SUPREME COURT
By _____ Deputy Clerk

APPEAL FROM THE DISTRICT COURT OF APPEAL
FIRST DISTRICT OF FLORIDA

INITIAL BRIEF OF AMICUS CURIAE, DRS. J. THOMAS ATKINS, MAX SUGAR, JOHN A. TIRPAK, AND MARVIN A. PERER

THOMAS J. MAIDA
PATRICIA H. MALONO
McCONNAUGHHAY, ROLAND, MAIDA,
CHERR & McCRANIE, P.A.
Post Office Drawer 229
Tallahassee, FL 32302-0229
(904) 222-8121

TABLE OF CONTENTS

TABLE OF CITATIONS

Statutes

PREFACE

This brief is submitted by Doctors J. Thomas Atkins, Max Sugar, John A. Tirpak, and Marvin A. Perer, who have requested, by motion filed December 26, 1990, this court's permission to appear in this action as amicus curiae in support of the position of Petitioners, representatives of the class of physicians who are licensed to practice medicine in Florida, but who are not eligible to qualify as "participating physicians" in the Florida Birth-Related Neurological Injury Compensation Plan ("Plan") because they do not practice obstetrics either full or part-time. Doctors Atkins, Sugar, Tirpak, and Perer are members of this class and were permitted to appear as amicus below by order of the trial court dated April 24, 1989.

The arguments presented in this brief are limited to challenging the correctness of the district court's holding that Florida's Birth-Related Neurological Injury Compensation Act is not violative of the constitutional rights to due process and equal protection, does not constitute an improper exercise of the police power, and is not an unconstitutional delegation of legislative powers. Consequently, the issue statements in this brief will differ somewhat from those contained in petitioner's initial brief.

References to the evidence will be by the name of the document referred to, for example, "ATF Fact-Finding Report" and "ATF Rec," as well as by reference to the appropriate page

in the record. References to the transcript of the trial will be designated "Tr. at ____," as well as by references to the appropriate pages in the record.

STATEMENT OF THE CASE AND FACTS

Doctors Atkins, Sugar, Tirpak, and Perer adopt and incorporate herein the statement of the case and facts contained in the Initial Brief of Petitioners.

SUMMARY OF ARGUMENT

The district court erroneously affirmed the trial court's conclusion in the Final Judgment rendered September 12, 1989, that sections 766.314(4)(b) and (5)(a) of the Florida Statutes (Supp. 1988) are constitutional even though they levy assessments to finance the Florida Birth-Related Neurological Injury Compensation Plan on physicians licensed in Florida who are not eligible to participate in the Plan because they are not obstetricians and do not provide obstetrical services. The provisions of the Plan assessing physicians who are not eligible to participate in the Plan are arbitrary because, in the face of a pervasive medical malpractice insurance crisis in Florida, the legislature has increased the medical malpractice costs of almost 45,000 physicians in order to provide medical malpractice protection for 535 obstetricians who have chosen to participate in the Plan. The assessment of ineligible physicians is discriminatory because they are the only ones subject to assessment who receive absolutely no benefit from the Plan.

The Plan includes in the class subject to assessment licensed physicians who are not similarly situated vis-a-vis the other groups and entities assessed because these physicians do not contribute to creating the risks of birth-related neurological injuries and will never be members of a class specifically benefitting from the Plan. Nor will they receive a benefit distinct from the benefit to the public as a whole. The assessment of ineligible physicians is not rationally related to the Plan's purpose of reducing medical malpractice premiums for those who deliver obstetrical services, and the assessment of ineligible physicians has one purpose only, to transfer wealth from one group of individuals to another, limited group of individuals and entities. For these reasons, sections 766.314(4)(b) and (5)(a), insofar as they impose assessments on physicians not eligible to participate in the Plan, violate the rights of those physicians to due process and equal protection and constitute an abuse of the police power.

In addition, those portions of sections 766.314(7)(b) and (5)(a) which allow the Department of Insurance and the Florida Birth-Related Neurological Injury Compensation Association to impose annual assessments, in addition to the assessments designated in section 766.314(4)(b), on licensed physicians ineligible to participate in the Plan are likewise unconstitutional because they constitute an unlawful delegation of legislature powers. Sections 766.314(7)(b) and (5)(a) contain no

guidelines to direct the Department or the Association in determining the amount of additional annual assessments to impose on ineligible physicians. In the absence of such guidelines, the Department and the Association may exercise the powers conferred by these statutes with unbridled discretion.

ARGUMENT

In a special session in February, 1988, the legislature enacted chapter 88-1, sections 60-77, Laws of Florida (1988) creating the Florida Birth-Related Neurological Injury Compensation Plan. This act was amended in the regular 1988 legislative session in chapter 88-277, sections 36-41, Laws of Florida (1988), and in the regular 1989 legislative session in chapter 89-339, section 1-8, Laws of Florida (1989). The act, as amended, is codified as sections 766.301-316 of the Florida Statutes.

The Plan was enacted as part of a comprehensive tort reform act relating to "medical incidents." The act was passed as a response to the "financial crisis in the medical liability insurance industry" in Florida and to the finding of the Academic Task Force for Review of the Insurance and Tort Systems that "a medical malpractice crisis exists in the State of Florida which can be alleviated by the adoption of comprehen-

sive legislatively enacted reforms." Preamble, ch. 88-1, Laws of Fla. In particular, the reforms were enacted based upon the legislature's conclusion that "the cost of medical liability insurance is excessive and injurious to the people of Florida and must be reduced." Id.

The legislature created the Plan as a means of controlling the cost of medical malpractice insurance, specifically, the cost associated with providing obstetrical services. The Plan provides for no-fault compensation for birth-related neurological injuries, § 766.303(1), which the legislature described as a "limited class of catastrophic injuries that result in unusually high costs for custodial care and rehabilitation." § 766.301(2). The legislature expressly stated that the Plan was designed "to result in the stabilization and reduction of malpractice insurance premiums for providers of . . . [obstetric] services in Florida." § 766.301(1)(c).

A claimant under the Plan receives compensation for all costs and expenses deriving from a neurological injury which is birth-related, but only when a physician participating in the Plan provides the obstetric services for the birth. See § § 766.31; .309(2). A "participating physician" is defined as a

> physicians licensed in Florida to practice medicine who practices obstetrics or performs obstetrical services either full time or part-time and who has paid or was exempted from payment at the time of the injury the assessment required for participation in the Birth-Related Neurological In-

jury Compensation Plan for the year in which the injury occurred.

§ 766.302(7). The hospitals protected by the Plan include "any hospital licensed in Florida" when a participating physician provides obstetrical services in connection with a birth covered by the Plan. § 766.302(6). Except for those circumstances in which there is "clear and convincing evidence of bad faith or malicious purpose or willful and wanton disregard of human rights, safety, or property," neither the participating physician nor "any person or entity directly involved with the labor, delivery, or immediate post-delivery resuscitation during which such injury occurs" may be sued for medical malpractice, since resort to the Plan provides the exclusive remedy for recovering damages for birth-related neurological injuries. § 766.303 (as amended ch. 89-339, § 1, Laws of Fla.)

All claims under the Plan are determined by a workers' compensation deputy commissioner, § 766.304, under a modified administrative procedure, § § 766.305-.31, with review of the deputy commissioner's determination by appeal to the appropriate district court. § 766.311(1). The Plan is administered by the Florida Birth-Related Neurological Injury Compensation Association ("Association"), but the Department of Insurance oversees the operation of the Plan and determines the amount of assessment increases which are needed to finance the Plan. § § 766.315; .314. The directors of the Association are required

to submit a plan of operation to the Department of Insurance for its approval, which plan shall include provisions for assessments sufficient to maintain the Plan on an actuarially sound basis, § 766.314(2)(a), (b); the plan of operation may be amended by the Association's directors, again subject to the approval of the Department of Insurance. § 766.314(c).

The awards made to claimants under the Plan are paid by the Association exclusively from the funds collected under the authorization of section 766.314(4), (5), & (7). § 766.314(3). Initial annual assessments to fund the Plan are mandated in the statute as follows: (1) hospitals must pay $50 per live infant delivered, with exemptions for hospitals owned or operated by governmental units and with the exception that infants born to charity patients or to patients covered under Medicaid shall not be included in calculating the assessments, §766.314(4)(a); (2) physicians who choose to participate in the Plan and who qualify as "participating physicians," that is, who practice obstetrics full or part-time, must pay $5,000, § 766.314(4)(c); and, (3) all physicians licensed to practice medicine under chapters 458 and 459 of the Florida Statutes must pay $250, except physicians in residency programs, retired physicians, physicians holding a limited license, and certain physicians employed by the state or federal governments. § 766.314(4)(b) (as amended by ch. 89-339, § 6, Laws of Fla.) A total of $20,000,000 from the Insurance Commissioner's Regulatory Trust

Fund was appropriated to the Plan in chapter 88-277, section 76, Laws of Florida (1988).

In addition to these mandatory assessments and appropriations, the legislature designated two sources of discretionary funds to finance the Plan. It authorized a transfer into the Plan of an additional $20,000,000 from the Insurance Commissioner's Regulatory Trust Fund, as needed to maintain the Plan on an actuarially sound basis. § 766.314(5)(b). And, finally, if the funds available are still not sufficient to maintain the Plan on an actuarially sound basis, the Department of Insurance shall asess each licensed casualty insurer writing liability and medical malpractice insurance policies in an amount up to .25% of the insurer's net direct premiums written on "the business activity forming the basis for its inclusion in the Plan." § 766.314(5)(c). These insurers may recover all amounts paid into the Plan by adding a surcharge to all future liability and medical malpractice insurance policies or by a prospective rate increase on such policies. § 766.314(5)(c)4.

The Department of Insurance is required to complete an "actuarial investigation" of the Plan based on the experience of the first year and, after the first year, to do an investigation at least biennially. § 766.314(7)(a). Based on the results of this investigatoin, the Department of Insurance shall establish the rate of contribution for casualty insurers for the year beginning January 1, 1990, id. and the assess-

ments for all persons and entities subject to such assessments shall be increased "on a proportional basis as needed," if the Department finds that the Plan "cannot be maintained on an actuarially sound basis" with the initial assessments specified in section 766.314(4) and (5). § 766.314(7)(b).

Section 766.314(5)(a) provides that, on January 1, 1990, physicians holding Florida licenses and participating obstetricians shall pay annual assessments equal to the initial assessments. Beginning on January 1, 1991, the Association shall levy additional assessments against these physicians, in an amount to be determined by the Association. § 766.314(5)(a) (as amended by ch. 89-339, § 6, Laws of Fla.) Such additional assessments are to be determined "in the manner required by the plan of operation," "subject to any increase" the Department of Insurance determines to be necessary pursuant to section 766.314(7)(b). The Association may sue any physician who fails to pay an assessment by filing suit in county court, and the Department of Professional Regulation shall not renew the license of a physician who has an unsatisfied judgment against him. § 766.314(6)(b) (as amended by ch. 89-339, § 6, Laws of Fla.)

I. THOSE PROVISIONS OF SECTION 766.314 IMPOSING ASSESSMENTS ON VIRTUALLY ALL PHYSICIANS LICENSED IN FLORIDA FOR THE PURPOSE OF PROVIDING MEDICAL MALPRACTICE PROTECTION TO PARTICIPATING OBSTETRICIANS AND HOSPITALS INVOLVED IN THE DELIVERY OF INFANTS WITH BIRTH-RELATED NEUROLOGICAL INJURIES ARE VIOLATIVE OF THE CONSTITUTIONAL GUARANTEES OF DUE PROCESS AND EQUAL PROTECTION AND CONSTITUTE AN IMPROPER EXERCISE OF THE POLICE POWER

In Florida jurisprudence, the tests for violations of due process and equal protection and for the improper use of the police power are virtually identical and the same basic analysis is used to evaluate legislation under each of these three theories. See Fraternal Order of Police v. Department of State, 392 So.2d 1296, 1302 (Fla. 1980) (due process and police power); State v. Walker, 444 So.2d 1337, 1338 (Fla. 2d DCA 1984) (due process and equal protection). The test for due process is "whether the statute bears a reasonable relation to a permissible legislative objective and is not discriminatory, arbitrary, or oppressive." Lasky v. State Farm Ins. Co., 296 So.2d 9, 15 (Fla. 1974). The test for the valid use of the police power is whether the "means utilized bear a rational or reasonable relationship to a legitimate state objective." Belk-James, Inc. v. Nuzum, 358 So.2d 174, 175 (Fla. 1978). The test for equal protection is whether the "classification is reasonable, nonarbitrary, and rests on some ground of difference having a fair and substantial relation to the object of

the legislation." In re Advisory Opinion to the Governor, 509 So.2d 292, 303 (Fla. 1987).

The stated purpose of the legislature in enacting the no-fault compensation system for birth-related neurological injuries was to stabilize and reduce malpractice insurance premiums for physicians and hospitals providing obstetrical services. § 766.301(1)(c). To accomplish this purpose, the legislature has chosen to provide a substantial portion of the funds for the Plan through annual assessments imposed on virtually all physicians licensed to practice medicine in Florida. § § 766.314(4)(b); (5)(a). The assessments on physicians not eligible to participate in the Plan bear no rational relationship to the legislative purpose of alleviating the high cost of medical malpractice insurance for those providing obstetrical services because they are arbitrary and discriminatory. Consequently, sections 766-314(4)(b) and (5)(a) violate the rights of ineligible physicians to due process and equal protection and constitute an abuse of the police power.

Of all the entities assessed under the provisions of section 766.314, licensed physicians who do not provide obstetrical services and who are, therefore, not eligible to participate in the Plan are the only ones who receive no meaningful benefit from the Plan. Both hospitals and obstetricians participating in the Plan receive complete immunity from suit for birth-related neurological injuries unless their actions

are malicious or in wanton disregard of human safety. See § 766.303(2). They may, therefore, expect a decrease in their medical malpractice premiums since claims for birth-related neurological injuries are "particularly high" and contribute to the increase in medical malpractice premiums for those providing obstetric services. See § 766.301(1)(d); ATF Fact-Finding Report at 7 (R at 578); ATF Rec. at 30-34 (R at 526-530).

Insurers subject to asessment are those writing liability insurance policies, which include medical benefits, and those writing medical malpractice insurance policies. § 766.314(5)(c)(1); § 624.605(1)(b),(k). These insurers can expect claims against these policies to decrease as claims for birth-related neurological injuries are paid from the funds collected to administer the Plan. In addition, the insurers are given the authority to recover all amounts paid as assessments to the Plan eithe through surcharges on liability and malpractice policies or through rate increases on these categories of policies. § 766.314(5)(c)4.

Physicians subject to assessment merely because they are licensed to practice medicine in Florida can expect nothing in return for their contribution except higher costs to maintain their own practices. The Plan does not provide immunity from suit for any injury except birth-related neurological injury, so that those physicians not practicing obstetrics can expect their medical malpractice premiums to continue to rise as the

trend toward ever higher loss payments to medical malpractice claimants continues. The Academic Task Force found that the primary cause of the increase in medical malpractice premiums was the increase in the size and number of claims on account of medical malpractice. ATF Fact-Finding Report at 7-8 (R at 578-79). In fact, the largest claims paid were malpractice claims against pediatricians, neurosurgeons, and thoracic surgeons, id. at 5, 12 (R at 576, 583), although medical malpractice premiums have dramatically increased for all physicians in Florida since 1983. Id. at 26-32 (R at 597-603).

Medical malpractice insurance premiums for physicians not practicing obstetrics will not be affected in any way by the hoped-for decrease in premiums for those providing obstetrical services because of the method by which insurance companies calculate medical malpractice rates. Insurers rate medical malpractice insurance on the basis of a "risk classification system." ATF Fact-Finding Report at 10-11, 97-109 (R at 581-82, 668-680). Under this system, physicians in Florida are grouped according to specialty and geographic area. Malpractice insurance rates are determined exclusively by reference to these two factors so that any rate decreases for obstetricians will not affect rates for physicians practicing any other specialty. See id. And, certainly, physicians who are licensed in Florida but who practice medicine out-of-state will experience no decrease in their malpractice premiums in

exchange for their contributions to the Plan. Thus, the Plan will not diminish the high cost of medical malpractice insurance for the physicians who are, nevertheless, required to contribute to the Plan to provide medical malpractice protection for obstetricians and to pay a surcharge or rate increase on their medical malpractice insurance to reimburse their insurers for the amounts the insurers are required to pay into the Plan. See § 766.314(5)(c)4.

The decision of the legislature to assess all licensed physicians for the purpose of reducing medical malpractice premiums for those providing obstetrical services flies in the face of the legislture's findings that the cost of medical liability insurance generally is excessive and the legislature's recognition that this cost must be reduced. See Preamble, chapter 88-1, Laws of Fla. At the present time, of the approximately 45,500 physicians licensed to practice medicine in Florida, only 535 obstetricians are participating in the Plan. Tr. at 127 (R at 306). Almost 45,000 physicians will, therefore, experience higher medical liability insurance costs as a direct result of the Plan and will be pushed further towards that financial crisis that the various reforms in chapter 88-1 were enacted to avoid. The Academic Task Force found that, for all physicians in Florida, the cost of medical malpractice insurance increased in 1987 to 11.6% of their income. ATF Fact-Finding Report at 33 (R at 604). Medical cost con-

trols make it increasingly difficult for physicians to recoup these increased costs through fee increases, id. at 36 (R at 607), so that physicians, unlike insurance companies, cannot merely pass through to their patients the increased costs generated by the Plan. Therefore, while the Plan might help alleviate the medical malpractice crisis for obstetricians, it will undoubtedly aggravate the medical malpractice crisis for physicians practicing in all other specialties.

It is not accurate to view the economic impact of the assessment imposed on ineligible physicians as minimal. The Virginia Statute on which Florida's Plan is modeled limits the annual assessment on ineligible physicians to $250. § 38.2-5020(A), Va. Code Ann.; see ATF Rec. at 68 (R at 564). The Florida Plan, however, assessed ineligible physicians $250 as the initial annual assessment, which was payable December 1, 1988 and January 1, 1990; beginning January 1, 1991, ineligible physicians must pay this $250 plus any additional assessments levied by the Association. There is no cap in the statute on the amount of these additional assessments, and it is conceivable that the assessments could rise to onerous levels in a very short period of time.

Elton Scott testified at trial that the assessments imposed by the Plan are an example of "cost-shifting," which he identified as a common mechanism for financing health care services. Tr. at 108, 109 (R at 287, 288). As described by

Dr. Scott, the funding mechanism of the Plan "is essentially a process that shifts the cost of paying for malpractice insurance for obstetricians to nonparticipating physicians." Id. at 109 (R at 288). Dr. Scott was aware of only one example of a cost-shifting program similar to that of the Plan, that used to fund the Public Medical Assistance Trust Fund ("PMATF"), sections 409.2662-2663 of the Florida Statutes. Id.

The PMATF is designed to reimburse hospitals providing medical care to indigent patients for losses those hospitals experience as a result of providing such care. § 409.2662(1). All hospitals licensed to operate in the state are required to contribute to this fund one percent of their gross operating revenue, § 409.2662(2), and the monies in the fund are distributed to hospitals which provide a significant amount of care to indigents for which they are not otherwise compensated. § 409.2663. The legislature enacted the PMATF because it found that "inequities between hospitals in the provision of unreimbursed services prevent hospitals which provide the bulk of such services from competing on an equitable economic basis with hospitals which provide relatively little care to indigent persons." § 409.2662(1). Thus, the PMATF was specifically created "for the purpose of providing equity among hospitals in the provision of indigent care services." § 409.2663(1).

Clearly, the similarities between the "cost-shifting" mechanism of the PMATF and that of the Plan are illusory.

Society has long accepted its responsibility to provide adequate medical care for the indigent, and this responsibility is shared by the taxpayer through the Medicaid program, as well as by hospitals and physicians. When some hospitals refuse to provide their share of indigent care, and thereby gain a competitive advantage over other hospitals, it is not arbitrary or discriminatory to equalize the burden among competing institutions. When hospitals accept the privilege of doing business in the state, they accept the responsibility for providing a certain level of care for those persons who cannot afford to pay the costs of that care.

On the other hand, physicians who do not practice obstetrics do not accept responsibility for assuring that obstetricians pay lower medical malpractice insurance premiums than is warranted by the rating system imposed on all medical specialties in Florida. Physicians who do not practice obstetrics are not competing with obstetricians for patients and do not gain a competitive advantage when the costs of medical malpractice coverage increase for those providing obstetrical services. Thus, the "cost-shifting" provisions of the Plan do not equalize the burdens of competing entities; rather, they arbitrarily and discriminatorily transfer wealth from physicians generally to obstetricians. Licensed physicians who are not eligible to receive any benefits from the Pan are, as Dr. Scott testified, now required to subsidize the costs of medical mal-

practice insurance for those providing obstetrical services.

Numerous laws imposing assessments or levies on specific groups or individuals have survived constitutional challenges. However, those laws all share one common characteristic: The persons or groups assessed either create the problem to be remedied or they receive an actual or potential benefit in exchange for their contribution. A case in point is the Florida Patient's Compensation Fund ("PCF"), section 768.54 of the Florida Statutes. The assessment provisions of the PCF were upheld against due process and equal protection challenges in Department of Insurance v. Southeast Volusia Hospital District, 438 So.2d 815 (Fla. 1983).

Although the purpose of both the PCF and the Plan at issue in this case is to provide "medical malpractice protection to the physicians and hospitals" participating in the programs, id. at 817, the provisions relating to participation and imposing assessments are strikingly dissimilar. Participation in the PCF is open to all physicians, and only those physicians choosing to participate are subject to assessment. Id. at 817-18. Assessments consist of a base fee of $500 for each participating physician, plus additional assessments based on specified criteria. Id. at 818; § 768.54(3)(c). Those criteria include loss experience for the physician's specialty and geographic area, the prior claims experience of the PCF member, and risk factors for physicians who are retired, semi-retired,

or practicing only part-time. Id. § 768.54(3)(c) 1-3. The base fees may be adjusted downward, and participants are entitled to refunds if there is a surplus in the fund. Id.; § 768.54(3)(c).

The court in Southeast Volusia Hospital District found that PCF was not violative of due process because "[t]he provisions of the statute plainly satisfy the purpose of the statute, namely, to provide medical malpractice protection for Florida health care providers under terms accepted by the participants." Id. at 821 (emphasis added). Under the Florida Birth-Related Neurological Injury Compensation Plan, however, a significant portion of the funds are contributed by physicians who are subject to mandatory assessment while not enjoying the medical malpractice protection provided by the Plan. Because they cannot participate, their assessments cannot be based on any loss experience, claims experience, or risk factors; indeed, no such criteria are present in the statute for any category of those assessed to finance the Plan. And, no provision is made for a decrease in the assessment or refund of surplus funds. The ineligible physicians are not contributing to a plan which will shield them from the possibility of loss, and they have no responsibility for creating the losses that the Plan is designed to cover. The risk that infants will be delivered with birth-related neurological injuries is not a risk borne by the profession as a whole, but is a risk borne by a

particular, narrow specialty within the profession.

In this respect, the Plan is distinguishable from those assessments which are mandatory for all members of a business or profession. In Meier v Anderson, 692 F.Supp. 546, (E.D. Pa. 1988), the court upheld the constitutionality of the Pennsylvania Health Care Services Malpractice Act against a due process challenge. The court found that the act was not arbitrary because it required all physicians to contribute to the program, in an amount based on their prior claims history, and, in return, provided excess medical malpractice protection to the physicians. The assumption underlying the program was that it was reasonable to predict "that all doctors might be actionably negligent, and that . . . it is reasonable to require all doctors to contribute to a fund designed to compensate malpractice victims." Id. at 553.

Likewise, in Bennett v. Oregon State Bar, 470 P.2d 945 (Or. 1970), the court upheld the constitutionality of a provision of the Bar requiring all lawyers to contribute to the client's security fund as a condition of Bar membership. The court relied on various theories stated in Lathrop v. Donohue, 367 U.S. 820 (1961), and held that the cost of reimbursing the clients of dishonest lawyers is a risk of the profession which "'should be shared by the subjects and beneficiaries of the regulatory program, the lawyers.'" Id. at 946 (quoting Lathrop, 367 U.S. at 843). A similar program for spreading the

risks among the entities benefitting from regulation is the Florida Insurance Guaranty Fund. That fund is financed by assessments on casualty insurers issuing a certain category of policies in Florida, and the monies collected are used to pay claims covered under the same class of policies issued by insurers which are insolvent. See O'Malley v. Florida Ins. Guar. Ass'n, 257 So.2d 9 (Fla. 1971).

Like the Pennsylvania Health Care Services Malpractice Act and the client security fund at issue in Bennett, the Florida Insurance Guaranty Fund assesses members of a particular group to cover risks associated with the activities of the group as a whole. In contrast, the Plan at issue in this case assesses all licensed physicians to cover risks associated solely with the activities of those providing obstetrical services. The Plan is not designed to alleviate the medical malpractice crisis affecting all licensed physicians, nor does it relate in any way to the risks associated with the practice of medicine generally. On this basis, the Plan is similar to the funding provision of the Crimes Compensation Act held unconstitutional in State v. Champs, 373 So.2d 874 (Fla. 1978).

In Champs, the court held that the legislature could constitutionally impose "additional penalties and costs on persons . . . who have committed non-violent (criminal) offenses, for the purpose of compensating certain victims of violent offenders." Id. at 879. This ruling was based on the conclusion

that the legislature could reasonably refuse to distinguish between violent and non-violent criminal offenders. Id. However, the court refused to permit the imposition of additional penalties and costs on persons paying civil fines. The court found that a "direct civil charge levied solely to compensate crime victims" was not reasonably related to the purpose of the Crime Compensation Fund. Id. Likewise, the assessment of ineligible physicians solely to compensate those suffering birth-related neurological injury is not reasonably related to the purpose of the Plan, which is to reduce medical malpractice premiums for those providing obstetrical services. Physicians who neither contribte to creating the problem nor benefit from the solution should not be forced to contribute to the Plan.

The notion that those subject to special assessments or levies contribute to the problem to be remedied or benefit from the use of the monies collected pervades due process, equal protection, and police power analysis. For example, in City of Naples v. Moon, 269 So.2d 355 (Fla. 1972), the court approved a special assessment on businesses for construction of downtown parking facilities, but cautioned that the guidelines used to determine the amount of the various assessments be carefully observed to insure that the amount paid by any particular business accurately reflect the benefits that business would derive from the improvements. In Contractors & Builders Ass'n v. City

of Dunedin, 329 So.2d 314, 321 (Fla. 1976), the court held that it was "arbitrary and irrational" to impose a user fee for the construction of a new utilities plant only on new users when the new plant would be used by new and old users alike. The court observed that the "costs of new facilities should be born by new users to the extent that new use requires new facilities, but only to that extent." Id. In Home Builders & Contractors Ass'n v. Board of County Commissioners, 446 So.2d 140, (Fla. 4th DCA 1983), the court held that an ordinance imposing an impact fee on new development for use in constructing roads would be valid only if "the improvements adequately benefit the development which is a source of the fee." See also United Gas Pipe Line Co. v. Bevis, 336 So.2d 560 (Fla. 1976); Alamo Rent-A-Car, Inc. v. Sarasota-Manatee Aiport Authority, 825 F.2d 367 (11th Cir. 1987).

Jay Weinstein testified at trial that the disruption of obstetric services affects the delivery of health care services in three ways: (1) it disrupts the day-to-day operations within a hospital, especially the provision of emergency medical care, Tr. at 72, 75, 77, 84 (R at 251, 254, 256, 263); (2) it affects the physician referral system because physicians have fewer obstetricians available to which they can refer pregnant patients, Tr. at 76-77, 79, 95 (R at 255-56, 258, 274); and, (3) it limits the ability of a hospital to provide obstetrical services for their female staff members, Tr. at 67-68, 95 (R at

246-47, 274). The impact of these effects is not, however, any more severe for physicians who do not provide obstetrical services than for the public at large, so that the alleviation of the medical malpractice crisis would not be of any greater benefit to ineligible physicians than to the general public. The unavailability of emergency room services affects patients who have suffered trauma; the unavailability of obstetrical referrals affects the patients who are pregnant; the female staff of hospitals are in no different position with regard to obtaining obstetrical services than any other pregnant women. To the extent that the loss of obstetrical services causes a negative effect on the level of care provided by physicians practicing other specialties, the impact is greatest on the patient. The impact on all licensed physicians of the medical malpractice crisis for providers of obstetrical services may be somewhat different in kind than the impact on the general public, but it is not so significantly different that the legislature is justified in singling out virtually all licensed physicians as that group required to contribute a substantial portion of the financing to alleviate the crisis for this limited group of practitioners.

Furthermore, it is unlikely that licensed physicians not trained as obstetricians will ever "practice obstetrics or perform obstetrical services full time or part-time," and, thereby, become eligible to participate in the Plan. §

766.302(7). The decision to become an obstetrician is made early in one's medical career, and, as Dr. Byron Masterson testified, a physician obtains hospital privileges to practice obstetrics only after he or she has completed a four-year residency in obstetrics and gynecology and is either board-qualified or board-certified in obstetrics. Tr. at 17 (R at 196). As a practical matter, a physician trained in one specialty will not change specialties in mid-career, so that the class of obstetricians is essentially closed to those physicians currently licensed and practicing a specialty other than obstetrics. As a result, the benefits offered by the Plan will never be available to licensed physicians currently practicing other specialties, even though these physicians are required by the Plan to pay annual assessments of an unknown amount, but never less than $250, to subsidize medical malpractice insurance premiums for those providing obstetrical services.

The provisions of the Plan assessing physicians who are not eligible to participate in the Plan are arbitrary because, in the face of a pervasive medical malpractice insurance crisis in Florida, the legislature has <u>increased</u> the medical malpractice costs of almost 45,000 physicians in order to provide medical malpractice protection for 535 obstetricians who have chosen to participate in the Plan. The assessment of ineligible physicians is discriminatory because they are the

only ones subject to assessment who receive absolutely no benefit from the Plan. The Plan includes in the class subject to assessment licensed physicians who are not similarly situated vis-a-vis the other groups and entities assessed because these physicians do not contribute to creating the risks of birth-related neurological injuries and will never be members of a class specifically benefitting from the Plan. Nor will they receive a benefit distinct from the benefit to the public as a whole. The assessment of ineligible physicians is not rationally related to the Plan's purpose of reducing medical malpractice premiums for those who deliver obstetrical services, and the assessment of ineligible physicians has one purpose only, to transfer wealth from one group of individuals to another, limited group of individuals and entities. See State v. Lee, 356 So.2d 276, 279 (Fla. 1978). For these reasons, sections 766.314(4)(b) and (5)(a), insofar as they impose assessments on physicians not eligible to participate in the Plan, violate the rights of those physicians to due process and equal protection and constitute an abuse of the police power.

II. SECTIONS 766.314(7)(b) AND 766.314(5)(a), INSOFAR AS THEY ALLOW THE DEPARTMENT OF INSURANCE AND THE ASSOCIATION TO INCREASE THE ANNUAL ASSESSMENTS LEVIED AGAINST PHYSICIANS INELIGIBLE TO PARTICIPATE IN THE PLAN, CONSTITUTE AN UNCONSTITUTIONAL DELEGATION OF LEGISLATIVE POWERS BECAUSE THEY CONTAIN NO STANDARDS OR GUIDELINES TO GOVERN SUCH INCREASES

In In re Advisory Opinion to the Governor, 509 So.2d 292, 311 (Fla. 1987), the court stated that the nondelegation doctrine requires that statutes "set out adequate standards to guide the agency in the execution of the powers delegated and must define those powers with sufficient clarity to preclude the agency from acting through whim, favoritism, or unbridled discretion." Section 766.314 identifies the five categories of individuals and entities required to contribute funds to the Plan. The initial annual assessments for hospitals, participating physicians, and licensed physicians ineligible to participate in the Plan are defined with specificity; hospitals are required to contribute $50 per live infant delivered, with certain delineated exceptions; participating physicians are required to contribute $5,000 each; and, ineligible physicians are required to contribute $250 each. Assessments for each of these three assessment categories will increase January 1, 1991, under the terms specified in section 766.314(7), that is, "on a proportional basis as needed" to maintain the Plan in an actuarially sound basis. § 766.314(5)(a) (as amended by ch.

89-339, § 6, Laws of Fla.); (7)(b).

Section 766.314(5)(b) provides for an appropriation of an amount "up to $20 million" from the Insurance Commissioner's Regulatory Trust Fund, if needed to maintain the fund on "an actuarially sound basis." And, taking into account the funds received from hospitals, participating physicians, and ineligible physicians and the funds contributed from the Insurance Commissioner's Regulatory Trust Fund, the Department of Insurance is empowered to assess certain casualty insurers at a rate not to exceed .25% of net direct premiums written for certain categories of policies. § 766.314(5)(c). The Department shall impose an assessment on these insurers beginning January 1, 1990, at a rate of contribution as needed to maintain the Plan on an actuarially sound basis.

The statute contains adequate standards by which the Department can calculate the total amount of contributions necessary to maintain the Plan on an actuarially sound basis. In Department of Insurance v, Southeast Volusia Hospital District, 438 So.2d 815, 819 (Fla. 1983), the court recognized "concepts of actuarial soundness to be a meaningful standard." However, unlike the Patients Compensation Fund at issue in Southeast Volusia Hospital District, the Florida Birth-Related Neurological Injury Compensation Plan does not contain adequate standards to guide the Department or the Association in determining the amount of additional assessments

to be imposed on physicians ineligible to participate in the Plan.

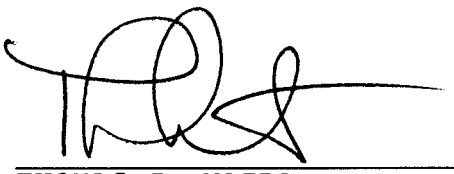
In the statute identifying the fees and assessments to be levied to finance the Patients Compensation Fund, the legislature required that additional assessments "fairly reflect the classifications prescribed above," that is, that such assessments be based on: "1. Past and prospective loss and expense experience in different types of practice and in different geographical areas within the state; 2. The prior claims experience of the members covered under the fund; and 3. Risk factors for persons who are retired, semi-retired, or part-time professionals." Id. at 818(quoting §768.54(3)(c)2d). The only standard given in section 766.314(7)(b) to guide the Department and the Association in determining the amount of additional assessments for hospitals, participating physicians, and ineligible physicians is that such additional assessments be calculated "on a proportional basis." In the context of the assessment provisions of the Plan, this standard is no more meaningful than the standard rejected in Conner v. Joe Hatton, Inc., 203 So.2d 154 (Fla. 1957), as too vague to satisfy the nondelegation doctrine. In Conner, the statute at issue empowered the Commissioner of Agriculture to impose an assessment on sweet corn producers at a rate calculated "per container or some other equitable basis." Id. at 155.

The proportionality standard prescribed in the Plan is meaningless because the Department has the discretion to contribute from the Insurance Commissioner's Regulatory Trust Fund an amount not to exceed $20 million and to assess insurers at a rate not to exceed .25% of net direct premiums. Nothing in the statute requires that these two sources of funds be exhausted before additional assessments are levied against ineligible physicians. The portion of the total amount necessary to maintain the Plan on an actuarially sound basis assignable to ineligible physicians will depend exclusively on the amount of money the Department decides, in its unbridled discretion, to pay into the Plan from the Insurance Commissioner's Regulatory Trust Fund and on the rate of contribution the Department decides, again in its unbridled discretion, to assess against casualty insurers. Consequently, the provisions of the Plan authorizing additional assessments to be levied against ineligible physicians "on a proportional basis" do not contain adequate standards to guide the Department of Insurance or the Association in calculating these assessments and, for this reason, these provisions constitute an invalid delegation of legislative powers.

CONCLUSION

For the foregoing reasons, amicus curiae, J. Thomas Atkins, M.D.; Max Sugar, M.D.; John A. Tirpak, O.D.; and Marvin A. Perer, M.D., request that this court reverse the decision of the district court below; declare sections 766.314(4)(b) and (5)(a) unconstitutional insofar as they levy assessments to finance the Plan on licensed physicians who are not eligible to participate in the Plan because they are not obstetricians and do not provide obstetrical services; and declare sections 766.314(7)(b) and (5)(a) unconstitutional because they constitute an unlawful delegation of legislative powers.

Respectfully submitted,



THOMAS J. MAIDA
PATRICIA H. MALONO
McConnaughhay, Roland, Maida,
Cherr & McCranie, P.A.
Post Office Drawer 229
Tallahassee, Fl 32302
(904) 222-8121

CERTIFICATE OF SERVICE

I HEREBY CERTIFY that a copy of the foregoing has been furnished by United States Mail this 14th day of January, 1991, to the following:

Wilbur E. Brewton, Esquire
Taylor, Brion, Buker & Greene
225 S. Adams Street
Suite 250
Tallahassee, FL 32301

William H. Adams, Esquire
Post Office Box 4099
Jacksonville, FL 32201

John Thrasher, Esquire
Florida Medical Association
760 Riverside Avenue
Jacksonville, FL 32204

Peter D. Ostreich, Esquire
Florida Department of Insurance
Room 412, Larson Building
Tallahassee, FL 32399-0300

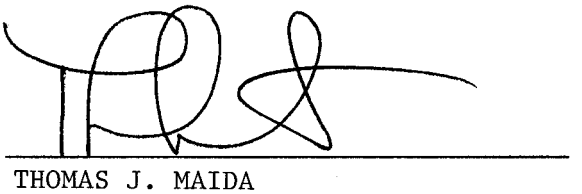
George L Waas, Esquire
Assistant Attorney General
Department of Legal Affairs
The Capitol - Suite 1501
Tallahassee, FL 32399-1050

Kent Masterson Brown, Esquire
1114 First National Building
167 West Main Street
Lexington, KY 40507

H. Reynolds Sampson, Esquire
Harper Field, Esquire
Florida Department of Professional
Regulation
1940 N. Monroe Street
Tallahassee, Florida 32399-0750

Ms. Julie Gallagher
204-B S. Monroe Street
Tallahasse, Florida 32301

Neil H. Butler, Esquire
Post Office Box 839
Tallahassee, Florida 32302



THOMAS J. MAIDA