58pgs
FILED
SID J. WHITE
AUG 19 1991
CLERK, SUPREME COURT
By ______
Chief Deputy Clerk

THE FLORIDA SUPREME COURT

CASE NO.: 78,210

UNIVERSITY OF MIAMI,
d/b/a THE UNIVERSITY OF
MIAMI SCHOOL OF MEDICINE,
a Florida corporation,

Appellant,

- vs. -

PATRICIA ESCHARTE, a minor,
by and through her parents
and natural guardians, NORMA
ESCHARTE and PEDRO ESCHARTE,
and NORMA ESCHARTE and PEDRO
ESCHARTE, individually,

Appellees.

ON APPEAL FROM

THE THIRD DISTRICT COURT OF APPEAL

APPELLANT'S INITIAL BRIEF

FOWLER, WHITE, BURNETT HURLEY,
BANICK & STRICKROOT, P.A.
Attorneys for University of Miami
11th Floor, Courthouse Center
175 Northwest First Avenue
Miami, Florida 33128-1835
(305) 358-6550
By: MICHAEL L. FRIEDMAN, ESQ.
STEVEN E. STARK, ESQ.

TABLE OF CONTENTS

	Page
INTRODUCTION	1
STATEMENT OF THE CASE AND FACTS	1
Statement of the Case	1
Legislative History	2
SUMMARY OF THE ARGUMENT	8
ARGUMENT	10
I. THE CONTINGENT CAP ON NON-ECONOMIC DAMAGES, DOES NOT VIOLATE FLORIDA'S CONSTITUTION, ART. I, §21 - THE RIGHT OF ACCESS TO COURTS	10
A. Overpowering Public Necessity and No Alternatives	10
B. Principles of Judicial Construction	11
C. The Statutes Provide Both a Reasonable Alternative and a Commensurate Benefit	23
II. THE STATUTES DO NOT VIOLATE THE RIGHT TO JURY TRIAL	32
III. THE STATUTE DOES NOT VIOLATE THE RIGHT TO SUBSTANTIVE OR PROCEDURAL DUE PROCESS	35
IV. THE STATUTES DO NOT DENY EQUAL PROTECTION	40
V. THE STATUTES DO NOT VIOLATE ARTICLE X §6 OF FLORIDA'S CONSTITUTION	47
VI. THE STATUTES DO NOT VIOLATE THE SINGLE SUBJECT REQUIREMENT OF ARTICLE 3, SECTION 6 OF THE FLORIDA CONSTITUTION	48
CONCLUSION	50
CERTIFICATE OF SERVICE	51

TABLE OF AUTHORITIES

Page

American Liberty Ins. Co. v. West and Conyers, Architects And Engineers,
491 So.2d 573 (Fla. 2d DCA 1986) 16, 19

Belk-James, Inc. v. Nuzom,
358 So.2d 174, 175 (Fla. 1978) 39

Boyd v. Bulala,
877 F.2d 1191 (4th Cir. 1989) 35, 45

Carr v. Broward County,
505 So.2d 568, (Fla. 4th DCA 1987) 17-20

Chapman v. Dillon,
415 So.2d 12 (Fla. 1982) 29, 44

Chenoweth v. Kemp,
396 So.2d 1122 (Fla. 1981) 48, 49

City of New Smyrna Beach v. Fish,
384 So.2d 1272 (Fla. 1980) 12, 21

Clausell v. Hobart Corp.,
515 So.2d 1275 (Fla. 1987) 48

Dandridge v. Williams,
397 U.S. 471, 485, 90 S.Ct. 1153,
1161, 25 L.Ed.2d 491 (1970) 41

Davis v. Omitowoju,
833 F.2d 1155 (3d Cir. 1989) 35, 45

Department of Insurance v. Southeast Volusia Hospital District,
438 So.2d 815, 821 (Fla. 1983) 44

Dillon v. Chapman,
404 So.2d 354, 357 (Fla. 4th DCA 1981) 30

Duke Power Co. v. Carolina Environmental Study Group, Inc.,
438 U.S. 59, 57, 98 S.Ct. 2620, L.Ed.2d 595 (1978) . . . 38

Edmunds v. Murphy,
573 A.2d 853 (Md. App. 1990) 35, 45, 46

Etheridge v. Medical Center Hospitals, Inc.,
237 Va. 87, 367 S.E.2d 525 (1989) 34

LAW OFFICES OF FOWLER, WHITE, BURNETT, HURLEY, BANICK & STRICKROOT, P.A.
ELEVENTH FLOOR COURTHOUSE CENTER, 175 NORTHWEST FIRST AVENUE, MIAMI, FLORIDA 33128-1835 • TEL. (305) 358-6550

TABLE OF AUTHORITIES
(continued)

Page

Fein v. Permanente Medical Group,
695 P.2d 665 (Cal. 1985) 45

Feldman v. Glucroft,
522 So.2d 798 (Fla. 1988) 12, 13

Florida Medical Center, Inc. v. Von Stetina,
436 So.2d 1022, 1029-30 (Fla. 4th DCA 1983) 42

Fraternal Order of Police, Metropolitan Dade County, Lodge No. 6 v. Department of State,
392 So.2d 1296, 1302 (Fla. 1980) 40

Glasser v. Youth Shop,
54 So.2d 686 (Fla. 1951) 32

Holley v. Adams,
238 So.2d 401 (Fla. 1970) 12, 20, 21

Holly v. Auld,
457 So.2d 217 (Fla. 1984) 12, 13

Kluger v. White,
281 So.2d 1 (Fla. 1973) . 10, 18, 19, 21, 23, 27, 28, 31-34

Lasky v. State Farm Insurance Co.,
296 So.2d 9 (Fla. 1974) 28, 29, 32, 35-37, 42

Mahoney v. Sears, Roebuck & Co.,
440 So.2d 1285 (Fla. 1983) 27

Martinez v. Scanlan,
16 F.L.W. S427 (Fla. June 6, 1991) 28

Overland Construction Co, Inc. v. Sirmons,
369 So.2d 572 (Fla. 1979) 16, 19

Peoples Bank of Indian River County v. State,
395 So.2d 521, 524 (Fla. 1981) 40

Pinillos v. Cedars of Lebanon Hospital Corp.,
403 So.2d 365 (Fla. 1981) 43

Rotwein v. Gersten,
36 So.2d 419 (Fla. 1948) 12, 14, 47

Sasso v. RAM Property Management,
452 So.2d 932 (Fla. 1984) 28

TABLE OF AUTHORITIES
(continued)

Page

Smith v. Department of Insurance,
507 So.2d 1080 (Fla. 1987) . . . . passim

State v. Bales,
343 So.2d 9, 11 (Fla. 1977) 12, 15

The Florida High School Activities Assoc., Inc. v. Thomas,
434 So.2d 306 (Fla. 1983) 41

Usery v. Turner Elkhorn Mining Co.,
428 U.S. 1, 15 96 S.Ct. 2882, 2892,
49 L.Ed.2d. 752 (1976) 39

Woods v. Holy Cross Hospital,
591 F.2d 1164 (Fla. 5th Cir. 1979) 41, 42

Other Authorities

§ 766.20, Fla. Stat. 1989 24

§ 766.207(7)(g), Fla. Stat. 25

§ 95.11(3)(c), Fla. Stat. 16

§ 95.11, Fla. Stat. (1985) 16

§ 458.320, Fla. Stat. 32

§ 768.51, Fla. Stat. 42, 43

§§ 766.207-.212, Fla. Stat. (Supp. 1988) 24

§ 48, Fla. Stat. 4

§ 95.11(4)(b), Fla. Stat. 18

§ 768.40, Fla. Stat. 13

§ 21, Fla. Stat. 34

§ 22, Fla. Stat. 34

§ 120.58(1)(a), Fla. Stat. 25

§ 120.68, Fla. Stat. 26

§ 766.207(2), Fla. Stat. (1989) 25

§ 766.207(7)(e), Fla. Stat. (1989) 25

LAW OFFICES OF FOWLER, WHITE, BURNETT, HURLEY, BANICK & STRICKROOT, P.A.
ELEVENTH FLOOR COURTHOUSE CENTER, 175 NORTHWEST FIRST AVENUE, MIAMI, FLORIDA 33128-1835 • TEL. (305) 358-6550

TABLE OF AUTHORITIES
(continued)

Page

§ 766.207(7)(h), Fla. Stat. (1989) 25

§ 766.207(f), Fla. Stat. (1989) 25

§ 766.209(3), Fla. Stat. (1989) 26

§ 766.211(1), Fla. Stat. (1989) 25

§ 766.211(2), Fla. Stat. (1989) 25

§ 766.212, Fla. Stat. (1989) 26

§ 768.50, Fla. Stat. 44

§ 768.81, Fla. Stat. 25

§§ 766.207 and 766.209, Fla. Stats. 1, 2

Art. I, §21 of the Florida Constitution 10

Art. 10, §6 of Florida's Constitution 47

Cal. Civil Code § 3333.2 22

Ch. 86-160, Laws of Florida 2

Chapter 88-1, Section 48, Laws of Florida (Special "E" Session), codified as §766.201, Florida Statues (1988) 7

Chapter 88-2 of the 1988 Special "E" Session §85 39

Medical Malpractice Reform Alternatives, October 2, 1987, Appendix 3 at page 5 20

Academic Task Force For Review of the Insurance and Tort Systems, Final Recommendations, March 1, 1988, page 89, fn.52 . . . . 24, 38

Academic Task Force Report on Medical Malpractice Recommendations, Appendix 4, p. 26 24

Academic Task Force Report on Medical Malpractice Recommendations, p. 27 24

The Academic Task Force for the Review of Insurance and Tort Systems, Final Recommendations, March 1, 1988, Appendix 5 at page 64 38

LAW OFFICES OF FOWLER, WHITE, BURNETT, HURLEY, BANICK & STRICKROOT, P.A.
ELEVENTH FLOOR COURTHOUSE CENTER, 175 NORTHWEST FIRST AVENUE, MIAMI, FLORIDA 33128-1835 • TEL. (305) 358-6550

INTRODUCTION

This is an appeal from the Third District's decision that Florida Statutes §§ 766.207 and 766.209 are unconstitutional. The Plaintiffs/Appellees, Patricia Escharte, a minor, by and through her parents and natural guardians, Norma Escharte and Pedro Escharte, and Norma Escharte and Pedro Escharte, individually, will be referred collectively as the "Eschartes". The Defendant/Appellant, University of Miami d/b/a the University of Miami School of Medicine, will be referred to as "University." Citations to the record on appeal will be by the letter "R" with appropriate page numbers. The appendix accompanying this brief will be referred to by appropriate section and page number. All emphasis is added unless otherwise indicated.

STATEMENT OF THE CASE AND FACTS

Statement of the Case

The Trial Court held that Florida Statutes §§ 766.207 and 766.209 are unconstitutional on grounds that the statutes violate the Eschartes' constitutional right of access to the court, right to trial by jury, equal protection guarantees, and procedural and substantive due process rights. Additionally, the Trial Court held that the statutes violate the Florida Constitution's single subject requirement and constitute a taking without compensation.

On appeal, the Third District affirmed the Trial Court's ruling that the statutes violate the Constitution's access to courts provisions, reasoning that the Legislature failed to

LAW OFFICES OF FOWLER, WHITE, BURNETT, HURLEY, BANICK & STRICKROOT, P.A.
ELEVENTH FLOOR COURTHOUSE CENTER, 175 NORTHWEST FIRST AVENUE, MIAMI, FLORIDA 33128-1835 • TEL. (305) 358-6550

demonstrate that there is an overpowering public necessity for this legislation and lack of alternative remedies to address the problem. The Third District also reasoned that the statutes do not provide a reasonable alternative and commensurate benefit in exchange for the damage cap. The Third District declined to consider the other grounds the Trial Court relied on to hold the statutes unconstitutional.

Legislative History

The Florida Legislature enacted Florida Statutes §§ 766.207 and 766.209 to protect the public from the medical malpractice crisis, which affects the availability and affordability of medical care. Before enacting these statutes, the Florida Legislature established the Academic Task Force For Review of The Insurance and Tort Systems to analyze the medical malpractice crisis and recommend solutions.[1] The Task Force was directed to report on its findings and recommendations by March 1, 1988. However, Governor Martinez and legislative leaders requested an expedited report. On August 14, 1987, the Task Force released its "Preliminary Fact-Finding Report on Medical Malpractice" (Appendix 2). On November 6, 1987, the Task Force released its Medical Malpractice Recommendations (Appendix 4).

---

[1] Ch. 86-160, Laws of Florida. The Task Force consisted of three university presidents and two businessmen with distinguished public service records. Additionally, the task force hired a professional staff with expertise in insurance and finance, actuarial science law, economics and medicine. The Task Force did not include members of special interest groups.

LAW OFFICES OF FOWLER, WHITE, BURNETT, HURLEY, BANICK & STRICKROOT, P.A.
ELEVENTH FLOOR COURTHOUSE CENTER, 175 NORTHWEST FIRST AVENUE, MIAMI, FLORIDA 33128-1835 • TEL. (305) 358-6550

After conducting an extensive study of the malpractice crisis, the Task Force recommended a comprehensive program to address the problems underlying the medical malpractice crisis. In the Medical Malpractice Preliminary Fact Finding Report, the Task Force identified the dollar amount of paid claims and the delays, costs, and uncertainty inherent in the tort system as major concerns.

In February 1988, the Governor called the Florida Legislature into a special session to address the medical malpractice crisis in Florida. The legislature relied on the Task Force's extensive study, weighed the various alternatives, balanced the policy reasons supporting each alternative, and promulgated legislation to meet this public need. The preamble to this legislation, Chapter 88-1, provides:

> WHEREAS, the Legislature finds that there is in Florida a financial crisis in the medical liability insurance industry, and
>
> WHEREAS, it is the sense of the Legislature that if the present crisis is not abated, many persons who are subject to civil actions will be unable to purchase liability insurance, and many injured persons will therefore be unable to recover damages for either their economic losses or their non-economic losses, and
>
> WHEREAS, the people of Florida are concerned with the increased cost of litigation and the need for a review of the tort and insurance laws, and
>
> WHEREAS, the Legislature believes that, in general, the cost of medical liability insurance is excessive and injurious to the people of Florida and must be reduced, and

LAW OFFICES OF FOWLER, WHITE, BURNETT, HURLEY, BANICK & STRICKROOT, P.A.
ELEVENTH FLOOR COURTHOUSE CENTER, 175 NORTHWEST FIRST AVENUE, MIAMI, FLORIDA 33128-1835 • TEL. (305) 358-6550

WHEREAS, the Legislature finds that there are certain elements of damage presently recoverable that have no monetary value, except on a purely arbitrary basis, while other elements of damage are either easily measured on a monetary basis or reflect ultimate monetary loss, and

WHEREAS, the Legislature desires to provide a rational basis for determining damages for noneconomic losses which may be awarded in certain civil actions, recognizing that such noneconomic losses should be fairly compensated and that the interests of the injured party should be balanced against the interests of society as a whole, in that the burden of compensating for such losses is ultimately borne by all persons, rather than by the tortfeasor alone, and

WHEREAS, the Legislature created the Academic Task Force for Review of the Insurance and Tort Systems which has studied the medical malpractice problems currently existing in the State of Florida, and

WHEREAS, the Legislature has reviewed the findings and recommendations of the Academic Task Force relating to medical malpractice, and

WHEREAS, the Legislature finds that the Academic Task Force has established that a medical malpractice crisis exists in the State of Florida which can be alleviated by the adoption of comprehensive legislatively enacted reforms, and

WHEREAS, the magnitude of this compelling social problem demands immediate and dramatic legislative action . . . .

Chapter 88-1, Laws of Florida (Special "E" Session) (amended and re-enacted Ch. 88-277, Laws of Florida). In addition to the preamble, the legislature made specific findings in Section 48, which are applicable to the issues herein:

(1) The Legislature makes the following findings:

(a) Medical malpractice liability insurance premiums have increased dramatically in recent years, resulting in increased medical care costs for most patients and functional unavailability of malpractice insurance for some physicians.

(b) The primary cause of increased medical malpractice liability insurance premiums has been the substantial increase in loss payments to claimants caused by tremendous increases in the amounts of paid claims.

(c) The average cost of defending a medical malpractice claim has escalated in the past decade to the point where it has become imperative to control such cost in the interests of the public need for quality medical services.

(d) The high cost of medical malpractice claims in the state can be substantially alleviated by requiring early determination of the merit of claims, by providing for early arbitration of claims, thereby reducing delay and attorney's fees, and by imposing reasonable limitations on damages, while preserving the right of either party to have its case heard by a jury.

(e) The recovery of 100 percent of economic losses constitutes overcompensation because such recovery fails to recognize that such awards are not subject to taxes on economic damages.

(2) It is the intent of the Legislature to provide a plan for prompt resolution of medical negligence claims. Such plan shall

LAW OFFICES OF FOWLER, WHITE, BURNETT, HURLEY, BANICK & STRICKROOT, P.A.
ELEVENTH FLOOR COURTHOUSE CENTER, 175 NORTHWEST FIRST AVENUE, MIAMI, FLORIDA 33128-1835 • TEL. (305) 358-6550

consist of two separate components, presuit investigation and arbitration. Presuit investigation shall be mandatory and shall apply to all medical negligence claims and defenses. Arbitration shall be voluntary, and shall be available except as specified.

(a) Presuit investigation shall include:

1. Verifiable requirements that reasonable investigation precede both malpractice claims and defenses in order to eliminate frivolous claims and defenses.

2. Medical corroboration procedures.

(b) Arbitration shall provide:

1. Substantial incentives for both claimants and defendants to submit their cases to binding arbitration, thus reducing attorney's fees, litigation costs, and delay.

2. A conditional limitation on noneconomic damages where the defendant concedes willingness to pay economic damages and reasonable attorney's fees.

3. Limitations on the noneconomic damages components of large awards to provide increased predictability of outcome of the claims resolution process for insurer anticipated losses planing, and to facilitate early resolution of

medical negligence
claims.

Chapter 88-1, Section 48, Laws of Florida (Special "E" Session), codified as §766.201, Florida Statues (1988).

The Legislature specifically found that a number of problems directly contributed to the malpractice crisis in the State of Florida, which adversely affects the availability and affordability of health care in Florida. The legislature considered numerous alternative solutions. See Appendix 2, Task Force's Discussion Draft of Medical Malpractice Reform Alternatives. However, the legislature determined that a comprehensive solution, which includes a contingent cap on non-economic damages and a contingent arbitration procedure, is required.

The contingent cap on non-economic damages is an integral part of this comprehensive legislative response. Indeed, Professor Gifford, the Associate Director of the Task Force, stated in a letter to Mr. Robert Henderson of the House Insurance Committee that there is no alternative to the damage cap:

> The research staff considered any number of possible solutions to the problem of dramatically increased loss payments, and we concluded that any approach not containing a cap on non-economic damages would not ameliorate escalating premium costs. If there is an alternative method of meeting the public necessity, our exhaustive consideration of possibilities did not find it.

Appendix 5. This is mirrored by the Academic Task Force Report, which specifically states:

LAW OFFICES OF FOWLER, WHITE, BURNETT, HURLEY, BANICK & STRICKROOT, P.A.
ELEVENTH FLOOR COURTHOUSE CENTER, 175 NORTHWEST FIRST AVENUE, MIAMI, FLORIDA 33128-1835 • TEL. (305) 358-6550

only a cap on noneconomic damages would reduce medical malpractice paid claims appreciably.

Medical Malpractice Reform Alternatives, October 2, 1987, Appendix 3 at page 5.

SUMMARY OF THE ARGUMENT

The statutes at issue do not violate the Florida Constitution's access to courts provision because they comply with both prongs of the Kluger test. In holding that the statutes do not comply with the Kluger test, the Third District effectively acted as a "super legislature" and substituted its judgement for the Florida Legislature's judgement, contrary to well-established principles of judicial construction. The Legislature conducted an extensive study of the medical malpractice crisis, determined that there was an overriding public necessity to address the crisis and that there are no alternative means available to address the perceived problems. The statute also provides both an alternative remedy and a commensurate benefit in lieu of a traditional recovery in tort.

Additionally, the statutes at issue do not violate Florida's constitutional right to jury trial. The statutes uphold the right of either party to obtain a jury trial and impose a contingent cap on non-economic damages only where the plaintiff refuses the alternative remedy of arbitration.

Further, the instant statutes do not violate procedural or substantive due process. The statutes contain reasonable, non-

arbitrary provisions that were designed to meet legitimate legislative goals.

The statutes at issue do not violate constitutional equal protection guarantees. Rather, the statutes provide rational classifications enacted to meet specific legislative goals. The means utilized to reach those goals are rationally related to the legislative goals.

In addition, the instant statutes do not amount to an unconstitutional taking of private property without due process of law. There is no property right in any particular remedy; nor is there any unconstitutional taking under the state's eminent domain powers.

The statutes do not violate the single subject requirement of Florida's Constitution. They are naturally and logically connected to a single subject and were promulgated in a special session devoted to the medical practice crisis identified by the Academic Task Force and specifically found to exist by the Florida Legislature.

Finally, the statutes do not usurp judicial powers in violation of Florida's Constitution. The statutes undertake a purely legislative goal of balancing duties and obligations of economic life and are an appropriate exercise of available legislative powers.

LAW OFFICES OF FOWLER, WHITE, BURNETT, HURLEY, BANICK & STRICKROOT, P.A.
ELEVENTH FLOOR COURTHOUSE CENTER, 175 NORTHWEST FIRST AVENUE, MIAMI, FLORIDA 33128-1835 • TEL. (305) 358-6550

ARGUMENT

I. THE CONTINGENT CAP ON NON-ECONOMIC DAMAGES, DOES NOT VIOLATE FLORIDA'S CONSTITUTION, ART. I, §21 - THE RIGHT OF ACCESS TO COURTS

The cap on non-economic damages in the statutes at issue does not violate Art. I, §21 of the Florida Constitution, which guarantees access to the courts. A legislative enactment which abolishes a pre-existing common law right does not violate Art I, §21 if: (1) the legislation provides a reasonable alternative remedy or commensurate benefit; or (2) there is a legislative showing of overpowering public necessity for the act and there is no alternative method of meeting such public necessity. Smith v. Department of Insurance, 507 So.2d 1080 (Fla. 1987), (citing Kluger v. White, 281 So.2d 1 (Fla. 1973)). The statutes at issue satisfy both prongs of the Smith/Kluger test and are, therefore, constitutional.

A. Overpowering Public Necessity and No Alternatives

The Legislature, through the Academic Task Force, conducted what has arguably been the most extensive study on the insurance and tort system, and medical malpractice issues arising within that system, in the history of the United States. As a result of this study, the legislature determined that a medical malpractice crisis exists, which adversely affects the availability and affordability of health care in Florida. Additionally, the legislature found that the crisis has made malpractice insurance "functionally unavailable" for some physicians, thereby threatening the ability of many injured patients to recover

LAW OFFICES OF FOWLER, WHITE, BURNETT, HURLEY, BANICK & STRICKROOT, P.A.
ELEVENTH FLOOR COURTHOUSE CENTER, 175 NORTHWEST FIRST AVENUE, MIAMI, FLORIDA 33128-1835 • TEL. (305) 358-6550

damages in medical malpractice cases. The Legislature concluded that the "magnitude of this compelling social problem demands immediate and dramatic legislative action."

The primary causes of the crisis, according to the legislature, are the high-end damage awards and the substantial litigation costs in medical malpractice cases. Accordingly, the comprehensive legislative remedy includes a contingent cap on non-economic damages to reduce the high-end awards and a streamlined arbitration procedure to reduce litigation costs if the defendant admits liability.

The legislature determined that there was no alternative to the contingent cap on non-economic damages. Between 1975 and 1988 the legislature enacted numerous statutes in an attempt to control the medical malpractice problem. During this period, virtually every other conceivable alternative short of a statutory limitation on damages was reviewed and enacted. As noted in the Task Force Report, these changes had only limited success. Faced with these previous unsuccessful attempts at reform, combined with the exhaustive analysis of the Academic Task Force, the 1988 legislature, in a special session called to address the specific problems of the medical malpractice crisis, adopted the only other alternative available to it: a damage cap.

B. Principles of Judicial Construction

The real issue in this case concerns the relationship between the legislative and judicial branches of our state government and the proper role of a court in determining whether

a legislative act is constitutional. The Third District improperly acted as a "super-legislature" by rejecting the Florida Legislature's findings that the medical malpractice crisis is an overpowering public necessity and that there are no alternative solutions. As discussed below, Florida's Courts have consistently upheld the legislature's ability to modify or abolish pre-existing causes of action when the legislature provides specific findings supporting its action. These decisions are based on principles of judicial construction that require the courts to abide by legislative findings when reviewing legislative enactments.

For example, this Court stated in State v. Bales, 343 So.2d 9, 11 (Fla. 1977) that:

> [W]e must bear in mind that any legislative enactment carries a strong presumption of constitutionality, including a rebuttable presumption of the existence of necessary factual support in its provisions.... If any state of facts, known or to be assumed, justify the law, the court's power of inquiry ends.... Questions as to the wisdom, need or appropriateness are for the Legislature...

Id. (citations omitted). Likewise, in Holley v. Adams, 238 So.2d 401 (Fla. 1970), this Court stated:

> First, it is the function of the Court to interpret the law, not to legislate. Second, courts are not concerned with the mere wisdom of the policy of the legislation.... Third, the Courts have no power to strike down an act of the legislature unless the provisions of the act, or some of them, clearly violate some express or implied inhibition of the Constitution. Fourth, every reasonable doubt must be indulged in favor of the act. If it can be rationally interpreted to harmonize with the Constitution, it is the duty of the

LAW OFFICES OF FOWLER, WHITE, BURNETT, HURLEY, BANICK & STRICKROOT, P.A.
ELEVENTH FLOOR COURTHOUSE CENTER, 175 NORTHWEST FIRST AVENUE, MIAMI, FLORIDA 33128-1835 • TEL. (305) 358-6550

Court to adopt that construction and sustain the act.

* * *

The judiciary will not nullify the legislative acts merely on grounds of the policy and wisdom of such act, no matter how unwise or unpolitic they might be.....

Id. at 404-405

In Holly v. Auld, 457 So.2d 217 (Fla. 1984), this Court upheld the constitutionality of the discovery privilege for medical peer review information contained in Florida Statutes, Section 768.40, reasoning:

> Inevitably, such a discovery privilege will impinge upon the rights of some civil litigants to discovery of information which might be helpful, or even essential to their causes. We must assume that the Legislature balanced this potential detriment against the potential for health care cost containment offered by effective self-policing by the medical community and found the latter to be of greater weight. It is precisely this sort of policy judgment which is exclusively the province of the Legislature rather than the courts.

Id. at 220.[2]

---

[2] See also Feldman v. Glucroft, 522 So.2d 798 (Fla. 1988), this Court had to decide whether other sections of the statute involved in Holly totally abolished defamation claims arising out of medical review committee proceedings and, if so, whether this violated the Florida Constitution's right of access provisions. This Court cited its earlier decision in Holly and held that the statute limited, but did not totally abolish, the defamation cause of action. Accordingly, this Court did not address whether the discovery privilege violated the constitutional access to court's provisions. Id. at 801. Nevertheless, in a concurring opinion, Justice Grimes stated that even if the statute was deemed to completely abolish the cause of action, it would still be sustainable under Kluger. He specifically cited the Preamble of the 1973 law adopting the privilege, noted that the Legislature had perceived an overwhelming need for medical review committees to function without a fear of retaliation in

LAW OFFICES OF FOWLER, WHITE, BURNETT, HURLEY, BANICK & STRICKROOT, P.A.
ELEVENTH FLOOR COURTHOUSE CENTER, 175 NORTHWEST FIRST AVENUE, MIAMI, FLORIDA 33128-1835 • TEL. (305) 358-6550

In Rotwein v. Gersten, 36 So.2d 419 (Fla. 1948), this Court upheld a statute that abolished causes of action for alienation of affections, criminal conversion, seduction, or breach of contract to marry. This Court stated:

> The Florida Statute is prefaced by a declaration of policy in which it is stated that actions for alienation of affections, criminal conversion, seduction and breach of contract to marry have been subject to grave abuses, causing extreme annoyance, embarrassment, humiliation and pecuniary damages to many persons wholly innocent and free from wrongdoing, that they have been exercised by the unscrupulous for their own enrichment and that the best interest of the people of Florida will be served by abolition of such remedies.
>
> * * * *
>
> The causes of action prescribed by the act under review were a part of the common law and have long been a part of the law of the country. They have no doubt served a good purpose, but when they become an instrument of extortion and blackmail, the Legislature has the power to, and may, limit or abolish them.

Id. at 420-21.

The Third District's decision conflicts with these principles of judicial construction. The Third District simply disagrees with the Florida Legislature's determination that there is a medical malpractice crisis and that only a damage cap can effectively address this crisis. For example, in concluding that "a careful review of the legislative findings does not demonstrate the requisite overpowering public necessity for

---

order to improve the quality of medical services and reasoned that the legislature acted appropriately to meet the need.

LAW OFFICES OF FOWLER, WHITE, BURNETT, HURLEY, BANICK & STRICKROOT, P.A.
ELEVENTH FLOOR COURTHOUSE CENTER, 175 NORTHWEST FIRST AVENUE, MIAMI, FLORIDA 33128-1835 • TEL. (305) 358-6550

restricting damages", the Third District disregarded the following legislative statements in the preamble and findings sections of the legislation at issue:

> WHEREAS, the Legislature finds that the Academic Task Force has established that a medical malpractice crisis exists in the State of Florida which can be alleviated by the adoption of comprehensive legislatively enacted reforms, and
>
> WHEREAS, <u>the magnitude of this compelling social problem demands immediate and dramatic legislative action</u> . . . .
>
> *   *   *
>
> (b) The primary cause of increased medical malpractice liability insurance premiums has been the substantial increase in loss payments to claimants caused by tremendous increases in the amounts of paid claims.
>
> (c) The average cost of defending a medical malpractice claim has escalated in the past decade to the point where it has become imperative to control such cost in the interests of the public need for quality medical services.

In rejecting these findings and determinations regarding the overpowering public necessity, the Third District clearly did not afford these statutes any presumption of constitutionality as required by <u>Bales</u>, including the presumption of the necessary factual support i.e. that there is a malpractice crisis which affects the availability and affordability of medical care in Florida. Further, the Third District offered no evidence that these findings are incorrect to overcome the presumption of constitutionality. Rather, the Third District simply substituted

its opinion for the legislature's opinion, which was based on an extensive study of the crisis.

The Third District erroneously relied on Overland Construction Co, Inc. v. Sirmons, 369 So.2d 572 (Fla. 1979). In Overland this Court invalidated a 12 year statute of repose applicable to construction on real property because the legislature did not express any perceived overriding public necessity for the legislation. However, in this case the legislature clearly expressed the perceived overriding public necessity in the preamble and the findings sections of the Act, which distinguishes this case from Overland. Further, the Florida legislature responded to Overland by enacting Florida Statute § 95.11 (1985), which is almost identical to the statute of repose in Overland. However, in the 1985 statute the legislature expressed the perceived overriding public necessity in the preamble. This statute was upheld against an access to courts challenge in American Liberty Ins. Co. v. West and Conyers, Architects And Engineers, 491 So.2d 573 (Fla. 2d DCA 1986). The American Liberty Court reasoned:

> The Legislature has the last word on declarations of public policy.... The courts are bound to give great weight to legislative determinations of fact.... It is not unusual for a subsequent legislative determination of the legality of purpose to be served by an undertaking to be deemed sufficient to overcome a prior judicial decision to the contrary.... In enacting the preamble to the new section 95.11(3)(c), we believe the legislature has met the requirements of Overland Construction Co., thereby sustaining the validity of the statute.

Id. at 575.

The Third District also erroneously distinguished Carr v. Broward County, 505 So.2d 568, (Fla. 4th DCA 1987), in holding that there is no overpowering public necessity. In Carr, the Fourth District upheld the medical malpractice statute of repose against an assertion that the statute violated the plaintiff's right of access to courts. The Statute of Repose completely abolished the right to sue seven years from the date of the alleged malpractice. The Court reasoned that the legislative preamble established an overpowering public necessity:

> The public necessity for the statutory reform embodied in the act was expressed by the legislature in the preamble as follows:
>
> > WHEREAS, the cost of purchasing medical professional liability insurance for doctors and other health care providers has sky-rocketed in the past few months; and
> >
> > WHEREAS, the consumer ultimately must bear the financial burdens created by the high cost of insurance; and
> >
> > WHEREAS, without some legislative relief, doctors will be forced to curtail their practices, retire, or practice defensive medicine at increased cost to the citizens of Florida; and
> >
> > WHEREAS, the problem has reached crisis proportion in Florida, NOW THEREFORE....
>
> We here determine, subject to supreme court scrutiny in this or a later appropriate case, that the legislature has established an overriding public interest meeting the Kluger test....

Id. at 575.

LAW OFFICES OF FOWLER, WHITE, BURNETT, HURLEY, BANICK & STRICKROOT, P.A.
ELEVENTH FLOOR COURTHOUSE CENTER, 175 NORTHWEST FIRST AVENUE, MIAMI, FLORIDA 33128-1835 • TEL. (305) 358-6550

This Court affirmed and held that the Fourth District properly applied the Kluger test:

> We agree with the district court that section 95.11(4)(b) [the medical malpractice statute of repose] was properly grounded on an announced public necessity and no less stringent measure would obviate the problems the legislature sought to address, and thus the statute does not violate the access-to-courts provision.

Carr v. Broward County, 541 So.2d 92, 95 (Fla. 1989). As in Carr the legislature expressed the public necessity for the statutes at issue in the preamble.

Contrary to the Third District's opinion, Carr is not distinguishable. The Legislative findings regarding the public necessity for the Medical Malpractice Reform Act of 1975, which was at issue in Carr, are similar to the legislative findings in the statute at issue i.e. skyrocketing malpractice insurance costs, which result in increased medical care costs. The legislature expressed this public necessity in both the 1975 Act and the 1988 Act at issue in this case. Additionally, in both cases the legislature responded to the crisis with a comprehensive legislative solution. The only significant difference is that the 1975 Act completely eliminated causes of action whereas the 1988 Act only limits damages. If the legislature could constitutionally respond to the malpractice crisis in 1975 by eliminating a cause of action, it should be able to constitutionally respond to the same crisis 13 years later by limiting damages.

LAW OFFICES OF FOWLER, WHITE, BURNETT, HURLEY, BANICK & STRICKROOT, P.A.
ELEVENTH FLOOR COURTHOUSE CENTER, 175 NORTHWEST FIRST AVENUE, MIAMI, FLORIDA 33128-1835 • TEL. (305) 358-6550

Carr, American Liberty and Overland demonstrate that a Court must abide by the legislature's determination of an overpowering public necessity. In Overland, this Court questioned whether there was a compelling need for a statute of repose. This was appropriate, and not inconsistent with principles of judicial construction, because the legislature did not express the perceived public necessity. However, consistent with principles of judicial construction, this Court in Carr and the American Liberty Court upheld statutes of repose against constitutional attacks because of the required deference to legislative findings and expressions of public necessity. Accordingly, in this case the legislative finding of overpowering public necessity meets the second prong of the Kluger test and, pursuant to principles of judicial construction, the Third District improperly rejected these legislative determinations.[3]

Additionally, the Third District erroneously rejected the Task Force's findings that there was no alternative method of meeting the public necessity. The Third District ignored Professor Gifford's statement to the House Insurance Committee that the Task Force could not find an alternative to the damage cap despite an exhaustive consideration of the alternatives.

---

[3] The legislature did not express any public necessity in the Act creating the absolute damage cap involved in Smith v. Department of Insurance, 507 So.2d 1080 (Fla. 1987).

LAW OFFICES OF FOWLER, WHITE, BURNETT, HURLEY, BANICK & STRICKROOT, P.A.
ELEVENTH FLOOR COURTHOUSE CENTER, 175 NORTHWEST FIRST AVENUE, MIAMI, FLORIDA 33128-1835 • TEL. (305) 358-6550

Likewise, the Third District rejected the Task Force's statement that:

> only a cap on noneconomic damages would reduce medical malpractice paid claims appreciably.

Medical Malpractice Reform Alternatives, October 2, 1987, Appendix 3 at page 5. In rejecting this finding, the Third District referred to the preamble in Ch. 90-401, 1990 Laws of Florida, which stated that the "reforms contained in this act are the only alternative available". The Third District concluded that the Academic Task Force's statement on the lack of alternatives, which was adopted by the Legislature, is insufficient and would require an "inference" that there are no alternatives. This is incorrect. The Task Force's statement is clear and does not require any additional inference. It means that of the alternatives, only the damage cap would reduce the high end awards that are the primary cause of the malpractice crisis. Interestingly, the statute involved in Carr did not even mention the lack of alternatives. Nevertheless, this Court upheld that statute.

Finally, although the Third District recognized that the legislature determined that damage caps would be effective in decreasing damage awards, the Third District concluded that "it is unclear how effective a damage cap would be in alleviating the cost of loss payments, paid claims, and liability insurance premiums." Pursuant to Holley, the Third District improperly

questioned the wisdom of this legislation. As this Court stated in Holley:

> The judiciary will not nullify the legislative acts merely on grounds of the policy and wisdom of such act, no matter how unwise or unpolitic they might be....

Holley, 238 So.2d at 405.

The proper role for a Court in determining the constitutionality of a legislative enactment is to ensure that the legislature is not acting arbitrarily or on a whim. As this Court stated in City of New Smyrna Beach v. Fish, 384 So.2d 1272 (Fla. 1980):

> There is a presumption that legislative determinations or findings of fact are correct and should not be voided absent a clear showing that they are arbitrary, oppressive, discriminatory or without basis in reason or justification.

Id. at 1276. Likewise, in Smith v. Department of Insurance, 507 So.2d 1080 (Fla. 1987), this Court held that an absolute cap on damages in all tort cases must meet the conditions of Kluger to ensure that the constitutional right of access to courts is not "subordinated to, and a creature of legislative grace, . . . 'majoritarian whim.'" id. at 1089. The Third District, at page 21 of its order, suggested that the statutes at issue are the result of legislative whim because they do not comply with the Kluger conditions.

However, the Florida Legislature did not act arbitrarily or on a whim in enacting the contingent damage cap at issue. Indeed, after the Smith Court declared the absolute cap on

damages unconstitutional, the Legislature responded by creating the Academic Task Force, which conducted one of the most extensive studies on the malpractice crisis in the history of the United States, in which many people- including members of the trial bar- participated in the process and submitted proposals. Based on this study, the legislature enacted the statutes at issue. Clearly, the legislature did not act arbitrarily or on a whim. Therefore, the statutes are constitutional regardless of whether the courts in this state agree with the wisdom of Legislature's policy.

Finally, the Florida Legislature has been portrayed as a group of overzealous individuals determined to destroy the rights of plaintiffs. Indeed, before the Third District the Eschartes characterized these statutes as a "cruel legislative joke", a "Rube Goldberg invention" designed to hurt the seriously injured and help the admittedly negligent. Compared to other states' statutory damage caps in medical malpractice cases, Florida has the least restrictive damage cap. For example, California enacted a damage cap that applies regardless of whether the defendant admits liability. Cal. Civil Code § 3333.2.[4] This is a "carrot" for the defendant because it applies regardless of whether the defendant admits liability. On the other hand, because Florida's damage cap only applies if the defendant admits

---

[4] Although this type of a cap is an alternative to Florida's cap, it is more onerous than Florida's for purposes of the Kluger test and, therefor, does not change the fact that the legislation at issue satisfies the Kluger test.

liability, Florida's cap carries a big stick because defendants face the potential of a multi-million dollar judgement if they do not admit negligence. Additionally, Florida's Statute addresses another aspect of the malpractice crisis that other states have not addressed- the substantial litigation costs involved in medical malpractice actions. The arbitration procedure is designed to lower these costs.

C. The Statutes Provide Both a Reasonable Alternative and a Commensurate Benefit

Florida's response to the medical malpractice crisis is also less restrictive than other states' responses because Florida's Statutes provide an "alternative remedy or commensurate benefit", thereby satisfying the first prong of the Kluger test. Both the Task Force and the legislature were cognizant of this Court's decision in Smith and the constitutional limitations upon its actions and struck a balance between the interests of the claimants, the interests of defendants, and the needs of society as a whole. Unlike the statute in Smith, which contained an absolute cap on non-economic damages and nothing for the injured plaintiff, the legislature established an alternative remedy and benefit in the instant statutes. As the Academic Task Force stated:

> This plan's conditional limitation on non-economic damages differs from the absolute cap that was held to be unconstitutional in Smith v. Department of Insurance. First, it applies only to medical malpractice claims, where a special need has been established by specific research findings. Second, it is part of a balanced plan to facilitate early resolution of meritorious claims, thereby

> providing commensurate benefits in exchange for the reduced damage remedy. The $250,000 conditional limitation on non-economic damages applies only with consent of both parties and the $350,000 limitation on non-economic damages applies only if the plaintiff has refused an opportunity to receive expedited payments of limited damages without having to prove at fault.

Academic Task Force Report on Medical Malpractice Recommendations, p. 27. In the preamble to Chapter 88-1, the legislature specifically adopted the findings and recommendations of the Academic Task Force and expressly found that the:

> Conditional limit on non-economic damages is warranted by the claimant's refusal to accept arbitration, and represents an appropriate balance between the interest of all patients who ultimately pay for medical negligence losses and the interest of those patients who are injured as a result of medical negligence.

(§766.20, Fla. Stats. 1989); See also Academic Task Force Report on Medical Malpractice Recommendations, Appendix 4, p. 26.

Florida Statutes §§ 766.207-.212, (Supp. 1988) were specifically intended to reduce delay, provide for prompt payment of claims, and reduce the amount of attorneys fees and costs which must be paid by both the claimant and the defendants. This alternative method of dispute resolution provides a certain, prompt, and even preferable alternative to uncertain, expensive and time consuming trials. The major advantages, for both defendant and plaintiff, of the arbitration proceedings are as follows:

1. By making an offer to have damages determined by voluntary binding arbitration the defen-

dant agrees not to contest the issue of negligence with respect to the care provided.

2. The defendant agrees to be bound by and comply with the decision of the arbitration panel.

3. The defendant is required to pay the claimant reasonable attorneys' fees and the costs in the arbitration proceeding. §766.207(f), Fla. Stat. (1989).

4. The defendant is required to pay interest on all accrued damages. §766.207(7)(e), Fla. Stat. (1989).

5. The defendant is required to pay the cost of all arbitration proceedings and the fee to all arbitrators. (§766.207(7)(g)).

6. The defendant(s) is held jointly and severally liable for all damages assessed in the arbitration proceeding, thus foregoing the applicability of the provisions of §768.81, which abrogated the doctrine of joint and several liability for noneconomic damages and for economic damages under certain circumstances. §766.207(7)(h), Fla. Stat. (1989).

7. The procedures for determination of damages in voluntary binding arbitration are much less complex and the evidentiary standards, set forth in §120.58(1)(a), Fla. Stat. are more relaxed, especially with regard to the admission of hearsay, than evidentiary standards applicable at trial. §766.207(2), Fla.Stat. (1989).

8. The defendant must pay an arbitration award within twenty (20) days after the determination of damages by the arbitration panel. §766.211(1), Fla. Stat. (1989).

9. If the defendant fails to pay the arbitration award within ninety (90) days after rendition, the award begins to accrue interest at the rate of eighteen percent (18%) per year, rather than the twelve percent (12%) statutory rate of interest normally incident to judgments obtained after trial. §766.211(2), Fla. Stat. (1989).

10. The arbitration award is only subject to a limited administrative type appeal pursuant to §120.68. In addition, an appeal does not serve to stay the arbitration award and neither the arbitration panel nor a circuit court judge can stay the award pending appeal. This abolishes the defendant's right to supersede a judgment by posting adequate and sufficient bond at twelve percent (12%) interest, and by its very terms forces an appeal proceeding to be completed more expeditiously. The Appellate Court can only stay the payment of an arbitration award if "manifest injustice" is shown, so an arbitration award will rarely be stayed. Furthermore, even if such stay is granted, interest will continue to run at the rate of eighteen percent (18%), rather than the twelve percent (12%) rate of interest normally incident to judgments on appeal. §766.212, Fla. Stat. (1989).

The claimant can also make an offer for voluntary binding arbitration to the defendant(s), thus utilizing these procedures to their own advantage as well. §766.209(3), Fla.Stat. (1989). If the defendant rejects this offer, the action proceeds to trial without any damage limitation. If plaintiffs prevail they can recover pre-judgment interest and attorneys' fees of up to 25% of the award, reduced to present value, neither of which remedies are otherwise available. Accordingly, unlike the statutes in Smith, the advantages from the statutes herein flow equally to plaintiffs and defendants. The statutes also provide increased claims predictability, more efficient loss planning, a reduction in the dollar amount of paid claims, and otherwise make insurance functionally available to all medical practitioners, thus increasing the availability of recovery for all claimants.

The Third District recognized the legislation at issue provides certain benefits to claimants, which distinguishes this statute from the statute in Smith. However, the Third District erroneously held that the aforementioned benefits are not commensurate with the claimant's loss of non-economic damages in excess of the cap. Indeed, in Mahoney v. Sears, Roebuck & Co., 440 So.2d 1285 (Fla. 1983), this Court held that the Worker's Compensation statutes comply with the Kluger test and provide a commensurate benefit despite the fact that the plaintiff college student received only $1,200.00 in pain and suffering damages for loss of vision in one eye that resulted in 24% disability. This Court recognized that the student could have received more for his vision impairment under traditional tort law, reasoning:

> In Acton v. Fort Lauderdale Hospital, 440 So.2d 1282 (Fla. 1983), we held that subsections 440.15(3)(a) and (b), Florida Statutes (1981) do not violate constitutional guarantees of access to the courts and equal protection. Mahoney might well have received more compensation for the loss of his eye prior to the legislative amendments to the Workers' Compensation Law in 1979. Mahoney, however, received fully paid medical care and wage-loss benefits during his recovery from his on-knee-job accident without having to suffer the delay and uncertainty of seeking a recovery in tort from his employer or a third party. Workers' Compensation, therefore, still stands as a reasonable litigation alternative. The $1,200 award for loss of sight in one eye may appear inadequate and unfair, but it does not render the statute unconstitutional. Accordingly, we approve the decision of the district court.

Id. at 1285-86.[5]

Beginning with Kluger, this Court has consistently held that the Workers Compensation Statutes provide a reasonable and even preferable alternative to a tort remedy because those statutes provide full medical care and wage loss benefits without the delay, cost and uncertainty of litigation. Additionally, fault need not be proven. The recovery of major salient economic losses more than made up for the loss of full recovery of general damages such as permanent disability, disfigurement, or pain and suffering, which were either unavailable or severely limited by the Workmen's Compensation Statutes. Additionally, this Court has upheld legislative amendments to the Worker's Compensation Act that lower the amount of damages recoverable even if the legislature does not provide any additional commensurate benefit. Martinez v. Scanlan, 16 F.L.W. S427 (Fla. June 6, 1991).

Likewise, this Court has consistently upheld Florida's No-Fault Automobile Insurance statutes against right of access to courts challenges. Lasky v. State Farm Insurance Co., 296 So.2d 9 (Fla. 1974), provides additional support for the proposition

---

[5] See Sasso v. RAM Property Management, 452 So.2d 932 (Fla. 1984) ("[W]e find that Sasso has been provided with a reasonable alternative. His medical expenses were covered by workers' compensation benefits and he received temporary total disability benefits during his convalescence. Permanent total disability benefits were available to him if he had qualified and any future medical expenses related to his injury are also covered. Sasso thus has received some of the compensation which a tort suit might have provided had he been forced to pay his own expenses and subsequently seek redress in court. Such partial remedy does not constitute an abolition of rights without reasonable alternative as contemplated in Kluger v. White.") Id. at 933-34 (quoting Acton and Mahoney).

that preserving major economic damages and a portion of noneconomic damages is constitutionally acceptable as a quid pro quo for completely abolishing a right of access to the courts.[6] In Lasky, this Court found that the Legislature had established a reasonable alternative to tort recovery for pain and suffering damages by requiring motor vehicle owners to maintain insurance. This security would assure injured parties recovery of all their major and salient economic losses, even when they were at fault; speedy payment by the insured's insurer of medical costs and lost wages (80%, if taxable); and immunity from suit/loss of a right of action for suits for pain and suffering unless permanent injury was established or certain threshold medical expense requirements were met.

Similar to the Workmen's Compensation Statutes, this Court held that later amendments that lowered the amounts recoverable were still constitutional because the plan continued to provide reasonable alternatives and benefits. Chapman v. Dillon, 415 So.2d 12 (Fla. 1982). The District Court in Chapman found that the reduction of recoverable medical expenses from 100% to 80% and lost taxable income from 80% to 60%, combined with an increase in the optional deductibles, amounted to an unconstitutional denial of access to the courts. The court found that these changes removed the primary reason for the Lasky decision--

---

[6] The cap herein does not completely abolish the right of access to courts, but rather retains the right of access with limited general damages under specific and rationally identified circumstances.

the prompt recovery of major economic losses and the reduction of the number of lawsuits -- and resulted in a statute that no longer provided a reasonable alternative remedy or commensurate benefit in exchange for the abolition of the right to recover damages for pain and suffering. Dillon v. Chapman, 404 So.2d 354, 357 (Fla. 4th DCA 1981).

This Court reversed, reasoning that the statutory changes had not fundamentally altered the essential characteristic of the no-fault law because an injured person still received prompt payment for his major economic losses, even when he was at fault. Thus, the provision still provided a reasonable alternative to the traditional action in tort. 415 So.2d at 12 (Fla. 1982).

The Arbitration Statutes at issue herein are similar to the Workmen's Compensation statutes and no-fault automobile insurance statutes. The statutes at issue also replace an uncertain, costly, and time consuming tort remedy with a more streamlined administrative procedure whereby the plaintiff recovers medical expenses, lost income, and other benefits, including attorneys' fees, costs and interest, without having to prove fault. In addition, plaintiffs are entitled to recover substantial amounts of general damages in direct proportion to their loss of ability to enjoy life as a result of any permanent injury.

As a result of the streamlined process these damages will be paid more promptly than in litigation. Furthermore, the claimant will not expend costs for the arbitration and recovers attorney's

LAW OFFICES OF FOWLER, WHITE, BURNETT, HURLEY, BANICK & STRICKROOT, P.A.
ELEVENTH FLOOR COURTHOUSE CENTER, 175 NORTHWEST FIRST AVENUE, MIAMI, FLORIDA 33128-1835 • TEL. (305) 358-6550

fees up to 15% of the award. This serves to reduce costs and delay and increase net recovery. In addition to economic losses, the arbitration procedures also provide for noneconomic losses, to a maximum of $250,000, which recovery is tied to the ability to lead a normal life. Thus the more seriously injured claimants are entitled to higher benefits, whereas persons with injuries that do not result in significant long-term suffering are entitled to less.

Furthermore, the statute is intended to provide these benefits to all medical malpractice victims in general and increase the availability of recovery for all potential plaintiffs by addressing the problem that makes malpractice insurance functionally unavailable. In this respect, the Arbitration Plan is even more favorable to both Escharte and the public in general than the Workmen's Compensation Statutes. Accordingly, the legislature acted pursuant to this Court's guidelines and ensured the availability of full economic damages to plaintiffs in medical malpractice actions, while providing limited general damages based upon its finding that such damages tend to be arbitrary and oftentimes amount to overcompensation in the tort system. This legislative balancing of benefits and detriments fully complies with the Kluger test.

The Third District erroneously concluded that the statutes at issue do not provide a commensurate benefit similar to the Workers Compensation and No-Fault Automobile Insurance Statutes. The Third District reasoned that the malpractice statutes at

issue do not create a no-fault basis for recovery similar to the Worker's Compensation Statutes and No-Fault Automobile Insurance Statutes. However, this is an erroneous distinction because the statutes at issue only apply if the defendant admits negligence. If the defendant does not admit negligence, the plaintiff can proceed in Court without any limitation on damages.

Likewise, the Third District erroneously relied on the fact that the statutes at issue do not require all physicians to purchase malpractice insurance. Of course, physicians were already required to maintain resources or purchase insurance in order to be able to satisfy judgements. Florida Statute §458.320.

Further, the Third District erroneously contends that the statutes at issue are distinguishable from the Worker's Compensation statutes because the defendant retains causation defenses in the statutes at issue. This contention ignores the fact that an employer retains causation defenses in Worker's Compensation cases because the employee must prove that the injury was job-related. See Glasser v. Youth Shop, 54 So.2d 686 (Fla. 1951).

For these reasons, the statutes at issue satisfy both prongs of the Kluger test and are, therefore, constitutional.

II. THE STATUTES DO NOT VIOLATE THE RIGHT TO JURY TRIAL[7]

As noted in Lasky, the Legislature can:

[7] The Third District's holding was limited to the access to court challenge. The remaining sections of this brief address the Trial Court's additional constitutional concerns.

> [abolish] all right of recovery of specific items of damage and specific circumstances, and, as to those areas, [leave] nothing to be tried by a jury.

1096 So.2d at 22. If the Legislature complies with the Kluger test, it could completely abolish a cause of action triable by a jury but still not violate the right to trial by jury through such enactment. The instant arbitration provisions are a specific alternative to jury trials. If neither party utilizes the arbitration statutes, the right to jury trial continues without modification. Only if the request is refused will the claimant be subject to a limitation of noneconomic damages or the defendant subject to an award of fees and interest.

The trial court relied on Smith in support of its finding that the statutes violated the right to jury trial. However, this Court's vague reference to the right to jury trial was in response to an argument that the absolute cap on damages did not totally abolish the right of access. This Court held that the access to the courts provisions must be read in conjunction with the constitutional jury trial provisions and noted that a plaintiff who receives a jury verdict for a certain sum of money has not received constitutional redress of injuries if the Legislature arbitrarily caps the recovery at a lesser figure. Accordingly, Smith involved an absolute and arbitrary cap on damages without an alternative remedy, commensurate benefit, or overriding public necessity for that curtailment. Nevertheless, this Court did state in Smith that damage caps are permissible if the statute complies with the Kluger test.

The statutes herein do not establish an absolute cap and, based on the extensive data presented in the Task Force report, are not arbitrary. In addition, the statutory scheme provides an alternative remedy and a commensurate benefit. Furthermore, it was enacted pursuant to a legislative finding that there was an overpowering public necessity for this conditional limitation and that none of the other alternatives analyzed by the Task Force would meet the established need. Because the statute at issue complied with both prongs of the Kluger test, it is not constitutionally infirm under either §21 or §22. The legislature specifically recognized the constitutional right to jury trial and maintained its availability. However, it also recognized that the traditional right to jury trial was subject to uncertainty, excessive costs, attorneys' fees and delays. The Legislature determined that public necessity required an alternative procedure to jury trials that would reduce these problems and benefit claimants, defendants, and the general public. The alternative remedy itself is constitutional and the additional limitation arising when that alternative remedy is not utilized is also constitutional.[8]

---

[8] Indeed, even absolute caps have been held constitutional by other courts. In Etheridge v. Medical Center Hospitals, Inc., 237 Va. 87, 367 S.E.2d 525 (1989), the Supreme Court of Virginia upheld the constitutionality of Virginia's $750,000 absolute cap on all damages. The Court noted that, although it is the role of the jury as fact finder to determine the extent of the plaintiff's injuries, it is not the role of the jury to determine the legal consequences of its factual findings, which is a matter for the Legislature. The Virginia Legislature decided that as a matter of law damages in excess of $750,000 were not relevant. Once the jury had made its findings of fact

III. THE STATUTE DOES NOT VIOLATE THE RIGHT TO SUBSTANTIVE OR PROCEDURAL DUE PROCESS

The trial court held the statutes at issue violated the procedural and substantive due process guarantees of both the Florida and federal constitutions:

> To cap a plaintiff's damages at a specified numerically-defined amount without regard to the actual damages caused by defendants' malpractice is, by definition, to draw an entirely arbitrary line between recovery and non-recovery. See Smith v. Department of Insurance, supra. In addition, a statutory scheme which allows insignificantly injured medical malpractice victims to recover the full amount of their damages, but which deprives seriously injured victims of a full recovery (with the extent of that deprivation increasing as the extent of injury increases) is both unreasonable and oppressive. Compare Lasky v. State Farm Insurance Co., 296 So.2d 9 (Fla. 1974). . . .

R. 90.

In Lasky, this Court stated:

> The test to be used in determining whether an act is violative of the due process clause of [the state and federal constitution] is whether the statute bears a reasonable rela-

---

with respect to damages, it fulfilled its constitutional function and the legislative mandate, that compensation would not be paid in excess of a limited amount did not violate the right to jury trial. 376 S.E.2d at 529. In Boyd v. Bulala, 877 F.2d 1191 (4th Cir. 1989) the Federal Court of Appeal upheld the same Virginia statute on Federal constitutional grounds, adopting in part the decision of the Virginia Supreme Court and other decisions of the United States Supreme Court. The Third Circuit Court of Appeal in Davis v. Omitowoju, 833 F.2d 1155 (3d Cir. 1989) upheld a Virgin Islands law which capped noneconomic damages at $250,000 against a Seventh Amendment challenge on similar grounds. Finally, in Edmunds v. Murphy, 573 A.2d 853 (Md. App. 1990), the court upheld a $350,000 cap on non-economic damages against a challenge that the cap violated a right to jury trial provision in the Maryland constitution that is virtually identical to the Florida provision applicable herein.

> tion to a permissible legislative objective and is not discriminatory, arbitrary or oppressive.

296 So.2d at 15. The Lasky court held that the no-fault insurance act bore a reasonable relationship to permissible legislative objectives, thus rendering the act constitutional.[9] With respect to the threshold limitations for recovery of intangible damages, the court also held that these were reasonably related to the legislative objectives. Although the court noted that these provisions allowed recovery of intangible damages in major situations where substantial and tangible damages are likely to be present, it also noted that:

> Admittedly, situations can be perceived in which severe pain might be uncompensated, and other situations in which suit could still be brought for extremely minor, intangible damages. But perfection is not required in classification; 'problems of government are practical ones and may justify, if they do not require, rough accommodations -- illogical, it may be, and unscientific.'. . . Some inequality in result is not enough to vitiate on due process grounds a legislative classification grounded in reason. . . .

296 So.2d at 17 (citations omitted). Accordingly, it is clear that courts do not require mathematical certainty, nor prohibit

---

[9] The court looked to the expressed statutory purpose for the no-fault insurance law, but found that this did not help to elucidate the law's underlying purpose. Nevertheless, the court determined from an analysis of the statute and other sources such as legislative debate, law review commentary and opinions of other courts testing the constitutional validity of other laws that the legislative objectives included a lessening of congestion of the court system, reduction in delays, reduction in automobile insurance premiums, and an assurance that persons injured in automobile accidents would receive some economic aid in meeting medical expenses and the like. The court specifically determined that these were permissible legislative objectives.

limitation of damages, even to those who may possibly be more seriously injured, as long as there is some reasonable relation to a permissible legislative objective. As Lasky makes clear, there could be situations in which individuals with minor tangible damages but major intangible damages, such as pain and suffering, would not be fully compensated. Likewise, although the statute at issue may preclude recovery for severe pain and suffering in some instances, this inevitable inequality is not sufficient to violate the constitution because the statute bears a direct and reasonable relationship to permissible legislative objectives, which are similar in substance to the permissible legislative goals identified in Lasky.

The Florida Legislature determined that a medical malpractice crisis exists and that the primary factor in this crisis was the dramatic increase in medical malpractice liability insurance premiums in recent years. This resulted in increased medical care costs for most patients and functional unavailability of some malpractice insurance for certain physicians. The legislature noted that the primary cause of increased premiums was the substantial increase in loss payments, caused by the tremendous increase in the dollar amount of paid claims and the increased cost of defending medical malpractice claims. The legislature determined that the cap on non-economic damages was necessary to reduce claims, decrease delays, increase certainty of recovery, reduce the amount of attorney's fees, provide for effective and essential loss planning by insurers, increase

availability of insurance for doctors in high-risk specialties, and otherwise assure the adequate and reasonable cost of medical care in the State of Florida. In addition, the statutes provided incentives to both claimants and defendants to utilize these procedures and thus effectuate the legislative plan.

Additionally, the $250,000/$350,000 cap was not arbitrarily selected. Rather, it arose after a balancing of the various interests involved was based on studies that showed the estimated savings in claims payments resulting from several different caps,[10] and the Task Force recommendations. The legislature was also influenced by several studies on the effects of malpractice damage caps in other states. A 1986 study by the General Accounting Office reported that malpractice insurance rates increased less in California than in New York and Florida between 1980 and 1986. The Attorney General's Tort Policy Working Group concluded that this difference was due to California's strong tort reform measures, including a $250,000 cap on non-economic damages. Academic Task Force For Review of the Insurance and Tort Systems , Final Recommendations, March 1, 1988, page 89, fn.52.

In Duke Power Co. v. Carolina Environmental Study Group, Inc., 438 U.S. 59, 57, 98 S.Ct. 2620, L.Ed.2d 595 (1978), the United States Supreme Court, upheld the Price Anderson Act, which limited the damages recoverable in the event of a nuclear

---

[10] The Academic Task Force for the Review of Insurance and Tort Systems, Final Recommendations, March 1, 1988, Appendix 5 at page 64.

accident to 560 million dollars, against due process and equal protection[11] attacks. In analyzing the statute, the court stated that:

> the liability-limitation provision of the statute [is] a "classic example of an economic regulation -- a legislative effort to structure and accommodate 'the burdens and benefits of economic life.'

438 U.S. at 2636.

In Usery v. Turner Elkhorn Mining Co., 428 U.S. 1, 15 96 S.Ct. 2882, 2892, 49 L.Ed.2d. 752 (1976):

> It is by now well established that legislative Acts adjusting the burdens and benefits of economic life come to the Court with a presumption of constitutionality, and that the burden is on one complaining of a due process violation to establish that the Legislature has acted in an arbitrary and irrational way.

Likewise, as stated by the Florida Supreme Court in Belk-James, Inc. v. Nuzom, 358 So.2d 174, 175 (Fla. 1978):

> [T]he proper standard by which we must evaluate the legislature's exercise of the police power in the area of economic regulation is whether the means utilized bear a

---

[11] In upholding the statute against an equal protection challenge, the court noted that Congress agreed to "take whatever action is deemed necessary and appropriate to protect the public from the consequences of a nuclear accident" and that this was a fair and reasonable substitute for the uncertain recovery of damages from the manufacturer, whose resources may be exhausted. Likewise, Chapter 88-2 of the 1988 Special "E" Session, §85 states:

> In the event that this act does not result in savings in medical malpractice premiums beyond those which would be otherwise realized, it is the desire of the legislature that the provisions of this act be readdressed by the legislature.

> rational relationship to the legitimate state objective.

Id. In analyzing such economic regulation under a due process analysis, this Court must necessarily defer to the legislative finding and cannot substitute its opinion for that of the legislature:

> The legislature is vested with wide discretion to determine the public interest and the measures necessary for its achievement. . . . The fact that the legislature may not have chosen the best possible means to eradicate the evils perceived is of no consequence to the courts provided that the means selected are not wholly unrelated to achievement of the legislative purpose. A more rigorous inquiry would amount to a determination of the wisdom of the legislation . . . and would usurp the legislative prerogative to establish policy.

Fraternal Order of Police, Metropolitan Dade County, Lodge No. 6 v. Department of State, 392 So.2d 1296, 1302 (Fla. 1980) (citations omitted). Furthermore, the legislature can constitutionally determine the extent to which legal rights may be asserted as long as a reasonable notice and a fair opportunity to be heard is provided. Peoples Bank of Indian River County v. State, 395 So.2d 521, 524 (Fla. 1981). Applying the foregoing cases, it is apparent that the statutes at issue bear a reasonable relationship to a legitimate legislative goal and provide both procedural and substantive due process.

IV. THE STATUTES DO NOT DENY EQUAL PROTECTION

The trial court held that the statutes at issue contained unequal and arbitrary classifications which were not rationally

LAW OFFICES OF FOWLER, WHITE, BURNETT, HURLEY, BANICK & STRICKROOT, P.A.
ELEVENTH FLOOR COURTHOUSE CENTER, 175 NORTHWEST FIRST AVENUE, MIAMI, FLORIDA 33128-1835 • TEL. (305) 358-6550

related to legislative goals and therefore denied equal protection.

In The Florida High School Activities Assoc., Inc. v. Thomas, 434 So.2d 306 (Fla. 1983), the Florida Supreme Court held:

> Under a 'rational basis' standard of review, a court should inquire only whether it is conceivable that the regulatory classification bears some rational relationship to a legitimate state purpose.... The burden is upon the party challenging the statute. This is to show that there is no conceivable factual predicate which would rationally support the classification under attack where the challenging party fails to meet this difficult burden, the statute or regulation must be sustained.

Id. at 308 (emphasis in original).

In Woods v. Holy Cross Hospital, 591 F.2d 1164 (Fla. 5th Cir. 1979) the court stated:

> 'In the area of economics and social welfare, a State does not violate the Equal Protection Clause merely because the classifications made by its laws are imperfect. If the classification has some "reasonable basis" it does not offend the Constitution simply because the classification "is not made with mathematical nicety or because in practice it results in some inequality."'

Id at 1174 (quoting Dandridge v. Williams, 397 U.S. 471, 485, 90 S.Ct. 1153, 1161, 25 L.Ed.2d 491 (1970)).

Applying the aforementioned standard, the legislative classification herein is rationally related to the legislature's goal of reducing the size of claims, reducing costs and delays, promoting arbitration of claims, increasing claims predictability and insurance availability, and otherwise assuring adequate,

available and inexpensive health care to Florida's citizens. As evidenced by Lasky and Wood, courts do not require mathematical certainty, nor prohibit limitation of damages as long as there is some reasonable relation to a permissible legislative objective. The legislature enacted the caps at issue, in part, because noneconomic damages are difficult to quantify and are often derived on a purely arbitrary basis. The mere fact that there is a possibility that certain plaintiffs may fall below the cap and certain plaintiffs may be above the cap does not change the fact that the cap applies equally to all plaintiffs. Whether recovery is through binding arbitration or through a jury trial, all claimants are provided with recovery of their economic losses regardless of the seriousness of their injury and are entitled to substantial general damages as well. Furthermore, under the arbitration provisions, the amount of general damages recoverable is directly related to the claimant's ability to lead a normal life and, therefore, provides greater recovery to those who are more seriously effected by their injuries.

The trial court's reliance on the Florida Medical Center, Inc. v. Von Stetina, 436 So.2d 1022, 1029-30 (Fla. 4th DCA 1983). case is misplaced. In Von Stetina, the Fourth District held that Florida Statute §768.51, regarding payment of Judgments in excess of $200,000 through periodic payments:

> Arbitrarily and invidiously discriminates against medical malpractice victims who have suffered damages in excess of $200,000.00 by placing all of the burden for alleviating the perceived 'medical malpractice insurance crisis' upon them, and no burden whatsoever

> upon any malpractice victim who suffers damages in an amount less than $200,000.00.

Id. at 1029-30.[12] However, the Supreme Court specifically upheld the constitutionality of §768.51, and, accordingly, did not reverse the Fourth District on other grounds as the trial court held, but directly reversed the Fourth District on grounds relevant to this case. As the Supreme Court stated:

> We strongly adhere to the view that 'the judiciary may not sit as a super legislature to judge the wisdom or desirability of legislative policy determinations made in areas that neither affect fundamental rights nor proceed along suspect lines.' . . . So long as the legislative measures are rationally related to legitimate state interest, we must not substitute our judgment for that of the legislature with respect to the need for, or wisdom of, a legislative enactment.

Id. at 789.

Additionally, in Pinillos v. Cedars of Lebanon Hospital Corp., 403 So.2d 365 (Fla. 1981) the court addressed whether the statutory abrogation of the collateral source rule in medical malpractice actions, violated the equal protection clauses of the Florida and federal constitutions. The plaintiff argued that the distinctions drawn between medical practitioners and other members of the public was arbitrary and unreasonable. Id. at 367. The court noted that the statutes preamble announced in detail the legitimate state interest supporting its enactment.

---

[12] This finding was based on a statutory provision that would have denied certain claimants economic losses in excess of the cap.

After reviewing this legislative history and determining that the rational relationship test applied, the court stated:

> We hold that the classification created by §768.50 bears a reasonable relationship to the legitimate state interest in protecting the public health by insuring the availability of adequate medical care for the citizens of this state.

Id. at 368.

In Chapman v. Dillon, 415 So.2d 12, 18 (Fla. 1982), the Supreme Court reviewed modifications to the no-fault statute that further limited the amount of recovery available to claimants. However, the court still found that the provisions were reasonably related to the legislative objection of minimizing the cost of insurance in the state and, accordingly, held the statute constitutional.

Likewise, in Department of Insurance v. Southeast Volusia Hospital District, 438 So.2d 815, 821 (Fla. 1983), the Supreme Court held that the provisions of the Florida Patient's Compensation Fund plainly satisfied the purpose of the statute, namely to provide medical malpractice protection for Florida health care providers under terms accepted by the participants.

Based on the aforementioned cases, it is clear that the legislative classification herein is rationally related to the Legislature's goal of reducing costs and delays in litigation, promoting arbitration of claims, providing increased claims predictability, and generally benefiting the health, safety and welfare of the citizens of the State of Florida.

Other states have upheld even absolute caps against similar equal protection attacks. In Fein v. Permanente Medical Group, 695 P.2d 665 (Cal. 1985), the California Supreme Court upheld California's $250,000 cap on noneconomic damages against a constitutional challenge on equal protection grounds, reasoning:

> [T]here is similarly no merit to the claim that the statute violates equal protection principles because it obtains cost savings through a $250,000 limit on noneconomic damages, rather than, for example, through the complete elimination of all noneconomic damages. Although plaintiff and a supporting amicus claim that the $250,000 limit on noneconomic damages is more invidious -- from an equal protection perspective -- than a complete abolition of such damages on the ground that the $250,000 limit falls more heavily on those with the most serious injuries, if that analysis were valid a complete abolition of damages would be equally vulnerable to an equal protection challenge, because abolition obviously imposes greater monetary losses on those plaintiffs who would have obtained larger damage awards than on those who would have recovered lesser amounts. Just as the complete elimination of a cause of action has never been viewed as invidiously discriminating within the class of victims who have lost the right to sue, the $250,000 -- which applies to all malpractice victims -- does not amount to an unconstitutional discrimination.

Id. at 386.[13]

Similarly, in Edmunds v. Murphy, 573 A.2d 853 (M.D. App. 1990) the Maryland Court of Special Appeals upheld a $250,000 cap on non-economic damages against an equal protection challenge.

---

[13] See also Davis v. Omitowoju, 883 F.2d 1155, 1158-9 (3d Cir. 1989); Boyd v. Bulala, 877 F.2d 1191, 1196-97 (4th Cir. 1989).

In Edmunds, the court noted that the Maryland legislature had before it three separate reports: the Governor's Task Force to study liability insurance;[14] a 28-member joint Executive/ Legislative Task Force on medical malpractice insurance; and a Federal Tort Policy Working Group on the causes, extent and policy implications of the current crisis in insurance availability. Each of these groups found excessive increases in the size of damage awards and attributed this increase to the subjective and arbitrary process of valuing non-economic losses. In addition, all groups noted that high-end awards were a primary factor in causing escalating premiums. In order to resolve this problem, all the groups recommended caps -- the State Task Force recommended a $250,000 cap on non-economic damages and the tort working group suggested a limit of $100,000. After reviewing this information, the court concluded:

> Based upon this legislative history, we have little difficulty concluding that the classifications created by [the statute] -- those plaintiffs who have been awarded non-economic damages greater than $350,000, and those who have been awarded noneconomic damages less than $350,000 -- have a 'fair and substantial relation to the object of the legislation' -- increasing the availability and affordability of liability insurance. Thus, we hold that the subject legislation is constitutional on all fronts.[15]

---

[14] This report contains language that is virtually identical to findings of the Academic Task Force and the Florida Legislature.

[15] The court also addressed the question of whether the legislation at issue was subject to a heightened level of scrutiny. Although the court, after an exhaustive analysis, ultimately determined that this was not an important personal

Id. at 868.

Applying the aforementioned cases to the statute at issue, it is clear that the legislative classification herein is rationally related to a legitimate legislative goal and does not deny equal protection.

V. THE STATUTES DO NOT VIOLATE ARTICLE X §6 OF FLORIDA'S CONSTITUTION

By relying on Article 10, §6 of Florida's Constitution to declare the damage cap unconstitutional, the Trial Court has effectively vacated 33 years of Florida Supreme Court jurisprudence regarding a legislature's ability to abolish or limit a cause of action. If Article 10, § 6 applies, the legislature could never abolish a cause of action unless it provides "compensation" to each potential claimant. However, Kluger and Smith allow the legislature to completely abolish a cause of action without providing any alternative remedy or benefit. If the Eschartes and the Trial Court are correct, the legislature will no longer have the ability to respond to societal problems as the legislature did when it abolished causes of action for alienation of affection, criminal conversion, seduction and breach of contract to marry, and the legislature and the courts will have to revisit Rotwein v. Gersten, 36 So.2d 419 (Fla. 1948) the Workers Compensation Act and all others

---

right that would be subject to heightened scrutiny, it indicated that it still would have held the statute constitutional because of the classifications created were reasonable, not arbitrary, and rested upon grounds of difference having fair and substantial relation to the object of the legislation. Id. at 867.

statutes/cases in which causes of action were abolished or limited. Perhaps this is why the Eschartes did not cite any cases in which a court relied on constitutional "taking" clauses in determining whether a legislature can abolish or limit a cause of action.[16]

VI. THE STATUTES DO NOT VIOLATE THE SINGLE SUBJECT REQUIREMENT OF ARTICLE 3, SECTION 6 OF THE FLORIDA CONSTITUTION

The trial court incorrectly held that the statutes at issue violate the "one subject" rule. The trial court's holding is inconsistent with the Florida Supreme Court's opinion in Chenoweth v. Kemp, 396 So.2d 1122 (Fla. 1981) and Smith v. Department of Insurance, 507 So.2d 1080 (Fla. 1987), which upheld legislation similar to the statutes at issue against "one-subject" requirement challenges.

In Chenoweth, the Florida Supreme Court stated:

> We have long held that the subject of an act 'may be as broad as the legislature chooses as long as the matters included in the act have a natural or logical connection.' . . . While Chapter 76-260 covers a broad range of statutory provisions dealing with medical malpractice and insurance, these provisions do relate to tort litigation and insurance

---

[16] Regardless, the statutes at issue provide a commensurate benefit as discussed above and, therefore, compensate for any "taking" that occurs. Additionally, the Eschartes did not have a property right in an action for non-economic damages. Clausell v. Hobart Corp., 515 So.2d 1275 (Fla. 1987). Indeed, the Eschartes were allegedly injured after the statute became effective so they had no expectation of recovering damages precluded by the statute at issue. If the Eschartes are entitled to compensation for this alleged "taking," then 42 years worth of broken hearts will demand compensation for the state's "taking" of their right to sue for breach of contract to marry.

LAW OFFICES OF FOWLER, WHITE, BURNETT, HURLEY, BANICK & STRICKROOT, P.A.
ELEVENTH FLOOR COURTHOUSE CENTER, 175 NORTHWEST FIRST AVENUE, MIAMI, FLORIDA 33128-1835 • TEL. (305) 358-6550

> reform, which have a natural or logical connection.

Id. at 1124 (citations omitted).

Likewise, in Smith, the Florida Supreme Court upheld the 1986 Tort Reform Act against a challenge that it violated the single subject requirement, reasoning:

> The test to determine whether legislation meets the single-subject requirement is based on common sense. It requires examining the act to determine if the provisions 'are fairly and naturally germane to the subject of the act, or are such as are necessary incidents to or tend to make effective or promote the objects and purposes of the legislation included in the subject.' . . . Each of the challenged sections is an integral part of the statutory scheme enacted by the legislature to address one primary goal: the availability of affordable liability insurance.

Id. at 1087 (citations omitted).

As in Smith, the statutes at issue are part of a broad legislative scheme to address one primary goal: the availability of affordable liability insurance in the medical malpractice field. As the Task Force Report states:

> The Task Force believes that reforms of the Civil Justice System, of the medical regulatory system, and of the insurance system compliment each other. All are necessary to address the complex problems with multiple causes analyzed in the Preliminary Fact-Finding Report on Medical Malpractice.

The legislature determined that the problem was broad based and required a comprehensive plan. The trial court's holding simply ignores Chenoweth and Smith.

CONCLUSION

When the Court considers the efforts of the Florida Legislature, in coordination with and in reliance on the Academic Task Force, to protect the public in the critical area of health care, it is indeed unreasonable to argue that the legislature has acted in an arbitrary and irrational manner. To the contrary, based upon clearly supported legislative findings of need, these statutes bear a rational relationship to a legitimate state objective and were promulgated pursuant to powers given solely to the Florida Legislature. Accordingly, the statutes are constitutional and the Third District's ruling to the contrary should be reversed.

Respectfully submitted,

FOWLER, WHITE, BURNETT, HURLEY,
BANICK & STRICKROOT, P.A.
Attorneys for UNIVERSITY OF MIAMI
CourtHouse Center - 11th Floor
175 Northwest First Avenue
Miami, Florida 33128-1817
(305) 358-6550

By: ______________________
for STEVEN E. STARK
Florida Bar No. 516864

By: ______________________
MICHAEL L. FRIEDMAN
Florida Bar No. 797911

CERTIFICATE OF SERVICE

I HEREBY CERTIFY that a true and correct copy of the foregoing Brief and accompanying Appendix was mailed this 16th day of August, 1991 to all counsel on the attached service list.

By:
MICHAEL L. FRIEDMAN

Escharte v. University of Miami, et al.
Case No.: 90-00982

SERVICE LIST

Joel D. Eaton, Esq.
Podhurst, Orseck, Josefsberg,
Eaton, Meadow, Olin & Perwin, P.A.
25 W. Flagler Street, Suite 800
Miami, Florida 33130

Neal Roth, Esq.
Grossman & Roth, P.A.
Grand Bay Plaza, Penthouse One
2665 South Bayshore Drive
Miami, Florida 33133

Debra Snow, Esq.
Stephens, Lynn, Klein & McNicholas
One Datran Center, Suite 1800
9100 South Dadeland Blvd.
Miami, Florida 33156

Jim Tribble, Esq.
Blackwell & Walker, et al.
2400 Amerifirst Building
One Southeast Third Avenue
24th Floor
Miami, Florida 33131

Louis Hubener, Esq.
Attorney General's Office
Suite 1501
The Capital
Tallahassee, Florida 32399-1050

APPENDIX

PAGE(s) MISSING

We need not consider all the asserted arguments because we hold that sections 766.207 and 766.209 offend article I, section 21, of the Florida Constitution. Kluger v. White, 281 So.2d 1, 3 (Fla. 1973). Article 1, section 21 provides that "[t]he courts shall be open to every person for redress of any injury, and justice shall be administered without sale, denial or delay." The statutes in question violate that principle. The final judgment states, in relevant part:

> The Court has jurisdiction pursuant to §86.011, Fla. Stat. (1987).
>
> As applied to the facts in this case, the challenged statutes give the admittedly negligent defendant the unilateral right to "cap" the plaintiffs' damage recovery at an amount which is significantly lower than the actual damages which its negligence caused. The statutes provide no reasonable alternative remedy or commensurate benefit to the plaintiffs. The legislature has also failed to demonstrate that this draconian restriction upon the plaintiffs' constitutional right of access to the courts is required by an overpowering public necessity and that no reasonable alternative exists. The challenged statutes therefore violate Article I, §21 of the Florida Constitution. Smith v. Department of Insurance, 507 So.2d 1080 (Fla. 1987).

In Smith v. Department of Ins., 507 So.2d 1080 (Fla. 1987), the court held that the test set forth in Kluger must be applied to determine whether a statutory scheme restricting *noneconomic* damages violates article 1, section 21. The Smith court held that such a restriction is not permissible "unless one of the Kluger exceptions is met: i.e., (1) providing a reasonable alternative remedy or commensurate benefit, or (2) legislative showing of overpowering public necessity for the abolishment of the right and no alternative method of meeting such public

necessity." Smith, 507 So.2d at 1088. Applying that test, the Smith court concluded that an absolute $450,000 cap on noneconomic damages in personal injury cases did not meet the first exception and held that it violated claimant's constitutional right of access to the courts.[16]

Addressing the first prong of the Kluger test, we hold that the statute before us, examined under the Smith and Kluger standards, violates article I, section 21 by failing to provide "a reasonable alternative to protect the rights of [medical malpractice victims] to redress for injuries . . . ." Kluger, 281 So.2d at 4. We disagree with the University's contention that the arbitration procedure provided in the statutory scheme constitutes a reasonable alternative remedy or commensurate benefit to claimants and thereby renders Smith inapplicable.[17]

In support of its argument, the University cites cases upholding the Workers' Compensation Law,[18] and Florida's No-Fault

---

16 The Smith court did not consider whether the statute met the second prong of the Kluger test.

17 At the outset, we reject the University's contention that the contingency factor -- permitting defendant unilaterally to cap claimant's damages -- distinguishes the absolute cap from the cap at issue. That is a distinction without a difference. Where, as here, defendant decides not to contest liability and determines that claimant's noneconomic damages will surely exceed $250,000, it is virtually certain that defendants will request arbitration. Moreover, we question whether allowing a defendant to cap claimant's noneconomic damages is permissible. Cf. Martinello v. B & P USA, Inc., 566 So.2d 761 (Fla. 1990)(defendant not entitled to choose theory under which case is tried).

18 Sasso v. RAM Property Management, 452 So.2d 932 (Fla. 1984); Mahoney v. Sears, Roebuck & Co., 440 So.2d 1285 (Fla. 1983); Acton v. Fort Lauderdale Hospital, 440 So.2d 1282 (Fla. 1983).

Automobile Insurance Act,[19] against right of access challenges. The Florida Supreme Court held the statutory schemes of those laws constitutional because they employ compulsory insurance coverage no-fault concepts that assure prompt recovery of certain losses. See Martinez v. Scanlon, 16 F.L.W. 427 (Fla. June 6, 1991); De Ayala v. Florida Farm Bureau Cas. Ins. Co., 543 So.2d 204 (Fla. 1989); Smith; Lasky v. State Farm Ins. Co., 296 So.2d 9 (Fla. 1974). The no-fault automobile statutes provide a reasonable alternative to tort litigation: vehicle owners are required to purchase insurance to assure injured persons prompt recovery of major economic losses. Chapman v. Dillon, 415 So.2d 12 (Fla. 1982); Lasky; cf. Kluger, 281 So.2d at 5. Moreover, a claimant may recover some damages despite fault below a certain threshold and enjoys "immunity from being held liable for the pain and suffering of the other parties to the accident. . . ." Lasky, 296 So.2d at 14. The failure to maintain insurance negates an owner's tort immunity. Chapman; Lasky.

For similar reasons, the supreme court also upheld workers' compensation statutes: those statutes "afford substantial advantages to injured workers, . . . without their having to endure the delay and uncertainty of tort litigation." Acton v. Fort Lauderdale Hosp., 440 So.2d 1282, 1284 (Fla. 1983); Martinez, 16 F.L.W. at 428; Sasso v. Ram Property Management, 452 So.2d 932 (Fla.), appeal dismissed, 469 U.S. 1030, 105 S.Ct. 498, 87 L.Ed.2d 391 (1984); Mahoney v. Sears, Roebuck & Co., 440 So.2d 1285 (Fla. 1983). Those advantages include prompt recovery of

---

[19] Chapman v. Dillon, 415 So.2d 12 (Fla. 1982); Lasky v. State Farm Ins. Co., 296 So.2d 9 (Fla. 1974).

medical expenses and lost wages without having to prove fault. Furthermore, "[t]he justification for limiting liability or granting immunity is the substitution of something else in its place, a quid pro quo. The duty to provide workers' compensation benefits supplants tort liability to those injured on the job." Employers Ins. of Wausau v. Abernathy, 442 So.2d 953, 954 (Fla. 1983).

Those benefits do not obtain under the statutes in issue. Here, a defendant retains causation defenses and the claimant must demonstrate reasonable grounds to initiate medical negligence litigation, § 766.203(2), Fla. Stat. (Supp. 1988), through an extensive presuit investigation procedure.[20] § 766.106, .203 - .206, Fla. Stat. (Supp. 1988); see Fla. R. Civ. P. 1.650. Thus, although defendant agrees to pay certain damages following presuit screening, the statute does not provide a no-fault basis for recovery. Additionally, because insurance coverage is not mandated, defendant's immunity from liability for noneconomic damages in excess of the cap is not dependent on insurance coverage and claimant is not assured recovery of its allowable losses. The statutory scheme does provide certain benefits to claimants. These benefits may include the right to demand arbitration, § 766.207(2), reasonable attorney's fees and costs, § 766.207(7)(b), interest on all accrued damages, § 766.207(7)(e), arbitration costs and fees, § 766.207(7)(g). In addition, defendants are held jointly and severally liable for

---

[20] Claimant is subject to sanctions upon the court's determination that the claim does not rest on a reasonable basis. § 766.206, Fla. Stat. (Supp. 1988).

damages awarded to claimant. § 766.207(7)(h). We hold, however, that those benefits are not commensurate with claimant's loss of noneconomic damages in excess of the damage cap.

Furthermore, unlike the workers' compensation statutes and the no-fault automobile insurance statutes, the benefits in the statutes under review are not balanced between claimant and defendant. The true benefit -- the damage cap -- inures only to the negligent defendant: "a medical patient . . . obtains no compensatory benefit from a cap placed on noneconomic damages because of the unlikeliness of negligence by a patient. . . ." Smith, 507 So.2d at 1088 (footnote omitted). Compare Martinez, 16 F.L.W. at 428; De Ayala, 543 So.2d at 206; Smith, 507 So.2d at 1088; University of Miami v. Matthews, 97 So.2d 111, 114 (Fla. 1957); Grice v. Suwanee Lumber Mfg. Co., 113 So.2d 742, 745-6 (Fla. 1st DCA 1959).

Finally, the University contends that the statutes provide benefits to all medical malpractice claimants and potential claimants. However, a benefit to society in general does not satisfy Kluger. The benefits must inure to the medical malpractice victim. Smith. Although the legislature found that the $350,000 cap "represents an appropriate balance between the interests of all patients . . . and the interests of those patients who are injured as a result of medical negligence," § 766.209(4)(a), Fla. Stat. (Supp. 1988), the Florida Supreme Court has held that such an analysis is relevant only if the statute meets the Kluger test. Smith, 507 So.2d at 1089. Accordingly, a balancing of interests does not support the University's contention that the arbitration procedure is a

benefit to claimant. For these reasons, we conclude that the arbitration procedure does not provide a reasonable alternative remedy or commensurate benefit permitting the legislature to restrict claimant's noneconomic damages.

For the reasons we next discuss, we also hold that the statutory scheme does not meet the second Kluger exception -- a legislative showing of "an overpowering public necessity for the abolishment of such right, and no alternative method of meeting such public necessity can be shown." Kluger, 281 So.2d at 4.

In Overland Constr. Co., Inc. v. Sirmons, 369 So.2d 572, 574 (Fla. 1979), the court stated: "[t]he . . . issue . . . is whether the legislature has shown an overpowering public necessity for this prohibitory provision, and an absence of less onerous alternatives." (emphasis supplied). The legislative finding that a crisis exists in the medical liability insurance industry is not sufficient to satisfy the requirements of Kluger and Overland. The findings must demonstrate an overpowering public necessity to cap noneconomic damages of the most seriously injured victims. However, a careful review of the legislative findings does not demonstrate the requisite overpowering public necessity for restricting damages.

In Carr v. Broward County, 541 So.2d 92 (Fla. 1989), the supreme court held that a statute of repose in medical malpractice actions does not violate plaintiffs' right of access to the courts. The court held that the legislature demonstrated an overpowering public necessity where the legislature found that absent a statute of repose "doctors will be forced to curtail

their practices, retire, or practice defensive medicine at increased costs to the citizens of Florida[.]" Carr, 541 So.2d at 94 (quoting preamble to chapter 75-9, Laws of Florida, Medical Malpractice Reform Act of 1975). Carr is distinguishable from the case before us. In Carr, the statute merely shortened the time during which claimants could recover the full amount of damages. The Florida Supreme Court has consistently "recognized that statutes of repose are a valid legislative means to restrict or limit causes of action in order to achieve certain public interests." Carr, 541 So.2d at 95; Blizzard v. W.H. Roof Co., Inc., 573 So.2d 334 (Fla. 1991). Here, however, the statute eliminates all recovery in excess of the cap. The supreme court has not recognized the necessity of limiting noneconomic damages absent an alternative remedy or a commensurate benefit.[21] See generally, Smith; Florida Patient's Compensation Fund v. Von Stetina, 474 So.2d 783, 789 (Fla. 1985). Moreover, the functional unavailability of insurance for some physicians[22] does

---

21 Indeed, "the Task Force recommended 'rejection of a plan that would limit recovery of non-economic damages to $100,000 in all tort cases, including claims for medical negligence.' Two reasons were given for the negative recommendation: first, that 'cost savings from this proposal would be achieved solely by penalizing the most seriously injured victims,' and second, that 'the $100,000 cap is too low . . . and removes recovery for legitimate damages in many cases without providing offsetting benefits for plaintiffs.'" Final Recommendations at 59 (quoting Medical Malpractice Recommendations at 35). However, the Task Force recommended a conditional limitation on noneconomic damages at a higher figure and as part of a plan to provide incentives for arbitration. Medical Malpractice Recommendations at 35.

22 The Academic Task Force found that "[w]hile representing an expensive, but affordable 'cost of doing business' item for many physicians, for some, liability coverage may be so costly as to be 'functionally unavailable.' (e.g., young practitioners in high

not rise to the level of a danger of inability to obtain medical care. Carr; Carter v. Sparkman, 335 So.2d 802, 805 (Fla. 1976)("At the time of enactment . . . there was an imminent danger that a drastic curtailment in the availability of health care services would occur in this state."), cert. denied, 429 U.S. 1041, 97 S.Ct. 740, 50 L.Ed.2d 753 (1977), receded from Aldana v. Holub, 381 So.2d 231 (Fla. 1980). Finally, it is unclear how effective a damage cap would be in alleviating the cost of loss payments, paid claims, and liability insurance premiums. The legislature found that caps provide an incentive for defendants to admit liability and to arbitrate damages thereby decreasing such costs.[23] Although the Task Force found

---

[22] Continued

risk specialities serving in less affluent medically underserved regions)." Preliminary Fact-Finding Report on Medical Malpractice, April 14, 1987 at 239-240 (emphasis supplied); Medical Malpractice Recommendations at 10 (same). Thus, "functional unavailability" occurs when insurance premiums are so costly that physicians do not obtain coverage despite its availability. The report states that malpractice insurance is "approaching unaffordability, if it has not already reached it," for some high-risk physicians. Id. at 36. However, the Task Force also stated that "medical malpractice insurance has always been available from some source." Id. at 37, 40 ("[T]he Task Force has concluded that there is no genuine availability problem. . . ."). Cf. De Ayala v. Florida Farm Bureau Cas. Ins., 543 So.2d 204, 206 (Fla. 1989)(workers' compensation program "replace[d] an unwieldy tort system that made it virtually impossible for businesses to predict or insure for cost of industrial accidents.")(emphasis supplied). Furthermore, the statute does not remedy the concomitant finding that as a result of the inability to obtain coverage, injured persons will not be able to recover damages; the statute does not mandate insurance coverage.

[23] The legislature also found that a damage cap incentive reduces high litigation costs. That problem, endemic in all litigation, is not sufficiently compelling to warrant a cap on damages. See Overland Constr. Co., Inc. v. Sirmons, 369 So.2d 572 (Fla. 1979);

that the "high-end awards are a substantial cause of the increas in paid losses," Medical Malpractice Recommendations, at 26; see § 766.201(1)(b), it failed to differentiate between economic and noneconomic damage awards. Its findings concerning prospective reduction of approximately 2.4% to 11% in loss payments are base on "hypothetical assumptions (rather than empirical data) as to the distribution of economic and non-economic losses in past pai claim data." Final Recommendations at 62. The Task Force warne that the "figures are offered only for what they say about relative magnitude [of savings from a cap on medical claims to savings from a cap on other liability claims]. They should not be misinterpreted as vouching for the amount of savings that might be realized from caps on non-economic damages." Final Recommendations at 63. Such assumptions provide an uncertain predicate for imposing a cap on noneconomic damages. The legislature has not demonstrated the requisite overpowering public necessity for restricting claimant's noneconomic damages.

The legislature must also show that no less onerous alternative method exists for meeting such necessity. Smith; Overland; Kluger. The legislature did not expressly find that no alternative method existed; however, the Task Force considered

---

[23] Continued

but see American Liberty Ins. Co. v. West & Conyers, Architects & Engineers, 491 So.2d 573 (Fla. 2d DCA 1986). The option to settle meritorious claims, resulting in reduced litigation costs, has always been available.

several alternatives[24] and stated that "[o]f these alternatives, only a cap on non-economic damages would reduce malpractice claims appreciably . . . ." Medical Malpractice Reform Alternatives, October 2, 1987 at 5. That qualified finding does not satisfy the Kluger test. See Ch. 90-401, preamble, 1990 Laws of Florida ("[T]he legislature finds that the reforms contained in this act are the only alternative available that will meet the public necessity of maintaining a workers' compensation system . . . .")(emphasis supplied); see also Overland, 369 So.2d at 573. We decline to infer the requisite showing from the passage of the legislation. Such an inference would render illusory this part of the Kluger test. The Smith court stated that "if it were permissible to restrict the constitutional right by legislative action, without meeting the conditions set forth in Kluger, the constitutional right of access to the courts for redress of injuries would be subordinated to, and a creature of, legislative grace or, . . . 'majoritarian whim'. [O]urs is not such a system." Smith, 507 So.2d at 1089 (emphasis supplied). Accordingly, we hold that the legislative findings do not satisfy this prong of the Kluger test.

In conclusion, we affirm the final summary judgment and hold that sections 766.207 and 766.209 violate article I, section 21, of the Florida Constitution.

Affirmed.

---

24 These alternatives included mandating proof of gross negligence in some situations, providing more specific jury instructions on damages, limiting or abolishing punitive damages, and changing the collateral source offset.

MEMBERS:

Marshall Criser, Chairman
Bernard Sliger
Edward Foote, II
Preston Haskell
P. Scott Linder
Executive Director:
Carl Hawkins
Associate Director:
Donald Gifford

ACADEMIC TASK FORCE FOR REVIEW OF THE INSURANCE AND TORT SYSTEMS

PRELIMINARY FACT-FINDING

REPORT ON MEDICAL MALPRACTICE

August 14, 1987

(c) 1987, Academic Task Force for Review of the Insurance and Tort Systems

ACADEMIC TASK FORCE
FOR REVIEW OF THE
INSURANCE AND TORT SYSTEMS

MEMBERS:

Marshall Criser, Chairman
Bernard Sliger
Edward Foote, II
Preston Haskell
P. Scott Linder
Executive Director:
Carl Hawkins
Associate Director:
Donald Gifford

P.O. BOX 14513
GAINESVILLE, FL 32604
904/392-9728

PRELIMINARY FACT-FINDING REPORT ON MEDICAL MALPRACTICE

August 14, 1987

EQUAL EMPLOYMENT OPPORTUNITY/AFFIRMATIVE ACTION EMPLOYER

TABLE OF CONTENTS

ACADEMIC TASK FORCE FOR REVIEW OF THE INSURANCE AND TORT SYSTEMS

FACT-FINDING REPORT ON MEDICAL MALPRACTICE

Table of Contents i

Executive Summary 1

Acknowledgments 18

Introduction 22

I. Medical Malpractice Insurance: The Extent of the Problem 26

A. Affordability 26

B. Availability 37

II. Potential Causes of Increased Costs for Malpractice Insurance 44

A. An Overview of Trends in Loss Payments 44

B. Insurance Industry Profitability and Market Structure 51

1. Profitability 51

2. Market Structure 64

C. Underwriting Cycle 89

D. Risk Classification System 97

III. Further Examination of Increased Claims Payments . . 110

A. Components of Increased Claims Payments 110

1. Increased Claims Frequency 111

2. Increased Claims Severity 126

3. Physicians with Multiple Paid Claims 142

B. The Role of the Legal System in Increasing Loss Payments 149

1. Litigation Trends 150

2. Changes in Tort Liability Rules 158

3. Attorneys' Fees and Other Litigation Costs 190

C. Other Factors That May Influence Medical Malpractice Claims and Litigation Frequency 218

D. Regulation of the Medical Profession 228

IV. The Effects of Malpractice Liability Upon Health Services and the Medical Profession 236

A. Financial Effects on Physicians 236

B. Effects on Health Care Provider Fees 240

C. Alterations of Health Care Delivery Patterns 242

D. Psychological and Intangible Effects on Physicians 250

E. Physicians' Attitudes on Professional Regulation 252

Appendix 1 258

Appendix 2 260

Appendix 3 262

EXECUTIVE SUMMARY

ACADEMIC TASK FORCE FOR REVIEW OF INSURANCE AND TORT SYSTEMS

PRELIMINARY FACT-FINDING REPORT ON MEDICAL MALPRACTICE

August 6, 1987

Florida's Academic Task Force for Review of the Insurance and Tort Systems was established by the Tort and Insurance Reform Act of 1986. The Legislature directed the Task Force to investigate problems with the affordability and availability of all types of liability insurance and to report to the Legislature with recommendations for change by March 1, 1988.

As the Task Force and its professional staff undertook their investigation, medical malpractice emerged as the most visible and probably the most serious area of concern within the tort and insurance systems. Representatives of the medical profession, as well as those who had been injured as a result of medical maloccurrences and their lawyers, spoke frequently and vigorously about the medical malpractice situation at public hearings in Tampa in October 1986 and in Miami in February 1987. The preliminary observations of the Task Force's research team, presented on June 11, 1987, suggested that the data they had collected confirmed that problems in the medical malpractice systems were more serious than in most other areas of the tort and liability insurance systems. In November, the Florida Medical Association and the Commissioner of Insurance both urged the Task Force to make recommendations to the Legislature during the 1987 session. The Task Force decided at that time, however,

that its research was not sufficiently developed to justify a departure from the schedule originally imposed by the Legislature.

On July 2, 1987, Governor Martinez met with Marshall Criser, Chairman of the Task Force, and with several representatives of the Task Force's professional staff. Governor Martinez informed Chairman Criser that a special session of the Legislature would probably be called during Fall 1987 and that a "Working Group" consisting of representatives of his office, the Senate, and the House of Representatives was being formed to consider legislation for the special session. Governor Martinez asked Chairman Criser to provide whatever assistance the Task Force could to the Legislature during the special session.

This Preliminary Fact-Finding Report on Medical Malpractice is the response of the Academic Task Force for Review of the Insurance and Tort Systems to the Governor's request. This report, based upon a series of research projects conducted by the research team of the Task Force, analyzes the extent of the problems in the state of Florida regarding the affordability and availability of medical malpractice insurance. It then discusses the underlying causes of these problems.

This Preliminary Fact-Finding Report does not make any recommendations regarding what, if any, actions should be taken by the Florida Legislature in response to the medical malpractice situation. Further, this report does not address in any detail many aspects of the medical malpractice situation that are endemic to the insurance and tort systems. This more comprehensive analysis of the tort and liability insurance

systems, as well as the recommendations of the Task Force, which may include recommendations specifically directed to the medical malpractice situation, will await the Final Report to the Legislature in March 1988.

In addition to a comprehensive review of other published studies and all relevant literature, the professional staff of the Academic Task Force is working on eight research projects specifically devoted to what is happening in Florida's tort and liability insurance systems. Six of these projects have substantial relevance to this Preliminary Fact-Finding Report on Medical Malpractice. They are: (1) the medical malpractice closed-claims survey for all Florida claims paid during the period 1975-1986; (2) a survey of insurance companies providing liability insurance in Florida; (3) data from A.M. Best regarding insurance carrier finances; (4) a survey of Florida physicians; (5) a survey of Florida attorneys; and (6) an analysis of Florida civil litigation rates.

Major Findings

The major findings of the Academic Task Force regarding Florida's medical malpractice situation are as follows:

1. Affordability. The cost of medical malpractice liability insurance has increased dramatically during the last eight years, with the largest share of this increase coming during the past two years. The extent of the problem of affordability varies greatly among medical specialties and between south Florida physicians and those in the remainder of the state.

2. Availability. At the current time, the availability of liability insurance for physicians does not pose a serious problem in Florida.

3. Cause of Price Increases. The primary cause of increased malpractice premiums has been the substantial increase in loss payments to claimants.

4. Profitability. During the period 1977 through 1985, medical malpractice insurers have been slightly more profitable than the property-liability insurance industry as a whole. For the same time period, the profitability of the property-liability insurance industry was slightly less than that of American industrial and financial corporations. The profitability of insurance companies varies dramatically from year to year.

5. Market Structure. The medical malpractice insurance market in Florida is highly concentrated, but so far this market concentration does not appear to have contributed to the problem of affordability of liability insurance.

6. Impact of Underwriting Cycle. The rate of price increases during the period 1983 through 1987 was disproportionately dramatic because of the insurance underwriting cycle. Over the course of an entire underwriting cycle, however, it is the increase in paid claims which causes higher premiums.

7. Risk Classes. The practice of dividing Florida physicians into risk classes by specialty, and into two different geographic areas, for rating and pricing purposes contributes to current affordability problems for high risk specialty practitioners, particularly those in South Florida.

8. Frequency of Claims Payments. The frequency of claims payments in Florida has increased 4.6 percent per year since 1975, but only 1.8 percent when adjusted for the increase in population.

9. Amounts of Claims Payments. The average cost of paid claims has increased at a compound rate of 14.8% per year since 1975. The increase in the size of loss payments is a substantially more important factor in the overall increase in paid claims than is the increasing frequency of paid claims.

10. Geographic Variations in Claims Payments. The frequency of paid claims per capita is twice as great in Dade and Broward Counties as in the rest of the state. The severity of claims also is greater in South Florida than in the remainder of the state, but the difference is not nearly so dramatic.

11. Variations Among Medical Specialties. There are considerable variations both in frequency and in severity of paid claims among medical specialties. Obstetrics and gynecology account for 13.6% of all paid claims, while specialities such as endocrinology, psychiatry and thoracic surgery each account for less than 2% of all paid claims. The largest average claims payments (1986) are in pediatrics, neurosurgery and thoracic surgery, with the average claim payment for pediatrics exceeding $350,000.

12. Multiple Claims. Nearly one-half of the amount of paid claims during the period 1975-1986 was accounted for by physicians with two or more paid claims. Physicians with two or more paid claims during this eleven year period are not necessarily "bad doctors."

13. Changes in the Law. During the past thirty years, there has been a national trend toward expanded legal liability for medical malpractice. The research conducted for this report does not reveal any major pro-plaintiff development in medical liability rules of law in Florida during the past two decades, but overall changes in the environment of the legal system appear to benefit plaintiffs.

14. Attorneys' Fees and Other Litigation Costs. Attorneys' fees and other litigation costs represent approximately 40% of the total incurred costs of insurance carriers, with claimants receiving 43.1% of the total incurred costs. The total amount of attorneys' fees is divided approximately equally between plaintiffs' attorneys and defense attorneys. During the past eleven years, the average legal cost of defending a malpractice claim has increased at an annual compound rate of 17%.

15. Possible Explanations for Increased Claims Frequency. Increased claims frequency probably results both from a greater number of injuries occurring as a result of medical maloccurrences and from a much greater likelihood that injured plaintiffs will file claims. Any increase in the aggregate number of medical injuries in Florida likely results from the greater number of contacts between physicians and patients as the number of Florida residents and physicians both increase, and does not imply any increase in the frequency of medical maloccurrences per physician.

16. Professional Regulation of Medical Care. The Department of Professional Regulation disciplines a relatively low percentage of physicians with multiple paid claims.

Affordability of Medical Liability Insurance

The cost of medical malpractice liability insurance has increased dramatically during the last eight years, with the largest share of this increase coming during the past two years. On the average, rates have increased two or three hundred percent during this time period, but the degree of rate increase has varied depending upon the specialty and the geographic area in which the physician practices. For example, current premium rates for neurosurgeons practicing in Dade or Broward Counties are approximately $192,420 per year, but family physicians (no surgery) practicing in areas other than south Florida pay only $10,277. Although physicians' gross revenues have risen during this same period of time, malpractice premiums absorb an increasingly larger share of the physicians' gross revenues. This does not necessarily mean that the physician's net income has been reduced, though in some instances that may be the result. In most instances, increased malpractice premiums result in higher health care costs; in some cases, rising premiums result in lower net income for physicians.

Availability of Medical Liability Insurance

The problem with medical malpractice liability insurance, at least at the current time, is predominantly a problem with the affordability and not the availability of liability insurance. In some instances, physicians may believe that liability insurance is functionally "unavailable" due to dramatically increased premium costs or because their coverage is being dropped by the carrier with whom they were previously insured.

The recent withdrawal of a major malpractice insurer from the state, and the indication by the state's largest medical malpractice insurer that it will withdraw at the end of the year, however, poses the possibility of availability problems in the future. Even here, however, the remaining insurers seem able and willing to provide coverage to the persons now covered by carriers threatening to withdraw from the state, and additional carriers are preparing to enter the state. It is impossible to predict whether physicians practicing in high risk specialities---or physicians with prior multiple malpractice claims---will experience temporary or more long-lasting availability problems. From today's perspective, however, availability is not as serious a problem as affordability. Whether or not availability concerns will become a serious problem in the future depends in large part on how insurance carriers with the ability to write medical malpractice coverage in Florida perceive the likelihood of long-term profitability. Insurance company concerns about Florida's legal and regulatory environment have the potential to produce availability problems in the foreseeable future.

Causes of Price Increases

The primary cause, over the past decade, of increased medical malpractice premiums has been the substantial increase in loss payments to claimants. The timing of the largest price increases, during the period 1984 through 1986, and the dramatic extent of these price increases, were exacerbated by insurance industry pricing practices and by general economic trends.

Although these reasons made the price increases during 1984 through 1986 sudden and dramatic, the increase in rates measured over an entire insurance underwriting cycle are the results of increased loss payments to claimants.

The increase in loss payments is attributable both to an increasing number of claims resulting in payments and more importantly to very substantial increases in the size of the average payment. In addition, the legal costs of defending claims have increased dramatically during the past decade. Since 1979, the total amount paid to medical malpractice claimants in Florida has increased at a compound annual rate of approximately 30% per year.

Profitability of Medical Malpractice Insurers

Excess profits on the part of insurance companies do not appear to be a cause of the affordability problems experienced in the medical malpractice insurance system. On the other hand, the financial position of the insurance industry is considerably less precarious than some of the statements of its spokespersons would suggest. The average return on net worth for property-liability insurers during 1977-1985 was slightly less than that of all U.S. industrial and financial corporations. The Task Force's own calculations show that during the period 1977 through 1985, medical malpractice insurers around the country have been slightly more profitable than the property-liability insurance industry as a whole. Insurance company profitability, however, often fluctuates dramatically from one year to the next.

Market Structure for Medical Liability Insurance

The Academic Task Force is concerned about the concentration of the medical malpractice insurance market in Florida in the hands of four major providers of coverage. So far, this market concentration does not appear to have contributed in any undesirable way to the problems of affordability or availability of liability insurance. This extent of market concentration does pose potential problems when one or more of the major medical mlapractice providers can threaten to withdraw from the market, and thereby create considerable political pressure. The market structure of the medical malpractice insurance system in Florida is such that insurers not currently providing medical malpractice insurance could move into this field with relative ease if they decided that doing so provided the likelihood of an attractive profit at an acceptable level of risk. It appears, therefore, that it is concerns about uncertain legal and regulatory environments, and not monopolistic market structures, that keep additional carriers from providing malpractice insurance within the state.

The Impact of the Underwriting Cycle

The rate of price increases during the period 1983 through 1987 was disproportionally dramatic because of the insurance underwriting cycle. During the earlier period 1978 through 1982, price increases in medical malpractice premiums were comparatively low and in some cases actually declined as insurers

sought to attract as many premium dollars as possible in order to invest these premium dollars at the unusually attractive investment rates then available. Insurers also charged comparatively low prices in order to maintain market share in the face of fierce price competition. As a result, during this period of time, insurance premiums did not increase proportionately to the increase in paid claims in Florida. These artificially low premiums continued until the underwriting losses exceeded the amount insurers were willing to bear. At that point, premium rates began to increase and the rate increases were dramatic because rates for several years had not reflected the continual increase in paid losses. Over the course of an entire underwriting cycle, however, it is the increase in paid claims and not the underwriting cycle, which causes the increase in malpractice premiums.

Insurance Company Risk Classification Systems

This paragraph discusses who pays the costs of the medical malpractice system---whatever they may be---instead of what factors increase or decrease such costs. For purposes of medical malpractice insurance, insurers divide physicians into "risk classes" in which physicians face similar exposure to legal liability. Risk classes with high legal liability exposure pay higher premiums. For example, neurosugerons in Florida pay as much as ten times more for malpractice insurance than do family physicians. The net result of dividing physicians into risk classifications using the current system may be that premiums for high risk physicians such as obstetricians or neurosurgeons are

unacceptably high from a societal perspective. In addition, medical malpractice coverage in the state of Florida typically provides no discounts for physicians with excellent records, nor does it provide surcharges for physicians with poor records.

Components of Increased Claims Payments

The frequency of medical malpractice claims has increased since 1975 at a rate in excess of the change in Florida's population. The increase has been at an annual compound rate of 4.6 percent per year, or at a rate of 1.8 percent per year when adjustment is made for the increase in population. Because the number of physicians practicing in the state has grown more rapidly than the population, the claims rate per physician is virtually unchanged since 1975. There are considerable variations in frequency of claims by geographical area and by specialty of practice. The frequency of paid claims per capita is twice as great in Dade and Broward Counties as in the remainder of the state. There is tremendous variation in susceptibility to claims among specialities. Obstetrics and gynecology account for 13.6% of all paid claims, while specialties such as endocrinology, psychiatry, and thoracic surgery each account for substantially less than 2% of all paid claims. The rate of increase in the frequency of claims is also great in obstetrics.

The increasing size of loss payments is even a more important contributing cause to the increase in total loss payments. Since 1975, the average cost of paid claims has

increased at a compound rate of 14.8% per year. The median claim payment---an appropriate measure for the "typical" payment---increased from $7,500 in 1975 to $30,000, once again at a rate of growth substantially in excess of inflation. The amount of claims are greater in Broward and in Dade Counties than in the remainder of the state, but the differential is not nearly as large as is the differential in frequency. The largest average claim payments are in pediatrics, neurosurgery and thoracic surgery. The average claim payment for pediatrics exceeded $350,000, having increased at an annual compound growth rate of 18.5% per year during the period 1975-1986.

Changes in medical malpractice claims payments in Florida are due, in considerable degree, to an increase in the size and number of large claims. If the <u>amount</u> of claims payments is examined, million dollar plus claims represented 4.9 percent of total paid claims in 1981. By 1986, this category accounted for 29.1% of total paid claims. From another perspective, in 1986 the <u>frequency</u> of claims payments in excess of one million dollars was less than one percent of all claims, but these few claims were responsible for 29 percent of the amount of claims payments.

The research team of the Academic Task Force found that nearly one-half of the amount of paid claims during the period 1975-1986 was accounted for by physicians with two or more paid claims. This does not mean that the medical malpractice problem in Florida is merely one of "a few bad doctors," nor does it necessarily indicate that doctors with multiple paid claims are incompetent. They may merely be practicing in high-risk specialities and in high-risk areas of the state.

The Role of the Legal System and Other Possible Explanations for Increased Loss Payments

Why have both the frequency and the severity of loss payments in the medical malpractice system increased dramatically during the past decade? This report concludes that increased frequency probably results both from a greater number of injuries occurring as a result of medical maloccurrences and a much greater likelihood that an injured patient will file suit. Increased severity and frequency probably have been affected by societal changes---for example, a greater willingness among injured patients to sue.

The tort settlement process functions on the premise that the vast bulk of claims that settle are influenced by the probable judgments if the cases had proceeded to trial. Unfortunately, data on litigation trends in Florida are sparse and virtually non-existent until the past two or three years. During 1986, a total of 1418 professional malpractice cases were filed, accounting for less than one-half of one percent of all circuit court cases. In Dade County, plaintiffs won just over half of the very tiny percentage of cases proceeding to trial and received an average award of compensatory damages of $885,767. Only a few plaintiffs received punitive damages. These Dade County judgments are somewhat less than medical malpractice verdicts in Chicago and San Francisco, the jurisdictions for which the best statistics are available. Studies from other jurisdictions show considerable increases in the amounts of judgments from the early 1960's through the mid-1980's.

During the past thirty years, there has been a national trend toward expanded legal liability for medical malpractice. The research conducted for this report does not reveal any major pro-plaintiff development in medical liability rules of law in Florida during the past two decades. Apart from judicial acknowledgment of doctrines that assist plaintiffs in the proof of negligence and causation in highly restricted circumstances, the principle features of new law during this period have been legislative attempts to particularize and, to some extent, restrain both the substance and procedure of medical malpractice actions. At the same time, however, changes in the overall legal environment may benefit the plaintiff in the trial and settlement processes. These changes include the propensity of juries to award higher verdicts, the reluctance of judges to control juries through the uses of summary judgments directed verdicts or remittitur, and bad faith claims against insurers who fail to settle within policy limits. Morever, the Task Force emphasizes that the finding that there has not been any major pro-plaintiff development in medical liability rules of law in Florida during the past two decades is strictly limited to medical liability rules and does not necessarily apply to other areas of tort doctrine. Assessment of liability trends in other areas of tort law will be considered by the Task Force in a later report.

Attorneys' Fees and Other Litigation Costs

Attorneys' fees for both parties represent a substantial share of the amount spent on the insurance and tort systems. Of the total costs paid by insurance companies for medical

malpractice claims, claimants receive approximately 43.1% and the attorneys for both parties receive approximately an additional 40%, roughly equally divided between them. During the past eleven years, the legal costs of defending an average medical malpractice claim has increased at an annual compound rate of 17%. The compensation for plaintiff's lawyers is determined on a contingency fee basis which is typically approximately one-third of the recovery, although this varies depending upon the complexity of the case and the stage at which it is resolved. Presumably, plaintiffs' legal costs increased proportionately as the amounts of paid losses increased.

Professional Regulation of Quality of Medical Services

A comprehensive examination of increases in medical malpractice paid losses must include attention to mechanisms for regulating the quality of medical care in the State of Florida, as well as study of the legal and insurance systems. The amounts of paid claims attributable to a relatively small number of doctors warrant attention to the mechanisms for regulating the quality of medical care in the state of Florida. The Department of Professional Regulation disciplines some physicians, but they are a relatively small portion of the physicians with multiple claims. Most frequently, license revocations and suspensions are due to factors such as alcohol or drug abuse by physicians. In addition, medical malpractice insurers have not used "experience rating" to provide differences in premiums for

doctors who have never paid a claim and doctors with multiple claims.

The Effects of the Malpractice System Upon Health Service and the Medical Profession

Although the focus of the Task Force has been on the affordability and availability of medical malpractice insurance, the legal system affects the medical system in a variety of ways other than merely the payment of increased malpractice premiums. Physicians alter their practices and their lives in a variety of ways other than just passing on increased costs to consumers. The Survey of Florida Physicians completed by the professional staff of the Task Force found that physicians responded to the threat of legal liability in many instances by adopting "defensive medicine."

Concluding Observations

The Legislature will be confronted with two questions when considering Florida's medical malpractice situation. First, should the state take actions that would reduce the overall cost of the medical malpractice system? Tort reform and increased professional regulation of doctors address this issue. Second, how should the costs of the system be financed? Various proposals already introduced in the Legislature---including those typically referred to as the "Ogden Proposal" and the "Gunter Proposal" address this issue.

The Task Force understands the Legislature's apparent need to consider various proposals during a special session this Fall.

On the other hand, some of the issues acutely raised by the medical malpractice system are pervasive throughout the tort and insurance systems and perhaps should be considered during the 1988 legislative session as part of a more comprehensive and well-developed proposal.

In the meantime, the Task Force submits this Preliminary Fact-Finding Report to illuminate some of the factual issues that may arise in a special session. Anyone having comments about the contents of this Preliminary Fact-Finding Report should submit them in writing to Executive Director Carl S. Hawkins so that the Final Report may benefit from such input. Those reading this report should understand that although the research results and interpretations presented here were completed in a careful and orderly fashion, the drafting and editing of this Preliminary Report was completed under severe time limitations resulting from the July 2 announcement of the Governor's plan to call a special session. The Task Force may supplement this Fact-Finding Report if its continuing research and investigation of Florida's medical malpractice system warrant additional contributions.

ACKNOWLEDGMENTS

The compilation of this Preliminary Fact-Finding Report on Medical Malpractice results from both the efforts of the professional staff of the Academic Task Force and the cooperation of a diverse group of organizations and individuals involved in Florida's medical malpractice systems. The members of the Academic Task Force would like to take this opportunity to express their appreciation to those organizations and individuals.

Executive Director Carl S. Hawkins, Guy Anderson Professor of Law at the J. Reuben Clark Law School of Brigham Young University, directed the Task Force's research and investigation into Florida's insurance and legal systems and the preparation of this report. He was assisted by Associate Director Donald G. Gifford, Professor of Law at the University of Florida. The other members of the research team responsible for this report include Dr. David J. Nye, Associate Professor of Finance and Insurance, University of Florida; Joseph W. Little, Professor of Law, University of Florida; Dr. Roger D. Blair, Professor of Economics, University of Florida; Mr. Bernard L. Webb, Professor of Actuarial Science, Risk Management and Insurance, Georgia State University; and Professor Kathryn D. Sowle, Professor of Law, University of Miami. In addition, Dr. Marvin Dewar, M.D., a second year law student at the University of Florida, served as a special consultant on parts of the report dealing with the survey

of Florida physicians. The Academic Task Force also expresses its appreciation to consulting social psychologist Dr. Cary Mills; to computer programmers Michael Kelly, Miriam Smith, Joan Lin, Patrick Van Rinsveldt and Jim Heaney; and to research assistants Peggy Lyon, Joe Delatorre, John Davis, Carolyn Schafer, and Scott Makar. Finally, administrative secretary Noreen Fenner deserves special mention, not only for manuscript preparation, but for administrative responsibilities too numerous to mention.

The University of Florida, and its College of Law, donated the physical facilities used by the Academic Task Force staff and considerable administrative assistance. The Task Force appreciates the cooperation of Dean Frank T. Read and Associate Dean Jeffrey Lewis in making available office space, computer terminals and supplemental secretarial help. Professor Betty Taylor, Director of Legal Information Services, and her library staff, were extremely helpful. In particular, the late R. Scott Rawnsley served with great dedication and distinction as a reference librarian assigned to work with the Task Force. Ed Poppel, Assistant to the Vice President for Administration, University of Florida, and Martina Pelley, administrative assistant at the College of Law, assisted in the administration of the project. Florida State University and the University of Miami also have provided support for this project in a number of ways.

The Academic Task Force received the cooperation of a wide variety of governmental agencies, organizations, corporations and

individuals. Explicit acknowledgment here of some of these individuals and groups is not intended to ignore the assistance provided by others too numerous to mention. Insurance Commissioner Bill Gunter, Deputy Commissioner Gerald Wester and the other members of the Commissioner's staff have provided important information and support. Chief Judge Gerald Weatherington of the Eleventh Judicial Circuit made available to the Task Force his studies of litigation trends in Dade County. Bill Bryant, Special Counsel to the Governor, assisted the professional staff in its research efforts. Similarly, Mike Bridenback, Director of the Dispute Resolution Center has provided input on litigation trends, and Mrs. Dorothy Faircloth, Executive Director of the Florida Board of Medicine, Department of Regulation provided information on professional regulation.

The various professional organizations involved in the medical malpractice insurance systems cooperated in a variety of ways, including in the administration of the surveys of Florida physicians and Florida tort lawyers. These organizations include the Florida Medical Association, the Florida Bar, the Academy of Florida Trial Lawyers and the Florida Defense Lawyers' Association.

The insurance carriers providing medical malpractice insurance coverage in the state of Florida provided important information about their loss payments, profitability and other aspects of their operation, as did the Florida Medical Malpractice Joint Underwriting Association. The Insurance Services Office, Inc., provided extensive data and customized

computer analysis of this data which involved the use of substantial personnel and computer resources. Under the supervision of Actuary Manager Arthur Cadorine, the cooperation of ISO has been an ongoing relationship with the Task Force.

Both the Rand Corporation's Institute for Civil Justice and the Federal Judicial Center provided numerous reports and studies to the Academic Task Force.

Despite the assistance of these many groups and individuals, the compilation, interpretation and presentation of this analysis remain solely the responsibility of the Task Force and its professional staff.

INTRODUCTION

Florida's Academic Task Force for Review of the Insurance and Tort Systems was established by the Tort and Insurance Reform Act of 1986. Responding to a perceived crisis in the availability and affordability of liability insurance, the Act adopted specific reforms affecting the insurance and civil justice systems. It directed the Task Force to study both systems broadly, to review the impact of newly enacted reforms, and to report its findings and recommendations by March 1, 1988. This Florida study differs from analogous efforts in other states and by various national study groups because the legislature has provided time and resources for research and fact investigation. The study includes, but is not limited to, medical malpractice liability insurance problems.

The Task Force was organized in August of 1986, with three university presidents and two public members: Chairman Marshall Criser (President, University of Florida); Edward T. Foote, II (President, University of Miami); Bernard Sliger (President, Florida State University); Preston Haskell (Jacksonville); and Scott Linder (Lakeland). The Task Force employed an Executive Director, an Associate Director, and a professional staff to undertake the necessary research.

After public hearings, the Task Force adopted, on November 25, 1986, a Study Plan with three major components:

(1) Problem Identification (nature and extent of problems in availability and affordability of liability insurance);

(2) Causation (attribution to insurance system, legal system, and other causes); and

(3) Evaluation of Reform Proposals and Recommendations (including tort reform and insurance reform).

At the same time, the Task Force adopted the following schedule for completion of the Study Plan:

- September 1, 1987: Research Team submits draft on Problem Identification and Causation (fact-finding) parts of Study Plan.

- November 1, 1987: Research Team submits draft on remainder of Study Plan (Proposals and Recommendations).

- January 1, 1988: Research Team submits draft of report to Task Force.

- March 1, 1988: Task Force submits report to legislature.

Since that time, the Task Force has undertaken and largely completed the following research efforts, aimed at finding the facts as to the extent of affordability and availability problems, and causes of the problems:

a. Seven public meetings, including hearings in Tampa and Miami to receive presentations, recommendations and comments from outside experts and scholars, and from interested Florida citizens and organizations.

b. Comprehensive literature search and review.

c. Eight research projects conducted in Florida:

   (1) Medical mlapractice closed-claims survey.

   (Data required by 1975 legislation, collected by Commissioner Gunter's office, provides information on more than 21,000 medical malpractice claims closed in Florida during 1975-1986; comprehensive computer analysis by the Task Force's professional staff.)

(2) Closed claims survey.

(Sample of all types of tort claims, mandated by 1986 legislation, collected by Commissioner's office.)

(3) Survey of insurance companies.

(28 of 31 major liability insurance carriers doing business in Florida, including medical malpractice carriers, completed a 160 page questionnaire on loss payments, profitability, and all aspects of their operations in Florida.)

(4) Data from Insurance Services Office (ISO).

(Non-profit organization which collects data and files rate applications for liability carriers nationwide; provided many customized computer analyses in response to Task Force's specific requests.)

(5) Survey of Florida Physicians.

(1,500 randomly selected physicians; questionnaire on how medical malpractice liability insurance problems affect them.)

(6) Survey of Florida Attorneys.

(Sample of 1,500 who regularly handle tort cases; equally divided between plaintiffs' attorneys and defense attorneys.)

(7) Computer analysis of A.M. Best Tapes.

(Financial situation of commercial liability insurance carriers providing medical malpractice coverage in Florida.)

(8) Analysis of Florida civil litigation rates.

(Data provided by State Courts Administrator's Office and by Court Administrator from Dade County.)

d. Staff previewed preliminary findings from above studies during 6-hour hearing in Gainesville, June 11, 1987.

On July 2, 1987, Chairman Criser met with Governor Martinez, who informed the Task Force that he would probably call a special session of the Legislature to deal specifically with the medical

malpractice liability insurance crisis. Chairman Criser informed the Governor that the Task Force would not be ready to offer recommendations or evaluation of proposed solutions for the medical malpractice liability insurance crisis in time for the proposed special session in September, but that the Task Force would make available before the special session a report on facts relating to problem identification and causes of the medical malpractice liability insurance crisis.

This report has been prepared for that purpose. Facts regarding problem identification and causes of the medical malpractice liability insurance crisis have been taken from the Task Force's broader study of the entire tort and liability insurance systems. A report covering fact findings in that broader context will be submitted later, as contemplated by the Study Plan. This report does not include any recommendations or any evaluation of proposed solutions to the medical malpractice liability insurance crisis.

I. Medical Malpractice Liability Insurance: The Extent of the Problem

The Tort and Insurance Reform Act of 1986 defines the problems to be investigated by the Task Force largely in terms of the affordability and availability of liaiblity insurance. This section of the report will discuss the extent of the affordability and availability problems as applied to medical malpractice liability insurance. Basically this discussion will show that affordability of malpractice insurance presents a more serious problem than availability.

A. Affordability

There have been many complaints that physicians can no longer afford to pay their medical malpractice insurance premiums. This section of the report examines this issue and finds that insurance costs have increased rapidly - not only in absolute terms but also relative to physician gross revenue.

1. Premium Increases

There can be no doubt that the cost of medical malpractice insurance, in absolute terms, has increased sharply in recent years. Table 1 (next page) shows the premiums for selected medical specialties for 1983 through July 1, 1987. The premiums listed are weighted averages of the rates charged for three major Florida insurers: St. Paul Fire and Marine Insurance Company (abbreviated STP in the table), Florida Physicians Insurance Company (FPIC), and Physicians Protective Trust Fund (PPTF). The weights were the number of doctors currently insured by each

TABLE 1

MEDICAL MALPRACTICE INSURANCE RATES IN FLORIDA

FOR SELECTED SPECIALTIES: 1983-1987

SPECIALTY	1-1-83	1-1-84	1-1-85	1-1-86	1-1-87	7-1-87
Family Practactioner - no surgery						
Dade/Broward	$4,310	$5,368	$7,206	$11,866	$15,123	$19,415
Rest of state	$3,123	$3,654	$4,825	$7,147	$9,122	$10,277
Internal Medicine/Minor surgery						
Dade/Broward	$7,825	$9,738	$14,179	$20,090	$25,511	$30,442
Rest of state	$5,606	$6,867	$9,472	$11,835	$15,075	$16,058
Emergency Medicine/no major surgery						
Dade/Broward	$9,777	$15,100	$22,925	$36,471	$47,925	$58,304
Rest of state	$6,992	$10,305	$15,306	$21,405	$28,175	$30,71[illegible]
General Surgery						
Dade/Broward	$21,971	$27,538	$38,483	$59,893	$78,918	$95,875
Rest of state	$15,705	$18,718	$25,664	$35,958	$47,454	$50,740
Anesthesiology						
Dade/Broward	$23,939	$27,538	$38,483	$55,915	$73,623	$88,838
Rest of state	$17,061	$18,718	$25,664	$33,317	$43,942	$47,024
Orthopedic surgery						
Dade/Broward	$27,073	$33,380	$47,863	$79,785	$105,167	$130,81[illegible]
Rest of State	$19,355	$23,008	$31,905	$47,893	$63,205	$69,31[illegible]
Obstetrics						
Dade/Broward	$30,433	$38,053	$57,218	$99,702	$131,360	$165,320
Rest of state	$21,679	$26,498	$38,158	$59,849	$78,979	$87,542
Neurological surgery						
Dade/Broward	$37,569	$49,787	$74,967	$115,548	$152,525	$192,420
Rest of state	$27,285	$34,480	$49,974	$70,423	$93,100	$102,339

Note: Figures are weighted averages of Florida insurers' premium rates.

Source: Calculated from rates provided by the Florida Department of Insurance.

company. The rates shown are those for a claims made malpractice policy with limits of $1 million per occurrence and $3 million aggregate at the companies' rates in effect on January 1 of the year indicated. The rates for July 1, 1987 are also shown.

Table 2 is an index allowing comparison of medical malpractice premium rates among various selected specialties and comparisons over time from January 1, 1983 through July 1, 1987 for all Florida counties except Dade and Broward. The basis of "100" for this index is the 1983 premium for a family physician who performs no surgery and practices outside of Dade and Broward counties. For example, the entry of "329" for the "family physician - no surgery" listed in the 7-1-87 column indicates that on July 1, 1987 a physician in that risk class was paying a premium equal to 329% of the premium paid in 1983, a 229% increase. Similarly, a comparison among specialties shows that in 1983 in Florida counties other than Dade and Broward, the rate for neurosurgeons was 829% the premium rate for family physicians. Table 3 makes the same comparison of premiums for physicians practicing in Dade and Broward Counties, once again using the 1983 premium for a family physician who practices outside of Dade and Broward Counties as an index baseline of "100."

The indices in Tables 2 and 3 show that : (1) that rates have increased sharply since 1983, (2) rates have increased more for the high-rated specialties for both rating territories than for the low rated specialties, and (3) rates have increased more

TABLE 2
INDICES OF MEDICAL MALPRACTICE INSURANCE RATES
FOR ALL FLORIDA COUNTIES EXCEPT DADE/BROWARD : 1983 -1987

MEDICAL SPECIALTY	1-1-83	1-1-84	1-1-85	1-1-86	1-1-87	7-1-87
FAMILY PHYSICIAN-NO SURGERY	100	117	154	229	292	329
PSYCHIATRY-NO ELEC-CONV THERAPY	100	117	154	229	292	329
RADIOLOGY-DIAGNOSTIC-NO SURGERY	100	117	154	229	292	329
INTERNAL MEDICINE-NO SURGERY	100	117	154	229	292	329
PEDIATRICS-NO SURGERY	100	117	154	229	292	329
RADIOLOGY-DIAGNOSTIC-MINOR SURG.	179	220	303	379	483	514
INTERNAL MEDICINE-MINOR SURGERY	179	220	303	379	483	514
FAMILY PRACTICE-MINOR SURGERY	179	220	303	426	545	580
SURGERY-OPTHAMOLOGY	232	244	332	453	578	613
SURGERY-URALOGICAL	283	295	395	514	666	827
EMERGENCY MEDICINE-NO MAJ. SURG.	224	330	490	685	902	984
ANESTHESEOLOGY	546	599	822	1067	1407	1506
SURGERY-OTOLARYN.-NO PLASTIC	472	586	822	1151	1520	1625
GENERAL SURGERY	503	599	822	1151	1520	1625
SURGERY-OTOLARYNG.-INC. PLASTIC	546	654	913	1279	1685	1864
CARDIOVASCULAR SURGERY	576	737	1022	1523	2024	2219
ORTHOPEDIC SURGERY	620	737	1022	1534	2024	2219
THORACIC SURGERY	576	737	1022	1534	2024	2219
OBSTETRICS-GYNECOLOGY	694	848	1222	1916	2529	2803
NEUROLOGICAL SURGERY	874	1104	1600	2255	2981	3277

Note: The base of 100 for this index is the 1983 premium for a family physician who performs no surgery and practices outside of Dade/Broward Counties.

Source: Developed from medical malpractice rates for the top three insurers supplied by the Florida Department of Insurance.

TABLE 3
INDICES OF MEDICAL MALPRACTICE INSURANCE RATES
FOR DADE AND BROWARD COUNTIES: 1983-1987

MEDICAL SPECIALTY	1-1-83	1-1-84	1-1-85	1-1-86	1-1-87	7-1-87	AVERAGE ANNUAL INCREASE (%)
FAMILY PHYSICIAN-NO SURGERY	138	172	231	380	484	622	39.7
PSYCHIATRY-NO ELEC CONV THERAPY	138	172	231	380	484	622	39.7
RADIOLOGY-DIAGNOSTIC-NO SURGERY	138	172	231	380	484	622	39.7
INTERNAL MEDICINE-NO SURGERY	138	172	231	380	484	622	39.7
PEDIATRICS-NO SURGERY	138	172	231	380	484	622	39.7
RADIOLOGY-DIAGNOSTIC-MINOR SURG.	251	312	454	643	817	975	35.2
INTERNAL MEDICINE-MINOR SURGERY	251	312	454	643	817	975	35.2
FAMILY PRACTICE-MINOR SURGERY	251	312	454	713	911	1107	39.1
SURGERY-OPTHAMOLOGY	327	360	497	754	961	1157	32.4
SURGERY-UROLOGICAL	391	430	590	876	1137	1354	31.8
EMERGENCY MEDICINE-NO MAJOR SURG	313	484	734	1168	1535	1867	48.7
ANESTHESEOLOGY	767	882	1232	1790	2357	2845	33.8
SURGERY-OTOLARYNG.-NO PLASTIC	665	865	1232	1919	2527	3060	40.4
GENERAL SURGERY	704	882	1232	1918	2527	3070	38.7
SURGERY-OTOLARYNG.-INC. PLASTIC	767	961	1370	2174	2859	3538	40.5
THORACIC SURGERY	804	1069	1533	2555	3367	4189	44.3
ORTHOPEDIC SURGERY	867	1069	1533	2555	3367	4189	41.9
CARDIOVASCULAR SURGERY	804	1069	1533	2555	3367	4189	44.3
OBSTETRICS-GYNECOLOGY	974	1218	1832	3193	4206	5294	45.7
NEUROLOGICAL SURGERY	1203	1594	2400	3700	4884	6161	43.7

Note: The base of 100 for this index is the 1983 premium for a family physician who performs no surgery and practices outside of Dade/Broward Counties.

Source: Developed from medical malpractice rates for the top three insurers supplied by the Florida Department of Insurance.

in Dade and Broward counties than in the rest of the state. Even the low-risk classifications in the "rest-of-state" experienced a sharp increase in malpractice insurance costs from 1983 to 1987. For example, as noted previously, a family practitioner who does not perform surgery experienced an average increase of 229% for the period.

Higher risk classes, such as neurosurgeons in the rest-of-state territory, sustained average rate increases of 275% for the four and one-half year period ending July 1, 1987, making their premiums at the end of the period almost four times higher than at the beginning of the period. The rates for obstetricians in absolute dollars (as shown in Table 1) are not quite as high as those for neurosurgeons, but the increase (304%) was even more precipitous, resulting in malpractice insurance costs slightly more than four times as high, on the average, in 1987 compared to 1983.

Table 3 shows that the increases in Dade and Broward County were even more extreme than for the remainder of the state. Family practitioners saw their malpractice insurance costs increase 300%, compared to 229% in the rest of the state. Rates for neurosurgeons increased 412%, compared to 275% in the rest of the state. Obstetricians' rates increased 444% in Dade and Broward, compared to 304% in the rest of the state.

All of these comparisons are based on the rates of the three major malpractice insurers, and the rates of other companies would probably show similar increases.

2. Relationship To Income

The increase in malpractice insurance rates is only one aspect of the affordability issue. Premiums relative to physician income is another aspect, but physician income data in sufficient comparable detail are not available. Consequently, this issue is examined by studying the medical market and surveying physicians.

Physicians' fees have been under severe pressure in recent years, especially in the urban areas. Part of the pressure has come from competition. A sharp increase in the number of practicing physicians in Florida, and the widespread development of preferred provider organizations (PPOs) and health maintenance organizations (HMOs) have brought intense competition to the healthcare market, which has generated pressure to hold down fees.

Competition also has increased due to the more sophisticated medical cost controls of organizations that pay for most health care services, principally the government, employers and insurers. These organizations have developed extensive computerized systems to screen doctors' fees and seek their reduction, or refuse to pay those that they consider excessive.

These developments have reduced the ability of doctors to pass along increased costs, including the cost of medical malpractice insurance. Table 4 attempts to measure the degree to which such increases have been absorbed rather than passed along to consumers.

Table 4 compares the index of of the malpractice rates for Florida Physicians Insurance Company (FPIC) for the period 1978 through May 1987 with the consumer price index for urban consumers (CPI-U) and the medical care portion of that index. The indices for physicians' fees and hospital costs are shown through 1985, the latest period for which they were available at the time of writing. It is apparent from Table 4 that malpractice insurance rates in Florida have increased much more rapidly than physicians' fees or other health care costs.

Florida physicians responding to a survey conducted by the Academic Task Force gave an even more graphic picture of the changing relationship between malpractice insurance costs and physicians' incomes. Table 5 shows a summary of their responses. For all responding physicians, the cost of malpractice insurance increased from 3.6% of gross income in 1971 to 11.6% in 1987. For surgical specialties, it increased from 4.2% in 1971 to 14.7% in 1977. Obstetricians sustained an increase from 4.2% to 23.1%. These figures do not reflect the most recent increases approved in mid-1987.

TABLE 4

FPIC MALPRACTICE RATE INDEX AND
CONSUMER PRICE INDEXES
1978-1987
1978 = 100

(1) Year	(2) FPIC Malpractice Rate Index	(3) Consumer Price Index (CPI-U)	(4) Medical Care Price Index	(5) Physicians Fee Index	(6) Hospital Service Price Index
1978	100.0	100.0	100.0	100.0	100.0
1979	92.8	111.3	109.3	109.2	111.4
1980	81.2	126.3	121.2	120.7	126.0
1981	106.6	139.4	134.2	134.0	144.7
1982	126.6	148.0	149.8	146.6	167.5
1983	173.1	152.7	162.9	157.9	186.4
1984	217.1	159.2	173.0	168.9	201.8
1985	281.4	164.9	183.7	178.8	213.7
1986	523.7	168.1	197.6		
1987	785.4	173.3	209.2		

Sources: 1) Calculated from rates supplied by the Florida Department of Insurance

2) U.S. Government, Bureau of Labor Statistics

TABLE 5

MALPRACTICE PREMIUMS AS A PERCENTAGE OF GROSS INCOME FOR DOCTORS RESPONDING TO THE ACADEMIC TASK FORCE SURVEY

	Malpractice Premiums as Percentage of Gross Revenue		
Year	All Respondents	OB-GYN	Surgery
1971-72	3.6%	4.2%	4.2%
1981-82	5.4	5.5	6.3
1982-83	--	8.9	7.8
1983-84	7.0	10.3	9.6
1984-85	8.6	16.1	12.1
1985-86	9.7	18.5	12.6
1986-87	11.6	23.1	14.7

3. Summary

The data presented in this section supports the conclusions that Florida medical malpractice insurance rates have increased substantially more rapidly than physicians' income or other medical costs during the past decade. The pace of premium increases was especially large during the past four years. The facts reported in this section suggest that the impact on physicians varied considerably. The rate increases were higher for high-risk physicians such as neurosurgeons and obstetricians, and Dade and Broward County physicians sustained substantially greater increases than the rest of the state. Some high-risk physicians now pay about one-fourth of their gross income for malpractice insurance, which suggests that malpractice insurance is approaching unaffordability, if it has not already reached it. Finally, the analysis of the Task Force shows that medical cost controls imposed by the government, employers and insurers make it increasingly difficult for doctors to pass along malpractice insurance cost increases to their patients.

B. Availability

This section of the report will examine the extent to which medical malpractice liability insurance may have been unavailable in Florida during the latest underwriting cycle.

As used in the present context, "availability" means "accessibility" or "obtainability." The Task Force has not discovered any indications that medical malpractice insurance has been absolutely unavailable in recent years. Those who cannot find coverage in the standard market must be insured by the Florida Medical Malpractice Joint Underwriting Association (JUA), which acts as the insurer of last resort. The operation of the JUA is described in Appendix 3 of this report. Thus, medical malpractice insurance has always been available from some source. There is, however, no doubt that when premiums rise sufficiently, affordability problems merge into functional unavailability as physicians decrease the limits of their coverage or simply do not purchase commercial medical malpractice insurance.

The availability of medical malpractice insurance has received substantial attention recently because of St. Paul Insurance Company's threat to withdraw completely from the Florida market due to allegedly inadequate rates. Given St. Paul's prominence as the main provider of medical malpractice insurance, this threat cannot be dismissed lightly. The Task Force has received indications, however, that many of St. Paul's previous policyholders will be able to find coverage with some of the other insurers or, as a last resort, with the JUA.

The total direct premiums written often is used as a measure of availability in the insurance industry. Table 6 displays the premium volume in medical malpractice over the 1981-1985 period in Florida. In the column headed DPW, we show the direct premiums written in normal (i.e., undeflated) terms. As a glance at Table 6 shows, DPW rose from $72,934,889 in 1981 to $215,121,870. Some care must be exercised in interpreting these data. First, these premium volumes have not been deflated to control for price changes. Second, the data cover malpractice insurance premiums for nurses, chiropractors, and hospitals as well as for physicians. Third, it was not possible to control for changes in coverage limits. Consequently, these data do not provide an answer to whether medical malpractice insurance is more or less available over time.

Table 6 also provides information on the number of physicians and premiums written per physician. Although some of the increase in direct premiums written can be explained by a 25 percent increase in the number of physicians in Florida, one can see that the average premium payment per physician rose from $4564 in 1981 to $10,755 in 1985.

Table 6

Trends in Medical Malpractice

Premiums Written

Year	DPW[1]	No. of Physicians[2]	DPW per Physician
1981	$72,934,889	15,979	$4,564
1982	$98,724,074	17,105	5,772
1983	$135,310,378	18,101	7,475
1984	$168,535,848	N/A	*
1985	$215,121,870	20,002	10,755

Source: Best's Executive Data Service, Property/Casualty and Life/Health, A.M. Best Company, Report of the Department of Insurance, State of Florida, 1984 and 1985, and the Florida Medical Malpractice Joint Underwriting Association.

[1]DPW direct premium written as reported to A.M. Best and the Department of Insurance, State of Florida.

[2]Numbers of physicians were provided by the American Medical Association. Figures for 1984 were not available.

Although the Task Force has concluded that there is no genuine availability problem, it has collected information on the number of policies in force by year. Table 7, which is drawn from Schedule 4 of the Insurance Company Questionnaire, shows by year the number of medical malpractice policies in force. These totals include coverage provided by the major medical malpractice insurers including the largest trust fund and the JUA, and show that the number of policies in force has declined in recent years. One cannot infer from this, however, that medical malpractice insurance has become unavailable. Some of the decrease is accounted for by shifts into some of the smaller trust funds. Moreover, as premiums rise, some physicians may elect to do without malpractice insurance -- a decision that is indicative of affordability problems rather than availability problems.

Table 7

Medical Malpractice Policy Counts
1981-1986

Year	Florida
1981	24,139
1982	26,150
1983	27,571
1984	23,456
1985	24,600
1986	21,844

Source: Schedule 4A of Insurance Company Questionnaire.

The Task Force also attempted to determine the extent of any problem caused by cancellations and/or non-renewals. Although the response rate to this part of the Insurance Company Questionnaire was not as high as the Task Force would have preferred, the largest medical malpractice insurers responded. Due to the way the respondents provided the data, the Task Force has combined cancellations, which are motivated primarily by the insurer, and the non-renewals, which may be at the discretion of either the insurer or the insured. The results are presented in Table 8. As one can see, the frequency of cancellations and non-renewals increased absolutely and as a percentage of total policies in force at the end of the year during the 1981-1985 period. Irrespective of how disruptive this may be to individual physicians, this cannot be construed as indicative of unavailability. Some of this represents exits from Florida medical practice due to retirement, death, departure from the state, and so on. Some of it represents moves to one of the smaller trust funds or decisions not to purchase medical malpractice coverage. Finally, some of it represents "churning" as physicians terminate coverage with one carrier and begin coverage with a different company.

Table 8

Medical Malpractice
Cancellations and Non-Renewals

Year	Number	Percent of Total Policies
1981	1948	8.0%
1982	2647	10.1%
1983	3144	11.4%
1984	4389	18.7%
1985	4520	18.4%
1986	2897	13.3%

Source: Schedule 4A of Insurance Company Questionnaire.

II. POTENTIAL CAUSES OF INCREASED COSTS FOR MEDICAL MALPRACTICE LIABILITY INSURANCE

The Task Force has investigated four factors as potentially contributing to increased malpractice insurance costs: (1) trends in loss payments, (2) insurance company profitability, (3) the insurance industry underwriting cycle, and (4) the insurance company risk classification systems. Basically the Task Force has found that increased loss payments have been the principal cause of increased malpractice insurance costs, and that the increases have not resulted from excess profits but have been aggravated by the underwriting cycle and the risk classification system. These four variables are discussed under the following four headings of the report.

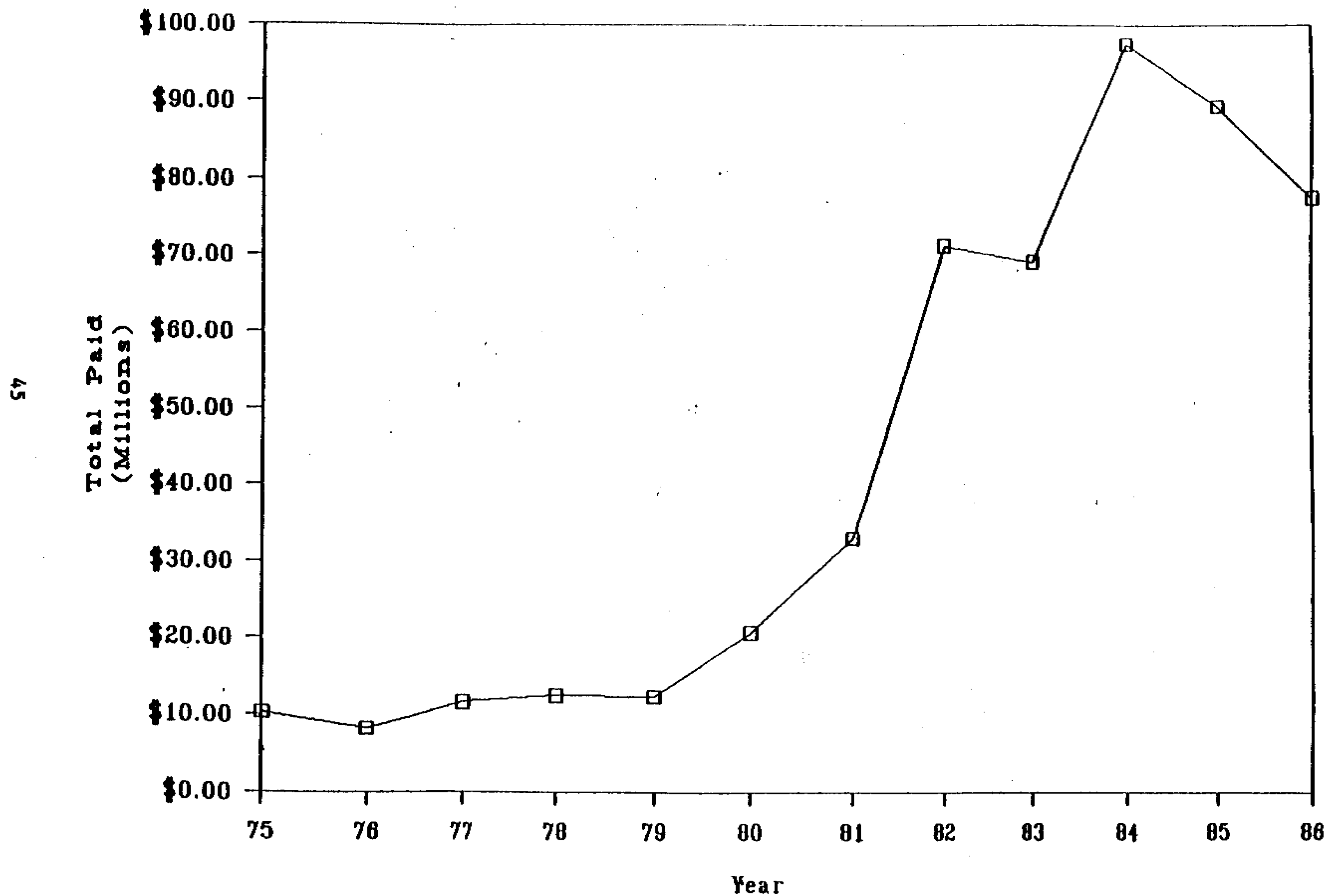
A. An Overview of Trends in Loss Payments

Approximately $513 million dollars was paid by insurance carriers during 1975-1986 for physician medical malpractice claims. This amount includes claims paid without a suit being filed as well as amounts paid due to legal action. Figure 1 shows that annual total paid claims were essentially unchanged from 1975 through 1979, followed by an extremely sharp increase from 1979 to 1984. Total claims have fallen from their 1984 level to a point which suggests that the peak for claims payments probably occurred in 1984.[1] During the entire time period, total paid

Footnotes are located at the end of each part of this report. For example, in this case, the footnote for Part II. B. follows the text of Part II. B.

FIGURE 1.

TOTAL MEDICAL MALPRACTICE PAID CLAIMS IN FLORIDA: ALL SPECIALTIES



SOURCE: FLORIDA DEPARTMENT OF INSURANCE MEDICAL MALPRACTICE CLOSED CLAIMS DATA SET.

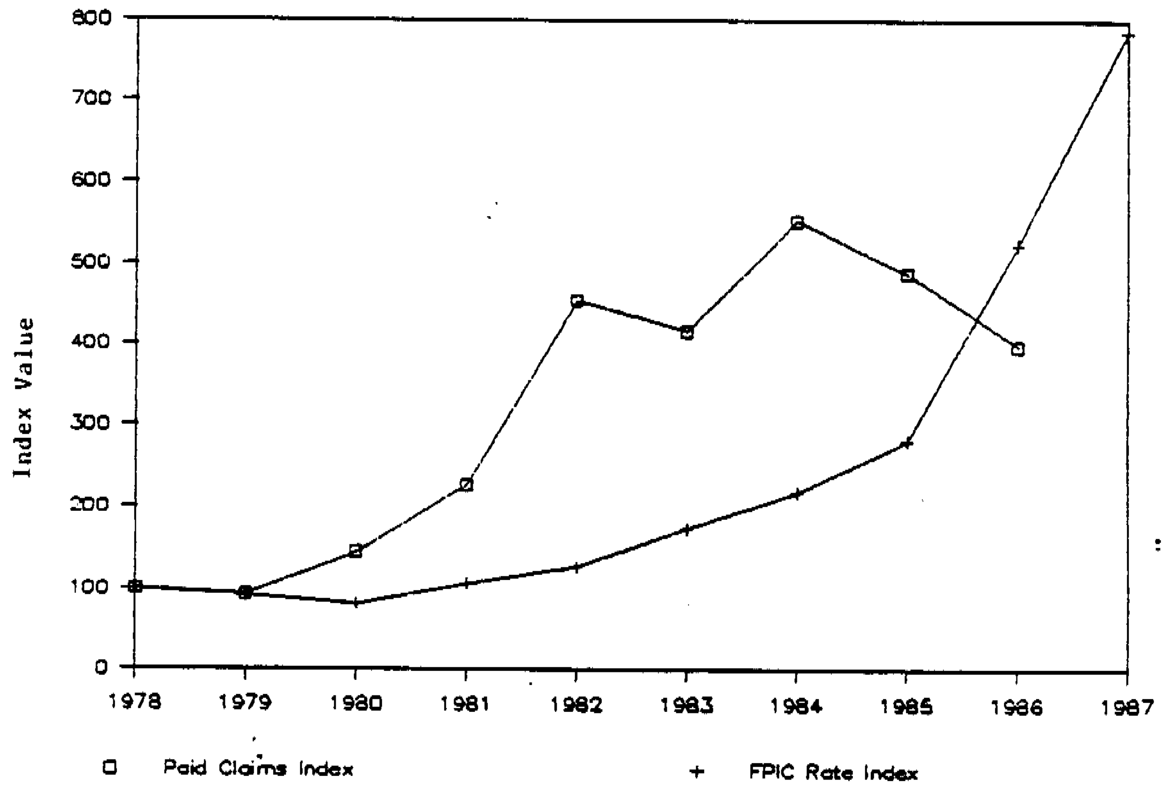
claims have grown at a compound annual rate of slightly more than 20 percent per year. Since 1979, the rate of increase has been almost 30 percent per year.

A comparison of an index of claims payments with an index of one insurer's medical malpractice insurance rates may help to illustrate the linkage between claims payments and premiums. Figure 1A contains an index of the average paid claim per physician since 1978. This year was selected as the starting point because it was the first year for which rate data from Florida Physician Insurance Company (FPIC) was available. Rate information for other companies is only available since 1983. The rate index is based upon FPIC's mix of insured risks which will not necessarily mirror the composition of physicians in the state. In spite of this possible limitation, the graph serves to point out that over the long run there must be a relationship between premiums and claims payments.

From 1978 to 1984 the rate of increase in claims payments outpaced the rate of premium increase. High interest rates helped to finance this short-fall but by 1984 the gap between the two indices was so large as to make the recent price increases inevitable if a balance between claims payments and premiums was to be restored.

Data for Florida closed claims are available by medical specialty, which makes it possible to determine which specialties accounted for the major portion of aggregate paid claims. Table 9 shows that for the entire time period, as well as the year 1982 through 1986, obstetrics and gynecology ranked highest in total paid claims. The next four highest ranked specialties for the

Figure 1A
Indices of Medical Malpractice Paid Claims Per Physician in Florida and Florida Physicians Insurance
(1978=100)



Source: Calculated from data supplied by the Florida Department of Insurance.

TABLE 9
RANKING OF MEDICAL SPECIALTIES ACCORDING TO
AGGREGATE PAID CLAIMS IN FLORIDA: 1975-1986

	CALENDAR YEAR OF CLOSING											
	ALL YEARS	1975	1976	1977	1978	1979	1980	1981	1982	1983	1984	1985
SPECIALTY	RANK	RANK	RANK	RANK	RANK	RANK	RANK	RANK	RANK	RANK	RANK	RANK
OBSTETRICS & GYNECOLOGY	1.0	8.0	2.0	3.0	3.0	1.0	1.0	2.0	1.0	1.0	1.0	1.0
ORTHOPEDICS	2.0	6.0	5.0	6.0	4.0	10.0	5.0	1.0	4.0	2.0	4.0	3.0
GENERAL SURGERY	3.0	1.0	1.0	4.0	1.0	3.0	9.0	5.0	2.0	4.0	9.0	5.0
GENERAL PRACTICE	4.0	2.0	3.0	1.0	5.0	2.0	3.0	8.0	9.0	5.0	8.0	2.0
INTERNAL MEDICINE	5.0	3.0	15.0	2.0	11.0	4.0	10.0	6.0	3.0	6.0	5.0	4.0
NEUROLOGY & NEUROSURGERY	6.0	11.0	9.0	5.0	8.0	6.0	13.0	4.0	6.0	7.0	3.0	6.0
ANESTHESIOLOGY	7.0	4.0	8.0	7.0	10.0	19.0	7.0	10.0	8.0	3.0	2.0	8.0
PEDIATRICS	8.0	9.0	10.0	14.0	6.0	9.0	17.0	11.0	7.0	9.0	6.0	9.0
RADIOLOGY & ROENTGENOLOGY	9.0	7.0	13.0	11.0	15.0	15.0	6.0	3.0	13.0	10.0	10.0	7.0
OSTEOPATHY	10.0	5.0	12.0	13.0	2.0	7.0	2.0	7.0	5.0	13.0	7.0	12.0

SOURCE: FLORIDA DEPARTMENT OF INSURANCE MEDICAL MALPRACTICE CLOSED CLAIMS DATA SET

entire time period (in decreasing order) were orthopedics, general surgery, general practice and internal medicine. Together, these five specialties accounted for 53 percent of paid claims.

Because increased loss payments are the principal cause of increased malpractice insurance costs, various components of increased loss payments are analyzed in extended detail in section III. A. of this report. For now it should be noted that increased numbers of claims ("frequency") and increased amounts per claim ("severity") have both contributed, with increased severity exerting greater influence on the growth of loss payments.

The Task Force's finding that increased loss payments have been the principal cause of insurance rate increases does not imply a conclusion that increases in loss payments were necessarily unwarranted. No judgment can be made on the basis of the systemic information analyzed here as to whether in particular instances payments have been made to claimants who were not entitled to them under current legal rules or whether the amounts of such payments were excessive. Nor does this Preliminary Fact-Finding Report make value judgments about current liability and damage rules; such judgments would require balancing policy considerations.

FOOTNOTES

II. A.

[1] This is not to imply that loss payments will continue downward. Population growth will cause payments to increase as will continued inflation in the cost of settling a claim. In the absence of any changes in the insurance and tort systems, loss payments can be expected to resume their upward trend.

B. Insurance Company Profitability and the Role of Market Structure.

1. Profitability

It has been alleged that excessive insurance company profits are one of the reasons that malpractice premiums are so high. On the other hand, the insurance industry claims that it has experienced a financial hemorrhage of the severest magnitude. Based upon its research, the Task Force finds that excess profits have not been a cause of the medical malpractice insurance problem, but, in general, the insurance industry's financial position is less precarious than it claims, when its total return is examined.

a. The Measure of Profitability: Return On Equity Model

The profitability measure used in this study is total return on equity. The rationale for using total return on equity, rather than one of its components, derives from the insurer's primary function, which is the taking of risk by providing insurance to society. The prerequisite for providing insurance is the availability of surplus (capital) to absorb fluctuations in the financial results of the company as well as to finance its growth. Unexpected increases in the number of claims or the amount paid to settle each claim could result in premiums being insufficient to cover the cost of claims. When this occurs, the company's surplus is used to finance the loss until the relationship between premiums and claims can be restored.

In the case of a stockholder owned insurance company, the return on equity must be competitive with returns that could be earned in other sectors of the economy with equivalent risk. If it is too low, capital will leave the insurance business which in turn will restrict the supply of insurance. This will cause prices to rise until profitability has been restored, at which point price and supply stability will return. In the United States, capital flows can take place relatively unimpeded. There are certainly few, if any, restrictions placed upon a firm's management when it wishes to increase the insurer's capital. While withdrawing capital or withdrawing from insurance markets is more difficult, it can and does take place when the firm's management has no expectation of return by remaining in the market.

Mutual companies also must earn profits -- i.e. an excess of income over costs. The economic principles of underwriting apply with equal force to mutual companies as to stock companies, but the goals of the owners (policyholders) may differ from those of stockholders. A mutual company must have surplus in order to absorb fluctuations in underwriting results; therefore it must also attract and retain capital. It also must generate surplus in order to finance the growth of the firm. If the market perceives that the firm is in danger of insolvency, then its insureds can (and will) simply cancel, or not renew their policy and shift their business to a more stable competitor, whether it is a stock, mutual or some other form of organization.

Figure 2 outlines the components of total return considered in this study.

b. Components Of Total Return

There are four parts to total return: underwriting, investment income, realized capital gains and unrealized capital gains. Underwriting refers to the profitability of the firm's insurance portfolio. The last three components result from the fact that insurance premiums are received by the firm before losses are paid, so the company has the use of the money for this time period. Net investment income represents cash income (mostly dividends and interest) net of the investment expenses incurred to manage these monies. Realized gains arise when the firm sells an asset, e.g. stocks, bonds, for more than its cost. Unrealized gains occur when the price of an asset goes up after its purchase by the company but the security has not yet been sold.

c. Property-Liability Insurance Industry Profits: 1977-1985

In April, 1987, the Insurance Services Office published a study of the profitability of the U.S. property-liability insurance industry compared to other American industry. The results of that analysis for the 1977-1985 period are summarized in Table 10.

These results show that for the most recent underwriting cycle, the average return on net worth for the U.S. property-liability industry was less than both the financial section and American industry as a whole.

Figure 2

COMPONENTS OF INSURER
TOTAL RETURN

UNDERWRITING GAIN (LOSS)	XX
NET INVESTMENT INCOME	XX
TAXES	-XX
AFTER TAX OPERATING RESULT	XX
REALIZED GAINS	XX
UNREALIZED GAINS	XX
TOTAL DOLLAR RETURN	XX

TABLE 10

Simplified GAAP Adjustment Return on Net Worth for the U.S. Property-Liability Insurance

Industry Compared to U.S. Industry

	S & P Financial	S & P 500 Stocks	Property-Liability Insurance
1977	14.1%	13.5%	16.8%
1978	15.6%	14.1%	18.8%
1979	15.7%	15.4%	18.4%
1980	13.8%	14.1%	17.5%
1981	12.7%	13.8%	8.1%
1982	11.4%	10.7%	11.1%
1983	11.6%	11.0%	8.9%
1984	9.1%	13.2%	-1.0%
1985	9.2%	10.7%	8.1%
Average	12.6%	12.9%	11.7%

Source: *Insurer Profitability: A Long-Term Perspective*, Insurance Services Office, Inc., April, 1987, p.51.

Notes:
1. End of year net worth was used in the calculations
2. Unrealized capital gains were reduced by 28 percent to account for Federal income taxes.

d. Medical Malpractice Liability Insurance Profits: 1977-1985

Table 11 displays statutory total return on equity for property-liability insurers who are classed as "Medical Malpractice Predominating" by A.M. Best & Co.[1] This group includes specialty companies that write only medical malpractice insurance as well as carriers whose major line of business is medical malpractice insurance.

The return on equity figure is broken down into its components so that the contribution of each part to the total can be ascertained. In addition, figures are presented for each year since the start of the last underwriting cycle in 1977. These data reveal several significant points. First, at the national level, insurers have consistently lost money on underwriting since 1977. Moreover, the underwriting loss has steadily deteriorated to the point where it produced a -69.4 percent loss on surplus in 1985 (the latest year for which data is available).

Second, investment income as a percent of equity has steadily increased and, except for 1985, has more than offset the underwriting loss. This result has occurred in spite of declining interest rates since mid-1981 and is attributable to the premium increases which substantially increased the industry's cash flow.

TABLE 11.
STATUTORY RETURN ON EQUITY FOR MEDICAL MALPRACTICE PREDOMINATING
PROPERTY LIABILITY INSURERS
1977-1986

	1985	1984	1983	1982	1981	1980	1979	1978	1977
Components:									
Underwriting	-69.4%	-55.7%	-47.3%	-39.3%	-35.4%	-23.5%	-16.6%	-6.7%	-13.2%
Net Investment Income	67.6%	65.2%	55.8%	62.9%	57.1%	48.9%	44.3%	37.7%	39.1%
Policyholder Dividends	-3.5%	-4.0%	-2.4%	-3.1%	-2.7%	-1.8%	-1.2%	-4.5%	-1.7%
Taxes	0.5%	0.9%	-4.0%	-0.4%	-1.6%	-5.2%	-4.8%	-6.1%	-7.7%
After Tax Operating Result	-4.7%	6.4%	2.1%	20.0%	17.4%	18.4%	21.7%	20.5%	16.5%
Realized Gains	12.3%	0.9%	5.2%	2.3%	0.3%	0.8%	0.4%	-2.4%	0.3%
Unrealized Gains	4.3%	-0.8%	-0.1%	0.4%	1.6%	2.8%	0.6%	-0.3%	0.2%
Total	11.9%	6.4%	7.2%	22.8%	19.3%	22.1%	22.7%	17.8%	16.9%

* Return on Equity Calculated Using Beginning of Year Surplus.
Source: Calculated from data reported by A. M. Best and Company, Aggregates and Averages, (1978-1986).

Third, the industry paid income taxes from 1977 through 1983. In 1984 and 1985 its underwriting losses were of sufficient magnitude to generate a recapture of income taxes paid in prior years.

Finally, the industry's after-tax operating profit showed a marked and sudden deterioration in 1983 compared to the six previous years. This result persisted in 1984, and in 1985 operating results produced a negative return on equity for this component of return for the first time during the 1977 - 1985 period.

e. Profits In Florida

Table 12 reports statutory return on surplus for two of the top three major medical malpractice insurers in Florida. Florida Physicians Insurance Company and Physicians Protective Trust Fund operate only in Florida and write only medical malpractice insurance. Consequently the profitability results solely from their Florida medical malpractice experience.

Care must be exercised in drawing conclusions from these data. Florida Physicians Insurance Company is emerging from a period of extreme financial distress, consequently its return figures are not indicative of its long-term profitability. Physicians Protective Trust Fund's early returns are distorted because the Trust Fund began operations in 1975 without any paid-in capital or contributed surplus. This means that its returns for those years are higher than its expected long-term profitability. The organizations' recent results are probably more representative of expected profitability, but they overstate

TABLE 12.

Statutory Return on Surplus For Two Major
Florida Medical Malpractice Insurers

	1976	1977	1978	1979	1980	1981	1982	1983	1984	1985	198
Florida Physicians Insurance Company											
Components of ROE:											
Underwriting	N/A	22.1%	47.6%	-98.7%	-47.1%	-91.0%	-149.1%	-12.3%	-188.8%	-164.1%	-101.
Interest, Dividends, etc.	N/A	16.5%	31.7%	47.4%	58.7%	82.9%	108.1%	33.6%	67.8%	129.8%	61.
Realized Capital Gains	N/A	-0.3%	0.0%	0.2%	-0.5%	6.8%	-19.2%	-4.0%	-71.3%	-13.9%	69.
Unrealized Capital Gains	N/A	0.2%	-0.2%	-7.0%	-2.8%	-22.8%	25.2%	7.5%	55.0%	-21.2%	-47.
Total Return *	N/A	38.5%	79.1%	-58.1%	8.3%	-24.1%	-35.0%	24.8%	-137.3%	-69.4%	-17.
Physicians Protective Trust Fund **											
Components of ROE:											
Underwriting	-78.2%	-166.2%	-55.2%	-61.4%	-416.1%	-1033.4%	-89.4%	-162.6%	-56.7%	-49.4%	-36.
Interest, Dividends, etc.	128.5%	222.2%	114.9%	106.2%	508.6%	1104.5%	94.4%	160.6%	88.0%	56.1%	45.
Realized Capital Gains	0.0%	14.8%	0.0%	1.3%	-9.5%	3.1%	2.1%	13.2%	1.7%	8.0%	8.
Unrealized Capital Gains	49.7%	-54.6%	-18.0%	-28.0%	-240.4%	-180.0%	80.9%	-68.8%	21.0%	33.6%	13.
Total Return ***	100.0%	16.2%	41.7%	18.1%	-157.4%	-105.8%	88.0%	-57.6%	54.0%	48.3%	31.

* Return is after policyholders dividends and after income tax. Note, however, that no Federal income tax was levied against unrealized capital gains. Such a tax liability may be incurred if and when the gains are realized. The amount of of the tax liability is unknown and will depend upon the extent to which the realized gain in securities prices is offset by underwriting losses. End of year surplus was selected by the company in calculating the return on surplus.

** See Appendix 2 for a cautionary letter from Physicians Protective Trust Fund concerning the use of total return on surplus figures for a trust fund.

*** See the above note concerning Federal and state income taxes. Beginning of the year surplus was used by PPTF in calculating the return on surplus.

Source: Insurance company questionnaire repsonses.

it because the insurers leverage ratio (i.e. premiums-to-surplus) is over twice as large as the typical insurer. This causes the return on equity figure to be higher than it would be if a lower leverage ratio were present.

St. Paul Fire and Marine Insurance Company, the main malpractice insurer in Florida, is a multi-line, multi-state firm. Its return on equity figures reflects not only its Florida medical malpractice experience but also the company's medical malpractice experience from other states and other lines of insurance. Under these circumstances, the firm underwriting result must be examined to gauge one part of the profitability of medical malpractice insurance. Underwriting results are available on a state-by-state basis whereas the return on equity figures is countrywide and reflects the experience of all lines of insurance.

Underwriting Results. Generally, the approach used in the previous section cannot be used in isolation to measure a company's financial performance in a given state because companies do not allocate their surplus on a state-by-state basis, nor do they allocate their expenses on a state-by-state basis. Consequently, it is necessary to examine the multi-line and/or multi-state company's loss ratio.

Table 13 contains the adjusted loss ratio for medical malpractice insurance for Florida and the same ratio for St. Paul's medical malpractice experience in Florida. The adjusted loss ratio is equal to losses incurred divided by premiums earned after policyholders dividends. It is an incomplete measure of

TABLE 13.

Adjusted Loss Ratio
Medical Malpractice Liability Insurance

	Florida		Countrywide	
Year	All Co.s	St. Paul	All Co.s	St. Paul
1975	16.6	4.4	66.5	7.1
1976	94.5	12.6	48.5	13.5
1977	57.6	13.6	41.8	22.3
1978	26.3	37.9	60.6	36.4
1979	67.6	47.9	75.3	48.2
1980	83.6	94.0	82.6	56.2
1981	56.2	48.8	99.5	61.8
1982	89.8	64.5	111.4	67.7
1983	89.7	77.5	112.3	77.1
1984	93.4	73.8	110.9	80.2
1985	131.4	113.6	120.7	86.9
1986	106.7	92.6	99.1	79.8
Average: 1976-1986	81.5	61.5	87.5	57.3

Source: A.M. Best & Co.

Note: Adjusted loss ratio is equal to losses incurred divided by premiums earned less policyholder dividends.

profitability because it does not take account of the company's expenses, nor does it include investment income or realized and unrealized gains.

The data reported in Table 13 cover the period 1975 (which was the first year that medical malpractice was reported as a separate line) to 1986. All companies writing medical malpractice insurance in Florida are included except Florida Physicians Insurance Company, the trust funds (of which Physicians Protective Trust Fund is the largest), the Patients Compensation Fund and the Florida Medical Malpractice Joint Underwriting Association.

1. Underwriting Profitability. The data for the past three years demonstrate the poor underwriting results both in Florida and across the country. Loss adjustment expenses and underwriting expenses must be added to measure underwriting profitability and these two items add about another 45 percent to the figures shown in Table 13. Thus, if the combined loss and expense ratio came to 130 percent, it means that a loss of 30 cents is occurring for every dollar of premium. As noted above, however, investment results need to be included in order to accurately assess profitability. Even when this is done (please see Table 11 and Table 12, the financial results from recent years show no excess profits and long term average return is very close to overall profitability for the property-liability industry.

a. Average Loss Ratio. The average adjusted loss ratio for Florida compared to the U.S. from 1976 to 1986 is 81.5 versus 87.5 respectively (1975 was excluded because of the possibility

that the results were distorted due to it being the first year the separate figures were reported). During these years, Florida's experience has been both higher and lower than the national average so there is no clear, persistent difference between Florida and the countrywide average. St. Paul's adjusted loss ratio is higher for Florida compared to its national average indicating lower profitability on its Florida business. At the same time, St. Paul's Florida results are below the statewide average, indicating better than average profitability. The reasons for this apparently conflicting result are not obvious but one possibility may be the mix of business (i.e. specialties) included in each data series.

f. Summary

This section analyzed the profitability of medical malpractice insurers. Both total return on surplus as well as underwriting results were reviewed. Profitability over a complete underwriting cycle was examined in order to avoid distorting the return on surplus results caused by fluctuations in securities prices.

During the period 1977-1985, the average return on surplus for insurers classified by A.M. Best & Co. as "medical malpractice predominating" was slightly above the average return for the industry as a whole. Two large Florida insurers whose only business is medical malpractice liability insurance had mixed results. One company had extremely poor returns. The other insurer's returns in recent years are above the national average but are not representative of the average firm because it

is operating at more than twice the usual premiums to surplus ratio and this will cause return numbers to be higher than otherwise.

Underwriting results for both Florida and the country were unprofitable in recent years. However, the industry's financial condition is not as serious as it claims when it bases it arguments on the narrower definition of profit.

2. The Role of Market Structure

Relatively few firms sell medical malpractice liability insurance in Florida. This invites concern as to whether insurers are charging non-competitive prices and thereby earning excessive profits.

The Task Force finds that the "highly concentrated" market structure for medical malpractice liability insurance in Florida suggests a potential problem. Since the four-firm concentration ratio indicates that the four largest firms hold more than 80% of the market, one may question whether prices are really competitive. But evidence as to the relative ease of entry into the market, and the presence of other large insurance firms with the potential to expand their presently small share of Florida's malpractice insurance market indicate that the market is still basically open and competitive. This, combined with previously discussed evidence that profits have not been excessive, leads to the conclusion that market structure has not been a demonstrable cause of increased premium rates.

Market structure refers to the number and size distribution of sellers and buyers, the existence of barriers to entry, the importance of scale economies in determining the minimum efficient sized firm, the extent of vertical integration, and the like. Empirical studies tend to confirm the theory that structure determines prices and profits.[2] More specifically, the closer that an industry's structure is to monopoly, the more likely we are to observe noncompetitive profits, which indicate that prices are above the competitive level while quantities are below the competitive level.[3]

a. Number and Size Distribution of Firms.

Table 14 displays the medical malpractice insurers that reported Florida sales to A.M. Best or to the Department of Insurance for 1985.[4] They are arranged in order from the largest to the smallest. Of the 61 insurers reporting, 14 did not underwrite any medical malpractice insurance during 1985. In addition, three reported negative premiums written, which indicates that they did not underwrite any medical malpractice insurance in 1985 and that they cleared their books from preceding years. Of the remaining 44 firms, it is obvious that many are quite small. Generally, these firms are writing national programs for nurses, chiropractors, and the like. Their Florida premiums represent Florida's share of their national plans. Medical malpractice insurers playing an important role in this market are listed at the top. It is important to recognize that this table does <u>not</u> cover all of the trust funds, which provide a substantial amount of medical malpractice

Table 14
Direct Premiums Written - Medical Malpractice
1985

Rank	Group Name	DPW Dollars
1	St. Paul Group	$89,674,038
2	Physicians Protect. Trust Fund	43,226,563
3	Florida Phys Ins Co.	24,257,375
4	Cigna Group	15,183,798
5	Evanston Group	8,532,532
6	CNA Ins Cos	7,463,104
7	Health Care Indemn	7,198,963
8	MMI Companies Group	4,875,153
9	Amer Intern Group	2,428,739
10	Hartford Ins Group	2,216,825
11	Fireman's Fund Cos	1,549,307
12	Travlers Ins Group	858,656
13	Nat Chiropractic Mut	850,021
14	Westco Ins Group	695,451
15	Continental Ins Cos	626,823
16	General Re Group	462,815
17	Integrity Ins Co	272,129
18	Cincinnati Fin Group	239,987
19	Amer Financial Group	182,838
20	Aetna Life and Cas Grp	146,440
21	WR Berkley CP Group	138,076
22	United States F&G GR	120,008
23	Protective Casualty	90,520
24	Ranger Ins Group	57,400
25	Orion Group	38,315
26	UMI Group	31,275
27	Virginia Ins Recip	30,060
28	Nationwide Group	23,277
29	Armco Ins Group	21,664
30	Crum and Forster Cos	21,443
31	Jefferson Ins Group	15,651
32	Chubb Grp of Ins Cos	11,560
33	United States Inv Gr	2,895
34	Church Mutual Ins	958
35	State Auto Mut Group	944
36	Bershire Hathaway	943
37	Seibels Bruce Group	537
38	Home Ins Group	524
39	Alliance Ins Group	375
40	Allstate Ins Group	363
41	Lincoln Nat Group	301
42	Safeco Ins Cos	283
43	Reliance Ins Cos	148
44	Comm Credit Group	141
45	Central Mut Ohio Grp	122
52.5	Amer General Group	
52.5	Royal Ins Group	

52.5	Zurich Amer Ins Group	
52.5	Amer Universal Group	
52.5	Foremost Corp Group	
52.5	Whiting National Ins	
52.5	MCM Crop Group	
52.5	Medical Protective	
52.5	Allianz Group	
52.5	Prudential of Am Grp	
52.5	Alexander Howden Grp	
52.5	Signature Group	
52.5	Employers Reins Grp	
52.5	Teledyne Group	
60	Liberty Mutual Group	76CR
61	Beneficial Ins Group	95CR
62	Internat Ins Co MD	219,554CR
YEAR		$211,329,615

Source: Best's Executive Data Service, Property Casualty and Life/Health, A.M. Best Company, and Report of the Department of Insurance, State of Florida, 1985.

coverage in Florida, nor does it include the Joint Underwriting Association.

b. Size Distribution of Firms.

There are various ways of summarizing the size distribution of firms in an industry. Two of the most common measures are the Herfindahl index and the concentration ratio. The Herfindahl index (H) equals the sum of the market shares times 100 squared. Table 15 presents the Herfindahl indices for medical malpractice insurance in Florida for 1981-1985.

Other things being equal, concentration is important because it affects the likelihood that one firm (or a small group of firms) could successfully exercise market power. In order to interpret the data in Table 15, some critical values are needed for H. The best expression of critical values is contained in the U.S. Department of Justice Merger Guidelines.[5] The Antitrust Division of the Department of Justice considers that if H is less than 1000, the market is <u>unconcentrated</u> and, as a result, the Antitrust Division will not challenge mergers in such industries. If the value of H falls in the interval between 1000 and 1800, the industry is considered to be <u>moderately concentrated</u>, which increases one's concern about exercises of market power. Nonetheless, a merger is not likely to be challenged unless it produced a 100 point increase in H. Finally, if H exceeds 1800, the industry is considered <u>highly concentrated.</u>

Table 15
Herfindahl Indices 1981-1985
Medical Malpractice Insurance

Year	Herfindahl Index
1981	2892
1982	2402
1983	2095
1984	2201
1985	2451

Table 15 shows that the medical malpractice market in Florida falls into the "highly concentrated" category since the Herfindahl index exceeds 2000 in every year. This is not unusual when one looks at the experience across the nation. Table 16 shows the Herfindahl indices for the individual states and the District of Columbia. Some 34 states have higher concentration than Florida while the remainder have lower concentration. Nonetheless, the value of H is high enough in Florida to warrant some concern.

Historically, the most popular measure of concentration among industrial organization and antitrust economists has been the concentration ratio. Its main virtue from a mechanical perspective is its simplicity. The n-firm concentration ratio simply reports the percentage of industry sales accounted for by the n largest firms. The Federal government publishes concentration ratio data on an aggregated basis. Due to disclosure rules, the government provides four-firm, eight-firm, 20-firm, and 50-firm concentration ratios for a very large number of industries. These data are the best that can be obtained for large-scale empirical studies. As a consequence of ready availability, most economists and antitrust lawyers are more familiar with concentration ratios than with any other measure. In addition, concentration ratios have been used extensively in empirical efforts to control for market structure.[6] Some 75-80 of these studies have been synthesized by Leonard Weiss in an

Table 16
Medical Malpractice
Market Structure ~ 1985

State	N[1]	H[2]	
South Carolina	37	7175	Most Concentrated
South Dakota	37	6308	
Mississippi	45	6055	
Oklahoma	39	5484	
Arkansas	41	5274	
Nebraska	41	4896	
Oregon	41	4659	
North Carolina	40	4295	
Maine	35	4207	
Illinois	58	4102	
Minnesota	40	4076	
Georgia	52	4050	
Alabama	43	4035	
New Jersey	55	3982	
Iowa	44	3833	
Arizona	50	3807	
North Dakota	34	3671	
Alaska	26	3527	
District of Columbia	37	3477	
Utah	39	3425	
Louisiana	46	3244	
Virgina	46	3138	
Vermont	28	3118	
New Hampshire	36	2975	
Tennessee	52	2871	
Rhode Island	36	2775	
Colorado	40	2735	
West Virginia	43	2718	
Wisconsin	42	2718	
Delaware	31	2675	
New York	63	2639	
Nevada	35	2631	
Kentucky	49	2586	
Kansas	44	2508	
FLORIDA	62	2451	
Idaho	38	2329	
Hawaii	35	2327	
Wyoming	36	2214	
Connecticut	40	2129	
Washington	45	2099	
Missouri	54	2045	
Montana	37	1998	
Pennsylvania	57	1909	
New Mexico	37	1875	
Ohio	53	1827	
Michigan	59	1767	
Texas	51	1651	
Indiana	56	1642	

Maryland	46	1531
California	71	1166
Massachusetts	47	1128 Least Concentrated

Source: Best's Executive Data Service, Property/Casualty and Life/Health, A.M. Best Company.

[1]N denotes the number of firms reporting.

[2] H denotes the Herfindahl index.

interesting survey.[7] The bulk of these studies indicates that market concentration and profits are positively correlated when the four-firm concentration ratio exceeds 75 percent.

Table 17 displays the one-firm, four-firm, eight-firm, and twenty-firm concentration ratios for the medical malpractice insurers in Florida during 1981-1985. The concentration ratios are quite high for medical malpractice insurance. In each of the years 1981-1985, the four-firm concentration ratio exceeded 75 percent. This picture is not much different from that presented by the Herfindahl indices. Before concluding that this may indicate a lack of competition, it is necessary to examine entry conditions since they can have a significant influence on the exercise of apparent market power.

c. Entry Barriers[8]

Market power is the ability to raise price above the competitive level by restricting output, i.e., the ability to create affordability and availability problems. A group of firms can exercise market power only if it is protected from entry. If entry into a market is so easy that existing competitors cannot succeed in raising price for any significant period of time, then market power is absent and competitive forces should determine prices and quantities. Because of the highly concentrated market structure for medical malpractice insurance in Florida, it is

Table 17
CONCENTRATION RATIOS* 1981-1985
MEDICAL MALPRACTICE INSURANCE

YEAR	1CR	4CR	8CR	20CR
1981	48.6	87.5	94.9	99.2
1982	40.2	82.7	93.5	99.2
1983	32.0	78.0	90.9	98.8
1984	38.0	81.3	92.6	98.9
1985	42.4	81.6	94.8	99.8

Source: Best's Executive Data Service, Property/Casualty and Life/Health, A.M. Best Company and Report of the Department of Insurance, State of Florida, 1984 and 1985.

*CR denotes concentration ratio, which measures the percentage of direct premiums written by the largest, four largest, eight largest, and 20 largest.

necessary to evaluate the condition of entry. Before proceeding, however, it should be noted that some of the giants in the property/casualty insurance industry have a small presence in Florida's medical malpractice market. These firms are displayed in Table 18. In 1985, these eight insurers accounted for some $36.6 billion in premiums written, which amounted to 24 percent of the entire property/casualty industry in the United States. These firms individually and collectively could provide formidable competition for the major medical malpractice insurers in Florida.

This analysis of market entry is in three parts. First, the report examines the statutory entry requirements, because in regulated industries permission must be obtained before a firm may enter. Second, the report reviews returns from a sample of insurers to identify the most important entry barriers. Finally, this report assesses the ease of entry into the Florida medical malpractice insurance market.

1. Statutory Entry Hurdles. Florida Statutes establish the requirements that domestic, foreign, and alien insurance companies must satisfy to sell insurance in the State of Florida. An "authorized" insurer is one receiving a certificate of authority from the Department of Insurance (DOI) to "transact insurance" in Florida.[9] Compliance with applicable provisions of the insurance code is a prerequisite to transacting business in the state.[10] Because the state has pre-empted the insurance

Table 18
Large Insurance Firms with a Small
Medical Malpractice Presence

Firm	Rank[1]	DPW
Allstate	2	$7.7 billion
Aetna	3	5.4 billion
Nationwide	5	4.9 billion
Travelers	7	4.5 billion
Hartford	8	4.4 billion
Continental	12	3.5 billion
Crum and Forster	13	3.3 billion
U.S.F. & G.	14	2.9 billion

Source: Best's Executive Data Service, Property/Casualty and Life/Health, A.M. Best Company.

[1]Based upon direct premiums written in all property/casualty lines during 1985.

field, no other political subdivision may require any additional registration or permits from businesses transacting insurance pursuant to state authority.[11]

a. Certificate of Authority. All insurers must receive certificates of authority unless a statutory exception applies.[12] The qualifications to receive a certificate of authority are threefold: (1) capital funds requirements (2) extensive disclosure of financial and other information and (3) operating histories for certain foreign insurers. Filing fees are $25 and annual license taxes are $200.

b. Capital Funds Requirements. Applicants wishing to transact medical malpractice insurance must meet various paid-in capital and surplus requirements. These capital and surplus requirements must be met for the original issuance of a certificate of authority. An insurer expanding into additional lines must meet the surplus requirements for each kind of insurance that the insurer proposes to transact.[13] Medical malpractice insurers must maintain $750,000 of paid-in capital unimpaired.[14]

In addition to paid-in capital, there are special surplus requirements. Each insurer must maintain surplus equal to the larger of $1,000,000 or an amount computed under an applicable statutory requirement. For medical malpractice insurers, the statutory requirement is 10 percent of the total of its net reserves.[15] Any insurer with surplus greater than $100 million, however, is not required to increase or maintain surplus in accordance with these provisions.[16] Also, insurers expanding into additional lines within three years of receiving an initial

certificate of authority must meet surplus requirements as would be required for an original certificate of authority covering all the kinds of insurance that the insurer proposes to transact.[17]

c. Information Disclosure. Applicants for a certificate of authority must file forms and comments with DOI that disclose (1) "administrative" information, and (2) operating plans for the next three years.

The "administrative" information is information such as charter, by-laws, and financial documents relating to the company structure, its operating history, and so on. Disclosure costs of these types of information are probably insignificant. The operating plans for the next three years may require more extensive disclosure costs. The DOI requires a three-year operating plan that must include: types of insurance, planned volume by line at three-month intervals, marketing plan including use of agents and brokers, use of reinsurance, statement of any expected changes, description of insurance history of each individual by expected changes, description of insurance history of each individual by management position in eight areas, and a statement of any consultants or experts the insurer uses.[18] Preparation of this three-year plan is probably moderately expensive, particularly for smaller insurers. Most of the information, however, should be readily available and not pose much additional cost.

d. Operating Histories for Foreign and Alien Insurers. A foreign insurer is not authorized to transact insurance in Florida unless it has operated satisfactorily for at least three

years in its state or country of domicile.[19] The DOI may waive this requirement if the foreign or alien insurer:

(1) has operated successfully and has capital and surplus of $5 million;

(2) is the wholly owned subsidiary of an insurer which is an authorized insurer in Florida;

(3) is the successor in interest through merger or consolidation of an authorized insurer; or

(4) provides a product or service not readily available to the consumers of this state.[20]

Thus, foreign insurers can avoid the three-year entry lag in providing medical malpractice coverage if the DOI feels that such coverage would otherwise not be readily available.

e. <u>Summary.</u> The entry into the Florida medical malpractice market is relatively easy. The primary barrier for domestic, foreign, and alien insurers is the capital and surplus requirements. Relative to manufacturing industries, these capitalization requirements are not severe. Moreover, entry can be accomplished quickly. An incumbent insurer can add lines or sub-lines by simply satisfying any additional capital and surplus requirements that the statutes demand. New domestic firms can start from scratch in as little as a year. Established foreign insurers (i.e., those with a satisfactory three-year operating record) can enter in a matter of months. Thus, the Florida Statutes impose few entry hurdles.

2. Questionnaire Results On Entry Barriers.[21] The barriers to entry that the surveyed insurers identified fall into three groups: (a) business considerations (b) legal considerations and (c) regulatory considerations.

a. Business Considerations. For the most part, the business considerations are not significant obstacles to entering a new line or sub-line of insurance in Florida. Typically, they involve ordinary business concerns that any firm must cope with in conducting business. They do not involve differentially higher costs for new entrants as opposed to incumbents. The obstacles identified include the following:

1. Capitalization: This refers to the firm's (i.e., entrant's) capital and surplus as well as access to the reinsurance market, which expands the firm's effective capital. The minimum requirements for capital and surplus in Florida are not a serious entry barrier.[22]
2. Underwriting Experience: This refers to the need for experienced personnel as well as to information on loss experience. Experienced personnel exist in the insurance industry. A firm interested in entering a particular line or sub-line must identify those with experience and hire them. Acquiring the necessary data base could be a more serious obstacle, but is not unique to new entrants.

3. Technical Support: This refers to the need for computer systems and personnel for efficient processing of claims. This is a developmental cost, but one with which most insurance firms are familiar.

4. Marketing: Some concern was expressed for determining the firm's competitive position in the market. Associated with that is a need for the insurer to be recognized as a supplier in that line or sub-line. Interestingly, no one expressed any serious concerns with developing a distribution system. Apparently, their existing system of employee agents or independent agents can handle additional lines or sub-lines for them.

b. Legal Considerations. For the most part, the legal concerns expressed by the insurers involved the tort system. The legal framework within which the insurers must operate is an environmental factor that may dissuade entry into medical malpractice insurance. Most of the responses were not very specific, e.g.,

1. Adverse tort law and judicial case law;
2. State's judicial climate; and
3. Legal environment.

In some instances, however, the respondents were a bit more specific. In those cases, the major concern was over the uncertainty that some judicial decisions have created. Two insurers were concerned about their ability to predict their

underwriting exposure, one due to the judicial climate, the other due to court decisions that expanded coverage beyond the bounds originally contemplated.

c. Regulatory Considerations. In a highly regulated industry, it is not unusual for the regulated firms to have concerns about the regulatory environment. After all, regulation imposes constraints on the business behavior of those firms. Most of the concerns expressed by the insurers involved incentives for entry rather than the process of entry. Very little concern was expressed about being permitted to enter the market, which is consistent with what the Task Force found in the section entitled Statutory Entry Hurdles.

The focus of the insurance questionnaire responses, naturally enough, was on the profit potential and regulation's impact on profit. More specifically, the firms expressed concern about:

1. The adequacy of rates,
2. Flexibility of rate setting and underwriting,
3. Excess profit laws,
4. JUAs, and
5. Undue restrictions on underwriting, claims, cancellations, and non-renewals.

Compounding their concerns about these aspects of regulation was their perception or impression of the regulatory environment. If the potential entrant perceives that the regulator is unresponsive to the insurer's need for adequate and reliable rates, then the firm may not enter. Similarly, if the potential entrant feels that regulation or legislation is unresponsive to

the insurer's need for a profit opportunity, entry is less likely.

The only other aspects of regulation that were mentioned by the insurers were as follows:

1. Regulation may preclude the use of preferred forms,
2. Regulation may require the approval of forms, rates, and rules, and
3. There may be approval delays.

No doubt, these can deter or delay some entry, but there does not appear to be a major problem here.

3. Assessing The Ease Of Entry.[23] The ease of entry into a market depends upon four factors:

a. The speed of entry;
b. The existence of cost or demand disadvantages;
c. The existence of scale economies; and
d. The presence of sunk costs.

The report will describe each of these factors and relate them to the evidence that the Task Force has gathered.

a. Speed of entry. The competitive threat posed by potential entrants depends upon how fast a firm can enter. If entry is slow, incumbent firms can raise price and enjoy extra profits long enough so that the subsequent entry will still leave them with net gains. In that case, the existence of potential entrants will not deter the incumbent firms from engaging in noncompetitive behavior. In Florida, the speed of entry depends upon the potential entrant's status. An existing insurer currently authorized to sell insurance in Florida can add a line

or sub-line of insurance very quickly. A foreign firm with a satisfactory record of performance elsewhere can enter Florida within a few months. In comparison to the time it takes to enter most other industries, this is relatively fast.

b. Cost and/or demand disadvantages. If entrants face significantly higher production or distribution costs than incumbents, the incumbents will enjoy a cushion that permits noncompetitive pricing without fear of entry. Similarly, if incumbents face demand disadvantages that require prolonged (or even permanent) price discounts, the incumbents will have a margin of safety.

In Florida, there are no obvious cost advantages that are unavailable to other efficient firms whether they be incumbents or entrants. Brand preferences do not appear to be important, given the presence and importance of a large number of insurers with no name recognition. Much insurance is distributed through the American agency system, which means that there is an extensive distribution system already in place for a potential entrant. There is, however, one major non-regulatory barrier blocking entry of new insurers into the Florida market. That barrier is the claims-made policy used by some insurers in Florida.

Traditionally, medical malpractice insurance was written under occurrence policies. Under those policies, the policy that was in force when a malpractice event occurred provided protection for that event, even if the claim was made twenty years later. A doctor could change insurers without sacrificing

coverage for malpractice events that occurred in the past, so market entry was relatively easy.

Beginning in 1975, the middle of the previous malpractice crisis, insurers began switching to claims-made policies. When a company issues a claims-made policy to a doctor, the policy includes two important dates, a retroactive date and an effective date. As the policy is renewed, the retroactive date remains constant, and the effective date moves up one year. In order for a claim to be covered under a policy, the alleged malpractice event must have occurred after the retroactive date, and the claim must be made when the policy was in force.

If a doctor terminates a claims-made policy with one insurer and buys a claims-made policy with another insurer, the new insurer will establish a new retroactive date equal to the effective date of its first policy. The doctor will no longer have coverage for malpractice events that occurred between the retroactive date of the old insurer and the retroactive date of the new insurer.

There are two solutions to the problem, but both are expensive. The doctor can have his former insurer issue an extended-reporting endorsement, or he can have his new insurer change its retroactive date to that of the same date as the former insurer. The premium for either change may be as much as three times the annual premiums. This burden for so-called "tail coverage" makes it very difficult for new insurers to enter the market, since its only prospects would be new doctors just entering practice.

c. Economies of scale. When there are economies of scale, average costs decline with increases in output - at least over some range. If scale economies are significant, this means that a firm must have a substantial volume of sales in order to experience competitive cost levels. This, in turn, means that entry must be on a large scale and consequently more difficult.

Market share data reveals that there are a large number of small firms in the Florida insurance markets. The persistence of these small firms over time indicates that they are not at a severe cost disadvantage.

d. Sunk costs. When a firm enters a new market, it engages in a risky venture. To the extent that expenditures must be made that cannot be recovered upon exit from the industry, these costs are considered "sunk," i.e., irreversible. These sunk costs raise the entrant's financial exposure and can deter entry.

In insurance, the major sunk costs are associated with establishing a competitive presence. Given the agency system of distribution, these costs need not be too great. While some major insurers attempt to establish name recognition through television and print media advertising, there is a substantial number of firms that do not follow this route.

On balance, entry into the medical malpractice insurance market in Florida appears to be relatively easy except for the prevalence of claims-made policies.

Footnotes
II. B.

1 An Official at A.M. Best & Co. defined "predominating" to mean a company whose medical mapractice insurance premium volume was 60 to 70 percent of its business. A list of these companies is contained in Appendix 1. Of these companies, only two, Health Care Indemnity and National Chiropractic Mutual write medical malpractice liability insurance in Florida.

2 For a survey of these empirical efforts, see Weiss, "The Concentration-Profits Relationship and Antitrust in Harvey J. Goldschmid, H. Michael Mann, and J. Fred Weston, eds., Industrial Concentration: The New Leaning, Boston: Little, Brown, 1974. Also see Donald A. Hay and Derek J. Morris, Industrial Economics, Oxford: Oxford University Press, 1979

3 These are obviously issues of affordability and availability.

4 For medical practice, at least two insurers did not report to A.M. Best in 1984 and 1985. These were added to the totals reported by A.M. Best.

5 See Justice Department Merger Guidelines, June 14, 1984, in Special Supplement, Antitrust and Trade Regulation Report, S-1 - S-16 (June 14, 1984).

6 There is a theoretical link between concentration ratios and an index of monopoly power. See Thomas R. Saving, "Concentration Ratios and the Degree of Monopoly, "International Economic Review Vol. II (February 1970), pp. 139-146.

7 Leonard W. Weiss, "The Concentration-Profits Relationship and Antitrust," in Harvey J. Goldschmid, H. Michael Mann, and J. Fred Weston, eds., Industrial Concentration: The New Learning, Boston: Little, Brown and Company, 1974, pp. 184-232.

8 An early advocate of the role that entry barriers play in industrial performance was Joe S. Bain, Barriers To New Competition, Cambridge: Harvard University Press, 1965. For a somewhat different interpretation, see George J. Stigler, The Organization of Industry, Homewood, Illinois: Richard D. Irvin, 1968 at pp. 67-70.

9 Fla. Stat. Ann. §624.09(1) (supp. 1987). "Transact" with respect to insurance includes (1) solicitation or inducement; (2) preliminary negotiations; (3) effectuation of a contract of insurance; or (4) transaction of matters subsequent to effectuation of a contract of insurance and arising out of it. Fla. Stat. Ann §624.10 (Supp. 1987).

10 Fla. Stat. Ann. §624.11 (Supp. 1987).

11 Fla. Stat. Ann. §624.410(3) (Supp. 1987).

12 Fla. Stat. Ann. §624.401(1) (Supp. 1987P. Exceptions are contained in Fla. Stat. Ann. §624.402 (Supp. 1987).

13 Fla. Stat. Ann. §624.408(2) (Supp. 1987).

14 Fla. Stat. Ann. §624.407 (Supp. 1987).

15 Fla. Stat. Ann. §624.408 (1) (b) (Supp. 1987).

16 Fla. Stat. Ann. §624.408 (Supp. 1987).

17 Fla. Stat. Ann. §524.408(2) (Supp. 1987).

18 See Organization of Insurance Company Under Laws of Florida, DOI Form.

19 Fla. Stat. Ann. §624.404 (2) (Supp. 1987).

20 Fla. Stat. Ann. §624.404 (2) (Supp. 1987).

21 This is a synthesis and summary of the responses to our Insurance Company Questionnaire, Part II, Question 12 which asked the respondent to identify the three most significant barriers to entry faced by a firm that wants to enter a line or sub-line of insurance.

22 See the discussion of capital and surplus requirements in the section entitled Statutory Entry Hurdles.

23 The following discussion relies upon Steven C. Salop, "Measuring Ease of Entry," The Antitrust Bulletin, Vol. 31 (Summer 1986), pp. 551-570.

C. THE UNDERWRITING CYCLE

The phenomenon known as the "underwriting cycle" is unique to the insurance industry and is a major cause of the periodic malpractice insurance crises. An entire cycle is defined by the period of years in which insurer underwriting profits cycle from above average to below average. Such cycles have always been a feature of the insurance industry and this is especially true for medical malpractice liability insurance, which generates large loss reserves for investment.

1. Causes Of Underwriting Cycles

Economic cycles usually result from changes in demand but, since the demand for insurance is rather constant, the insurance underwriting cycle results from changes in supply.

The cycle may begin when insurance is very profitable and, as a result, capital flows into the industry as new insurance companies are formed. To attract business, the new companies cut rates forcing the existing companies to cut rates in order to protect their market share. The rate cutting continues until the underwriting losses exceed the amount that insurers are willing to bear. At that point, some insurers will withdraw from the marketplace, some because of insolvency and others voluntarily. This shrinkage in supply permits the remaining insurers to raise rates to more profitable levels. The rate increases come quickly, and usually are accompanied by tighter underwriting standards, which result in more frequent refusals by insurers to provide insurance. The higher rates restore profitability, which

attracts new capital into the marketplace, and a new cycle begins.

<u>Effect of Interest Rates on Underwriting Cycle</u>

Underwriting cycles are frequently, but not always, driven by changes in interest rates. In addition, interest rates may prolong an underwriting cycle. The most recent cycle (the longest in history) was probably influenced by both types of effect.

The historically high interest rates which peaked in 1981 permitted substantial rate reductions or, at least, a delay in rate increases as insurers competed for premium dollars to invest. As interest rates declined, premium increases became necessary to offset the effect of reduced investment income.

Within the past two years, interest rates have returned to more normal levels, corresponding with the period of largest price increases as insurers sought to restore overall profitability.

Evidence of their success has been the leveling off of price increases and, in some cases, price decreases as insurers once again expand their underwriting capacity.

Column (2) of Table 19 shows the combined ratio for the insurance industry for the years 1967-1986. The combined ratio relates incurred claims and expenses (other than investment expenses) to premiums. A combined ratio in excess of 100% indicates an underwriting loss while a ratio less than 100% indicates an underwriting profit. Table 19 covers three

TABLE 19

THE PROPERTY-LIABILITY INSURANCE
UNDERWRITING CYCLE
1967-1986

AND FLORIDA MALPRACTICE INSURANCE RATES
1978-1987

(1) Year	(2) Combined Ratio*	(3) FPIC Rates	(4) St. Paul Rates	(5) PPTF Rates
1967	99.5%			
1968	100.9			
1969	101.5			
1970	100.2			
1971	96.7			
1972	96.4			
1973	99.1			
1974	105.9			
1975	108.2			
1976	102.6			
1977	97.7			
1978	97.4	$ 2,680		
1979	100.6	2,486		
1980	103.5	2,177		
1981	106.2	2,857		
1982	110.1	3,393	$ 4,004	
1983	113.3	4,638	4,868	$ 4,433
1984	120.5	5,819	6,414	5,704
1985	117.9	7,541	8,820	8,349
1986	108.1**	14,034	10,115	12,107
1987	103.6***	21,049	20,425	14,663

* After dividends to policyholders.
Source: A.M. Best Co., Best's Aggregates & Averages 1986, p. 76

** Source: A.M. Best Co., Best's Review, July 1987, p. 90.

*** First quarter only.
Source: A.M. Best Co., Best's Review, July 1987, p. 91.

underwriting cycles which include a rather mild cyclical trough in 1969, more severe troughs in 1975 and 1984.

2. The Cycle And Insurance Rates

Column (3) of Table 19 contains medical malpractice rates for Florida Physicians Insurance Company (FPIC) for the years 1978-1987. The trends in rates shown is for a family practice physician (no surgery) in the Miami area, but other specialties and other sections of the state show similar trends.

Note that FPIC's rate reduction in 1979 and 1980 correlates with the rising industry combined ratio. FPIC's rates began rising in 1981, with the rate of increase accelerating sharply and correlating again with the falling industry combined ratio in 1985, 1986 and the first quarter of 1987.

Column (4) of Table 19 shows St. Paul Fire & Marine Insurance Company's Miami rates for a family physician for the years 1982 through the middle of 1987. They follow essentially the same pattern as FPIC's rates. The rates for Physicians Protective Trust Fund (PPTF), shown in Column (5) for the years 1983-1987 also show a similar trend.

The sharp acceleration in rates concurrent with the upturn in the underwriting cycle and the tightened underwriting standards that accompany them are a major exacerbating cause of the crises in medical malpractice insurance during the last three years.

3. Cycles And Affordability

Over the past several years, and especially since the bottom of the underwriting cycle in 1984, the cost of medical malpractice insurance in Florida has increased substantially more rapidly than all other medical care cost indices, shown in Table 20. For example, FPIC's malpractice rates lagged behind all of the consumer price indices for the first three years of the period. Thereafter, the malpractice rate index quickly caught up and passed consumer price indices, so that by May 1987, the malpractice rate index was 4.5 times as high as the CPI-U index, and 3.75 times as high as the medical care price index, even though they all started from the same base in 1978.

The average annual increase in FPIC's rates for the entire period, including the two years in which they declined, was 24.5%. The average annual increase in CPI-U for the period was 6.0% while the annual increase in the medical price index was 8.2%. The physicians' fee index and the hospital index were only available for 1978 through 1985, and their average annual increases for that period were 8.7% and 11.5%, respectively.

With malpractice rates increasing so much more rapidly than physicians' fees, it is apparent that malpractice insurance premiums are absorbing an increasing share of physicians' income, a finding that corroborates the results from the Florida's Physicians Survey. Apparently, the rate increases are occurring so quickly that doctors are unable to immediately pass them on to their patients, causing a reduction in physician net income.

TABLE 20

FPIC MALPRACTICE RATE INDEX AND CONSUMER PRICE INDEXES
1978-1987
1978 = 100

(1) Year	(2) FPIC Malpractice Rate Index	(3) Consumer Price Index (CPI-U)	(4) Medical Care Price Index	(5) Physicians Fee Index	(6) Hospital Service Price Index
1978	100.0	100.0	100.0	100.0	100.0
1979	92.8	111.3	109.3	109.2	111.4
1980	81.2	126.3	121.2	120.7	126.0
1981	106.6	139.4	134.2	134.0	144.7
1982	126.6	148.0	149.8	146.6	167.5
1983	173.1	152.7	162.9	157.9	186.4
1984	217.1	159.2	173.0	168.9	201.8
1985	281.4	164.9	183.7	178.8	213.7
1986	523.7	168.1	197.6		
1987	785.4	173.3	209.2		

4. Underwriting Cycles And Availability

As noted earlier, insurers tighten their underwriting standards and increase rates at the upturn of the underwriting cycle. This occurred in the mid-1970s and resulted in many medical organizations forming their own insurance companies. Florida was no exception, and several self-insurance trusts also were established. Consequently, availability of insurance has not been a problem up to the present time.

The announced withdrawal of The St. Paul Companies and The Cigna Companies from the Florida market may cause some temporary dislocations, but it seems likely that the existing insurers and new insurers now entering the state can take up the slack. The current malpractice crisis has been, and seems likely to remain, a crisis of affordability rather than availability.

5. Can Underwriting Cycles Be Controlled?

It is probably not possible to control the underwriting cycle and avoid its adverse effects on the malpractice insurance market. There are three possible sources of control for underwriting cycles. They are: (1) the insurance industry, (2) the states, and (3) the Federal government.

Control by the industry is highly unlikely in the forseeable future. The industry is composed of a very large number of insurance companies, over 2,000 in total with approximately 900 operating on a national or near-national basis. Effective coordination of the activities of such a large number of sellers

is difficult if not impossible. The cycles were moderated in the years prior to the mid-1950s when company-owned rating bureaus were able to establish and enforce rates, but a return to that system seems unlikely.

No single state represents a sufficiently large part of the national insurance industry to exercise control over the cycles. A state could shield its doctors from the rate fluctuations that accompany the cycle by controlling both rate reductions and rate increases. It would be necessary for the regulatory authorities to mandate necessary rate increases or decreases if the insurers fail to apply for them voluntarily. The result would probably be more stable, but higher rates.

The Federal government could, through rigid control of insurance rates, control the underwriting cycle. Again, the result would be more stable, but probably higher, rates. In any case, the federal government has been moving steadily in the direction of deregulation rather than reregulation.

D. Risk Classification System

A problem which contributes to the rate of premium increase is the risk classification system used in medical malpractice liability insurance. The existing classification system has served a purpose up to this point, but the level of loss payments in certain specialties may have become too large in relation to the number of physicians available to pay for the losses. Stated differently, there may be insufficient spreading of the risk of loss among certain high-risk specialties.

In addition to the risk classes being too small in certain cases, the risk classification system does not appear to provide adequate market based incentives to avoid losses nor does it seem to measure accurately individual exposures to loss. Consequently, physicians with widely differing loss experience and exposure are placed in the same risk pool and charged the same price, even though their expected loss payments are significantly different.

1. Description of Risk Classification

Medical malpractice liability insurance is a financing mechanism by which the cost of administering, determining liability, measuring loss and paying the claim is spread over a group of individuals or organizations. Risk classification is the process by which actuaries analyze this cost and, in conjunction with senior management of the company, determine how to allocate claims costs to groups of risks - in this case physicians. On the basis of some factor or factors, premium

differentials between the groups will then be determined. Once this has been accomplished, the insurer will request approval to use the risk classification plan and its indicated premiums from the Florida Department of Insurance.

2. Purpose of Risk Classification

In making these cost allocations, an attempt is made to group together individuals of similar loss propensity so as to produce a system which is fair and equitable as well as cost effective. In other words, the insurer must try to choose risk classification variables which measure as accurately as possible the likelihood of loss but which also are cost effective to collect and are not subject to manipulation by actual or potential insured's. For example, carrying out a surgical procedure is more likely to produce a claim than is a routine annual physical examination.

3. Risk Classification Variables

The class plan used by the St. Paul Fire and Marine Insurance Company was reviewed by the Task Force and it shows a division of physicians according to medical specialty and surgical activity. Also included are classifications for active military personnel, full-time federal government employees, and retired physicians. The state is also divided into two territories for rate-making purposes. Dade and Broward counties are one territory and the rest of the State is the other territory. No specific factors are included for the physician's level of activity, i.e. number of patients seen per year or the

number of surgical procedures performed per year, nor is there any price adjustment based upon the number and amount of claims incurred by the physician.[1]

4. Number of Practicing Physicians

A total of 25,566 Florida non-federal physicians (i.e., not employed in the military, V.A. hospitals, or in any other capacity by the federal government) were registered with the American Medical Association in 1985 (1986 data was not available at the time of writing). Of this total, 4,271 physicians were classified as inactive, 1,472 were in medical teaching, administration, research or other professional activity and 821 were not classified. Consequently, the AMA reported that in 1985 a total of 20,002 physicians were involved in patient care in Florida as their major professional activity and this figure is presented in Table 21. Comparable figures for previous years are also reported.

Number of Physicians By Specialty. The number of physicians whose major professional activity is patient care is reported for a number of specialties in Table 21. As noted above, medical malpractice liability insurance is rated by specialty so the figures shown in Table 21 represent the financing base for paid and reserved claims and expenses in the state. In some cases, e.g., surgery, the base is even smaller because the risk classes are further subdivided according to the riskiness of the surgical procedures performed.

TABLE 21
NUMBER OF PRACTICING PHYSICIANS IN FLORIDA

	CALENDAR YEAR OF CLOSING											
	1975	1976	1977	1978	1979	1980	1981	1982	1983	1984	1985	1986
	N	N	N	N	N	N	N	N	N	N	N	N
SPECIALTY												
ANESTHESIOLOGY	437	469	579	590	642	705	726	818	897	.	1,005	.
GENERAL PRACTICE	1,767	1,986	2,167	2,239	2,414	2,541	2,497	2,800	2,696	.	3,009	.
GENERAL SURGERY	1,057	1,068	1,162	1,154	1,218	1,267	1,276	1,351	1,422	.	1,516	.
INTERNAL MEDICINE	1,478	1,618	1,868	1,830	2,030	2,138	2,231	2,438	2,534	.	2,921	.
NEUROLOGY & NEUROSURGERY	231	246	283	298	331	337	370	419	446	.	488	.
OBSTETRICS & GYNECOLOGY	791	816	913	934	995	1,060	1,101	1,182	1,249	.	1,354	.
ORTHOPEDICS	479	501	560	574	624	652	673	722	758	.	821	.
OTORHINOLARYNGOLOGY	216	217	259	265	277	290	274	296	315	.	325	.
ALL SPECIALTIES	10,930	11,600	13,163	13,584	14,498	15,486	15,979	17,105	18,101	.	20,002	.

1984 AND 1986 DATA ARE NOT AVAILABLE

SOURCE: AMERICAN MEDICAL ASSOCIATION

Losses Have Increased Faster Than The Number Of Physicians. In certain areas claims paid have grown much faster than the number of physicians available to finance the losses. For example, in the earlier years of 1975, 1976 and 1977 total paid claims in the OB/GYN category amounted to $595,266, $900,335 and $1,497,881 respectively. In comparison, for the later years 1984, 1985 and 1986, paid claims were $17,423,465, $18,394,761 and $14,677,155 respectively. The average total paid has gone from about $1 million in the mid-seventies to $16.8 million in the mid-eighties (this represents a compound growth rate of 32.7 percent per year). During this same time period, the number of OB/GYN physicians in the state has increased from an average of 840 in 1975-1977 to 1354 in 1985, which is a growth rate of 4.9 percent per year.[2]

5. Rate Relativity by Specialty

The difference in rates between certain specialties within a rating territory will be examined in this part of the report. The analysis will show that, for the sample risk classes examined, the relativities for the three major medical malpractice insurance carriers in the State are quite similar. Second, for all three organizations, the spread in rates between the high and low risk classes has increased.

Table 22 shows the relationship between the premiums for three high risk groups and the premium for a low risk category. The first entry in the table (6.33 for 1983) means that the rate for an orthopedic physician in Dade/Broward was 6.33 times

TABLE 22.
Selected Medical Malpractice Rate Relatives: Florida

Dade/Broward	1983	1984	1985	1986	1987
Orthopedics to: Family Physicians-No Surgery					
Florida Physicians Insurance Co.	6.33	6.33	6.72	6.72	7.03
Physicians Protective Trust	6.15	6.33	6.72	6.72	7.03
St. Paul Fire and Marine	6.37	6.55	6.65	6.67	6.69
Obstetrics to: Family Physicians-No Surgery					
Florida Physicians Insurance Co.	7.28	7.28	8.40	8.40	8.79
Physicians Protective Trust	6.13	5.78	6.68	6.83	7.34
St. Paul Fire and Marine	7.41	7.63	8.29	8.33	8.34
General Surgery to: Family Physicians-No Surgery					
Florida Physicians Insurance Co.	5.08	5.08	5.04	5.04	5.27
Physicians Protective Trust	6.13	5.78	6.68	6.83	7.34
St. Paul Fire and Marine	5.32	5.46	4.99	5.01	5.02

Rest of State	1983	1984	1985	1986	1987
Orthopedics to: Family Physicians-No Surgery					
Florida Physicians Insurance Co.	6.15	6.33	6.72	6.72	7.03
Physicians Protective Trust	6.13	6.21	6.68	6.83	7.34
St. Paul Fire and Marine	6.32	6.48	6.59	6.62	6.65
Obstetrics to: Family Physicians-No Surgery					
Florida Physicians Insurance Co.	7.08	7.28	8.40	8.40	8.79
Physicians Protective Trust	6.13	6.21	6.68	6.83	7.34
St. Paul Fire and Marine	7.36	7.55	8.22	8.26	8.31
General Surgery to: Family Physicians-No Surgery					
Florida Physicians Insurance Co.	4.94	5.08	5.04	5.04	5.27
Physicians Protective Trust	6.13	6.21	6.68	6.83	7.34
St. Paul Fire and Marine	5.28	5.41	4.95	4.97	5.00

Note: The rates used by St.Paul Fire and Marine are as follows: 10/1-/83, 9/1/84, 7/1/85, 12/31/85, 7/1/87. The effective dates for rates by Florida Physicians Insurance Company and Physicians Protective Trust Fund are January 1 of the respective year.

Calculations use rates for mature claims - made coverage for $1,000,000 limit of liability per occurance and $3,000,000 annual aggregate. FPIC has rates 50 percent higher in Palm Beach county than in the rest of the state.

Source: Bureau of Rates.

greater than the rate for a family physician performing no surgery in Dade/Broward. The second entry in the same column shows that the Physicians Protective Trust Fund (PPTF) was charging orthopedists a rate which was 6.15 times higher while St. Paul's rate was 6.37 times higher, i.e., there was very little difference in the relationships between the rates. This does not necessarily mean the actual premiums were almost the same, since the base price for each of the three companies can be, and usually was, different.

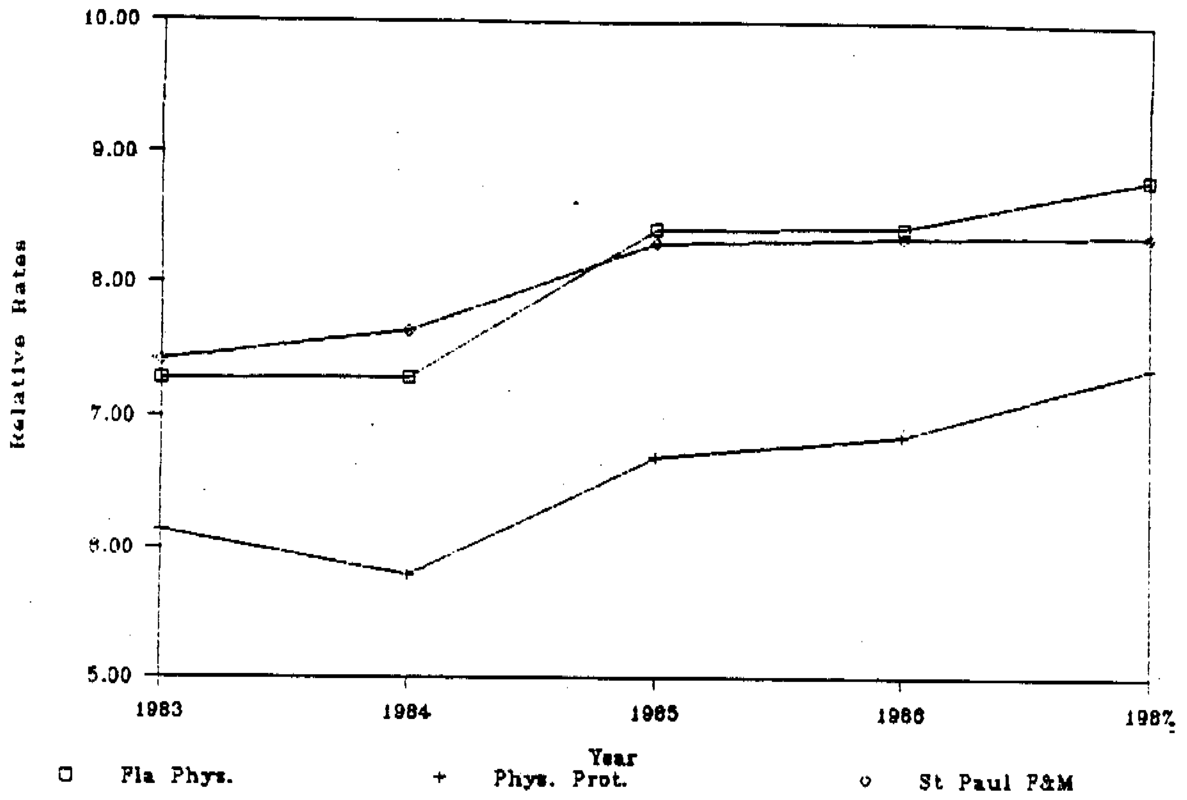
Figure 3 shows how the relationship between obstetrics rates and family physicians rates has changed, i.e., the spread between the rates has increased from 1983 to 1987. Florida Physicians Insurance Company (FPIC) was charging 8.79 times more (as of 1/1/87) compared to 7.28 times more in 1983. The important point here is that the multiple has increased for all companies. This may by relevant, because some proposed reforms would involve changing the differential between high and low risk classes. For example, one Department of Insurance proposal called for a maximum rate which was no more than 5 times greater than the lowest rate. While the data here show that such a proposal could produce rate reductions for high risk specialties, the Task Force has not assessed potential offsetting costs and disadvantages of such a proposal.

6. Rate Relativities Within Florida

This section concerns premium variations among different parts of the state and shows that the rate spread for physicians in Dade/Broward has increased relative to the rest of the State.

FIGURE 3.

Obstetrics Premium Divided by Family Physician-No Surgery Premium for Dade/Broward Counties



Source: Table 22

The first entry in Table 23 means that FPIC charged family physicians in Dade/Broward 41 percent more than they charged family physicians in the rest of the state. By July 1, 1987 they were charging twice as much in Dade/Broward as in the rest of the state. PPTF increased its differential by 25 percentage points during the same time period, while St. Paul held off making a change until July 1, 1987 when it increased the differential by 50 percentage points. These changes are graphed in Figure 4.

7. Summary

This section has been concerned with the factors used to categorize physicians into risk classes and also with the size of the resulting risk classes. It was found that paid losses have increased substantially faster than the number of physicians available to pay them, leading to an inexorable rise in premiums. In addition, it was found that the extra amount charged high risk specialties compared to low risk groups has increased as has the surcharge for Dade/Broward physicians compared to the rest of the State. While the closed claim data indicate that the surcharges are justified, they have contributed to the premium increases for the affected groups.

It was also noted that the risk classification plans in use during the time period studied made no specific provision for experience rating, i.e., there were no specific surcharges for those physicians who had paid claims. Thus, during the time period studied, there were no market price incentives in place for the person best able to control losses (the physician). In

Table 23.
Territorial Rate Differences in Florida
For Selected Medical Specialties*
Dade/Broward Compared to Rest of State

	1983	1984	1985	1986	1987
Family Physicians-No Surgery					
Florida Physicians Insurance Co.	1.41	1.45	1.50	2.00	2.00
Physicians Protective Trust	1.25	1.47	1.50	1.50	1.50
St. Paul Fire and Marine	1.49	1.48	1.48	1.49	1.97
General Surgery					
Florida Physicians Insurance Co.	1.45	1.45	1.50	2.00	2.00
Physicians Protective Trust	1.25	1.37	1.50	1.50	1.50
St. Paul Fire and Marine	1.50	1.50	1.50	1.50	1.99
Orthopedics					
Florida Physicians Insurance Co.	1.45	1.45	1.50	2.00	2.00
Physicians Protective Trust	1.25	1.37	1.50	1.50	1.50
St. Paul Fire and Marine	1.50	1.50	1.50	1.50	1.99
Obstetrics					
Florida Physicians Insurance Co.	1.45	1.45	1.50	2.00	2.00
Physicians Protective Trust	1.25	1.37	1.50	1.50	1.50
St. Paul Fire and Marine	1.50	1.50	1.50	1.50	1.99

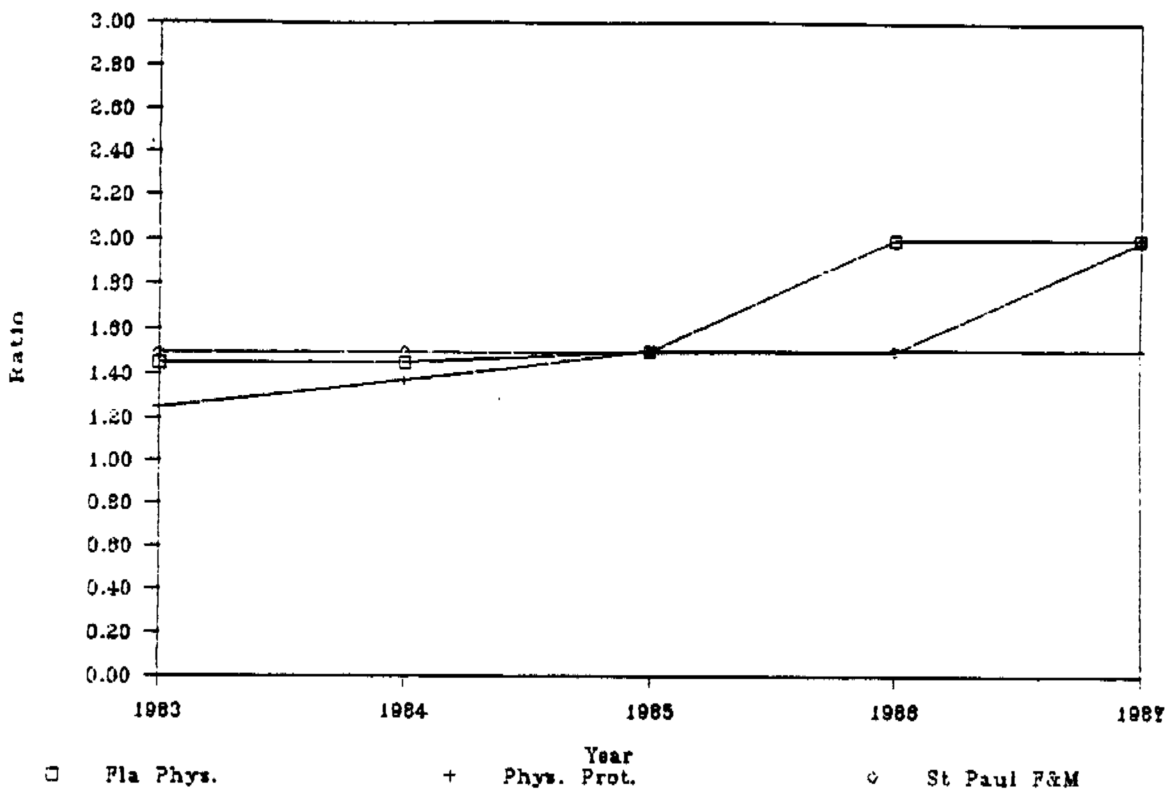
* Note: The rates used by St.Paul Fire and Marine are as follows: 10/1-/83, 9/1/84, 7/1/85, 12/31/85, 7/1/87.
The effective dates for rates by Florida Physicians Insurance Company and Physicians Protective Trust Fund are January 1 of the respective year.

Calculations use rates for mature claims - made coverage for $1,000,000 limit of liability per occurance and $3,000,000 annual aggregate. FPIC has rates 50 percent higher in Palm Beach county than in the rest of the state.

Source: Bureau of Rates.

FIGURE 4.

Obstetrics Premiums in Dade/Broward Compared to Obstetrics Premiums in the Rest of the State



Source: Table 23

addition, the risk classification system did not allocate specifically a portion of the claims costs to the group that generated them.

FOOTNOTES
II. D.

1 The Tort Reform and Insurance Act of 1986 created a new statute §627.6055 which requires that rates reflect the number of surgical procedures performed each year by individual health care providers as well as their claims experience.

2 It should be emphasized that the average paid claim per physician SHOULD NOT be compared to current premiums because paid claims do not include amounts for: (1) reserves for unpaid losses, (2) reserves for incurred but unreported claims, (3) insurer expenses and profit, and (4) contingent liabilities for FMMJUA losses. Also, these figures cannot be compared with current rates because the paid claim data does not breakout the type of surgical activity involved whereas the class plan noted above distinguishes between no surgery, minor surgery and surgery.

III. FURTHER EXAMINATION OF INCREASED CLAIM PAYMENTS

Part II. A. of this report concludes that increased loss payments for medical malpractice have been the principal cause of increased liability insurance premiums. This part of the report will undertake a more detailed examination of the reasons for increased loss payments. First, it will break out the statistical components of loss payments in term of claims frequency, claims severity, and physicians with multiple claims, in order to identify the relative importance of their respective contributions to increased loss payments. Second, this part of the report will discuss the role of the legal system, including litigation trends, changes in tort liability rules, and attorneys' fees and other litigation costs. Finally, this part of the report will consider other factors that may have influenced medical malpractice claims and litigation frequency.

A. Components of Increased Loss Payments

This report has shown previously the increase in total loss payments for medical malpractice which took place in Florida during 1975 to 1986. During the last half of the 1970's total loss payments were virtually constant. In 1980, an extremely rapid rise in loss payments began which probably peaked in 1984.[1] The stability of the 1970's was due to a decline in the number of claims. This was followed by a swift increase in the number of paid claims through 1985. During the entire period under review, there has been a strongly upward trend in the amounts of claim

payments, although there were fluctuations from one year to the next.

It is important to understand what caused the increase in total loss payments because different cost control techniques may be warranted depending upon whether frequency or severity has driven up costs. If costs are rising due to increased frequency of claims, then possible solutions include means of reducing the number of iatrogenic injuries, reducing the incentives for making claims, or controlling the conditions and circumstances under which liability is assessed against physicians or hospitals. If the rise in the cost of each incident is responsible for increased loss payments, then possible solutions include ways of reducing the severity of medical injuries, reducing the costs resulting from medical injuries, or controlling the amount of jury awards and settlements. When increased frequency and severity are both causing costs to increase, a more complex package of changes may be necessary in order to have a substantial impact on loss payments.

1. Increased Claims Frequency

a. Data Source

During the mid 1970's, Florida experienced a problem with regard to both availability and affordability of medical malpractice liability insurance. Effective in 1975, the Florida Legislature passed a law requiring all medical malpractice insurers in the State to report closed claim information on physicians to the Department of Insurance. Approximately

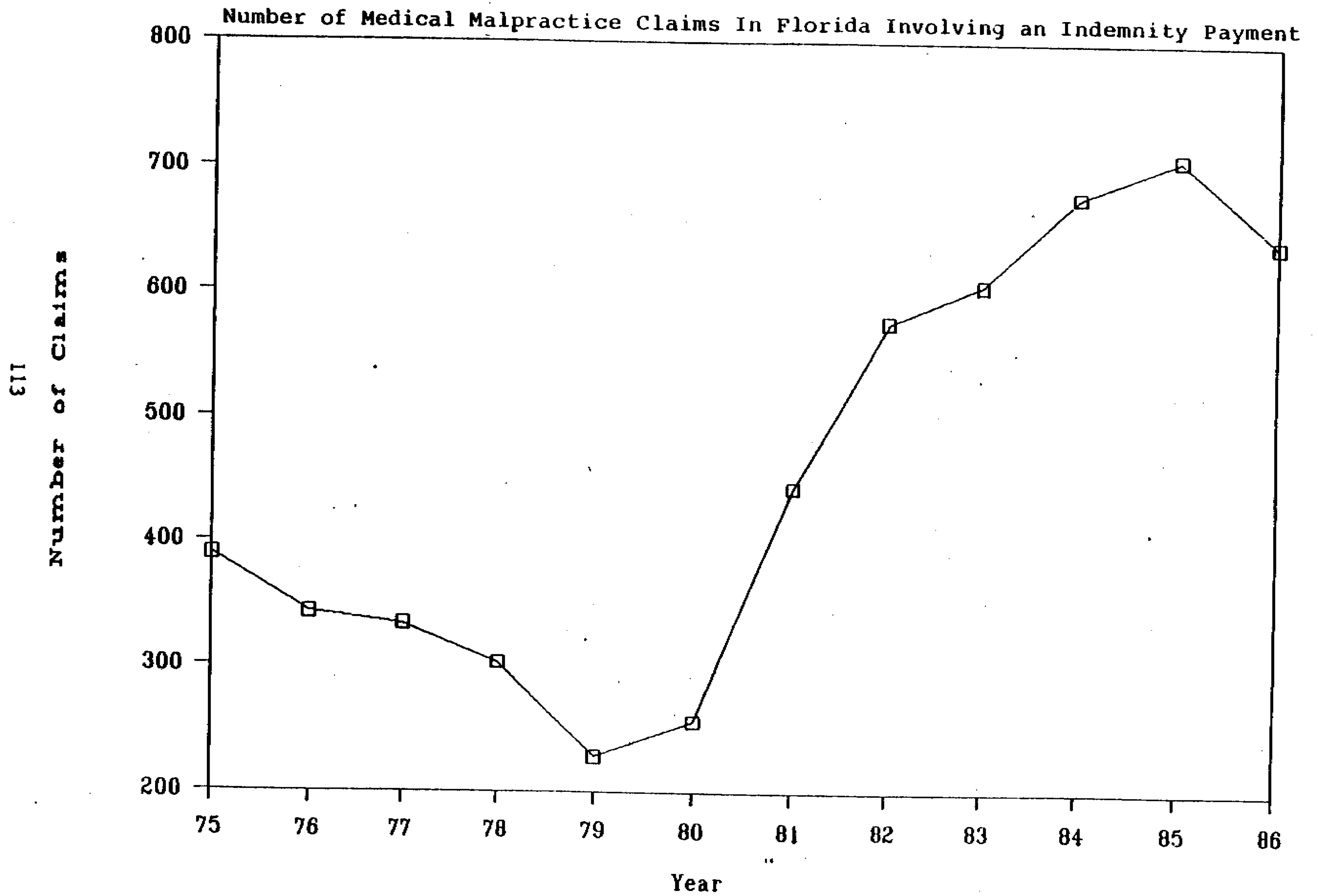
21,000 claims for the period 1975-1986 were reported to the Department, of which 5503 claims involved an indemnity payment.[2] This section is an analysis of those claims.

b. Number of Claims Closed

Without any adjustments to the data for changes in the number of physicians practicing in the state or for population growth, the number of closed claims in Florida, as illustrated in Figure 5, is increasing at a rate of approximately 4.6 percent per year. When the year to year changes are examined, there is a steady decline in the number of claims closed each year between 1975 and 1979 at an annual compound rate of 12.5 percent, followed by a sharp increase between 1979 and 1986, at an annual compound rate of 15.9%. The 1986 figure was significantly lower than 1985, but this was partially due to a lengthening of the time between incident occurrence and the settlement date. Consequently, there is nothing to indicate at this point that the number of claims will either stabilize or continue to decline.

Impact of Mandatory Mediation. The decline in the number of closed claims from 1975 to 1979 probably was caused by legislation requiring mediation of medical malpractice claims. It was enacted in 1975 in an effort to control the cost of claims by reducing the adversarial nature of the claims settlement process. In addition, it was hoped that mediation would result in more

FIGURE 5



Source: Florida Department of Insurance Medical Malpractice Closed Claim Data Set

claims being resolved without legal action, thereby reducing the burden on the courts and decreasing the time required to resolve those claims which might otherwise involve trials and the delay associated with trials.

The constitutionality of the mandatory mediation provision was challenged in court. This created uncertainty for the plaintiffs' bar as to whether to accept a mediated award or wait, in the expectation that the mediation requirement would be declared unconstitutional. As a result, the average time to resolve a claim apparently increased. In 1980, the mediation rule was eliminated, and the surge in claims in the early 1980's probably was due in large part to the processing of these earlier cases. If this analysis of the impact of the mandatory mediation rule is accepted, the period 1975 through 1982 should probably be viewed in its entirety without focusing on year-to-year changes. If this is done, the claims rate is relatively stable during this time, with---perhaps---a slight upward trend.

c. Adjusted Trends in Frequency.

Since 1975, the state's population has increased 35 percent, from 8.6 million to 11.7 million in 1986.[3] Part of the increase in the number of claims filed and paid probably is due to this population growth. Increases in frequency beyond that attributable to population increase may be caused by an increase in the iatrogenic injury rate, an increased claims propensity on the part of the general public, or other factors.

Frequency per 100,000 Population. Table 24 shows the number of claims closed each year in which an indemnity payment was made. This figure was then divided by the State's population to obtain the claims rate per 100,000 people. On average during this time period, there were 4.56 claims paid per 100,000 people and the upward trend in frequency noted above persisted even after adjusting for population change, but it was at a much more modest rate. Overall, the growth rate in claims per 100,000 people from 1975 to 1986 was 1.8 percent per year. The frequency of claims per 100,000 people actually decreased at an annual compound rate of 14.5 percent per year from 1975 to 1979, but increased at an annual compound rate of 12.5 percent from 1979 through 1986. Once again, the Task Force believes that the entire eleven year period probably should be considered as a whole as a result of the impact of the litigation surrounding the mandatory mediation provision.

Frequency per 100 Physicians. The figures also were analyzed by adjusting for the increasing number of physicians practicing in the State.[4] During the period that Florida's population increased by 35 percent, the number of physicians practicing in the state grew by 95 percent (see Table 24). As a result of this relatively greater growth in the number of physicians compared to population, the closed claims rate per physician has remained virtually unchanged from 1975 to 1986. The rates vary markedly from specialty to specialty, however.

Table 25 shows that for all specialties, the average number of paid claims per 100 physicians per year was 2.75. The average

TABLE 24.
ADJUSTED MEDICAL MALPRACTICE
CLOSED CLAIMS RATES

	1975	1976	1977	1978	1979	1980	1981	1982	1983	1984	1985	1986
Number of Indemnity Claims (All Specialties)	389	343	334	303	229	256	443	576	606	677	708	640
Population (Florida) (000's)	8,619	8,744	8,920	9,157	9,449	9,747	10,106	10,375	10,592	10,930	11,298	11,655
Number of Practicing Physicians	10,930	11,600	12,163	13,584	14,498	15,486	15,979	17,105	18,101	*	20,092	*
Claims Rate Per 100,000 People	4.51	3.92	3.74	3.31	2.41	2.63	4.39	5.55	5.72	6.19	6.27	5.49
Claims Rate Per 1,000 Physicians	3.56	2.96	2.54	2.23	1.57	1.65	2.77	3.37	3.35	NA	3.54	NA

* Figures Not Reported by AMA

Sources: Department of Insurance Medical Malpractice Closed Claims Data Set; Bureau of Economic and Business Research, College of Business; American Medical Association, Various Bulletins.

TABLE 25
NUMBER OF MEDICAL MALPRACTICE PAID CLAIMS PER 100 PHYSICIANS: FLORIDA

	CALENDAR YEAR OF CLOSING												
	1975	1976	1977	1978	1979	1980	1981	1982	1983	1984	1985	1986	ALL YEARS
	$	$	$	$	$	$	$	$	$	$	$	$	$
SPECIALTY													
ANESTHESIOLOGY	5.72	5.33	1.73	2.20	0.62	1.56	2.34	4.16	4.91	.	2.89	.	3.15
GENERAL PRACTICE	3.96	2.87	3.05	1.38	1.57	1.14	2.12	1.89	2.46	.	2.23	.	2.27
GENERAL SURGERY	6.05	5.43	4.30	4.51	2.22	1.89	3.61	5.26	3.80	.	4.29	.	4.14
INTERNAL MEDICINE	1.96	0.74	1.28	0.60	0.59	0.75	1.03	1.76	1.82	.	1.61	.	1.21
NEUROLOGY & NEUROSURGERY	6.06	2.85	3.89	4.03	2.11	2.67	6.22	5.25	4.48	.	5.53	.	4.31
OBSTETRICS & GYNECOLOGY	5.31	5.02	5.81	4.71	3.42	3.68	4.90	5.25	6.73	.	8.05	.	5.29
ORTHOPEDICS	6.68	6.39	4.82	3.31	4.17	3.37	5.79	8.31	8.71	.	9.99	.	6.15
OTORHINOLARYN-GOLOGY	5.09	6.91	3.47	1.89	0.36	2.76	6.57	5.41	4.76	.	4.31	.	4.15
ALL SPECIALTIES	3.56	2.96	2.54	2.23	1.67	1.65	2.77	3.37	3.35	.	3.54	.	2.75

SOURCES: 1) FLORIDA DEPARTMENT OF INSURANCE MEDICAL MALPRACTICE CLOSED CLAIMS DATA SET
2) AMERICAN MEDICAL ASSOCIATION

number of paid claims per 100 physicians was 92% greater for obstetricians and 225% greater for neurologists than the average physician. In recent years however, the differential for obstetrics was much greater. Major specialties with an apparent downward trend in the number of paid claims per 100 physicians include Anesthesiology, General Practice and General Surgery.

d. Statewide Geographical Variations In Frequency.

Although the long-term growth rate in closed claim frequency adjusted for statewide population growth is low, there are marked variations in the growth rates in different parts of the State. Table 26 shows the closed claim frequency in counties whose 1986 population exceeded 250,000 as well as the statewide average closed claim frequency. Smaller counties were excluded from the analysis because their claims frequency may be too low to provide meaningful results.

The counties in the table are arranged in descending order based upon the average claims rate for the 1975-1986 time period. Four counties---Broward, Dade, Orange and Hillsborough---had a claims frequency above the statewide average. Moreover, the closed claims frequency for Broward county increased rapidly. In 1975, Broward county claims frequency was 49 percent greater than the statewide average. By 1986, it was 109 percent greater than the average for the state. Dade and Hillsborough counties also experienced rising claims rates during this time period. Orange county is a notable exception to the pattern of rapidly increasing claims frequency, because no clear upward trend in

TABLE 26
MEDICAL MALPRACTICE CLOSED CLAIMS (INDEMNITY CLAIMS ONLY)
PER 100,000 OF POPULATION: FLORIDA
COUNTIES WITH 1986 POPULATIONS GREATER THAN 250,000

PAID CLAIMS PER 100,000 PEOPLE	CALENDAR YEAR OF CLOSING												
	MEAN	1975	1976	1977	1978	1979	1980	1981	1982	1983	1984	1985	1986
	CLAIM RATIO	CLAIM RATIO	CLAIM RATIO	CLAIM RATIO	CLAIM RATIO	CLAIM RATIO	CLAIM RATIO	CLAIM RATIO	CLAIM RATIO	CLAIM RATIO	CLAIM RATIO	CLAIM RATIO	CLAIM RATIO
COUNTY													
BROWARD	8.36	6.73	4.92	5.53	4.83	4.05	4.91	7.83	11.15	12.68	13.90	11.74	12.01
DADE	6.51	6.82	6.16	4.95	6.09	3.26	3.51	6.46	8.04	8.17	10.38	7.45	6.81
ORANGE	5.59	6.88	5.76	7.06	6.68	2.82	2.76	4.15	6.06	5.52	7.35	5.95	6.06
HILLSBOROUGH	4.87	3.64	4.15	4.13	2.76	2.85	1.85	5.29	4.72	5.05	7.20	9.75	7.09
ALL OF FLORIDA	4.51	4.51	3.92	3.74	3.31	2.41	2.63	4.38	5.55	5.72	6.19	6.27	5.49
PINELLAS	4.34	5.69	3.39	3.20	3.28	2.24	2.88	4.31	5.95	6.91	6.26	4.50	3.43
PALM BEACH	4.27	3.32	4.93	4.43	2.14	1.84	3.12	3.25	5.80	6.90	5.13	4.91	5.45
DUVAL	4.25	7.04	3.33	2.82	2.29	2.63	4.55	6.08	4.31	4.60	4.62	4.65	4.03
SARASOTA	4.01	2.43	4.80	4.64	3.29	3.10	0.99	3.82	4.18	5.82	2.16	6.30	6.54
VOLUSIA	3.46	1.83	4.02	0.87	2.94	2.02	1.93	5.22	3.61	4.92	3.72	3.58	6.90
POLK	3.18	3.10	3.39	3.34	2.31	1.28	2.80	3.02	5.31	2.32	2.81	6.83	1.59
PASCO	2.95	2.82	3.35	3.21	0.61	1.69	1.55	2.44	3.78	4.13	1.77	5.57	4.49
BREVARD	2.94	4.05	4.91	0.80	2.74	1.14	1.10	1.42	3.69	2.59	2.17	5.90	4.76
LEE	2.41	.	0.61	0.59	1.10	2.59	1.46	2.33	4.84	2.12	1.99	4.92	3.97
ESCAMBIA	1.78	.	0.44	1.74	2.17	1.29	0.43	0.84	1.63	2.00	0.78	5.67	2.56

SOURCE: FLORIDA DEPARTMENT OF INSURANCE MEDICAL MALPRACTICE CLOSED CLAIMS DATA SET

frequency is apparent in spite of its increasing population and urbanization during this time period.

Trends In The Most Recent Three Years. Figures for the most recent three years are more important than older data, because under state law they have more influence on premium prices than older data. The most recent three years (1984-1986) show that average frequency for indemnity claims in Broward county is more than twice as great as the statewide average. Dade county has a lower frequency than Broward, but it is still substantially above the statewide average. A number of other urban counties in the state appear to be catching up to and in some cases surpassing the statewide average. For example, Hillsborough county is exhibiting a strong upward trend in frequency and now has passed the statewide average. Other counties with an apparent upward trend in frequency are Palm Beach, Sarasota, Volusia, Pasco, Lee and Escambia counties. Orange, Pinellas, Duval and Brevard seem to be relatively stable as of the end of 1986. The higher frequency trends now appearing in other parts of the state may result in malpractice insurers realigning rating territories in the future.

Dade/Broward Compared With The Rest Of The State. As noted above in the discussion of risk classification plans, insurers divide the state into two parts for rating purposes. Dade/Broward is one territory while the rest of the state is combined to form the other territory. Accordingly, the Task Force staff also analyzed frequency of paid claims per 100,000 of population by

grouping Dade/Broward figures and then combining the other 65 counties of the state into another category. These results in Table 27 provide a very interesting pattern. During the 1975 - 1986 period, the frequency of paid claims in Dade/Broward counties has been twice as large as the rest of the state. Moreover, there is no evidence that this trend has "exploded" in recent years although the average frequency in the last three years has exceeded the long term average.

The premium rate differential for Dade/Broward is justified based upon the closed claim analysis of claims frequency. Further, looking only at the frequency data, it seems that an even higher differential in rates between Dade/Broward and the rest of the state may have been justified. However, rates charged by each company are dictated to a large extent by their individual experience and these unique differences undoubtedly account for the observed lower differential in rates between different parts of the state.

e. Analysis by Specialty.

Since malpractice rates vary according to specialty, it is important to analyze the data to determine which specialties account for most of the claims. Table 28 displays the proportion of claims closed by specialty with the specialties ranked in descending order according to the proportion of claims closed over the entire period. The last two columns show the contribution each specialty has made to the total number of claims.

TABLE 27
FLORIDA MEDICAL MALPRACTICE
FREQUENCY OF OF CLAIMS PER 1,000 OF POPULATION

	CALENDAR YEAR OF CLOSING												
	MEAN	1975	1976	1977	1978	1979	1980	1981	1982	1983	1984	1985	1986
	CLAIM COUNT	CLAIM COUNT	CLAIM COUNT	CLAIM COUNT	CLAIM COUNT	CLAIM COUNT	CLAIM COUNT	CLAIM COUNT	CLAIM COUNT	CLAIM COUNT	CLAIM COUNT	CLAIM COUNT	CLAIM COUNT
TERRITORY													
DADE/BROWARD	0.07224	0.06785	0.05700	0.05170	0.05608	0.03558	0.04047	0.06978	0.09227	0.09897	0.11740	0.09121	0.08854
ALL OF FLORIDA	0.04512	0.04514	0.03923	0.03744	0.03309	0.02413	0.02626	0.04384	0.05552	0.05721	0.06194	0.06272	0.05490
THE REST OF THE STATE	0.03527	0.03650	0.03249	0.03203	0.02439	0.01982	0.02097	0.03406	0.04196	0.04207	0.04242	0.05295	0.04363

SOURCES: 1) FLORIDA DEPARTMENT OF INSURANCE MEDICAL MALPRACTICE CLOSED CLAIMS DATA SET
2) FLORIDA STATISTICAL ABSTRACT

TABLE 28.
PROPORTION OF MEDICAL MALPRACTICE CLAIMS CLOSED IN FLORIDA FROM 1975 TO 1986

Specialty	1975	1976	1977	1978	1979	1980	1981	1982	1983	1984	1985	1986	Total % 75-86	Cumulative Percent of Total
Obstetrics & Gynecology	10.8	12.0	15.9	14.5	14.9	15.2	12.2	10.8	13.9	15.4	15.4			
General Practice	18.0	16.6	19.8	10.2	16.7	11.3	12.0	9.2	10.9	8.3	9.5	13.1	13.63	13.63
General Surgery	16.5	16.9	15.0	17.2	11.8	9.4	10.4	12.3	8.9	9.9	9.2	13.3	12.19	25.82
Orthapedics	8.2	9.3	8.1	6.3	11.4	8.6	8.8	10.4	10.9	9.5	11.6	8.9	11.54	37.36
Internal Medicine	7.5	3.5	7.2	3.6	5.3	6.3	5.2	7.5	7.6	8.1	6.6	12.5	9.98	47.34
Emergency Room	0.8	0.6	1.8	4.6	8.8	8.6	8.8	8.9	5.9	7.8	5.8	7.3	6.63	53.97
Osteopathy	6.2	3.2	1.5	6.3	6.6	12.1	7.4	7.3	5.8	4.3	4.1	3.6	5.63	59.60
Anesthesiology	6.4	7.3	3.0	4.3	1.8	4.3	3.8	5.9	7.3	6.5	4.1	0.0	4.96	64.56
Radiology & Roentgenology	4.9	3.5	5.4	3.0	3.5	4.3	5.0	4.0	5.9	4.9	6.1	2.7	4.96	69.53
Neurology & Neurosurgery	3.6	2.0	3.3	4.0	3.1	3.5	5.2	3.8	3.3	3.1	3.8	5.3	4.87	74.40
Pediatrics	2.3	3.8	2.4	3.6	2.2	1.6	4.3	5.2	2.1	2.7	4.1	2.7	3.45	77.85
Plastic Surgery	2.8	5.8	2.7	3.6	1.8	2.7	2.0	2.6	3.0	2.5	3.4	3.6	3.31	81.16
Otorhinolaryngology	2.8	4.4	2.7	1.7	0.4	3.1	4.1	2.8	2.5	3.5	2.0	3.1	3.00	84.15
Cardiolovascular	2.3	1.5	1.8	2.3	1.8	0.4	2.7	1.0	3.1	2.1	3.0	2.8	2.80	86.95
Urology	1.3	1.2	3.9	1.7	3.1	4.3	1.4	1.6	2.6	2.4	2.7	4.7	2.44	89.39
Opthamology	1.3	2.9	0.6	1.7	0.9	2.3	0.7	1.6	2.5	2.4	1.7	2.0	2.25	91.64
Dermatology	1.8	0.6	2.7	7.3	3.5	0.0	1.8	2.1	1.7	1.6	1.0	2.2	1.80	93.44
Thoracic Surgery	1.0	2.3	0.6	1.0	0.9	0.4	1.8	0.9	0.3	1.3	1.0	0.3	1.78	95.22
Pathology	0.0	0.3	0.6	0.3	0.4	1.6	1.4	0.9	0.3	1.0	1.8	1.6	1.11	96.33
Gastroeternology	0.0	0.3	0.0	1.0	0.0	0.0	0.0	1.0	0.5	1.0	1.3	1.6	0.94	97.27
Not Classified	0.0	0.6	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.6	1.6	0.71	97.98
Psychiatry	0.8	0.6	0.9	1.3	0.4	0.0	0.5	0.2	0.0	0.3	0.4	4.7	0.65	98.64
Nephrology	0.0	0.6	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.9	0.0	0.5	0.44	99.07
Endocrinology	0.0	0.0	0.0	0.0	0.0	0.0	0.2	0.2	0.8	0.0	0.3	0.5	0.20	99.27
Proctology	0.0	0.0	0.0	0.7	0.4	0.0	0.2	0.0	0.2	0.0	0.1	0.0	0.16	99.44
Allergy	0.0	0.3	0.0	0.0	0.4	0.0	0.0	0.0	0.0	0.1	0.4	0.0	0.11	99.55
Hematology	0.3	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.1	0.0	0.0	0.11	99.65
Physical Medicine & Rehab	0.3	0.0	0.0	0.0	0.0	0.0	0.2	0.0	0.0	0.1	0.0	0.5	0.09	99.75
Pulmonary Diseases	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.1	0.0	0.3	0.09	99.84
Oncology	0.3	0.0	0.3	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.6	0.07	99.91
Public Health	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.1	0.0	0.05	99.96
Rheumaltology	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.1	0.0	0.0	0.02	99.98
	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.2	0.02	100.00
Totals	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	

Source: Florida Department of Insurance Medical Malpractice Closed Claims Data Set.

Obstetrics and Gynecology have accounted for about 14 percent of all indemnity claims over the entire period, followed by General Practice, General Surgery, Orthopedics and Internal Medicine. These five specialities account for over one-half of the claims in which indemnity was paid. These proprotion of paid claims by specialty are shown on Table 28.

Changes Over Time. For the five major specialities mentioned above, the proportion of the total number of claims accounted for by General Practice and General Surgery have declined since 1975, and the proportion of claims from Internal Medicine has remained relatively stable. Significantly, Obstetrics and Gynecology and also Orthopedics are an increasing proportion of an increasing number of claims.

f. Time Lag From Occurrence Date To Closure Date.

This section will examine the time elapsed from the date of occurrence to the date a claim was closed. It is important to study this issue because it has been charged that insurers delayed the closing of claims during times of high interest rates in order to gain extra investment income. This time lag also may help to explain why the number of claims closed in Florida during 1975-1979 declined, while it is generally perceived that during recent decades the frequency of claims is increasing rather than decreasing.

The time lag from occurrence date to closure date lengthened from 1975-1979, and this was a major cause of the decline in the

number of closed claims during this time period.[5] After peaking in 1979, the time lag declined until 1983 when it again began to increase. A review of interest rate data provides conflicting evidence regarding the claim that there is widespread deliberate delay in paying claims due to high interest rates. Such a policy would be a two-edged sword, in the sense that the delay would also involve a risk that the value of the claim might rise more than the additional investment income gained. The mandatory mediation requirement and its subsequent elimination probably had more of an impact on closure rates than has any conscious, widespread insurance industry policy to dealy closing cases in order to earn additional investment income.

g. Summary.

This section of the report has described what has happened to the number of medical malpractice claims paid in Florida during 1975 to 1986. The average annual compound increase in the number of paid claims has been almost 5 percent. After adjusting for population growth in the state, there has still been an increase in the frequency of paid claims but not of the sort which could be characterized as "explosive".

There has not been a steady year-to-year increase. Rather, the past eleven years should be divided into two distinct time periods: 1975-1979 during which paid claims steadily declined, and 1979-1985 during which the number of paid claims steadily increased. The initial decline was probably caused by the mandatory mediation rule which created a backlog of during from the 1975-1979 period; these cases then were cleared during 1980

and 1981, accounting for the huge increase in paid claim during those two years. Averaging the closure rate over the entire period of 1975-1986 smooths out such factors and shows a growth rate in paid claims of about 5 percent per year. It does not appear that the patterns in claims closure rates is caused by widespread insurance industry policy to adjust closure rates in response to interest rates.

There is a marked differential in claims frequency between Dade/Broward counties and the rest of the state. On a population adjusted basis, the claims frequency in Dade/Broward has averaged about twice that of the rest of the state during 1975 - 1986. However, several urbanized counties in the state have exhibited a clear upward trend in frequency, although Orange county was a notable exception to this development.

2. Increased Claims Severity

Total paid claims in a given year equal the number of claims paid (frequency) times the cost per claim (severity). The previous section of this report described what has happened to the number of paid claims in Florida. This section will analyze what has happened to the cost of those claims in which an indemnity payment was made. It will show that the rate of increase in severity has been much higher than the rate of increase in frequency. Consequently, the increase in total paid claims is due more to growth in severity than growth in frequency. Stated differently, higher insurance company

settlements are a more important cause of increased medical malpractice insurance rates than are the higher number of paid claims.

The closed claim data also show that the severity increase is due to both more of the largest category of paid claims, as well as an increase in the number of paid claims in the medium to large range. Finally, average severity in Dade/Broward counties is higher than average severity in the rest of the state. However, while average frequency in Dade/Broward has been almost twice as high as the rest of the state, average severity has averaged only about 15 percent higher than the rest of the state. During 1984 to 1986, however, average severity was much higher than the long term average. In other words, compared to the rest of the state, people in Dade/Broward seem to have been more claims conscious during the entire 1975 -1986 period, but it is only recently the average costs of paid claims have accelerated relative to the rest of the state.

These conclusions have important cost control implications, because it suggests that effective measures to reduce frequency will have relatively more impact in south Florida while effective measures to control severity will have statewide impact. If the legislature is concerned with decreasing the total costs of the malpractice system (as opposed to redistributing them), and if the Legislature's primary concern is with the more acute problems being experienced in Dade and Broward Counties, measures to reduce both frequency and severity might be needed. On the other

hand, measures to reduce severity might be effective in reducing total claims costs for the rest of the state.

a. Average Cost Per Claim.

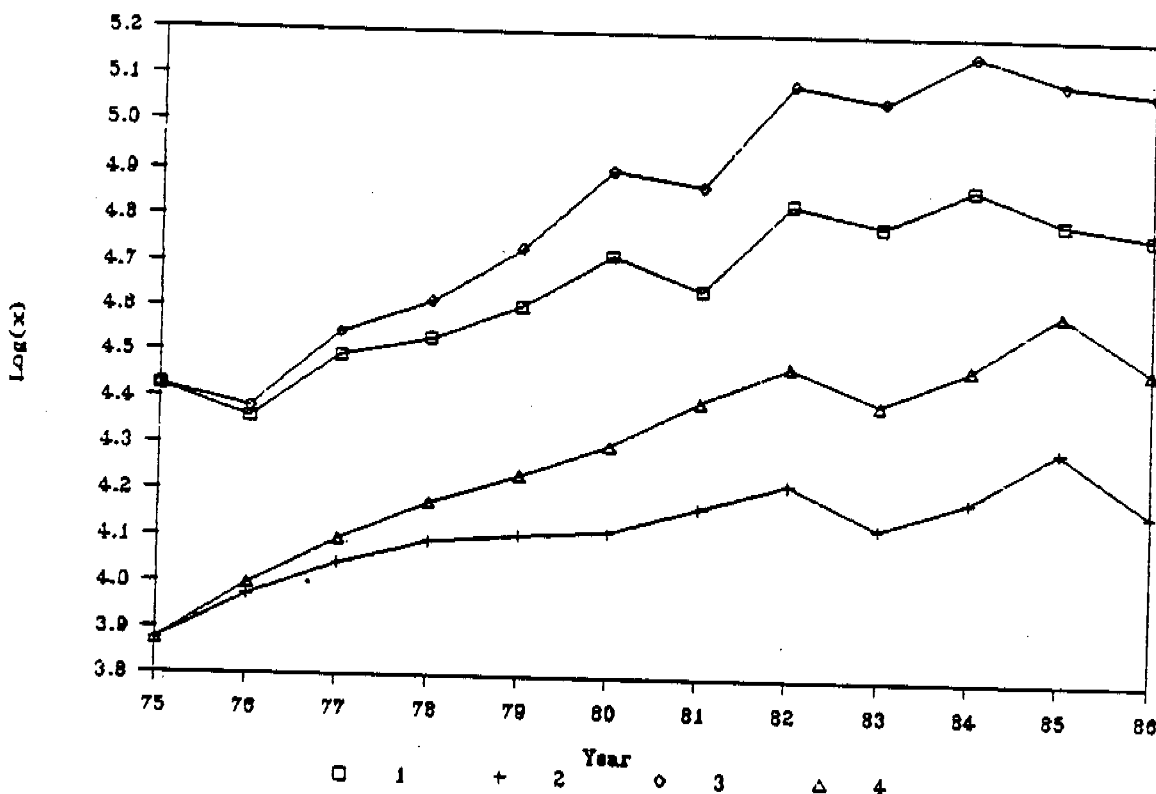
Figure 6 graphs the average cost as well as the median cost per claim for all medical specialties. Two points should be noted concerning the average cost. First, average severity grew at a compound annual rate of almost 15 percent from 1975 to 1986. Second, 1984 may have been the peak year in the current cycle for average severity although it is not possible to be certain of this because there may be some unpaid excess claims for 1986.

Cost Differences Among Specialties. Table 29 shows the average annual claims cost and the median cost for many specialties during the years 1975 to 1986. Many cases could be selected from this table to illustrate the extent to which the average cost of a paid claim has increased, but only a few will be discussed here. Pediatrics provides the most striking example of what has happened in Florida, because the average cost of a claim in this specialty has increased over $300,000 from 1975-1986. This corresponds to an annual compound growth rate of 18.5 percent, or, the average cost of a pediatrics claim was doubling approximately every 3.9 years during the time period studied.

Other major specialties with a substantial increase in the average claims cost during the same time period were Neurology (increase of $194,000), Anesthesiology (increase of $180,000), Pathology (increase of $164,000) and Obstetrics and Gynecology

Figure 6.

Mean and Median Paid Medical Malpractice Claims in Florida: All Specialties.



(Figures plotted are the natural logarithms of each number).

KEY

1. Mean, Adjusted for Inflation
2. Median, Adjusted for Inflation
3. Mean, Unadjusted for Inflation
4. Median, Unadjusted for Inflation

Note: This graph plots the logarithm of each number to show that the growth rates of both the average and the median are high (the steeper the slope of the line, the higher the growth rate).

Source: Calculated from the Florida Department of Insurance Medical Malpractice Closed Claims Data Set.

TABLE 29.
MEAN AND MEDIAN MEDICAL MALPRACTICE CLAIMS: FLORIDA
(Figures Include Paid Claims Only and are Unadjusted for Inflation)

Specialty		1975	1980	1984	1985	1986	Change 1975-1986
ANEST	MEAN	43,014	137,954	225,928	144,579	222,683	179,669
	MEDIAN	15,000	70,000	27,500	57,500	66,650	51,650
CARDI	MEAN	18,144	162,500	86,849	140,106	60,473	42,329
	MEDIAN	7,500	162,500	29,584	50,000	25,000	17,500
EMERG	MEAN	3,517	74,131	73,678	71,093	55,485	51,968
	MEDIAN	1,800	13,750	15,000	10,000	8,500	6,700
GPRAC	MEAN	16,768	94,560	103,734	149,571	81,296	64,528
	MEDIAN	5,000	25,000	35,000	55,000	25,000	20,000
GSURG	MEAN	26,142	40,262	83,338	98,351	79,704	53,562
	MEDIAN	10,000	11,250	30,000	37,500	37,500	27,500
INTER	MEAN	40,141	45,885	170,095	173,669	132,611	92,470
	MEDIAN	12,000	16,250	35,000	75,000	32,500	20,500
NEURO	MEAN	34,352	25,867	468,424	192,095	228,220	193,868
	MEDIAN	12,000	10,000	40,000	50,000	100,000	88,000
OBGYN	MEAN	14,173	96,261	167,533	168,759	174,728	160,555
	MEDIAN	5,500	28,500	48,388	40,000	40,000	34,500
ORTHO	MEAN	21,822	73,396	147,838	121,238	116,904	95,082
	MEDIAN	12,500	26,476	30,000	46,500	25,000	12,500
OSTEO	MEAN	33,899	96,388	209,362	91,933		(33,899)
	MEDIAN	12,125	37,500	60,000	50,000		(12,125)
PEDIA	MEAN	55,738	27,393	382,485	102,539	359,779	304,041
	MEDIAN	20,000	4,750	65,000	20,000	63,028	43,028
PSYCH	MEAN	26,083		13,750	39,333	31,945	5,862
	MEDIAN	20,000		13,750	50,000	33,334	13,334
RADIO	MEAN	36,055	146,781	122,289	109,085	149,293	113,238
	MEDIAN	2,500	27,390	30,000	35,000	10,833	8,333
THORA	MEAN	84,375	9,130	102,130	56,107	243,278	158,903
	MEDIAN	36,250	9,130	25,000	12,500	137,500	101,250

Source: Florida Department of Insurance Medical Malpractice Closed Claims Data Set.

(increase of $161,000). None of the major specialties showed a decrease in average claims cost during the time period studied.

b. Inflation Adjusted Severity.

The average cost per claim was adjusted for the effects of inflation, and it still exhibited substantial increases over the 1975-1986 period. Table 30 displays the inflation adjusted average and median cost per claim by speciality, as well as for the average and median cost for all claims. After eliminating the impact of inflation on paid claims, the average cost of a paid claim increased at a compound rate of 7.6 percent per year.

c. Median Cost Per Claim.

The median size claim is simply the middle number obtained when all claims are arranged in order from the highest amount to the lowest amount. It is a useful measure of the rate of cost increase because it is not disproportionately influenced by a few very large or very small claims. For rate-setting purposes, however, the average claim is the number which should be used. The upward increase in cost is apparent in the size of the median claim as well as the average claim. The median claim size increased from $7,500 in 1975 to $30,000 in 1986. Overall, the average annual growth rate in this number has been 13.4 percent; a number substantially in excess of the inflation rate.

TABLE 30.
MEAN AND MEDIAN MEDICAL MALPRACTICE CLAIMS: FLORIDA
(Figures Include Paid Claims Only and are in 1975 Dollars)

		1975	1980	1984	1985	1986	Change 1975-1986
ANEST	MEAN	43,014	90,106	117,067	72,334	109,307	66,293
	MEDIAN	15,000	45,721	14,249	28,768	32,716	17,716
CARDI	MEAN	18,144	106,139	45,002	70,096	29,684	11,540
	MEDIAN	7,500	106,139	15,329	25,016	12,272	4,772
EMERG	MEAN	3,517	48,419	38,177	35,569	27,236	23,719
	MEDIAN	1,800	8,981	7,772	5,003	4,172	2,372
GPRAC	MEAN	16,768	61,763	53,751	74,832	39,905	23,137
	MEDIAN	5,000	16,329	18,136	27,517	12,272	7,272
GSURG	MEAN	26,142	26,298	43,162	49,206	39,124	12,982
	MEDIAN	10,000	7,348	15,545	18,762	18,407	8,407
INTER	MEAN	40,141	29,970	88,136	86,889	65,094	24,953
	MEDIAN	12,000	10,614	18,136	37,523	15,953	3,953
NEURO	MEAN	34,352	16,895	242,719	96,107	112,025	77,673
	MEDIAN	12,000	6,532	20,726	25,016	49,086	37,086
OBGYN	MEAN	14,173	62,874	86,809	84,432	85,768	71,595
	MEDIAN	5,500	18,615	25,073	20,012	19,635	14,135
ORTHO	MEAN	21,822	47,939	76,604	60,657	57,384	35,562
	MEDIAN	12,500	17,293	15,545	23,264	12,272	(228)
OSTEO	MEAN	33,899	62,957	108,483	45,995		(33,899)
	MEDIAN	12,125	24,494	31,090	25,016		(12,125)
PEDIA	MEAN	55,738	17,892	198,189	51,301	176,603	120,865
	MEDIAN	20,000	3,103	33,680	10,006	30,938	10,938
PSYCH	MEAN	26,083		7,125	19,679	15,681	(10,402)
	MEDIAN	20,000		7,125	25,016	16,362	(3,638)
RADIO	MEAN	36,055	95,871	63,366	54,576	73,283	37,228
	MEDIAN	2,500	17,890	15,545	17,511	5,317	2,817
THORA	MEAN	84,375	5,963	52,920	28,071	119,417	35,042
	MEDIAN	36,250	5,963	12,954	6,254	67,494	31,244

Source: Florida Department of Insurance Medical Malpractice Closed Claims Data Set.

d. Impact of Changes In Loss Size Distribution Upon Average Cost.

Increases in the cost of the average claim naturally lead to the question of what caused the increase. Was it simply a few extremely large claims that drove up the average cost or did it also increase because there was a greater number of slightly larger than average claims? Past research efforts have generally been unable to answer this question due to a lack of data with which to make the analysis. Such was not the case in the present study. Because of actions taken by the Florida legislature in the mid-1970's, the Florida Department of Insurance was able to supply data enabling the professional staff of the Academic Task Force to determine the cost of virtually every medical malpractice claim closed in the State since 1975. Using these data it was possible for the Task Force to analyze where the cost increases occurred.

The professional staff's analysis shows that both of the factors noted above have caused the average cost to increase. Not only did the number and size of large paid claims increase, there was also a greater proportion of the number of paid claims in the medium to large size category.

e. Large Paid Claims

A few large claims can cause very large increases in loss payments which are ultimately reflected in higher insurance premiums. Medical malpractice loss payments in Florida are due, in large part, to an increase in the size and number of large claims. Table 31 displays large claims for the years 1975 - 1986.

TABLE 31.

Analysis of Large Medical Malpractice Claims in Florida
1975 - 1986

	1975	1976	1977	1978	1979	1980	1981	1982	1983	1984	1985	1
Largest Paid Claim: ($,000)	$500	$300	$950	$850	$600	$960	$1,624	$2,530	$1,536	$5,114	$3,045	$4,
Number of Paid Claims Greater Than:												
$250,000	5 (0.52)	2 (0.19)	3 (0.22)	8 (0.55)	12 (0.82)	21 (1.31)	31 (1.53)	79 (2.99)	75 (2.96)	102 (3.73)	94 (5.34)	(4
$500,000			2 (0.15)	1 (0.07)	3 (0.21)	6 (0.38)	10 (0.49)	33 (1.25)	31 (1.22)	46 (1.68)	30 (1.70)	(1
$750,000			2 (0.15)	1 (0.07)		5 (0.31)	4 (0.20)	21 (0.79)	18 (0.71)	31 (1.13)	15 (0.85)	(1
$1,000,000							1 (0.05)	5 (0.19)	7 (0.28)	12 (0.44)	9 (0.51)	(0
$1,500,000							1 (0.05)	1 (0.04)	1 (0.04)	10 (0.37)	5 (0.28)	(0
$2,000,000								1 (0.04)		3 (0.11)	3 (0.17)	(0.
$3,000,000										1 (0.04)	1 (0.06)	(0.
$4,000,000										1 (0.04)		
$5,000,000										1 (0.04)		
Number of Claims Closed:	968	1036	1335	1453	1457	1597	2032	2644	2536	2733	1760	14

Key: Open figures are the number of claims.
Figures in parentheses ( ) represent the percent of the number of claims closed that year.

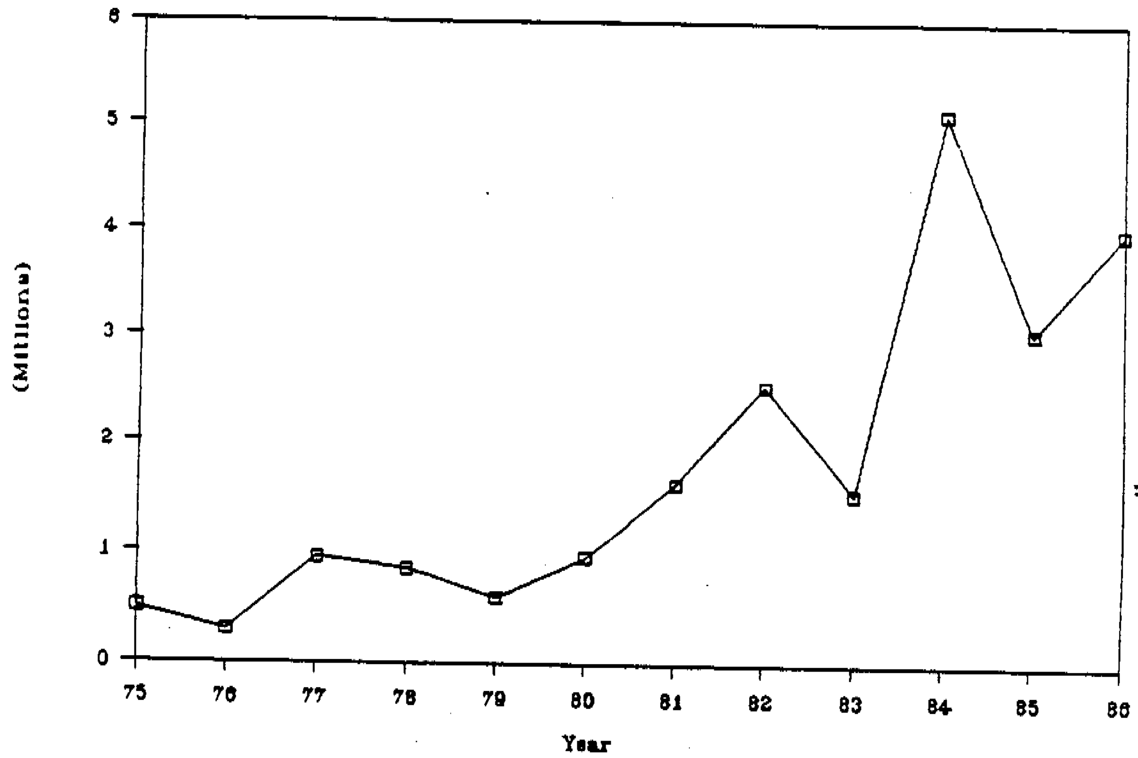
Source: Florida Department of Insurance Medical Malpractice Closed Claims Data Set

The first part of Table 31 displays the largest paid claim in each year from 1975 to 1986. The results are dramatic but probably not surprising to those who have been dealing with the medical malpractice problem. In 1976 the largest claim was $500,000 and the trend during the intervening years has been one of almost uninterrupted growth as shown in Figure 7. The remainder of Table 31 is a year-by-year analysis of large claims. For any given year, it shows the number of claims in excess of $250,000, $500,000, etc. For example, prior to 1980, there were no paid claims in excess of $1,000,000. The year 1981 saw one claim greater than a million dollars, while there were 12 Florida paid claims in 1986 that exceeded $ 1 million.

The figures in parentheses below the number of claims is the percentage which that number represents of the total claims closed in that year. As such, it shows that not only is the number of claims greater than $ 1 million increasing, but also that such claims account for an increasing proportion of the number of claims. In this case, they were 0.05 percent of claims in 1981; by 1986 they accounted for 0.83 percent of claims.

If the amount of claims is examined, million dollar plus claims represented 4.9 percent of total paid claims in 1981. By 1986, this group accounted for 29.1 percent of total paid claims. This point bears restating. In 1986, paid claims of more than $1 million were less than 1 percent of the number of claims but were responsible for 29 percent of the amount of claims.

Figure 7.
Trend in Largest Medical Malpractice Paid Claim in Florida (1975-1986)



Source: Table 31

f. Increase in the Proportion of Medium Claims

The increase in the proportion of medium claims can be seen by making a year-to-year comparison of the data in Table 32.

The first entry in the table shows that in 1975, 90.39 percent of the <u>number</u> of claims were for $25,000 or less. Reading across the row, it can be seen that in 1981 89.67 percent of claims were for $25,000 or less and this percentage fell to 76.96 by 1986. Thus, cost shifts caused by more frequent payment of larger claims can be detected by noting a declining percentage in smaller dollar categories.

The proportion of claims less than $25,000 declined by about 10 percentage points - the largest change during the twelve years analyzed. Large declines also took place in the categories up to $100,000 with smaller declines carrying through to the $300,000 level.

In summary, there has been a general increase in the number and proportion of claims in larger size categories which has caused the overall cost of an average claim to rise. Far more important, however, is the increase in the number and size of the very large claims. There has been a dramatic increase in the size of the largest claim along with an equally dramatic increase in the number of large claims.

TABLE 32.
PROPORTION OF THE NUMBER OF MEDICAL MALPRACTICE CLAIMS
CLOSED IN FLORIDA ACCORDING TO SIZE.

Claim Size Zero through:	1975	1976	1977	1978	1979	1980	1981	1982	1983	1984	1985	1986
$25,000	90.39	92.09	91.84	93.12	94.10	93.05	89.67	88.96	88.37	86.86	77.39	76.96
$50,000	94.53	96.24	95.43	95.39	96.02	94.74	92.67	91.30	91.17	90.63	82.44	83.29
$75,000	96.07	97.59	96.78	96.49	97.05	96.12	94.34	92.55	92.63	92.39	85.17	86.31
$100,000	98.55	98.94	99.03	98.42	98.35	97.31	96.56	94.86	94.76	94.22	90.28	90.65
$150,000	99.07	99.42	99.33	98.90	98.70	97.81	97.44	95.58	95.54	94.99	92.16	92.30
$200,000	99.17	99.61	99.63	99.24	99.04	98.50	98.13	96.33	96.33	95.65	93.47	93.81
$300,000	99.79	100.00	99.78	99.66	99.31	98.94	98.82	97.47	97.36	97.00	95.63	96.15

Source: Florida Department of Insurance Medical Malpractice Closed Claims Data Set.

g. Cost Variations Within the State.

There are major differences in the average cost of a claim between different parts of the State. All non-zero claims were analyzed for the period 1975-1986. Because of the low number of claims in the smaller counties, only the results for counties with population in excess of 250,000 are reported. Table 33 ranks these counties in descending order according to the average claim size. Caution is necessary in interpreting these figures because the average is affected by one or more large numbers. Thus, year-to-year variations in the averages should also be examined. For example, Polk county has the second highest average claim in the State; however, the numbers producing that average range from $4,825 in 1976 to $389,575 in 1984. This caution also applies to Pasco county and, to a lesser extent, to Palm Beach county.

Table 34 displays the average severity for Dade/Broward counties and the rest of the state. Broward county has a long term average paid claim which is 11 percent higher than the statewide average. During the most recent three years, the average has been 13.3 percent higher. Equivalent figures for Dade county are 8.9 percent and 28 percent respectively. If a Dade/Broward versus the rest of the State comparison is made, those two counties were 18.6 percent higher than the rest of the state for the twelve year time period and 42.4 percent higher during 1984-1986.

In summary, of the two factors (frequency and severity of claims), that drive total claims the best data available to the

TABLE 33

MEAN SEVERITY OF FLORIDA MEDICAL MALPRACTICE PAID CLAIMS FOR SELECTED COUNTIES

	MEAN	CALENDAR YEAR OF CLOSING											
		1975	1976	1977	1978	1979	1980	1981	1982	1983	1984	1985	1986
COUNTY	MEAN SEVERITY	MEAN SEVERITY	MEAN SEVERITY	MEAN SEVERITY	MEAN SEVERITY	MEAN SEVERITY	MEAN SEVERITY	MEAN SEVERITY	MEAN SEVERITY	MEAN SEVERITY	MEAN SEVERITY	MEAN SEVERITY	MEAN SEVERITY
PALM BEACH	$117,236	$42,694	$15,675	$107,484	$57,678	$115,072	$258,606	$47,964	$95,484	$159,890	$141,900	$269,990	$94,395
POLK	$95,410	$6,540	$4,825	$23,250	$15,510	$55,500	$9,316	$81,113	$122,085	$159,179	$389,575	$93,332	$184,695
DUVAL	$93,892	$38,574	$22,714	$16,408	$61,908	$53,867	$75,924	$112,405	$90,858	$202,741	$92,915	$193,301	$165,083
BROWARD	$89,317	$20,625	$25,211	$26,477	$58,227	$35,575	$86,839	$80,927	$171,580	$122,822	$164,300	$135,769	$143,457
DADE	$87,597	$28,310	$28,571	$31,326	$41,692	$70,918	$50,194	$79,150	$107,529	$112,495	$173,056	$148,792	$179,129
PASCO	$87,185	$10,563	$23,200	$26,225	$1,000	$53,000	$23,833	$64,800	$258,871	$89,036	$303,488	$84,184	$108,015
ALL OF FLORIDA	$80,454	$26,540	$23,991	$34,985	$41,193	$54,361	$80,556	$74,592	$123,700	$114,105	$144,018	$126,334	$121,073
BREVARD	$79,452	$20,150	$28,581	$16,500	$25,101	$27,000	$54,167	$52,000	$268,056	$130,875	$95,978	$156,875	$78,144
LEE	$69,857	.	$30,000	$3	$26,000	$60,736	$6,667	$16,259	$328,668	$40,470	$76,153	$124,161	$59,309
ORANGE	$67,088	$28,190	$22,140	$30,861	$28,856	$99,192	$56,481	$29,869	$94,601	$177,406	$100,805	$82,480	$54,180
PINELLAS	$62,768	$29,852	$21,329	$16,333	$23,342	$10,861	$127,452	$82,492	$67,308	$103,915	$77,010	$114,393	$78,926
ESCAMBIA	$61,084	.	$16,250	$5,760	$70,801	$133,482	$100,000	$36,675	$67,500	$76,200	$50,750	$75,656	$38,850
HILLSBOROUGH	$61,075	$25,306	$14,732	$28,764	$41,104	$62,883	$96,528	$66,908	$46,121	$59,016	$104,414	$70,367	$116,760
VOLUSIA	$54,855	$5,875	$43,549	$5,000	$36,786	$8,201	$98,500	$61,384	$164,274	$33,722	$79,614	$81,989	$49,373
SARASOTA	$47,185	$11,642	$22,611	$17,637	$24,833	$23,464	$20,000	$177,403	$28,574	$36,877	$33,000	$62,368	$107,827

SOURCE: FLORIDA DEPARTMENT OF INSURANCE MEDCIAL MALPRACTICE CLOSED CLAIMS DATA SET

TABLE 34
MEAN SEVERITY OF MEDICAL MALPRACTICE PAID CLAIMS IN FLORIDA:
DADE/BROWARD COMPARED TO THE REST OF THE STATE

	MEAN	CALENDAR YEAR OF CLOSING											
		1975	1976	1977	1978	1979	1980	1981	1982	1983	1984	1985	1986
TERRITORY	MEAN SEVERITY	MEAN SEVERITY	MEAN SEVERITY	MEAN SEVERITY	MEAN SEVERITY	MEAN SEVERITY	MEAN SEVERITY	MEAN SEVERITY	MEAN SEVERITY	MEAN SEVERITY	MEAN SEVERITY	MEAN SEVERITY	MEAN SEVERITY
DADE/BROWARD	$88,190	$25,494	$27,492	$29,379	$47,086	$55,552	$67,318	$79,905	$137,072	$117,566	$169,045	$142,256	$160,122
ALL OF FLORIDA	$80,454	$26,540	$23,991	$34,985	$41,193	$54,361	$80,556	$74,592	$123,700	$114,105	$144,018	$126,334	$121,073
THE REST OF THE STATE	$74,387	$27,278	$21,662	$38,424	$36,064	$53,556	$90,063	$70,491	$112,851	$111,153	$119,648	$116,924	$94,528

NOTE: FIGURES ARE UNADJUSTED FOR INFLATION
SOURCE: FLORIDA DEPARTMENT OF INSURANCE MEDICAL MALPRACTICE CLOSED CLAIMS DATA SET

Task Force shows that increases in both factors have been responsible for the increase in medical malpractice insurance rates. However, the rate of increase in average cost per paid claim substantially exceeds the growth in frequency. Stated differently, more generous verdicts and higher insurance company settlements have contributed more to Florida's increased medical malpractice loss payments than has increased litigiousness or increased claims consciousness on the part of Florida's population.

3. Physicians with Multiple Claims

At the Task Force's public hearing in Miami on February 6, 1987 the question was raised whether a few doctors generated a disproportionate amount of claims and thereby became a major cause of the malpractice problem. It was suggested that there would be no medical malpractice crisis if there were no "bad" doctors but the latter term was left undefined by the witnesses. There are a number of reasons why a physician with multiple claims should not be considered a "bad" doctor. Multiple claims could occur because a physician is practicing in a high risk specialty or a high risk area of the state. In addition, some physicians may be more willing to treat high risk patients for which unfavorable results are to be expected more frequently.

The Task Force has analyzed the number of physicians with two or more claims and, <u>without</u> characterizing such physicians as "bad" doctors, found that of the approximately one-half billion dollars paid to claimants and their attorneys during the period

1975 to 1986, almost one-half was accounted for by physicians with two or more paid claims.

These facts have important implications for controlling the frequency of claims. If a substantial amount of paid claims is due to physicians with multiple paid claims, then it raises the question of what means were in place to review or regulate the quality of medical care practiced by such physicians. Two types of external discipline are possible. One is a market based type of discipline such as experience rating which would surcharge physicians who generate excessive amounts of claims. The other is non-market based regulation or peer review such as would be conducted by the Department of Professional Regulation, the Florida Medical Society or a county medical society.

Until the state recently imposed a requirement for experience rating, no market based incentives existed for physicians insured in the standard market (ie. physicians that were not in the Florida Medical Malpractice Joint Underwriting Association). The Department of Professional Regulation has disciplined a number of physicians, but it is unknown what proportion of them were disciplined because they incurred one or more malpractice insurance claims. We have no evidence as to discipline of physicians with multiple claims by the Florida Medical Association and local medical societies.

a. Claims Analysis.

An investigation into the number of claims experienced by each physician during the period 1975-1986 was accomplished by merging the closed claims data file with a list containing the names of physicians practicing in the state. The name of each physician in the approximately 21,000 closed claims was examined to determine how many claims were closed for each physician during the 12 year period or any portion thereof. Table 35 shows the number of physicians who experienced 1, 2, etc. claims in which an indemnity payment was made. Column 1 displays the number of claims involved. Column 2 shows that a total of 3,229 physicians experienced 1 indemnity claim each and this accounted for 78.8 percent of the number of paid claims. The sum of $296.7 million was paid to resolve these claims and this amount represented 57.8 percent of the total amount paid during the time period. The balance of the table is read in a similar fashion.

Examining the cases where 2 or more claims are involved, the data show that a total of 867 doctors fell in this category. This is approximately 4 percent of the number of physicians whose major professional activity was practicing medicine in the state in 1986. This group was responsible for $216.9 million dollars in paid claims which is 42.2 percent of the total paid out during the time period. Figure 8 provides a graphical breakdown of this result.

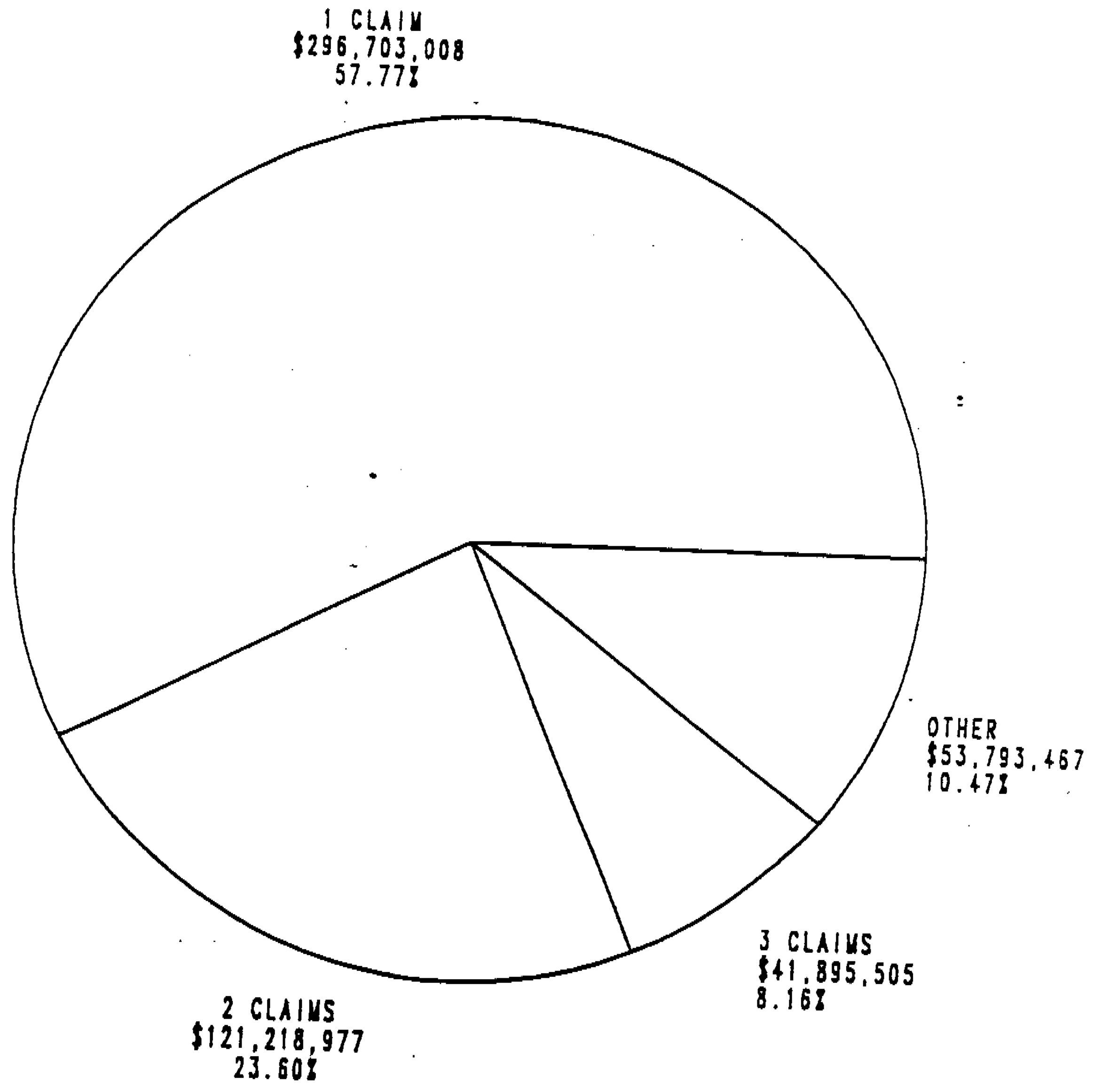
TABLE 35
MULTILPLE CLAIM ANALYSIS OF
MEDICAL MALPRACTICE CLOSED CLAIMS IN FLORIDA
1975 - 1986

NUMBER OF NON-ZERO CLAIMS PER PHYSICIAN/SURGEON FREQUENCY	NUMBER OF PHYSICIANS	NUMBER OF CLAIMS	PERCENT OF CLAIMS	CUMULATIVE PERCENT OF CLAIMS	TOTAL INDEMNITY AMOUNT	PERCENT OF INDEMNITY	CUMULATIVE PERCENT OF INDEMNITY
1	3,229	3,229	78.8330	78.8330	$296,703,008	57.7680	57.7680
2	588	1,176	14.3555	93.1885	$121,218,977	23.6013	81.3694
3	164	492	4.0039	97.1924	$41,895,505	8.1571	89.5264
4	53	212	1.2939	98.4863	$19,009,391	3.7011	93.2275
5	38	190	0.9277	99.4141	$17,519,203	3.4110	96.6385
6	12	72	0.2930	99.7070	$5,333,256	1.0384	97.6769
7	3	21	0.0732	99.7803	$5,147,520	1.0022	98.6791
8	2	16	0.0488	99.8291	$1,517,650	0.2955	98.9746
9	3	27	0.0732	99.9023	$3,320,868	0.6481	99.6228
10	1	10	0.0244	99.9268	$175,000	0.0341	99.6568
11	1	11	0.0244	99.9512	$315,761	0.0615	99.7183
13	1	13	0.0244	99.9756	$379,836	0.0740	99.7923
34	1	34	0.0244	100.0000	$1,066,983	0.2077	100.0000
TOTALS	4,096	5,503	.	.	$513,610,967	.	.

SOURCE: FLORIDA DEPARTMENT OF INSURANCE MEDICAL MALPRACTICE CLOSED CLAIMS DATA SET

FIGURE 8

MEDICAL MALPRACTICE PAID CLAIMS IN FLORIDA ACCORDING TO THE NUMBER OF PAID CLAIMS PER PHYSICIAN 1975 - 1986



FIGURES ARE NOT ADJUSTED FOR INFLATION
SOURCE: TABLE 35

b. Analysis by Specialty.

Since the closed claim data set contained information on physician specialty, it was possible to determine which specialties contained physicians with multiple claims as distinguished from those physicians with only one paid claim. General practice accounted for almost 14 percent of the cases for those physicians who had only one paid claim during the time period. Obstetrics and gynecology had the second highest proportion of physicians with one paid claim, followed by general surgery. OB/GYN cases were the most frequent when two and four or more claims are involved and were second most frequent when three cases are involved. Orthopedics, general surgery and general practice were the other specialties which account for a major portion of the claims.

This analysis is not intended to imply that all physicians with multiple claims can be induced to alter their actions or regulated to the point where there would be no physicians who experience multiple claims. That point is unlikely to be reached because people make mistakes and bad results will occur even in the absence of negligence. Consequently, a certain number of physicians can be _expected_ to have multiple claims. This section of the report has shown the _actual_ number of physicians with paid claims and suggests that there is significant potential for reducing paid claims by controlling the losses generated by physicians with multiple claims.

FOOTNOTES
III. A.

1 This is not to imply that loss payments will continue downward. Population growth will cause payments to increase as will continued inflation in the cost of settling a claim. In the absence of any changes in the insurance and tort system loss payments can be expected to resume their upward trend.

2 The ratio of 5503 divided by 21,000 should not be interpreted to mean that about 25 percent of all claim result in payment because it does not reflect the increasingly frequent situation of multiple defendants being named in a case, e.g., the physician, hospital and maker of medical equipment may be named in a lawsuit. For any number of reasons, one physician may be dropped from the suit leaving the other parties to pay.

3 Figures are mid-year as reported by the Bureau of Economic and Business Research, College of Business, University of Florida.

4 Physician data broken down by specialty is available, but there is no breakdown by both specialty and county.

5 Ideally, the time period should be measured from the date the claim was reported to the insurer to the date of closing. The date of reporting, however, was not available because it was not required to be reported during the study time period.

B. The Role of the Legal System in Increasing Loss Payments

This section of the report will examine elements within the legal system that may have contributed to problems with the affordability or availability of liability insurance.

Under the first subject heading the report will review litigation trends. Data are not available to measure trends in the numbers of medical malpractice suits filed in Florida courts but there is some evidence from other jurisdictions indicating an increase in the number of medical malpractice trials and a very dramatic increase in the size of malpractice verdicts over the last 20 years. Statistics for Dade County show that the percentage of plaintiffs' verdicts in malpractice trials is comparable to several jurisdictions outside Florida and that the amounts of malpractice verdicts in Dade County would probably be roughly comparable to these other locales in the same time periods. Punitive damages were awarded in only 4.8% of successful malpractice verdicts in Dade County.

The next subject heading reviews the changes in tort liability rules as applied to medical malpractice claims accross the nation and in Florida. These legal changes presumably have influenced liability payments, to some extent that cannot be measured in quantifiable terms.

The final heading in this section will examine attorneys' fees and litigation costs. Legal defense fees for medical malpractice claims in Florida more than tripled during the period 1975 through 1984, and aggregate defense costs increased by 543%.

In medical malpractice cases nationwide in 1985, legal defense costs were 17.0% of total incured costs and estimated claimants' legal costs were 21.5%.

1. Litigation Trends

a. Frequency of Lawsuits

Statewide statistics on the number of malpractice cases filed in court were not available until 1986, when the State Court Administrator's Office began collecting such data.[1] During 1986, there were 1418 professional malpractice cases -- including medical malpractice, legal malpractice and all other types of professional malpractice -- filed in the state of Florida. These malpractice cases comprised less than one-half of one percent of all cases filed in Florida's circuit courts. All categories of tort cases comprise 11.0% of all civil actions filed in Florida's circuit courts, and professional malpractice claims constitute only 4.2% of all tort lawsuits.

Because data showing the number of malpractice cases is not available prior to 1986, it is impossible to measure trends in the number of malpractice lawsuits in the state of Florida.

Research from other jurisdictions shows that medical malpractice <u>trials</u> are increasing. It is important to recognize the difference between frequency of <u>trials</u> and frequency of <u>filed complaints</u> as measures of litigiousness. Most filed cases (over 90%) are settled before trial, and therefore jury trials represent a small percentage of case filings. Frequency of jury trials is dependent not only upon the propensity of plaintiffs to file lawsuits, but also upon the ability of plaintiffs and