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FLORIDA HOSPITAL ASSOCIATION
MEDICAL MALPRACTICE ANALYSIS
NOVEMBER 7, 2002

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INTRODUCTION

Milliman USA, Inc. (Milliman) was engaged by the Florida Hospital Association (FHA) to assist their evaluation of potential legislative solutions to the medical malpractice problem in Florida. The goals were to provide an objective evaluation of the medical malpractice problem in Florida and formulate recommendations for changes that we expect to be most effective in addressing the problem. This report documents our findings. We will be happy to answer any questions regarding our analysis.

BACKGROUND INFORMATION

We note that in a report prepared in 1994 by the American Academy of Actuaries, it was noted that a package of tort reforms is more likely to achieve savings in medical malpractice insurance premiums than one or two tort reforms. Specifically, that report highlighted both caps on non-economic damages and mandatory recognition of compensation from collateral sources as two key components of an effective tort reform package. We understand that for Florida, a claimant's damages must be reduced by the amounts paid to the claimant from certain collateral sources¹.

Damage Caps

It is widely viewed that caps on non-economic damages are the most effective reform measure to help control escalating medical malpractice costs. Non-economic damages are generally considered to include compensation for pain and suffering. Florida law currently provides for caps on non-economic damages in a relatively small percentage of cases through its voluntary binding arbitration process. (i.e., where the defendant admits fault and offers to permit the amount of damages to be determined by arbitration. Non-economic damages are capped at \$350,000 when the claimant refuses the defendant's offer to arbitrate and \$250,000 plus attorneys fees if claimant agrees to arbitration).

An attempt to apply non-economic damage caps across a broader spectrum of cases is likely to be challenged in the Florida court system. Though statutes related to damage caps have been upheld in several states, we note that some states have found such statutes to be unconstitutional (examples are Ohio, Illinois, and Washington). In Texas, the original statute that limited damages to \$500,000 (with annual adjustments for inflation) was intended to apply to all medical malpractice cases, but was held to be unconstitutional except with respect to wrongful death cases. Four issues that relate to the effectiveness of a cap on non-economic damages are:

- a) the cap limit,
- b) whether the cap is indexed for inflation,
- c) how the cap applies across defendants, and
- d) the number of exceptions to the cap

¹ Damages are reduced by first party insurance benefits. Other sources, such as payments from suits against other defendants may not reduce damages in Florida.

Obviously, the stronger each of these conditions is, the greater the likelihood of reductions in losses and/or premiums. However, as noted in the American Academy of Actuaries report, poorly constructed reforms will not result in lower medical malpractice losses and premiums and may increase costs. Recently, Nevada has enacted a \$350,000 cap on non-economic damages, though caps of \$500,000 and \$750,000 had been discussed by the Nevada legislature. Several exemptions to the cap were initially proposed, but we understand the cap will not apply in cases of gross negligence and cases with clear and convincing evidence of exceptional circumstances. Mississippi has also recently passed a law that caps non-economic damages to \$500,000. This cap is scheduled to increase to \$750,000 in 2011 and \$1,000,000 in 2017. We understand that this cap does not apply to cases where the judge determines that a jury may impose punitive damages. We also understand damages for disfigurement are not included in the cap.

Milliman has performed an analysis of the impact of proposed caps on non-economic damages in New York. Based on this analysis, we have estimated the following percentage savings:

Estimated Savings on Medical Professional Liability Losses and Loss Adjustment Expenses		
Limit on Non-Economic Damage Award	Primary Limits of Coverage \$1,000,000/\$3,000,000	Excess Limits of Coverage \$1,000,000/\$3,000,000 XS
\$250,000	29%	59%
500,000	20%	42%
750,000	14%	32%
1,000,000	11%	26%

We note that the results of this analysis are intended to apply to physician's malpractice. We expect that hospital losses and loss adjustment expenses would also be reduced substantially, although the effect may be different for hospitals than for physicians. Hospital claims tend to be somewhat smaller than physicians' claims (which would reduce the effect of a cap). However, hospital claims tend to involve more co-defendants than physician claims (which would increase the effect of a cap). As is discussed below, the data that we have evaluated indicates that a large percentage (i.e., well above 50%) of total loss amounts correspond to non-economic damages versus economic damages, both for physician claims and for hospital claims. This implies that caps on non-economic damages would effectively reduce total losses for both physicians and hospitals.

If legislation is enacted to cap non-economic damages, it is possible that other systemic or behavioral changes will occur to counter the predicted reduction to losses. For example:

- 1) It is possible that jury awards and settlements for economic loss will increase to partially offset the cap on non-economic loss, or that the percentage of defense verdicts will decline,
- 2) Legal arguments might be devised to narrow the types of damages subject to the cap, or to define new forms of damages that are outside the limitations on non-economic loss,
- 3) It is possible that certain types of lawsuits or damages may be exempted (either by statute or court decision) from the award cap,
- 4) Greater care might be taken by plaintiffs to carefully define and fully list all elements of economic loss, if the possibility no longer exists to use non-economic losses as a catchall for ill-defined damages.

Our analysis of estimated percentage savings was based upon the assumptions that the above events will not occur.

The strongest argument that can be made in favor of caps on non-economic damages is that it has appeared to work so well in California since 1975. California law prescribes a \$250,000 cap on non-economic damages and malpractice losses per physician are much lower than the countrywide average (i.e., about 50% of the countrywide average from 1991 to 2000). Thus, there appears to be clear evidence that a cap would be effective in reducing the cost of medical malpractice claims.

OBSERVATIONS/CONCLUSIONS

- Florida medical malpractice paid losses rose over 150% between 1991 and 2000, including a 28% increase from 1999 to 2000.
- During 2000, medical malpractice paid losses per physician were 50% higher in Florida than the countrywide average.
- Florida medical malpractice insurance premiums are over 50% above the countrywide average.
- Florida medical malpractice paid loss dollars per unit of population increased 8.7% per year from 1991 to 2000.
- Non-economic damages, i.e., pain and suffering, comprise approximately 77% of medical malpractice loss payments for Florida hospitals.
- Medical malpractice claim frequency, i.e., number of claims closed per 100,000 population, has increased 57% in Florida over the 9-year period 1991-2000. Florida claim frequency increased about 14% from 1999 to 2000.
- During 2000, Florida claim frequency per physician was higher than every state except PA, MT, NV and WV, and 36% above the countrywide average.
- During 2000, Florida malpractice losses per physician were higher than every state except PA, MT, NY, NV, DC and WV and 50% above the countrywide average. California losses per physician are less than 50% of the countrywide average.

The above conclusions from our analysis are described in more detail in the following sections of this report. They paint a bleak picture for Florida, but we believe it could get worse in the coming years if no corrective action is taken. We know that, in 2002, medical malpractice awards are increasing in severity to record levels throughout the U.S. Claim frequency also appears to be increasing and medical malpractice insurance premiums continue to rise throughout the U.S. Many insurers and reinsurers have left or are leaving the medical malpractice insurance market, creating severe availability problems in many states. Medical malpractice insurance premiums may become unaffordable and/or coverage may become unavailable at any price to many physicians and hospitals.

In Florida, we understand that some physicians and hospitals have reduced their limits of medical malpractice insurance coverage, and some have become uninsured, due to the high cost of such coverage. Some hospitals choose self-insurance or other market mechanisms in an effort to save premiums, at the risk of under-funding their exposure.

One of the primary drivers of the current medical malpractice crisis is that a large percentage of medical malpractice losses (77% in Florida) apply to non-economic damages, i.e., pain and suffering. Pain and suffering is subjective in nature, in that it can't be tied to actual costs incurred by injured patients. Every new record award sets a new higher value on pain and suffering, and precedents keep getting established for higher valuations on all future awards and settlements.

We believe that caps on non-economic damages are particularly effective because they limit the escalation of awards for pain and suffering, which fuels large increases for all awards and settlements. The impact of a cap on non-economic damages would be an immediate savings and a tempering of one of the primary components of future loss trends. Non-economic damage caps seem to have worked extremely well in California, where medical malpractice costs are about 50% of the countrywide average. We feel that this is the strongest evidence that caps on non-economic damages, if there are no large loopholes and exceptions, are the most effective tort reform.

ANALYSIS

Our goal in the remainder of the report is to provide factual information and analysis which defines and quantifies the nature and scope of the medical malpractice problem in Florida. With the FHA, we have formulated a list of 9 relevant questions to be addressed. These are summarized below and individually addressed in the remainder of the report:

What is the historical average annual increase in loss payments/expense for medical liability claims?

What is the historical average annual increase in premiums for the same period?

How are those increases broken down between economic damages, non-economic damages and defense costs?

How are economic damages broken down between wages and medicals and how do those increases compare to the inflation index for wages and health care? Is there any way to tell if economic damages and defense costs are growing faster than non-economic damages?

What are the historical trends on frequency of claims? What would they be when population growth is factored?

What kinds of comparisons can be made between South Florida and North Florida in terms of claims data, premiums, frequency, etc.?

How much of the premium dollar goes to plaintiff's attorney's, defense attorneys, defense costs, claimant, underwriting costs/profit?

What are the average payouts per state?

What % of claims arises out of the emergency room including any subsequent surgery?

DATA SOURCES

Below, we list and describe our data sources used to address the above questions:

Florida Department of Insurance Medical Malpractice Closed Claim Database

The data we received from the Florida Department of Insurance (Florida DOI) was provided in two databases: "Archive" and "Current". The "Archive" database contains claims closed prior to 6/25/99. The "Current" database consists primarily of claims closed between 6/25/99 and 4/30/02. This database also includes a relatively small number of claims with closing dates prior to 6/25/99. The databases contain only closed claim data; there is no provision for pending cases.

An adjustment was required to the data in the Current database to avoid double counting duplicate records in cases involving multiple defendants. For example, a \$1 million case against a hospital and three physicians would be included in the Current database as four records (one for the hospital and one for each physician) with *each* showing a settlement of \$1 million. We adjusted this database by removing duplicate records on multiple entry claims to obtain a more accurate claim count and loss amount. This issue does not apply to the Archive database as each case appears to be represented by a single entry.

Additionally, we have found that the Current database is limited to claims that are closed with an indemnity payment (e.g., a settlement amount or verdict paid to the injured party) while the Archive database also contains cases closed without indemnity payments. Given this inconsistency, we confined our analysis of this data to claims closed with an indemnity payment.

The Florida DOI database contains and distinguishes claims filed against hospitals and physicians, and so we were able to analyze each separately. Furthermore, there was a lot of other information available from the Florida DOI database that was not available from other sources, such as subdivisions of claim amounts between economic and non-economic losses. The Florida DOI database was our best source of data for Florida hospitals.

National Practitioner Data Bank Public Use Data File

The National Practitioner Data Bank (NPDB) Public Use Data File contains selected variables from medical malpractice payment reports on physicians, dentists, and other licensed health care professionals. It also includes reports of adverse licensure, clinical privileges, professional society membership, and Drug Enforcement Administration (DEA) reports (adverse actions), and Medicare and Medicaid exclusion actions taken by the Department of HHS Office of Inspector General. The NPDB is maintained by the U.S. Department of Health and Human Services, Health Resources and Services Administration, Bureau of Health Professions, Division of Quality Assurance.

The NPDB has been collecting information on cases closed since September 1, 1990. Claims data are collected from all states, so this database provides a rich source of information for geographical and temporal analyses. We obtained the Public Use Data File with data through 4/30/01.

The NPDB Public Use Data File contains information on "physician" claims only. There is no information collected on medical malpractice actions against hospitals or other entities. Further, reports are submitted to the NPDB only when a payment is made. Therefore, there is no information on either pending claims or claims closed without an indemnity payment. We limited our NPDB analysis to medical malpractice claims (by eliminating adverse event reports) against physicians (by eliminating claims against dentists, chiropractors, nurses, etc).

The NPDB data are expressed on a slightly different basis than the Florida DOI database described above. Because information is collected on a per physician basis, the value of each "claim" (in a multiple defendant case) is limited to each physician's share. Thus, a \$2 million claim that involves two physicians each apportioned a 50% share would appear as two \$1 million claims in the NPDB. Moreover, reports are made to the NPDB by each paying entity, so that if, for example, a primary insurer covers the first \$1 million per claim and an excess insurer covers amounts over the first \$1 million, a \$1.5 million case will appear as two claims: a \$1 million (primary) claim and a \$500,000 (excess) claim. In the Florida DOI database, the same case would appear once as a \$1.5 million entry.

This structural difference between the NPDB and Florida DOI databases will cause differences in the perceived level of average claim severity (i.e., the Florida DOI severity will appear higher because multiple defendant claims will be counted as single large claims, while they will be separated into defendant components in the NPDB database). However, the trends measured from both databases should be consistent and the total number of dollars of loss should be approximately the same.

The Texas Department of Insurance Closed Claim Databases (Texas DOI)

This database contains information on commercial liability closed claims involving bodily injury settled under Texas law with indemnity payments over \$10,000. The database includes the following lines of insurance: General Liability, Medical Professional Liability, Other Professional Liability, Commercial Automobile Liability, and the liability portion of Commercial Multi-peril. We obtained a database with claims closed between 1/1/1990 and 12/31/2000.

Texas DOI reports information on a "per claim" basis so that a lawsuit involving several physicians appears as single entry with the indemnity loss being the total value of the case. Texas DOI distinguishes between physician and hospital cases.

PIAA Claim Trend Analysis

The Physicians Insurers Association of America (PIAA) is a national organization of physician-owned companies formed to provide a medium for information exchange and problem solving. The PIAA sponsors a Data Sharing Project, which has detailed data on over 170,000 medical and dental malpractice claims and publishes "Claim Trends" using information reported to the PIAA Data Sharing Project.

Twenty PIAA member companies from across the country participate in the Data Sharing Project. Because this is not a complete (or random) collection of countrywide data, the results are not necessarily reflective of the country as a whole. Nevertheless, PIAA data accurately reflect general medical malpractice trends.

The PIAA only collects information on closed physician cases and, like the NPDB, information is collected on a per physician basis, limiting the value of each "claim" (in a multiple claimant case) to each physician's share. The PIAA does collect detailed and reliable data on cases closed without indemnity loss payments.

We used PIAA data from the Claim Trend Analysis 2000 Edition.

Annual Statements and Rate Filings

Insurance companies provide specific financial, premium, and claims information as part of their Annual Statements. This information is limited to licensed insurance companies (losses reported by self insurance programs are not reported) and detailed claim-by-claim data are not available. Annual Statement data are consolidated for research purposes by Thomson Financial Company. We used Annual Statement data to estimate total premium and overall insurance rates.

Rate filings contain manual rates charged by individual companies for specific specialties and territories. We obtained rate filings for several Florida medical malpractice carriers as well as the Insurance Services Office (ISO) and also used summarized rate information published in the Medical Liability Monitor.

Other Data Sources

Consumer Price Indices were compiled by the United States Bureau of Labor Statistics.

Census Data were compiled by the United States Census Bureau.

Numbers of physicians per state were compiled by the American Medical Association, Chicago, IL., (copyright) in Table 187, Statistical Abstract of the United States, 2000.

RESPONSES TO QUESTIONS

Question 1:

What is the historical average annual increase in loss payments/expense for medical liability claims?

Total Loss Payments

Over the past 10 years, total paid losses (as reported to the NPDB), both countrywide and for Florida, have increased dramatically. The total amount paid out both in Florida and countrywide in 2000 appears to be 150% (FL) and 80% (CW) more than the annual amount paid out a decade earlier (Exhibit 1a). Florida losses are now in excess of \$400 million per year with hospital losses accounting for about 38% of total losses (Exhibit 1b). Details of the losses are included in Attachments 1a-c for Florida, PIAA, and NPDB databases (respectively).

The NPDB data indicate more rapid growth of losses in Florida than in the entire U.S. (Exhibit 1a). Florida physician payments reported to the NPDB grew from about \$120 million in 1991 to over \$300 million in 2000. This reflects an average annual growth of 10.8%. In comparison, countrywide physician payments reported to the NPDB grew at a rate of 6.8% during the same period and were over \$3.8 billion in 2000 (see also, Attachments 10 a-d).

Average Loss Payments

Exhibit 1c shows the average paid loss (severity) for medical malpractice claims since 1975 in Florida and countrywide. Four graphs are shown:

1. Florida DOI Hospitals average severity
2. Florida DOI Physicians average severity
3. PIAA Physicians average severity (countrywide)
4. Florida NPDB Physicians average severity

A more detailed examination of NPDB data (Exhibit 1d) shows that through 1996, Florida had a higher claim severity, but a lower severity trend, than the countrywide average. From 1997 through 2000, NPDB data indicate that Florida's severity and severity trend mirror the U.S. as a whole (see also, Attachments 10a-d). Note also that claim severity growth was quite high during 1999 and 2000.

When adjusted for differences in the physician population, the "pure premium" (losses per physician) for Florida physicians is higher than the countrywide average and has grown from 15% above average in 1991 to 50% higher in 2000 (Exhibit 1e).

Defense Costs

Exhibit 1f, and Attachments 1d-e, show defense costs for Florida and PIAA cases (the NPDB does not capture expense costs). Florida hospitals and physicians have historically paid more than PIAA cases on a per case basis for defense costs. However, Florida average defense costs peaked in the mid 1990s and have remained fairly level since then while PIAA countrywide physician defense costs continue to increase at an annual rate of nearly 6%.

Question 2:

What is the historical average annual increase in premiums for the same period?

Since 1996, the total written premium (reported in insurance company Annual Statements) for medical malpractice insurance coverage in Florida increased 64%, to nearly \$650 million, while the total U.S. written premium increased 26%, to nearly \$7.6 billion (Exhibit 2a, Attachment 2a). Note that these amounts represent commercially insured, filed written premium; self-insurance, off shore captive, and international premiums are not included in these totals. A significant amount of this growth appeared between the last two years of available data (2000-2001), though Florida's continuous growth contrasts with several relatively flat years for the entire U.S.

As a comparative index of medical malpractice insurance rates, we divided the total² written premium by the number of physicians (Exhibit 2b, Attachment 2a). Florida's rate is over 55% greater than the countrywide average (\$16,424 vs. \$10,373 in 2001).

The specific insurance rates for Florida physicians, compiled from selected insurance companies and states, are substantially higher than comparative rates in New York, California and Texas. Moreover, between 1995 and 2002, Florida rates have increased dramatically faster than the rates in those states. (Exhibit 2c, Attachments 2 b-e). The increase in Florida has been even more dramatic during the past two years; the FPIC rate for internal medicine in Dade County increased 71% since 2000, including an increase of over 46% in 2002.

The effect of California's strong tort reform regulations is clear when comparing rates between Los Angeles and Dade counties. Moreover, Dade County rates have been increasing continuously since 1995, while NY and Los Angeles rates have been stable during the same period.

² Annual Statement written premium includes both physician and hospital premium.

Question 3:

How are those increases broken down between economic damages, non-economic damages and defense costs?

Economic v. Non-Economic Losses

Based on the Florida DOI medical malpractice data, over 75% of the paid loss is non-economic loss (Exhibit 3a, Attachments 3 a-c). Note that only about a quarter of the records in the Archive database had payments broken out in these categories, while around 87% of the records in the Current database included this. Additionally, of cases showing this economic and non-economic split, only 55% of them sum to the actual total paid loss. We assume that economic and non-economic values are initial estimates of what will ultimately be paid and not necessarily components of the actual paid loss.

Similarly, only one third of the cases in the Texas DOI database have indemnity payments broken out into economic, non-economic, and "other" (exemplary/punitive damages and pre-judgment interest) categories. The cases with categorized indemnity payments tend to be the larger cases; severity for these cases is about 30% higher than the average severity. Unlike Florida, the indemnity components in the Texas DOI database sum to the total paid to plaintiffs in the Texas DOI database. Over \$1 billion has been paid during the past 10 years for non-economic damages in Texas (Attachment 3c). In Texas, non-economic damages account for about 60% of the total paid loss while an additional 10% are in punitive and interest charges so that Florida and Texas both show that only 20%-30% of loss payments are for economic losses.

Loss v. Defense Costs

The Florida DOI database indicates that about 15% of total loss payments are for defense costs (Attachments 1a and 1d). However, this database does not include all of those cases in which defense costs were paid on cases without an indemnity loss payment. The 15% ratio thus understates the total paid out in defense costs. Based on other information from insurer rate filings and financial statements, we estimate that total defense costs exceed 20% of loss payments.

Additionally, defense costs do not appear to be a fixed percentage of total cost; defense costs tend to increase at a slower rate than loss payments. That is, it is relatively more expensive to defend a \$50,000 case than a \$5 million case. The relationship between losses and defense costs for Texas cases is shown as a log-log least squares regression³ (Exhibit 3b). Though there is considerable variability in the relationship ($r^2=0.243$), a 10% increase in indemnity is accompanied by a 4.2% increase in LAE. Thus, if a \$50,000 case costs \$12,750 (25%) to defend, then a \$500,000 is expected to cost about \$41,230 (8%), and a \$5 million case is expected to cost about \$133,335 (3%) in defense costs.

³ In this analysis, we eliminated 174 cases that had no LAE payment.

Question 4:

How are economic damages broken down between wages and medicals and how do those increases compare to the inflation index for wages and health care? Is there any way to tell if economic damages and defense costs are growing faster than non-economic damages?

Economic Damages: Wages and Medical Expenses

The Florida DOI database indicates that about three quarters of economic losses is related to medical expenses (Exhibit 4a; Attachment 3a,b). This percentage appears to be decreasing slowly, while the proportion of loss for wages are increasing.

Growth of economic losses, non-economic losses, and defense costs

Exhibit 4b presents a summary of results showing the growth of claim severity for losses and for defense costs. Also shown are indicated growth rates for the non-economic and economic damage portions of losses. Results are shown from several data sources, including:

- Florida DOI data
- NPDB data for Florida and nationwide
- PIAA nationwide data
- Texas data (from a Texas Insurance Department data base)

The growth rates are computed on a long-term (i.e. "historical") basis, using 10 or 11 years of data. They are also calculated on a more current basis, using the last 3 or 4 years.

The results generally show that the current growth rates are higher, indicating that the severities have increased in the most recent years. Results are somewhat spurious for some of the categories, particularly the current indications for hospitals, and for non-economic or economic damages, where the data is less extensive. Furthermore, the growth rates from the Florida physician DOI data are slightly less believable than the growth rates based upon the Florida NPDB data, because the DOI data was taken from two sources (the Archive and Current data bases described above) and the growth rate calculation is based on the assumption that the two data base sources are exactly comparable to each other. (The results are very close, but not exactly identical, between the two data sources.)

The results show high current severity growth rates for physician losses and defense costs in Florida and countrywide. The Florida NPDB data shows a current severity growth rate of approximately 10% for physicians.

The data underlying the growth rate calculations for non-economic and economic damages includes only those claims where non-economic and economic damages were separately identified. It appears that, in Florida, economic damages have historically increased at a greater rate than non-economic damages.

Question 5:

What are the historical trends on frequency of claims? What would they be when population growth is factored in?

Based on Florida population information from the Census Bureau, we have analyzed the relationship of claims to population over time. The Florida DOI database indicates that the number of claims per physician increased from 1990 through 1997. This is shown graphically in Exhibit 5a and numerically in Attachment 5. As we understand the Current database may only be capturing a subset of the claims in the Archive database, we do not feel that the data would be appropriate to gauge a frequency trend for the most recent years after 1997.

Exhibit 5b shows a graphical comparison between Florida and countrywide claim frequency using data reported to the NPDB (see also the table immediately below). These data show a strong upward trend in the number (and frequency) of Florida claims and a corresponding stationary pattern for countrywide claims. Between 1991 and 1995 the population-adjusted frequency for Florida was approximately equal to the countrywide average but, unlike the relatively stationary countrywide trend, the Florida rate has been increasing. By 2000, Florida's rate (7.56 NPDB reported claims per 100,000 per year) was 36% higher than the countrywide average and 57% higher than it had been a decade earlier. During the same period, the countrywide average remained unchanged.

	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000
Population x 100,000										
USA	2,530	2,565	2,599	2,631	2,663	2,694	2,726	2,759	2,790	2,814
Florida	134	137	139	142	145	149	152	155	158	160
Cases										
USA	13,711	14,739	14,667	15,171	14,050	15,275	14,609	14,086	15,117	15,602
Florida	644	719	786	811	849	1,076	1,100	1,025	1,045	1,209
Frequency (Cases / Population x 100,000)										
USA	5.42	5.75	5.64	5.77	5.28	5.67	5.36	5.11	5.42	5.54
Florida	4.82	5.27	5.64	5.70	5.84	7.24	7.24	6.62	6.63	7.56

Question 6:

What kinds of comparisons can be made between South Florida and North Florida in terms of claims data, premiums, frequency, etc.?

Based on the Florida DOI database, we have analyzed the data in three separate groups. Territory 1 includes Dade and Broward counties; Territory 2 includes Palm Beach, Hillsborough, Pinellas, Orange and Duval counties; and, Territory 3 includes the remaining counties in Florida. Overall, since 1985, claims counts have been split *approximately* evenly between the three territories (Attachment 6a), with Territory 1 accounting for 35%-37% of claims, Territory 2 for 33%, and Territory 3 for 30%-32%. However, there appears to be a shift in frequency underway (Exhibit 6a). The percentage of cases in Territory 3 is growing and the percentage of cases in Territory 1 is shrinking (with Territory 2 remaining stationary at about one-third of claims). During the mid-1980's, Territory 3 accounted for about 28% of physician claims; in the most recent years, about 40% of claims occur in Territory 3.

Similarly, over the last 18 years, Territory 1 has accounted for 35%-39% of paid losses; Territory 2, 33%-34%; and Territory 3, 27%-32% (Attachment 6b). The paid loss pattern follows the claim count pattern; Territory 3 is growing, while relative losses in Territory 1 have been decreasing (Exhibit 6b).

There appears to be little difference in the size of claims between territories (Exhibit 6c,e; Attachments 6c-e). Although there is great variability in relative average claim size from year-to-year (and much more variability in hospital claims than physician claims), all three territories show *approximately* the same average cases size (Territory 3 *might* have a slightly lower relative severity than the other two territories). There is no clear trend in relativity between territories.

Relative expense size does not appear to have varied over time, though it does appear that defense costs in Territory 1 are highest, followed by Territory 2, and finally Territory 3 (Exhibits 6 d, e; Attachments 6 f-h).

Population adjusted relative claim frequency (Exhibit 6f; Attachments 6i-k) is much lower in Territory 3 than the other two territories. However, relative claim frequency is slowly growing in Territory 3 (from about 0.60 to 0.85 times the statewide average) and falling in Territory 1 (from over 1.50 times the statewide average down to near unity). Additionally, census bureau data indicate that the population of Territory 3 is growing at a faster rate than the other two territories (2.3% v. 1.9%) and Territory 3 now makes up for about 47% of Florida's population (up from 45% in 1985). These factors (population growth in Territory 3, increase in relative per capita claim rate in Territory 3, decrease in relative per capita claim rate in Territory 1) account for the shift in total claims and paid losses from Territory 1 to Territory 3.

Question 7:

How much of the premium dollar goes to plaintiff's attorney's, defense attorneys, defense costs, claimant, underwriting costs/profit?

Plaintiff's attorney's fees are a portion of losses, which are paid by the successful plaintiffs to their attorneys. We have no data from any of our sources to accurately quantify the percentage of losses which are paid in attorneys fees. However, we believe that attorneys fees equal approximately 30% of losses.

The portion of the premium dollar to cover various loss and expense amounts varies by insurer and by state. However, much information is available from insurer Annual Statements about many of these expense components. Based on this information, plus our experience and judgment, we estimate the following percentages.

Plaintiffs (exclusive of plaintiff's attorneys fees)	49%
Plaintiff's attorneys fees	21%
Defense attorneys fees	17%
Other defense expenses	3%
Insurer administrative expenses and profit	<u>10%</u>
Total	100%

Question 8:

What are the average payouts per state?

Exhibit 7 shows NPDB losses for the 10 largest medical malpractice states. These states account for about two-thirds of medical malpractice losses in the United States (Attachment 7a-e).

Perhaps the most dramatic finding within the NPDB is the extremely low loss rate for physicians in California. Presumably, California's per physician loss rate of just below 50% of the countrywide average is due to the well-known and long established tort reforms in place (California's Medical Injury Compensation Reform Act of 1975 "MICRA"). As previously discussed, the lower losses result in significantly lower premiums for California physicians (Exhibit 2c). MICRA apparently impacts both frequency and severity of malpractice cases. The 2000 claim frequency for California physicians equals about 75% of the U.S. average. Additionally, the 2000 average claim severity in California is less than 60% of the U.S. average and the 2000 loss per physician (pure premium) equals about 42% of the U.S. average.

In Florida, the rate at which physician claims get reported to the NPDB (frequency) is more than 25% higher than the countrywide average over the 10-year period ending 4/30/2001. Coupled with a 6% higher cost per case (severity) leaves Florida physicians with a total exposure 36% higher than the countrywide average over the 10-year period (and more than 250% greater than California!).

For cases reported in 2000, the Florida statistics show more deterioration. Claim frequency increases to 50% above the U.S. average and pure premium increases to 55% above the U.S. average. The 2000 Florida claim frequency is exceeded only by the claim frequency in Nevada, West Virginia, Pennsylvania, and Montana. The 2000 Florida pure premium is exceeded only by the pure premiums in Nevada, West Virginia, Pennsylvania, D.C., New York, and Montana (Attachment 7e).

Question 9:

Can you determine what % of claims arises out of the emergency room including any subsequent surgery?

The Florida DOI database contains a field for "Event Location" that includes the following categories:

- Hospital Inpatient
- Emergency Room (E/R)
- Physician's Home/Office
- Hospital Outpatient
- Nursing Home
- Patient's Home
- Other Outpatient (presumably free standing clinics, for example)
- Other (Non-Specified) Location
- Other Hospital/Institution

During the 17-year period (1986-2001) for which these data have been collected, nearly 90% of all events occurred in the Hospital Inpatient, E/R, and Physician's Office categories (with each of the remaining categories accounting for less than about 5%). Emergency Room cases make up about 10% of claim counts and dollars (Exhibit 8a; Attachment8)⁴.

Over time, there has been considerable variability in the proportion of E/R cases, but there is no indication of a change in the relative size of this category (Exhibit 8b). However, the relative proportion of Hospital Inpatient cases has been decreasing (from about 70% to about 50%) while the relative size of the Outpatient categories ("hospital" and "other" combined) has grown and now appears to make up about 10% of total losses. No other single category appears to show a change in frequency.

⁴ Note that while the 10% pertains to claims, which originated directly from the E/R, there may be additional related claims, which apply to treatment in other areas, (e.g. surgery) after leaving the E/R. Thus the true percentage of claims attributable to E/R treatment may be understated.

LIMITATIONS

Data

In performing this analysis we have relied on data and other information obtained from publicly available sources. We have not audited, verified, or reviewed this data and other information for reasonableness and consistency. Such a review is beyond the scope of our assignment. If the underlying data or information is inaccurate or incomplete, the results of our analysis may likewise be inaccurate or incomplete.

Variability of Results

Any estimate of future claim activity, particularly with respect to the potential impact of various tort reform measures, is necessarily subject to a substantial amount of uncertainty. Tort reform measures that may account for apparent reductions in one state may not have a similar effect in other states. The actual loss experience that develops subsequent to enacted tort reform measures may turn out to be substantially different than expected.

Distribution

Our analysis has been done at the request of the Florida Hospital Association and they are the only party that can rely on our report. The FHA has expressed its intention to distribute this report and, in particular, to distribute the Observations / Conclusions section of the report to other interested third parties. Milliman agrees to such distribution with the understanding that Milliman does not intend to benefit any third party recipient of its work product or create any legal duty from Milliman to a third party. As such no third party receiving this report may rely on the work or conclusions contained herein. We recommend that any recipient have it's own actuary or economist review the work and form an independent opinion. We also require that any press release that refers to the report be submitted to Milliman for prior approval.