

WISCONSIN STATE  
LEGISLATURE  
COMMITTEE HEARING  
RECORDS

**2005-06**

(session year)

**Assembly**

(Assembly, Senate or Joint)

**Task Force on  
Medical  
Malpractice  
(ATF-MM)**

Sample:

Record of Comm. Proceedings ... RCP

- 05hr\_AC-Ed\_RCP\_pt01a
- 05hr\_AC-Ed\_RCP\_pt01b
- 05hr\_AC-Ed\_RCP\_pt02

➤ Appointments ... Appt

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➤ Clearinghouse Rules ... CRule

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➤ Committee Hearings ... CH

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➤ Committee Reports ... CR

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➤ Executive Sessions ... ES

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➤ Hearing Records ... HR

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➤ Miscellaneous ... Misc

➤ **05hr\_ATF-MM\_Misc\_pt40**

➤ Record of Comm. Proceedings ... RCP

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**\*1285 THE NEW FLORIDA MEDICAL MALPRACTICE LEGISLATION AND ITS LIKELY CONSTITUTIONAL CHALLENGES**

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I. Introduction

Because of the fundamental importance of the health care market, it is uniquely situated alongside other crucial product and services markets in the United States. While other markets such as foodstuffs, consumer goods, or transportation may be considered "necessary" to maintain a certain way of life, the driving force behind the health care market is sustenance of life itself. When viewed as a chain of events, this market begins and ends with the consumer. A consumer's need sets into motion a multifarious cast of characters who assist him or her. There are hospital staffs of maintenance workers, custodial employees, nurses and doctors whose primary point of contact is the consumer. There are medical, biomedical and pharmaceutical research companies that provide innovative products. There are employers in other sectors of the economy who generate the income necessary to pay for these services.

Even with this great complexity in the health care market, however, from a consumer perspective two characters are considered most important: the doctor and the insurance company. In many ways, these two work together in servicing the consumer. The doctor manages the protocols necessary to meet consumer health care needs, and the insurance company provides broad risk pools necessary to spread health care costs and reduce the fees charged the consumers themselves. But there is also great tension in the system. Consumers rely on the knowledge and skill of the doctor to correctly manage the protocols, while doctors rely on insurance companies to again spread the risk of their misjudgments.

Central in this tension is the legal process. Health care is highly regulated because of its complexity and position as a singularly important market. Similarly, laws dictate how physicians practice and what level of skill and knowledge they will be required to possess. Regulations dictate how insurance companies operate and spread the risks of physicians who fall short of these requirements. Courts determine what level of care consumers can expect to receive, and what redress consumers \*1286 may seek when they are injured by a doctor's failure to meet the mandated standards of their profession.

At present, imbalance in the system is causing lawmakers at the state and federal level to consider alternative methods of policing the market. Consumers are paying high health care costs, and corresponding high premiums for health care insurance. Doctors are paying higher prices for malpractice insurance, without which they are told by the regulators they cannot practice medicine. Insurance companies are paying higher litigation costs and recouping less from investment income, forcing them to raise rates for both doctors and consumers.

The health care system is maintained only through a series of compromises. Insurance companies (or, more properly, their regulators) need to choose a level of profitability that does not require either patient or provider to pay exorbitant premiums. Doctors and health care administrators need to reach a level of efficiency that at once cuts the cost

of health care without harming the quality of care provided to consumers. Patients need to prioritize health through lifestyle choices so as to cut their exposure to life-threatening injury, and at the same time be willing to pay fees for health care services. Imbalance comes from excessive profit taking or funds mismanagement by insurance companies, poor quality of care by physicians, and overwillingness by consumers to litigate undesirable results where there is no error. The present dysfunction in the system has come from all three sources. In addition, outside factors influence the system, and the legislative compromises presently being mulled must properly address all these complexities. However intricate these proposals, lawmakers should keep in mind that health care is a necessary market. Central to the functioning of that market is the role of the patient, the doctor, and the insurance company.

It is in this imbalanced context that the Florida Legislature enacted new legislation during August 2003. The new legislation attempts to streamline the process by which medical malpractice disputes are litigated. It also attempts to rationalize the exposure that doctors face when performing procedures, and that insurers face when covering doctors. It is designed to lower premiums paid by doctors to maintain professional liability insurance.

This Comment will first address the history of medical malpractice reform in Florida, briefly pointing to what measures were enacted in the past. Understanding what occurred in the past will provide some insight into the push to enact the new measures that culminated in Senate Bill 2-D in August 2003. The focus will then shift to the constitutional standard by which the new legislation will be judged, discussing \*1287 what similar legislation was found unconstitutional in the past, and what challenges to the current act can reasonably be foreseen. In an effort to meet the constitutional standard for the new legislation, certain findings of fact were set forth in the legislation. These will be challenged based on a statistical and logical examination of the findings of the legislature. Finally, this Comment will examine the likely effect of the present reforms.

It is foreseeable that the new measures will do little to curb the present medical malpractice insurance "crisis" facing Florida. In its haste to pass some measure of reform in a Fourth Special Session, the legislature made too many compromises, and in effect neutralized the effect of the Bill. The fundamental flaw with the legislation is that insurers remain free to set malpractice insurance rates without any real checks against the insurance practices that are arguably the best explanation for what caused the present "crisis" in the first place.

## II. A Brief History of Medical Malpractice Reform in Florida

Capping non-economic damages awarded in medical malpractice is not a new proposition. In the 1970s and 1980s, the Florida Legislature passed several measures meant to discourage frivolous medical malpractice claims, including a non-economic damages cap that was later determined to be unconstitutional by the Florida Supreme Court. [FN1]

In 1975, the Florida Legislature passed the Comprehensive Medical Malpractice Reform Act, [FN2] with the stated purposes of normalizing the cost of medical malpractice insurance, discouraging frivolous lawsuits, and ensuring the population of Florida would have access to health care. [FN3] At the time that legislation was passed, the state was undergoing a crisis of rising medical malpractice insurance premiums similar to the present experience. Also similar to the current situation, a legislative Task Force was convened to examine the problems and solutions to those problems. [FN4]

The 1975 Act enacted procedural hurdles over which a claimant in a medical malpractice action had to jump before being able to file a lawsuit. A claimant was required to submit the action to a mediation \*1288 panel before filing it with a clerk of court. [FN5] Several other "reform" measures were passed, but most of these spoke to the amount of awards rather than measures enacted to discourage frivolous lawsuits. The measures provided that a judge could adjust a jury award considered ineffectively low or unacceptably high. [FN6] A "Patient's Compensation Fund" was set up to cover losses exceeding the limits

of the doctors' or hospitals' malpractice policies. [FN7] Nonetheless, the only procedural barrier to actually filing a lawsuit that was enacted at the time was the provision for a mediation panel, and the Florida Supreme Court eventually deemed even that unconstitutional. [FN8]

In 1985, the 1975 Act was amended, imposing some real barriers to filing a medical malpractice claim. These provisions required a claimant to follow a pre-suit screening procedure, including investigation into the validity of the claims and the possibility of court-ordered arbitration of the claims. [FN9] Even though the arbitration determination was non-binding, these provisions, meant to screen out frivolous claims, finally erected real barriers to filing a medical malpractice cause of action. If the claim was still brought after a plaintiff complied with all pre-filing requirements, the 1985 amendments added further protection for doctors and hospitals in the form of a \$450,000 cap on non-economic damage awards. [FN10]

The cap on non-economic damages did not survive constitutional challenges. In 1987, the Florida Supreme Court declared the cap unconstitutional as a violation of a claimant's right of access to the courts. [FN11] Nevertheless, some strong measures still remain to reduce the amount of exposure that hospitals and doctors face in medical malpractice actions. These include a \$250,000 cap on non-economic damages in voluntary binding arbitration, which is reduced in percentage terms by the plaintiff's capacity to enjoy life. [FN12] Refusing an opponent's invitation to enter into voluntary binding arbitration has consequences. For the plaintiff, refusing the offer would result in capping non-economic damages at \$350,000. For the defendant, refusal results in the award of interest and attorneys' fees if the plaintiff succeeds at trial. [FN13] Therefore, as it stands \*1289 today, there are hurdles to bringing a medical malpractice claim in Florida, and consequences if the claimant decides not to submit to arbitration of the claim.

In addition, the medical lobby has been instrumental in getting other "tort reform" [FN14] measures passed in the legislature. In 1999, for example, the legislature made significant changes to the rule of joint and several liability of tortfeasors. [FN15] These changes were heavily supported by the Florida Medical Association, which felt that the measure would be beneficial to those doctors and hospitals that were responsible for only a very limited percentage of the injury to the plaintiff. [FN16]

However, faced with the rising medical malpractice premiums in the late 1990s, the prior reform measures were deemed insufficient by the medical community. Doctors renewed their call for caps on damages awarded to victims of their negligence, requesting a \$250,000 cap on non-economic damages in order to reduce the burden of malpractice premiums. [FN17] The medical profession largely blamed frivolous lawsuits and "runaway jury awards" for the heavy premium increases they faced.

### III. The New Legislation--A Brief Overview

On August 14, 2003, the Florida Legislature heeded the call of doctors' groups and the insurance industry and passed Senate Bill 2-D, enacting wide-ranging medical malpractice reforms. [FN18] Key provisions of the reforms included capping non-economic damages that can be awarded in malpractice lawsuits, limiting bad faith actions that may be brought against insurance companies, and enacting certain measures designed to protect consumers from medical negligence. [FN19]

The most widely cited change brought about by the new legislation was the adoption of a cap on non-economic damages in medical negligence actions. [FN20] Section 54 of Senate Bill 2-D enacted Florida Statutes section 766.118, which provides, among other things, that non-economic \*1290 damages "shall not exceed \$500,000 per claimant." [FN21] The level of \$500,000 was greater than the \$250,000 cap first envisioned for the legislation, as the Florida Senate proved unwilling to go along with a ceiling of \$250,000. [FN22] In return for the higher level for the caps on non-economic damages, the Senate gave in to the House's demands for changes in insurance bad faith law and adopted the House's legislative findings of fact. [FN23]

Yet the \$500,000 cap on non-economic damages is not absolute. If medical malpractice

victims are left in a "permanent vegetative state" or die from negligent medical care, the total non-economic damages can increase, up to \$1 million. [FN24] Furthermore, even if the victim is not left in a permanent vegetative state, the non-economic damages can increase to \$1 million if: (a) the trial court determines that the non-economic harm to the patient was "particularly severe" and (b) the malpractice caused the victim to suffer a "catastrophic injury." [FN25]

For hospitals and other "nonpractitioner defendants" in malpractice lawsuits, the cap on non-economic damages is \$750,000, up from the \$500,000 cap for "practitioner defendants." [FN26] As with practitioners, the cap is doubled if the negligence leaves the victim dead or in a permanent vegetative state, or if the non-economic damage was particularly severe and the patient suffered catastrophic injury. [FN27] For the most severe injuries caused by medical negligence, a claimant could potentially recover up to \$1 million in non-economic damages from the negligent doctors, and \$1.5 million from the negligent hospitals or other non-practitioner defendants to the lawsuit.

A second key provision to Senate Bill 2-D is its limitation of bad faith actions against insurance companies. [FN28] The legislature enacted Florida Statutes section 766.1185, erecting certain barriers to recovery of excess damages from insurers who were not willing to deal with malpractice claimants in good faith. [FN29] An insurance company can avoid a claim for bad faith if it tenders the limits of a defendant's policy within 210 days after service of process of the initial complaint in the cause of action. This time period is extended by an additional 60 days if the claimant provided new information to the insurance company after 150 \*1291 days following service of process. [FN30]

Alternatively, the 210/270-day time period may be set aside if the insurer tenders an offer for the policy limits within 60 days of the following events: (1) deposition of all claimants; (2) deposition of all defendants; (3) deposition of all the claimant's medical experts; (4) the initial disclosure of witnesses and production of documents; and (5) mediation as required by Florida Statutes section 766.108. [FN31]

Furthermore, where the time limits outlined above are inapplicable to the bad faith claim, the legislature provided that the trial court shall balance evidence of 10 different criteria in determining whether an insurer acted in bad faith regarding a malpractice cause of action. [FN32] These ten factors vary from the actions of the insurer in attempting to settle the claim to any misrepresentations made by the claimant in the settlement negotiations. [FN33]

While limiting the legal rights afforded victims of medical errors, the legislature passed certain measures calculated to reduce the chance that consumers would suffer from medical negligence. These include:

- Requiring licensed medical facilities to adopt a patient safety plan and a patient safety committee to oversee compliance with the plan. [FN34]
- Notification of patients where there has been "adverse incidents that result in serious harm to the patient." [FN35]
- Requiring doctors to undergo a two-hour course in limiting medical errors as part of their continuing medical education. [FN36]
- Creation by the Florida Department of Health of a "practitioner profile," containing certain information about each doctor that consumers may access. [FN37]
- Placing records of medical negligence causes of action within each practitioner profile maintained by the Florida Department of Health. [FN38]

As passed, the new medical malpractice legislation comprehensively overhauled the legal system by which claimants alleging negligence may recover for medical mistakes. While the most contentious provisions have been briefly outlined here, the breadth of the legislation \*1292 is outside the scope of this Comment. By capping a claimant's recovery and limiting bad faith actions against insurers, the legislature virtually ensured that there will be constitutional challenges to the legislation. [FN39] It remains to be seen whether the new legislation will pass constitutional muster in the face of promised challenges to the Act.

#### IV. The Constitutional Standard

In Florida, malpractice reforms have historically been challenged on the basis of denying persons access to the courts, a right guaranteed by the state's constitution. [FN40] It is a common criticism of any effort to limit victims' recoveries; the basis for these challenges is that victims of negligence or other wrongs are entitled to adjudication of their grievances and compensation from the tortfeasors. These arguments fundamentally are rooted in the philosophy of who should bear the burden of a person's wrongdoing. Tort reform is therefore challenged because of a belief that: "Although isolated victims may suffer at the negligent hands of another, society as a whole should not be forced to bear the burden of misconduct by the wrongdoer who does not fear legal or moral restraints. Accountability must be encouraged in a civilized society; indeed, it must be mandated." [FN41] Taken further away from mere accountability, it is a calculus that puts the rights of victims ahead of the maintenance of commerce. [FN42] The argument, then, is that without allowing victims to hold wrongdoers accountable, the costs of their wrongdoing shifts from the guilty party to society as a whole, instituting a system of corporate welfare. [FN43]

When the Florida Supreme Court analyzed whether legislation violates Article I, section 21 of the Florida Constitution, it determined in *Kluger v. White* [FN44] that legislation cannot abolish the right of access to the courts without providing some alternative method of redress. [FN45] Where there is no alternative redress provided, the legislature must show "an overpowering public necessity for the abolishment of such right" and that there is no way to meet that necessity without abolishing the \*1293 right of access to the courts. [FN46]

It was on the basis of Article I, section 21 of the state constitution that both the Academy of Florida Trial Lawyers and the insurance industry attacked parts of the 1986 comprehensive tort reform legislation, specifically the bill's \$450,000 cap on non-economic damages and limits on joint and several liability. [FN47] As to the \$450,000 cap on non-economic damages, the Florida Supreme Court held that under *Kluger* there was neither a reasonable alternative remedy or commensurate benefit nor "a legislative showing of overpowering public necessity for the abolishment of the right and no alternative method of meeting such public necessity." [FN48] It was specifically reasoned that a medical patient would get no "compensatory benefit" from a cap on non-economic damages because it is not likely that the medical patient's negligence causes the medical error and the injury in the case. [FN49]

The court used rather strong language for determining when the legislature could cap non-economic damages, clearly establishing that its reception of such legislative caps would be cool if there were no explicit benefit granted the tort victim in return. [FN50] As to the limits placed on joint and several liability of defendants, however, the Florida Supreme Court determined that this was not a violation of Article I, section 21, as the right to access the courts did not include the right "to recover for injuries beyond those caused by the particular defendant." [FN51]

While the *Kluger* and subsequent *Smith* decisions seem to point to jurisprudence that would render the cap on non-economic damages unconstitutional for violation of Article I, section 21, there are some exceptions inherent in the reasoning of these cases that would point to ways in which the legislature could frame its findings of fact to make the \*1294 caps constitutional. First, the legislature could provide some alternate remedy or commensurate benefit to victims of medical malpractice in exchange for the caps. [FN52] For example, the Automobile Reparations Reform Act, [FN53] which provided for tort immunity for defendants under some circumstances, was deemed constitutional because it provided a benefit in exchange for the inability to sue for non-economic damage. [FN54] Second, the legislature could make extensive findings of fact, showing some overriding public necessity was met by capping non-economic damages at \$500,000, and that there was no way to meet this public necessity other than the caps. [FN55] In passing the 2003 law, the legislature chose to do both: it erected some concomitant patient protection measures in addition to the caps and made extensive findings of fact as to the necessity of the caps.

Yet the legislative findings of fact do not end the courts' constitutional scrutiny of the

new legislation. In a recent Florida Supreme Court decision, it was determined that the courts may second-guess the legislature's statements of policy and fact in enacting new legislation. [FN56] The court upheld the maxims that the legislature's statements of policy and fact are presumptively correct and entitled to deference by the courts. [FN57] Nonetheless, the court also established that when assessing the constitutionality of the legislation, it is the duty of the trial court to scrutinize these statements, and only uphold them where they are based on actual findings of fact rather than mere conclusory statements. [FN58] Therefore, where the facts recited by the legislature do not jibe with the factual findings of the trial court, the court may substitute its own determinations of the facts supporting the legislation for those of the legislature. [FN59] In enacting the \$500,000 cap on non-economic damages, the legislature advanced certain factual findings that these caps are necessary to ensure adequate levels of health care are provided to Florida consumers. \*1295 However, courts should be willing to rule on evidence as to the basis for these findings. If a claimant can show that no correlation exists between caps on non-economic damages and access to health care, the courts have the power to declare the statute unconstitutional on the basis of the Kluger and Smith decisions.

Furthermore, the benefit to the consumer may not survive judicial scrutiny. If the measures discussed in Section III, supra, prove ill suited to protecting consumers from medical errors, a court could also determine that the legislation is unconstitutional. Following Kluger and Smith, the concomitant benefit to consumers must be real. If patient safety measures enacted by Senate Bill 2-D are ineffectual, the courts could determine that the legislation provides no consumer benefit corresponding to the detriment of the non-economic damages caps, and could thereby rule the statute unconstitutional.

In any event, both sides--those representing doctors and those representing plaintiffs--should ready themselves with empirical evidence to present to a court when either challenging or reaffirming the legislative findings. The remainder of this Comment will discuss these findings of fact and scrutinize them in light of present information that either supports or challenges the findings.

#### V. Legislative Findings

To deal with potential constitutional challenges, section 1 of Senate Bill 2-D sets forth several legislative findings. [FN60] These can broadly be broken up into three categories: (1) findings of the state of the present malpractice insurance market; (2) findings from the Governor's Select Task Force on Healthcare Professional Liability Insurance, convened to make recommendations about how to lower malpractice insurance rates; and (3) findings detailing the necessity of caps on non-economic damages in medical malpractice actions.

##### A. The State of the Industry

The first set of Legislative Findings in S.B. 2-D includes six findings that point to problems in the present industry that will be addressed before this legislation: [FN61]

(1) The Legislature finds that Florida is in the midst of a medical malpractice insurance crisis of unprecedented magnitude.

(2) The Legislature finds that this crisis threatens the quality and availability of health care for all Florida citizens.

\*1296 (3) The Legislature finds that the rapidly growing population and the changing demographics of Florida make it imperative that students continue to choose Florida as the place they will receive their medical educations and practice medicine.

(4) The Legislature finds that Florida is among the states with the highest medical malpractice insurance premiums in the nation.

(5) The Legislature finds that the cost of medical malpractice insurance has increased dramatically during the past decade and both the increase and current cost are substantially higher than the national average.

(6) The Legislature finds that the increase in medical malpractice liability insurance rates

is forcing physicians to practice medicine without professional liability insurance, to leave Florida, to not perform high-risk procedures, or to retire early from the practice of medicine.

There is no question that the cost of medical malpractice insurance for doctors in Florida is on the rise. [FN62] After experiencing relatively stable costs for medical malpractice coverage during the majority of the 1990s, doctors face increases in average malpractice premiums that are estimated to have been as high as 30% in each of 2001 and 2002. [FN63] In percentage terms, these are very large increases, but the raw percentage growth must be put into context.

Between 1996 and 2001, the total value of written premiums in Florida jumped 64%, to a level of \$650 million. [FN64] This contrasts to growth of just 26% throughout the United States as a whole, as total written premiums nation-wide grew to \$7.6 billion. [FN65] Stated in terms of per-doctor averages, the premium levels across Florida in 2001 eclipsed those in the country as a whole, averaging \$16,424, 55% greater than the \*1297 nationwide average of \$10,373 per doctor. [FN66]

While growing in current terms, the values are less stark when adjusted into real terms, factoring in the Consumer Price Index for Medical Care Services. The table below shows that by comparing data in terms of 2000 dollars, the average premium per doctor actually declined by 32.5% between 1991 and 2000 to a value of \$7,844 per doctor. Of course, this data is incomplete and analyzing this growth will require updated figures for 2001 and 2002, since much of the premium growth occurred over the past two years. In addition, Florida-specific analysis is required to put this data in context.

#### UNITED STATES AVERAGE MEDICAL MALPRACTICE PREMIUM PER DOCTOR [FN67]

Year	Total Premiums Collected (US\$)	Consumer Price Index Medical Care Service	Average Premium per Doctor(US\$)*
1991	4,862,170	176.1	11,614
1992	5,138,395	189.7	11,033
1993	5,174,055	202.6	10,119
1994	5,931,898	212.6	10,828
1995	6,080,639	223.5	10,031
1996	5,992,394	231.9	9,302
1997	5,917,038	238.7	8,701
1998	6,195,047	246.5	8,581
1999	6,155,241	254.6	8,051
2000	6,375,401	265.6	7,844
% Change	31.1%	50.8%	-32.5%

Note: \* All average values of premiums collected per doctor are given in terms of US dollar amounts adjusted for inflation to 2000 levels, based on the Consumer Price Index of Medical Care Services as of July 1 of each year.

In addition to statistics showing high premium growth, the legislature's concern was fuelled by anecdotal accounts of doctors forced to either practice elsewhere or give up certain specializations in the face of higher medical malpractice insurance premiums. [FN68] Some high-risk specialists in areas such as surgery or obstetrics and gynecology have felt a \*1298 squeeze and are declining to offer their services, moving into general practice or out of the practice of medicine altogether. [FN69] These doctors cite an inability to turn a profit due to increased medical malpractice premiums charged by their insurance companies and an inability to pass these costs onto their patients because of managed care contracts and low Medicare payouts. [FN70]

Stories about doctors who have left the profession as a result of high medical malpractice insurance premiums and low compensation from managed care groups abound. Most are similar to that of Dr. Terrance Havig, a surgeon who retired in August 2002, when his annual premium reached \$78,000 for half-time practice; he determined that he could no longer profitably practice general surgery. [FN71] There are also stories of hospitals--such as the NCH North Collier Hospital--dropping emergency surgery or obstetrical services because there are not enough physicians to offer these services. [FN72]

But the problem extends beyond rising premium costs. There is also a decided lack of



insurance coverage in general as several companies have stopped doing business in the state. Between 1998 and 2000, seven insurers dropped the medical malpractice line of services in Florida. [FN73] Five of these companies, Unisource, Gulf Atlantic, Caduceus, Frontier, and PHICO stopped selling insurance altogether as they have gone out of business. [FN74] The other two insurers, Scottsdale and Fireman's Fund, are still selling insurance, but no longer offering medical malpractice lines. Further, one of the largest insurers, The St. Paul Companies, has recently exited the market. [FN75] Whereas there were over 40 insurers in Florida writing medical malpractice policies in 1998, there were less than 10 in 2002. [FN76]

The problems of high medical malpractice insurance premiums and \*1299 lower compensation within the medical profession pose a threat to the variety and quality of medical services offered in the state. [FN77] The current period of premium increases is distinguishable from similar costs increases in the 1970s and 1980s in that doctors can no longer pass through these costs to their patients; more patients are part of HMO or other managed care groups which have the bargaining power to refuse higher costs. [FN78] In this environment, different governmental and private groups have taken action in an attempt to resolve the problems facing doctors in Florida.

#### B. The Governor's Select Task Force on Healthcare Professional Liability Insurance

The legislature also made three findings referencing the Governor's Select Task Force on Healthcare Professional Liability Insurance: [FN79]

(8) The Governor created the Governor's Select Task Force on Healthcare Professional Liability Insurance to study and make recommendations to address these problems.

(9) The Legislature has reviewed the findings and recommendations of the Governor's Select Task Force on Healthcare Professional Liability Insurance.

(10) The Legislature finds that the Governor's Select Task Force on Healthcare Professional Liability Insurance 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.

Governor Jeb Bush convened the Task Force on August 28, 2002. [FN80] Its role was to examine the causes of the increasing costs of medical malpractice insurance and propose solutions to the problem. [FN81] The Governor's Select Task Force on Healthcare Professional Liability Insurance was composed of five members, all of whom were either a president or trustee at a leading Florida university. [FN82] These academic leaders were charged with gaining an understanding of the insurance market, the litigation environment, and all other issues implicated in the rising costs of medical malpractice premiums. [FN83]

In January 2003, this Task Force recommended that medical malpractice \*1300 awards for non-economic damages be capped at \$250,000. [FN84] From this recommendation, the panel had only one dissenter, Donna Shalala, President of the University of Miami, who instead recommended a flexible cap on non-economic damages, which would take into account catastrophic situations where the \$250,000 cap would prove insufficient. [FN85] Rejecting Shalala's position on sliding scale caps, the Task Force went even further, recommending sovereign immunity for emergency room physicians and mandated mediation in medical malpractice claims, to occur within 120 days of filing a lawsuit. [FN86]

Armed with the Task Force recommendations, private groups of physicians and hospitals began efforts to lobby the legislature for a \$250,000 cap on non-economic damages in medical malpractice litigation. [FN87] In addition, the Florida Medical Association began a push to get an amendment capping medical malpractice awards onto the 2004 ballot. [FN88] The efforts of the medical community, therefore, centered on capping non-economic damages, premised on an assumption that the reason the premiums are on the rise is because of large awards given by juries in medical malpractice cases. They also pointed to similar caps in other states such as California, Colorado, and South Dakota as successful model legislation upon which to base their efforts.

It is undisputed that the cost of medical malpractice insurance in Florida has increased

over the past two years, and that the problem potentially threatens many doctors who practice in the state. Significant disagreement exists, however, over the reasons for the sudden increase: Proponents of caps on non-economic damages point to statistics of runaway jury awards; those who disagree with that position point to other factors such as losses taken by insurance companies in the stock market. The Task Force considered evidence and recommendations from a variety of sources. [FN89] Its findings were published and ultimately adopted by the legislature in enacting Senate Bill 2- D. Therefore, any attack on the sufficiency of the legislature's findings of fact in the Bill should necessarily involve a critique of the Task Force's findings and recommendations. The next section will detail possible attacks on several of these \*1301 conclusions that could be advanced in challenging the constitutionality of the legislation.

#### A. The Need for Caps on Non-Economic Damages

The third category of legislative findings dealt with the necessity for the measures enacted in Senate Bill 2-D, including caps on non-economic damages in medical malpractice actions: [FN90]

(7) 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.

(11) The Legislature finds that making high-quality health care available to the citizens of this state is an overwhelming public necessity.

(12) The Legislature finds that ensuring that physicians continue to practice in Florida is an overwhelming public necessity.

(13) The Legislature finds that ensuring the availability of affordable professional liability insurance for physicians is an overwhelming public necessity.

(14) The Legislature finds, based upon the findings and recommendations of the Governor's Select Task Force on Healthcare Professional Liability Insurance, the findings and recommendations of various study groups throughout the nation, and the experience of other states, that the overwhelming public necessities of making quality health care available to the citizens of this state, of ensuring that physicians continue to practice in Florida, and of ensuring that those physicians have the opportunity to purchase affordable professional liability insurance cannot be met unless a cap on non-economic damages is imposed.

(15) The Legislature finds that the high cost of medical malpractice claims can be substantially alleviated by imposing a limitation on non-economic damages in medical malpractice actions. [FN91]

There are two primary areas in which these findings may be challenged. First, the measures were not necessary to ensure access to medical care in Florida, because access to medical care was not threatened in the first place. Second, the statement that capping non-economic damages is the only way to alleviate the doctors' burdens of high malpractice premiums is simply untrue.

##### \*1302 1. Ensuring Access to Medical Care

The first challenge to the legislative findings of necessity for the new malpractice legislation is that the measures passed are not necessary for ensuring consumer access to medical care in the state. Even as malpractice rates rose over the past several years, the number of doctors practicing in Florida has been on the rise, and anecdotal evidence from the state and county medical boards that record numbers of doctors are leaving the state has not been borne out statistically.

At the same time as the Special Session of the Florida Legislature was finally ratifying the Act, the U.S. General Accounting Office published its report to Congress detailing the impact of rising malpractice premiums on the access to medical care. [FN92] In this report, the GAO found evidence that contradicted the widely reported anecdotes that doctors were leaving the state of Florida in record numbers. Specifically, the GAO found that:

Reports of physician departures in Florida were anecdotal, not extensive, and in some

cases we determined them to be inaccurate. For example, state medical society officials told us that Collier and Lee counties lost all of their neurosurgeons due to malpractice concerns; however, we found at least five neurosurgeons practicing in each county as of April 2003. Provider groups also reported that malpractice pressures have recently made it difficult for Florida to recruit or retain physicians of any type; however, over the past 2 years the number of new medical licenses issued has increased and physicians per capita has remained unchanged. [FN93]

Therefore, the anecdotal evidence of the plight of physicians leaving the state because of high malpractice premiums is not borne out statistically, when one looks at the number of physicians practicing here. Nonetheless, it is logical to expect that if Florida's malpractice premiums continue to rise at a greater rate than premiums in other states, this situation could change. Anecdotal evidence of doctors quitting practice or refusing to perform risky procedures should be heeded. Yet, the policy of ensuring patient access to care should be examined from a broader perspective than merely how many doctors are practicing in Florida.

The public policy of ensuring access to medical care is stated in two different ways. Proponents of doctor- and insurer-favorable mechanisms for lowering malpractice premiums take the position that keeping premiums low results in more doctors and therefore better access to care for consumers. The flip side of this argument is that mere doctor/patient \*1303 ratios may hint at a better quantity of care available, but that the current system ensures a better quality of care by holding doctors fully accountable for malpractice. Therefore, the legislature has to account for both quantitative and qualitative measures of patient access to medical care in Florida.

As to numbers of physicians, the legislature accepted anecdotal and pseudo-quantitative evidence that doctors are leaving practice or Florida because their premiums are too high. Dr. Denise Baker, who was invited by the White House to speak to the problem in early 2003, quoted statistics from the Florida Medical Association that 900 doctors left the state in 1999 and another 1,200 left in 2000. [FN94] Her estimates placed the number leaving Florida in 2001 at 5,000. [FN95] The problem with her data is that it does not account for new doctors either moving to the state during these years or beginning practice within the state. Furthermore, there is nation-wide evidence that suggests that capping damages will not necessarily keep doctors in the state. [FN96] Supplementing this problematic data on doctors leaving the state, there is anecdotal evidence to suggest that doctors who would otherwise still be practicing medicine in Florida are no longer doing so because of high malpractice premiums. [FN97] These stories often lead advocates of reform to make conclusions that departure of practitioners hinders access to medical care:

Other physician specialists and sub-specialists in medicine face the same plight of unavailable or unaffordable insurance. They are closing their doors, discontinuing coverage for hospital emergency rooms, or simply leaving the state. The departure of these highly-skilled sub-specialists disrupts the referral process utilized by primary care physicians, further hindering access to the best of modern medical care contained within the skilled medical team. If the team cannot \*1304 be assembled when a patient is in need, that patient will suffer. [FN98]

No matter how many doctors are available to treat patients, however, the system can only meet consumer needs if there is high-quality care available that engenders consumer confidence in the system. It is argued that the threat of malpractice gives doctors incentives to practice better medicine, paying greater attention to areas of their practices which may give rise to malpractice claims. [FN99] Doctors and hospitals have adopted practices of better record keeping, spending more time with patients, and having more involved discussions leading to informed consent in order to reduce their exposure. [FN100] It is argued that, "Given the dangerously uneven quality of state medical board regulation of doctors, it is extremely important that patients be able to 'regulate' the quality of doctor care by holding them accountable in court." [FN101] Challenging legislative findings on access to medical care in Florida may therefore consider the quality of available care rather than merely the quantity of doctors. Both

quantity and quality must be considered when assessing whether capping non-economic damages enhances access to medical care. If premiums are too high as a percentage of doctor compensation, this could result in some physicians leaving practice or leaving the state, negatively impacting the quantity of care. However, if the recovery standards are too lax, the quality of care may suffer as physicians and medical groups lose incentives to institute quality assurance programs. Merely limiting patient recovery in order to drive down insurance premiums may ensure that doctors practice medicine in Florida, but the legislation will only ensure that there is "quality health care available to the citizens of this state" if it effectively controls the quality of the health care delivered by these physicians.

## 2. The Necessity for the Caps

"Everybody's suing, it seems like. There are too many lawsuits in America, and there are too many lawsuits filed against doctors and hospitals\*1305 without merit." [FN102] Another aspect embedded in the legislature's findings of fact in favor of capping non-economic damages is that plaintiff verdicts have strained the system by providing "certain elements of [non-economic] damage presently recoverable that have no monetary value, except on a purely arbitrary basis." [FN103] In nearly every call for malpractice reform in Florida, plaintiff verdicts have been held up as a primary culprit, threatening the practice of medicine with arbitrary damages awards. For example, in enacting the 1988 reform measures to medical malpractice, the Florida Legislature similarly found that "[t]he 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." [FN104] Because this argument is seemingly at the root of every call for reform from the medical and insurance communities, the bases and data used in shaping the argument must be examined within the present context.

### a. The Case for Caps

In both federal and state venues, calls for capping non-economic damages for medical malpractice claims have been couched in terms of "runaway litigation" and "excessive jury awards." [FN105] At a speech at the University of Scranton, President Bush stated that "excessive jury awards will continue to drive up insurance costs, will put good doctors out of business or run them out of your community." [FN106] Going even further, the American Medical Association has deemed the entire jury system in the United States a "lottery, where select patients receive astronomical awards, and others pay higher costs for health care and suffer access problems because of it." [FN107] To support this view, statistics are often used which show the very high value of awards to plaintiffs in medical malpractice causes of action. National data is the most readily available and the data most often cited to by proponents of capping non-economic damages. For example, a statistic often cited is that of median jury verdicts against doctors. The St. Paul Companies developed data that showed the \*1306 median jury verdict in medical malpractice cases in 1994 to be \$375,000, rising to \$800,000 by 1999. [FN108] These figures accord with those promulgated by Jury Verdict Research based in Horsham, Pennsylvania, which stated that the median medical malpractice jury award was \$800,000 in 1999, up from \$750,000 in 1998. [FN109] These averages from the late 1990s are contrasted to the situation in the early 1990s where "the frequency of medical malpractice claims that physicians filed with insurance companies declined and the dollar amounts attached to those claims ... hovered around or below \$500,000." [FN110] In addition to high verdicts from juries, the values of settlements are also increasing, with the median settlement in 1999 reaching \$650,000, up 30% from the 1998 level. [FN111] Another common strategy for valuation of jury awards is to cite the very high values of individual awards. Statistics have been cited that in 1997, only two verdicts topped \$20 million, but in 2001 there were 12 over the \$20 million mark, with a \$269 million judgment given by a jury in Dallas, Texas. [FN112] Jury Verdict Research has been cited to show that some 45% of plaintiff awards during 1998 and 1999 were greater than \$1 million, up from 39% of awards between 1997 and 1998. [FN113] Without citing the

source of their data, the Florida Chapter of the American College of Cardiology cited one of the highest figures as to the average jury award, stating, "[T]he average jury verdict has increased 57% in the last five years nationally, from \$2 million to \$3.5 million."

[FN114]

A systematic account of national data on rising costs from jury awards can be found from the Insurance Information Institute. [FN115] This association presented information that the average jury award in medical malpractice cases increased from \$1.14 million in 1994 to \$3.48 million in 2000 (see table below). During this same time, cumulative underwriting losses among medical malpractice insurers increased from \$1.7 billion in 1994 to \$6.6 billion in 2000. The total underwriting loss for 2001 was estimated at \$9.6 billion.

United States: Average Jury Award and Underwriting Losses in Medical Malpractice Cases [FN116]

US\$, million	Average Award	Underwriting Losses
1994	1.14	-1,747
1995	2.04	-1,733
1996	1.90	-2,022
1997	1.97	-2,410
1998	2.98	-3,215
1999	3.43	-4,744
2000	3.48	-6,583

**\*1307** As to damages collected on medical malpractice claims in Florida, several sources of statistics are used to show that awards are increasing and therefore must be curbed. A primary data source is the Florida Department of Insurance Closed Claims Database. Proponents of reforms often use this source to show a 150% increase of paid losses between 1991 and 2000. [FN117] Yet, there are some recognized limitations to the use of this Closed Claims Database. [FN118] The Closed Claims Database is actually two separate databases: (1) an "Archive" database containing claims to June 25, 1999, and (2) a "Current" database containing claims which closed after June 25, 1999. The latter database has been found to be incomplete. [FN119] Therefore, statistics are usually cited to 1999 for the Department of Insurance database, and statisticians then often switch to cite statistics from the National Practitioners Data Bank.

A second source of data on Florida claims against doctors is the National Practitioners Data Bank (NPDB). This source is presumably more accurate than the Florida Department of Insurance for claims after 1999, because of the shortcomings discussed above, and is therefore often cited for the total value of claims made after that date. The NPDB revealed that in 2001, 1,303 claims against doctors were made in Florida, grossing compensation of \$326.1 million. [FN120]

When taken as a whole, the argument from proponents of reform measures such as capping non-economic damages is that juries are awarding more money than ever before in the state of Florida, and that these higher awards are a major reason for the current increases in malpractice **\*1308** premiums. They claim that the current state of affairs has resulted in a "lottery" system whereby juries sometimes ignore facts and sound scientific reasoning, providing astronomical awards not supported by the evidence presented to them. It is argued that a cap on non-economic damages would force juries to compensate victims for their medical costs and their lost wages, while curbing sentimentalism in the jury process.

More fundamental than mere statistics is the point of view that juries are incapable of comprehending the factual complexity of medical malpractice actions, and are easily manipulated by the plaintiff's bar. [FN121] The argument usually presents facts showing the medical malpractice standard of care to be beyond a typical juror's comprehension, and jurors are therefore open to emotional manipulation when presented with a plaintiff with significant injuries. [FN122]

As a whole, then, the argument against allowing the normal civil jury trial system to

determine damages in medical malpractice cases is that they are unsophisticated, undereducated, and too prone to manipulation of their sympathies. Statistics are cited for the proposition that the end result of this skewed jury process in Florida has been a 150% increase in compensation for medical malpractice victims in the 1990s, resulting in the current market instability for medical malpractice insurers.

b. The Case Against Caps

On the other side of the issue are those who claim that the jury process is not out of control. These groups typically include the trial bar and consumer protection groups that come armed with contrary data to thwart what they see as misstatements by groups clamoring for reforms on the other side.

As a first point of departure, those opposing medical malpractice reforms usually begin by attacking the statistic that the average jury award was \$3.48 million in 2000.

[FN123] There are two main attacks of this enormous figure. First, they argue that the figure comes from Jury Verdict Research, which admits the number is flawed. [FN124] Jury Verdict Research acknowledged that there are large gaps in its database, the \*1309 award information is collected unsystematically, and that the service does not know how many cases are missed by the service. [FN125] Furthermore, the database only captures jury awards for the plaintiff; the average figures are not hedged by the number of times that doctors and hospitals actually win a defense verdict, which Jury Verdict Research claims is about 62% of the time. [FN126]

A second attack on the \$3.48 million average jury award figure is data which purports to cover average paid claims throughout the country. The Florida trial bar actually quotes data provided by FPIC, Florida's largest malpractice insurer, which states that the average paid claim in 2000 was \$288,637, with Florida's average coming in at \$247,860. [FN127]

Opponents to currently proposed reform measures also cite Florida-specific data as to the amount of paid claims over a historical period. However, a significant amount of the data that is propounded by this side comes adjusted for inflation, reducing the value of the numbers and chilling the appearance of growth over a historical period. [FN128] Using data from the Florida Department of Insurance, the AFTL argues that adjusted for inflation, "the average payout [to victims of medical negligence in Florida] has gone down by over 14% since 1991." [FN129]

FLORIDA INFLATION-ADJUSTED CLAIMS VALUE, 1990-2000 [FN130]

	*Current Value of Claims	**C.P.I. All Items	*Real Value of Claims	**C.P.I. Medical Care	*Real Value of Claims
1990	\$113,800	130.7	\$113,800	162.8	\$113,800
1991	\$147,254	136.2	\$141,308	177.0	\$135,440
1992	\$133,304	140.3	\$124,183	190.1	\$114,160
1993	\$126,635	144.5	\$114,541	201.4	\$102,364
1994	\$160,362	148.2	\$141,426	211.0	\$123,730
1995	\$208,762	152.4	\$179,037	220.5	\$154,134
1996	\$241,020	156.9	\$200,773	228.2	\$171,946
1997	\$206,961	160.5	\$168,535	234.6	\$143,620
1998	\$183,826	163.0	\$147,399	242.1	\$123,614
1999	\$183,017	166.6	\$143,579	250.6	\$118,895
2000	\$170,969	172.2	\$129,766	260.8	\$106,725
% Change 1990-2000	50.24		14.03		-6.22

Note: \*Values in US\$; \*\*1982-84=100

\*1310 c. Analysis of Available Data

The most comprehensive compilation of data publicly available on medical malpractice awards is that compiled by the Governor's Task Force surrounding their recommendations promulgated January 2003. [FN131] In this report, the Task Force gathered data from the Florida Department of Insurance Closed Claims Database, as well as the National Practitioner Data Bank. [FN132] More accurately, data from these sources was provided the Task Force by Dr. DeHaven-Smith and Milliman USA, Inc., who reviewed the data and collected annual figures. [FN133] The Task force gathered data

from these two statistical analyses and compared their findings for the years 1991 to 2001. [FN134] DeHaven-Smith found that between 1991 and 2001, total paid claims increased by over 60% from \$148.9 million to \$239.2 million. During this same time period, the number of claims also grew, totaling 958 in 2001. Taking these figures together, the value paid per claim during 2001 averaged \$249,726, some 31.8% higher than the average during 1991. This increase reflects a compound average growth rate of 2.8% for the period. Put into perspective, the average income of Florida residents during the period 1991 to 2000 grew from \$20,068 to \$27,764, a compound annual increase of 3.67%. [FN135] Analyzing per-claim data from the other methodologies reveals even lower results. In the Mailman USA study of the Department of Insurance Closed Claims Database, the average paid claim in 2001 was \$233,220, representing a compound annual growth rate of 2.1% since 1991. [FN136] The company's analysis of the National Practitioners Data Bank revealed a per-claim average of \$240,047, representing compound annual growth of 2.4% since 1991. [FN137] In all these methodologies, it can be seen that per claim value growth for medical malpractice lawsuits over the past decade actually underperformed income growth. Certainly, if the reason for capping non-economic damage awards is a compelling need to limit juries, we would expect that awards per claim would outperform income growth throughout the state. It is logical to presume that normal growth in economic damages would mirror growth in average incomes, and therefore the underperforming per claim \*1311 values awarded between 1991 and 2001 are strong evidence that economic damage awards are keeping pace with income levels. However, the data still evidences growing levels of claims and per-claim payouts. The most significant growth was shown in DeHaven-Smith's data, reflecting per-claim growth of 31.8% in the decade to 2001. Even starker is the 60% growth in the total paid claims data, an increase that had to be absorbed by residual loss reserves, investment gains or higher premiums. Therefore, while growing claims are not likely the most compelling component of the current premium adjustments, they are a factor to consider when devising legislative solutions to rising premiums.

FLORIDA: TOTAL CLOSED CLAIMS BY YEAR, 1991-2001 [FN138]

	DeHaven-Smith DOI Database		Mailman USA, Inc. DOI Database NPDB				Independent Analysis DOI Database	
	Total Paid*	Closed Claims	Total Paid*	Closed Claims	Total Paid*	Closed Claims	Total Paid*	Closed Claims
1991	\$148.9	786	\$146.5	771	\$121.4	644	\$147.3	776
1992	\$131.4	643	\$133.8	657	\$144.5	719	\$133.3	664
1993	\$126.2	736	\$125.8	724	\$146.4	786	\$126.6	733
1994	\$152.4	769	\$159.8	802	\$169.7	811	\$160.4	814
1995	\$203.3	933	\$206.4	942	\$189.0	849	\$208.8	960
1996	\$241.1	1,100	\$239.9	1087	\$237.7	1,076	\$241.0	1106
1997	\$208.8	1,003	\$202.8	955	\$223.5	1,100	\$207.0	975
1998	\$189.3	1,032	\$182.2	1001	\$214.2	1,025	\$183.8	1020
1999	\$207.5	791	\$221.0	828	\$238.9	1,045	\$183.0	714
2000	\$214.5	881	\$223.1	891	\$306.4	1,209	\$171.0	594
2001	\$239.2	958	\$205.7	882	\$102.5	427	\$144.4	642

Note: \*All value figures are in US\$, million; independent analysis is the result of the author's own data gathering from the Department of Insurance Closed Claims Data Base.

FLORIDA: AVERAGE CLAIMS VALUE 1991-2001 [FN139]

	DeHaven-Smith DOI Database		Mailman USA, Inc. DOI Database NPDB				Independent Analysis DOI Database	
	Value per Claim*	Percent Change	Value per Claim*	Percent Change	Value per Claim*	Percent Change	Value per Claim*	Percent Change
1991	\$189,409		\$190,013		\$188,509		\$189,761	

1992	\$204,324	7.9%	\$203,653	7.2%	\$200,974	6.6%	\$200,760	5.8%
1993	\$171,409	-16.1%	\$173,757	-14.7%	\$186,260	-7.3%	\$172,763	-13.9%
1994	\$198,187	15.6%	\$199,252	14.7%	\$209,248	12.3%	\$197,005	14.0%
1995	\$217,950	10.0%	\$219,108	10.0%	\$222,615	6.4%	\$217,461	10.4%
1996	\$219,164	0.6%	\$220,699	0.7%	\$220,911	-0.8%	\$217,921	0.2%
1997	\$208,218	-5.0%	\$212,356	-3.8%	\$203,182	-8.0%	\$212,268	-2.6%
1998	\$183,395	-11.9%	\$182,018	-14.3%	\$208,976	2.9%	\$180,222	-15.1%
1999	\$262,379	43.1%	\$266,908	46.6%	\$228,612	9.4%	\$256,327	42.2%
2000	\$243,453	-7.2%	\$250,393	-6.2%	\$253,433	10.9%	\$287,827	12.3%
2001	\$249,726	2.6%	\$233,220	-6.9%	\$240,047	-5.3%	\$224,968	-21.8%
Compound Annual Growth Rate								
1991-2001		2.8%	2.1%		2.4%		1.7%	

Note: \*All value figures are in US\$.

### \*1312 VI. Legislative Omissions of Fact

In addition to problems with the actual findings of fact in the malpractice reforms, the legislature omitted certain factors that have certainly contributed to the current crisis involving medical malpractice insurance premiums. There are three main factors that were not discussed in Senate Bill 2-D, but which have contributed to the present state of the market: (1) insurance companies' mismanagement of loss reserves; (2) negligent practitioners and the ease with which bad doctors are licensed to practice in Florida; and (3) the financial leverage of managed care companies in the health care industry, which prevents doctors from passing on higher premium costs to consumers. By not addressing these contributing factors, it is rather disingenuous of the legislature to claim that capping non-economic damage awards is the only way to solve the present crisis facing doctors in paying higher liability insurance premiums.

#### A. Insurance Company Mismanagement of Funds

One contributing source of increasing premium costs is insurance companies' mismanagement of loss reserves as investments took a hit in equities markets over the past several years. Stock market performance over the past four years has lagged well below the robust growth of the period 1995 to 1999. Because insurance companies invest funds in the market, it is common sense that poor returns have hurt their financial \*1313 positions. However, the extent to which this has impacted insurers is a point of great disagreement.

##### 1. The Economy and Investment Yields Did Not Influence Premiums

In a recent report, Brown Brothers Harriman undertook to study the effect of both poor economic performance and a declining stock market on medical malpractice insurers. [FN140] Analyzing the effect of changing economies and interest rates on medical malpractice premiums, the study searched for correlation between premium levels, annual changes in GDP, and investment yield measured in terms of 5-year Treasury bonds. [FN141] Performing a regression analysis of macro-economic indicators, investment yields, and medical malpractice premiums, the study failed to produce a coefficient of determination of higher than 0.1505, leading to the author's conclusion that "investment yield and the performance of the economy and interest rates do not influence medical malpractice premiums." [FN142] Turning away from interest rates as a measure of investment and focusing on returns from the stock market, the study further concluded: "The decline in equity valuations is not the cause of rising medical malpractice premiums." [FN143] In arriving at this conclusion, the study first analyzed the degree of equities in insurance company portfolios. Over the five years prior to 2001, medical malpractice insurers maintained a fairly stable equity position, comprising just 9.03% of their portfolios' values in 2001. [FN144] Further, the equity investing that was done by these insurers was found to have been done in "a reasonable market-like fashion." [FN145] Because of the low level invested in equities and the conservative method of diversified investing practiced by medical malpractice insurers, the study concluded that this was not the root cause of the poor position of these companies over the past three years. The analysis additionally investigated the "Paid Loss Ratio," measured as a percentage



of premium dollars that are paid out to losses. [FN146] Between 1975 and 2001, the study found that the average paid loss ratio was 47%, with a low of 15.9% in 1976 and a ratio of 74.4% in 2001. [FN147] \*1314 In concrete terms, this means that in 2001 "for every dollar that comes in the door, 75 cents is paid out." [FN148] Moreover, this figure is exclusive of other expenses "such as incurred losses, loss adjustment expenses, general operating expenses, etc., as well as income from investment." [FN149] An outstanding figure calculated when analyzing the data in this way is that "for the loss ratio to drop to its nadir during [the 1975 to 2001 period], premiums would have to increase by 368%." [FN150]

While the current paid loss ratio is at an astronomical level, and premiums would need to increase dramatically to return the industry to its "nadir," it must be kept in mind that its "nadir" was a ratio of 15.9%. Therefore, only 15.9% of the turnover generated from premiums was used to pay claims, which begs the question as to what the companies were doing with the other 74.1% of premiums collected, and what level is sustainable to meet other expenses of these companies to operate profitably.

The Brown Brothers Harriman study reveals that the paid loss ratio exceeded 50% only twice before 1991, and never dropped below that level from 1991 to 2001. [FN151] Key questions for legislative policymakers, therefore, should include: (1) why did the ratio increase so significantly from 1991 to 2001 when aggregate paid claims stabilized, or even declined when measured against inflation (see Section IV(A)(2), supra); (2) at what level of paid loss ratio should insurance companies be allowed to operate; and (3) what should insurance companies be required to do with over-capitalized reserves. There is evidence to show that it was the misuse of excess reserves to boost net profitability during the first half of the 1990s that not only depleted the reserves but also sparked intense price competition within the medical malpractice industry with an end result of pushing up the paid loss ratio to its current untenable level. These claims are examined in the next section.

## 2. Recent Losses of Profitability Are Due to Mismanagement

A key component to the arguments advanced by opponents of the current reform measures is that the crisis facing medical malpractice insurers is largely self-inflicted. There are two major components to this argument. The first is that insurers over-capitalized their reserves and irresponsibly "released" these funds to boost their net incomes during the 1990s. The second part of this argument is that insurers kept premiums low during the 1990s through large gains on investments, and since \*1315 the downturn in securities markets, companies have had to institute large premium increases to overcome investment losses. Both arguments signal a need to look internally at what insurance companies are doing with funds provided them in the form of premiums, and call for more stringent regulation of medical malpractice insurers. In understanding this debate, it is important to keep in mind the nature of the insurance market. The insurance market in the US is cyclical, with periods of "hard" and "soft" markets. [FN152] A "hard" market essentially means that insurers are raising prices for premiums; the corresponding "soft" market means that insurance rates are remaining stagnant, or flat. Within this terminology, it is telling that "soft" does not mean that rates are declining; in current-value terms, a period of declining premiums has rarely, if ever, existed with medical malpractice insurance lines. [FN153] Therefore, a descriptive term of art does not exist that accounts for a period where premiums are actually declining. At present, the industry has moved from a soft to a hard market, and there are many that point to insurance companies themselves for the reasons why this has happened. [FN154]

The first claim of insurer irresponsibility has its roots in growing medical malpractice awards of the 1980s, where actuarial calculations were reworked to reflect large increases in insurance awards that then never materialized in the 1990s. [FN155] Using the example of St. Paul, [FN156] the industry is seen as having set aside too much money for malpractice claims during the late 1980s, compiling excess reserves that were eventually used between 1992 and 1997 to inflate the company's net income. [FN157] A note from the company's annual report states the basis for these changes in accounting

practices:

In 1993, The St. Paul adopted the provisions of Statement of Financial Accounting Standards (SFAS) No. 113, "Accounting and Reporting \*1316 for Reinsurance of Short-Duration and Long-Duration Contracts." This statement required, among other things, that reinsurance recoverables on unpaid losses and LAE [loss adjustment expenses] be shown as an asset, instead of the prior practice of netting this amount against insurance reserves for balance sheet reporting purposes. [FN158]

Depleting loss reserves was called "reconciliations" in the notes to the balance sheets, and resulted in adjustments "totaling \$248 million, \$328 million and \$223 million in 1995, 1994 and 1993, respectively." [FN159]

Emboldened by the profitability shown by St. Paul, smaller insurers entered the market during the early part of the 1990s, attracting customers by undercutting competitors. [FN160] However, the medical malpractice line of insurance turned out not to be profitable and these companies learned that "the so-called profitability of the '90s was the result of those years in the mid-80s when the actuaries were predicting terrible trends." [FN161]

The net result was insurers who "knew [medical malpractice premium] rates were inadequate from 1995 to 2000." [FN162] In this way, stiff competition within the industry developed the soft market of the 1990s, but insurers' reserves were either irresponsibly funneled out of their reserves to feed their bottom lines, or were never adequately capitalized in the first place, leaving insurers poorly positioned to deal with declining equities markets and a hardening medical malpractice insurance market after 1999. [FN163]

Because of these developments, many critics of malpractice reform have stated that capping non-economic damages will not achieve the desired premium savings. In fact, the insurance industry has admitted that tort reform does not necessarily achieve premium savings for doctors. [FN164] According to a press release of the American Insurance Association, "The insurance industry never promised that tort reform would achieve specific premium savings." [FN165] Further, Donald Zuk, the CEO of SCPIE Holdings, a California medical malpractice insurer, admitted that "I don't like to hear insurance-company executives say it's the tort system--\*1317 it's self-inflicted." [FN166]

### 3. A Tale of Two Insurers: St. Paul and FPIC

The poor treatment of loss reserves somewhat complicates the issue of why medical malpractice insurers have suffered significant losses over the past three years that now must be recouped through higher premiums charged to policyholders. In addition to loss payments for paid or defended claims, poor investment performance, strict competition, and new accounting standards eroded insurers' ability to pay and defend lawsuits. Statements in the annual reports of two of the largest medical malpractice insurers during 2000, St. Paul and FPIC, attest to the complexity of assessing the market for medical malpractice insurance.

The St. Paul Companies, Inc.

Between 1996 and 2000, the position of the St. Paul Companies regarding their Global Healthcare lines of business changed dramatically. Eventually, the company exited the market, claiming that "overall deterioration in our major accounts results in 2000" caused them to conduct "a comprehensive review of our strategic options regarding these operations." [FN167] The deterioration in the company's reserves was prompted by losses attributed to long-term care and major accounts:

The significant deterioration in underwriting results compared with 1999 was driven by losses incurred in our long-term care and major accounts books of business, including business acquired in the MMI purchase. Amounts awarded in jury verdicts against the large entities served by the major accounts business center increased sharply in 2000, causing us to strengthen previously established loss reserves for these coverages.

[FN168]

The situation in 2000 contrasts with the company's position only four years prior, where favorable loss developments led the company to "reconcile" loss adjustment expense reserves, adding to St. Paul's bottom line. [FN169] In their 1996 report to the SEC, the

company claimed:

Medical Services has accounted for the majority of favorable prior-year loss development in each of the last three years. Our conservative reserving philosophy in this operation is the product of many years of experience underwriting liability coverages in that unique and often volatile market .... The medical liability claims environment in recent years has been relatively favorable, but our response in terms of reserving has been cautious and gradual, since our prior \*1318 experience with these coverages has shown that reserves previously believed to be adequate can rapidly revert to a deficiency due to shifting trends in social, legal and regulatory factors. [FN170]

In just four years, the company went from "reconciling" loss reserves to add to its profitability and touting its conservative preparation for handling "unique and often volatile market" conditions to a situation where it began blaming jury verdicts against its insureds and considering dropping medical malpractice liability coverage altogether. Indeed, the company did exit the market in 2002, as its loss reserves ultimately proved inadequate to run the business unit profitably. [FN171]

FPIC Insurance Group, Inc.

Contrast the situation of St. Paul with that of FPIC, Florida's largest medical malpractice insurer. [FN172] Rather than using reserves to add to their bottom line during the 1990s, the company positioned itself conservatively to build a strong customer base that has helped FPIC weather market changes over the past three years. The company explained:

Specifically, hardening markets have proven favorable for us. It is essential to maintain adequate pricing, even in a competitive environment. Over the past several years, we have maintained a more stable pricing structure than many of our competitors and, as a result, have been able to maintain our strong policy-holder base. In fact, during the year, we added more than 3,300 professional liability policyholders, increased our market share in Florida and Missouri and entered or grew in other selected markets. Our strong growth fueled an increase in cash flow, investments and total assets. [FN173]

Because the company did not over-compete on price during the late 1990s, it was better positioned than most of its competitors when facing hard market conditions, and currently has great opportunity to gain market share as its competitors exit the market. [FN174] Similar to St. Paul, the company experienced adverse changes in 2000 in terms of increased closed claims with indemnity payments, slowdown in closure rates for pending claims, and increased severity of payments. [FN175] However, the \*1319 company strengthened reserves to weather these adverse changes rather than "reconciling" the loss reserves as the St. Paul Companies had done. [FN176]

Lessons Learned

The complex array of factors that have caused the current "hard" market for medical malpractice insurance was not given a great deal of attention by the legislature when deciding how best to deal with the crisis facing doctors. Factors of insurance company accounting practices and under pricing over the past decade during the "soft" market were not adequately dealt with in order to prevent future crises from eroding the ability of doctors to secure insurance and patients from obtaining relief for medical negligence. By looking at the past actions of the insurance companies, it is clear that lowering the value of damages awarded plaintiffs is not adequate to completely resolve the problem of rising malpractice premiums. The legislature should have ensured greater fiscal responsibility on the part of insurance companies.

4. All Insurance Rates Are Increasing

Yet another factor that the legislature failed to consider is the general insurance cycle, which has witnessed increasing premiums on a number of different commercial lines of business. In 2001, the Council of Insurance Agents and Brokers identified a number of commercial line premium increases including: (1) a 21% increase in premiums on small commercial accounts; (2) a 32% increase in premiums for mid-size commercial accounts; and (3) a 36% increase for premiums on large commercial accounts. [FN177]

The premium growth is seen as a part of the normal underwriting cycle, where the industry is coming out of the "soft" market of the late 1980s and 1990s that was

accentuated by stock market gains and high interest rates, and entering a "hard" market in all commercial lines, not just medical malpractice. [FN178] In considering the state of medical malpractice insurance, however, it is dangerous to point to an insurance cycle across all lines of business in assessing the effects of rate hikes. It is of little use to claim that medical malpractice premiums are part of rising premiums globally throughout the industry, as this does not render premiums more affordable to either doctors or hospitals. Nonetheless, there is value in looking across commercial lines when addressing activities of insurance carriers. It may be that growing premiums are a part of larger price-gouging practices that unfairly take advantage of the "hard" market but are not justified \*1320 in terms of losses that have been suffered. [FN179] Or, more likely, it may reflect poor industry-wide decisions in treating investments and loss reserves, decisions that would naturally be reflected across all lines of insurance rather than just medical malpractice. [FN180] Regardless of the problematic nature of assessing medical malpractice premiums as merely a "natural" cycle in the industry, the problem must be assessed in industry-wide terms, across all lines of business, as malpractice insurers do not operate in a vacuum, and increasing rates among other commercial lines may indicate larger mismanagement of loss reserves.

#### B. Too Many Bad Doctors

Yet another factor contributing to high malpractice insurance premiums is that doctors are committing too many negligent errors. Simply stated, the argument is that the cost of malpractice is due to malpractice itself, and that any increases in the size or number of malpractice verdicts are the result of negligent practitioners. Discussing this position necessarily draws upon not only the actions of the doctors themselves, but also the state Board of Medicine, which is responsible for oversight of the profession.

##### Doctor Error

The primary claim is that doctor error kills too many people in the United States each year. According to an Institute of Medicine report, between 44,000 and 98,000 people die each year from preventable medical error, and medical errors cost between \$17 billion and \$29 billion per year in lost productivity and excess medical expenses.

[FN181] Another often-cited study from Harvard University states that one out of every 200 patients admitted to a hospital dies because of a medical mistake made by that hospital. [FN182]

In addition to practitioners who fall below the standard of care, there are many hospitals that do not adequately deal with infection. The Center for Disease Control estimated that in 2000, there were 90,000 deaths linked to infections which were contracted within the hospital itself. [FN183] Of this number, the Center estimated that 75,000 were preventable \*1321 by the exercise of sterilization and cleanliness in compliance with minimum state and federal standards. [FN184] These numbers are championed by opponents of further medical malpractice liability reforms as evidence that the quality of care is actually quite low, and that claims for malpractice are the result of medical errors being committed on patients rather than patients with "poor outcomes" bringing lawsuits because of the promise of potentially large jury awards. [FN185]

Even medical practitioners have advocated the position that "reducing lawsuits requires preventing errors." [FN186] Dr. Wayne Cohen, who was the medical director at the Bronx Municipal Hospital, stated that "The city was spending so much money defending obstetrics suits, they just made a decision that it would be cheaper to hire people who knew what they were doing." [FN187] Other practitioners have recognized that "there is more malpractice committed than is recognized, litigated or compensated." [FN188]

While even practitioners see the value of minimizing medical errors, there are some well-taken criticisms of the studies used to support the argument that the primary reason for medical malpractice lawsuits is bad medicine. The first criticism is that the Institute of Medicine's report was based on evidence gathered in two studies: the higher figure was taken from the 1990 Harvard Medical Practice study of New York hospitals while the lower figure was taken from a 1992 study of Colorado and Utah hospitals.

[FN189] These studies, critics argue, were based on poor outcomes from procedures, not necessarily medical mistakes. [FN190] Furthermore, a large number of the patients in the survey group in both studies were "at, or near, the end of their lives." [FN191] The argument is that the results are somewhat suspect given the small patient population, the institutionalized status of the patients, and the fact that there is no differentiation between medical mistakes amounting to negligence and merely poor outcomes that were not malpractice.

Whether biased, unscientific, or otherwise, the Institute of \*1322 Medicine's report does illustrate the problem of medical errors, some of which are preventable. In assessing alternative methods of reducing the weight of malpractice on practicing physicians, then, the legislature needs to address medical error. Various solutions to the problem of errors range from advocating more stringent licensure to allowing high malpractice awards to act as a deterrent to practicing bad medicine. However, it is clear that many mistakes either are not discovered until it is too late to bring an action, or never result in a claim. [FN192] In this environment, most consumers look to the Florida Board of Medicine to guard against poor practitioners.

#### Poor Oversight

Under Florida law, the Board of Medicine regulates medical practitioners. [FN193] Pursuant to its authority under section 456.079, Florida Statutes, the Board of Medicine promulgates disciplinary guidelines by which doctors practicing in the state must abide. [FN194] These provide a great deal of oversight for physicians and a range of penalties, purportedly to deal with the problem of the unsafe practice of medicine by incompetent physicians. [FN195] For the purposes of malpractice, there are several guidelines that the Board has at its disposal to discipline doctors.

It is against these guidelines for a doctor to violate Florida Statute section 458.331(1)(t) and commit "[g]ross or repeated malpractice or the failure to practice medicine with that level of care, skill, and treatment which is recognized by a reasonably prudent similar physician as being acceptable under similar conditions and circumstances." [FN196] For a first offense of this provision, the Board recommends an administrative fine of between \$1,000 and \$10,000 plus a penalty of between two years probation to revocation or denial of the license to practice medicine. [FN197] For a second offense, the Board recommends suspension, revocation or \*1323 denial of licensure, plus an administrative fine of between \$5,000 and \$10,000. [FN198]

While the Board mandates certain disciplinary action, and the legislature has worded the purpose for instituting a Board of Medicine in the first place in very strong language, [FN199] the Board has been criticized for being too lenient towards infractions. For example, consumer group Public Citizen states:

The Florida Board of Medicine is dangerously lenient with doctors, repeatedly letting serious and sometimes repeat offenders off the hook. There are many physicians now practicing in Florida who, had they been practicing in states with more patient-protective medical boards, would have either lost their licenses to practice or at least have been given a more serious disciplinary action. Because they are practicing in Florida, many have escaped with fines or letters of reprimand or concern. Most of their patients likely are not aware of their offenses. [FN200]

#### Recidivism

The confluence of too many bad doctors and poor Board of Medicine oversight has led to a small number of doctors that are responsible for a larger than proportionate share of the malpractice claims both in Florida and across the United States. In its analysis of data from the National Practitioner Data Bank ("NPDB"), consumer rights group Public Citizen found that there were 2,674 doctors in Florida with more than one paid claim for medical malpractice. [FN201] Analyzing data provided since September 1990, the group determined that only 6% of doctors in the state have paid out multiple claims, but that these multiple payers have accounted for 47% of the dollar amount paid since the inception of the NPDB. [FN202]

The group's statistics were based on a universe of 44,747 doctors throughout the state, which contradicts the Bureau of Labor Statistics ("BLS") data. However, even taking the

BLS' statistic of 20,980 doctors in Florida during 2000, we see that 12.7% of the state's doctors accounted for 47% of the total dollar amount paid in claims since 1991. [FN203] This number may creep even higher if we average the number of doctors operating in the state between September 1991 and the end of 2000, but in no event does the number of doctors with more than one \*1324 paid claim total greater than 25% of the practitioners in the state. [FN204]

Information from the Florida Department of Insurance closed claims database reveals that of the 455 paid claims of over \$1 million since 1975, doctors with multiple paid claims accounted for 58%, or 264 claims. [FN205] Put differently, doctors with one paid claim were 38.1% more likely to record claims of over \$1 million than doctors who had no prior paid claims.

#### Anecdotal Information

In addition to data about practitioners who are still allowed to practice medicine even after scoring multiple paid claims, there are many anecdotes about poor doctors who are not disciplined by the Florida Board of Medicine. These "repeat malpractitioners" are well-known in stories currently circulated by opponents to new measures to protect doctors. Many of these illustrations purportedly illuminate the mediocre state of the medical practice in Florida among these habitual violators of the standard of care.

In the National Practitioner Data Bank, some 23 physicians in Florida were identified as having paid more than 10 claims. [FN206] Only 12 of these doctors were ever disciplined by the Board of Medicine. [FN207] Consumer group Public Citizen has released much anecdotal information about different recidivist physicians that the Board has failed to discipline, including:

- "Physician Number 98892 settled 18 malpractice lawsuits between 1991 and 1997 involving improper performance of surgery. The damages added up to some \$2 million. This physician has never been disciplined."
- "Physician Number 27908 worked in New York State, where he lost one malpractice suit and settled nine others for a total of \$3.7 million. Around 1991, Physician 27908 moved his practice to Florida, where he settled seven more malpractice suits for a total of \$3.3 million. This doctor, with 17 malpractice lawsuits totaling \$7 million, finally surrendered his New York medical license in 1999, 15 years after the first incident. He still has not been disciplined by Florida authorities."
- "Physician 69310 practiced medicine in Indiana, where he accumulated \*1325 eleven lawsuits. Around 1996 he moved to Florida and settled 4 more, paying some \$2 million in damages to injured patients. This physician has not been disciplined by either Indiana or Florida authorities." [FN208]

When faced with this anecdotal evidence of large payouts from a small number of physicians, it is tempting to be taken over by sensationalism, claiming that the current crisis is the result of a few bad doctors who have interrupted the practice for other practitioners. However, these anecdotes are only illustrative of a small number of doctors in Florida who have been able to practice negligent medicine with little intervention of the Board of Medicine. Because the new malpractice legislation has limited the right of patients to sue negligent doctors, it should have provided for greater oversight of the way that the Board of Medicine's applies its disciplinary standards. This is yet another shortcoming of Senate Bill 2-D passed in August, 2003.

#### C. Managed Care Has Changed the Health Care Industry

A final factor that the legislature failed to consider when enacting the new legislation is changes in the health care industry in general. In this respect, the largest change is the business aspect of practicing medicine, which increasingly necessitates navigating the managed care system. Because of the high cost of medical care, managed care is a "necessary evil" that has developed as consumers look for ways to cut their expenditures. [FN209] Between 1980 and 2000, increases in the cost of medical care has outpaced increases in the consumer price index in general, with the exception of 1980 when the CPI for all good grew by 13.5% compared to 11% growth in the CPI for medical care. [FN210] In this environment, consumers have traded traditional health

insurance policies for managed care of Health Maintenance Organizations (HMOs) and Preferred Provider Organizations (PPOs).

Managed care has brought several changes to the way that doctors do business. First, managed care requires primary care physicians to act as gate-keepers limiting access to higher-cost specialists within organizations. [FN211] With doctors increasingly pressured not to refer patients to specialists, many opponents of the managed care system have argued \*1326 that doctors are at an increased risk for missing diagnoses. [FN212] Doctors themselves have recognized these pressures and often have complained that the system of managed care is reducing the overall quality of medical care throughout the country. [FN213]

The increased role of managed care is a response to the very real problem of increasing health care costs throughout the country. Between 1980 and 2001, private health care expenditures increased by 578.8% to a projected level of \$1.4 trillion, representing compound annual growth of 8.72%. [FN214] While it is not unreasonable for managed care to have stepped in to respond to this ballooning of medical costs, one way in which they have attempted to keep costs down is by limiting remuneration for doctors such that practitioners are no longer able to pass increased medical malpractice premiums on to consumers. [FN215]

The unfortunate result of an inability to pass on malpractice premium costs is illustrated by the small percentage of total health care costs attributed to premiums. As a ratio of just private health care expenditures during 2000, malpractice premiums amounted to only 0.56% of health care costs. [FN216] As a function of total health care costs, therefore, the cost of malpractice insurance declined from nearly 1% in 1988 to 0.56% in 2000. However, it has been recognized that large premium growth over the past two years has pushed this level back to around the 1% range. [FN217]

#### Medical Malpractice Premiums as a Percentage of Health Care Expenditures [FN218]

Year	Total Malpractice Premiums Earned	Private Health Care Expenditures	Premiums as a % of Total Expenditures
1988	5,322	562,000	0.95
1989	5,379	623,900	0.86
1990	5,157	699,400	0.74
1991	5,015	766,800	0.65
1992	5,127	836,500	0.61
1993	5,367	898,500	0.60
1994	5,896	947,700	0.62
1995	6,207	993,700	0.66
1996	6,190	1,042,500	0.59
1997	6,402	1,092,400	0.59
1998	6,559	1,146,000	0.57
1999	6,703	1,211,000	0.55
2000	7,360	1,311,000	0.56

\*1327 Even if costs have approached the 1% range by 2003, it would appear that allowing these costs to be passed to the consumer in exchange for adequate judicial protection from adverse medical error would not significantly add to the enormous cost of health care paid by consumers. Certainly, the one percent cost savings to consumers could have been realized in some way other than curbing injured patients' access to the courts. The legislature failed to assess whether there really was no alternative to achieving this savings [FN219] in areas such as administrative costs, systems efficiencies, or other cost cutting that could reasonably be implemented throughout the health care industry.

#### VII. Conclusion

In examining the findings of fact upon which the legislature based Senate Bill 2-D, as well as the factors leading to higher malpractice premiums that were omitted in these findings, it is clear that there were certainly alternative methods of ensuring access to

medical care in the state of Florida. In terms of reducing malpractice premiums paid by doctors, there is significant evidence that the measures passed will not result in premium savings, and that insurance reform measures not enacted could have achieved the same result. Because of these shortcomings, there is a good likelihood that constitutional challenge to the measures passed in Senate Bill 2-D will be successful.

There are a variety of factors that have led to the current "hard" insurance market facing doctors. Not only are large patient awards to blame, but also stiff competition during the past decade among insurers \*1328 in all lines of business, poor medical care and lax oversight by the Board of Medicine, and the changing face of medical care as managed care companies attempt to control the high cost of medical services. Many of these factors were not dealt with by Senate Bill 2-D. Instead, the legislature focused on only one aspect of the problem: large damage awards. This Comment has attempted to show why the present cap on non-economic damages that resulted from this narrow focus is probably the least appropriate method for dealing with the problem of skyrocketing malpractice insurance premiums.

Certain large questions have not yet been addressed by the legislature. For example, there were no provisions for how insurance companies account for the premiums that they collect. Taking a cross-section of data from this report, we see that summing up FPIC's market share in Florida for 2001 by its collected premiums yields a figure of \$570.7 million in total written premiums throughout the state. [FN220] For the same year, the highest estimated total value of paid claims was \$239.2 million, from 958 total claims. [FN221] If we divide this figure by the highest estimated percentage of how many filed claims never result in plaintiff payments (70%), we arrive at an estimated 3,193 malpractice claims for the year 2001. If each of these claims is then multiplied by the average cost of defending a claim, \$24,669, and add the result to the value of paid claims, the total spending on defending and paying claims in Florida for 2001 was \$317.98 million.

In this estimation, we can see that some \$252.7 million, or 44.3% of all premiums collected by insurance companies, were not used for either paying or defending claims. Put into per-doctor terms, the total written premiums divided by 20,980 doctors yields an average of \$27,201 on written premiums. Of this value, \$15,156 per doctor is applied to defending current claims and paying closed claims. This leaves a residual value of \$12,045 from the monies collected from these doctors.

Certainly, there should have been some accountability for how these monies were applied to administrative costs, loss reserving, and other uses by insurance companies. It was irresponsible of the legislature to pass measures that limited victims' recovery for malpractice without having passed measures to ensure that loss reserves were not squandered by high administrative fees, poor investment choices, or "reconciliations" that add to insurance companies' net profitability without holding monies in reserve to pay future claimants.

\*1329 Presented with a good opportunity to pass more comprehensive changes to the way the entire industry operates with regards to medical malpractice insurance, the legislature fell short. It took away part of a malpractice victim's right to recover for damages from negligent medical care, and provided no proven method to guarantee that Florida consumers would receive better treatment. Capping non-economic damages does have certain broad economic benefits to doctors and insurers by limiting exposure and ensuring more stable risk environments. However, to take advantage of these benefits, insurance companies should be pressured to transparently account for how their written premiums are spent, and doctors should be pressured to account for the level of care they provide. At the same time, some attention should be given to why doctors cannot pass through the cost of higher malpractice premiums to consumers, possibly adjusting the way that managed care companies do business in Florida. Ultimately, the courts will be left to determine whether the benefits to doctors and insurers are sufficient to justify the detriment to consumers and that there is no other way to achieve relief for doctors from high malpractice premiums than partially closing the courts to victims of medical negligence.



[FN1]. The constitutionality of the cap on damages was challenged in Smith v. Department of Insurance, 507 So. 2d 1080 (Fla. 1987). In that case, the Florida Supreme Court found that a \$450,000 cap on non-economic damages violated the plaintiff's right of access to the courts.

[FN2]. 1975 Fla. Laws ch. 75-9, codified as Fla. Stat. ch. 769.133 (1975).

[FN3]. *Id.*

[FN4]. This Task Force was discussed in the University of Miami v. Echarte case, where the 3d DCA took notice of the work of the task force, as well as its recommendations and proposed solutions to the legislature. 585 So. 2d 293, 296 n.11 (Fla. 3d DCA 1991).

[FN5]. Fla. Stat. ch. 768.44 (1976).

[FN6]. Fla. Stat. ch. 768.49 (1976).

[FN7]. Fla. Stat. ch. 768.54 (1976).

[FN8]. See Aldana v. Holub, 381 So. 2d 231 (Fla. 1980).

[FN9]. Fla. Stat. ch. 768.495, 768.575 (1985).

[FN10]. Fla. Stat. ch. 766.202 (1993).

[FN11]. Smith v. Dep't of Ins., 507 So. 2d 1080 (Fla. 1987).

[FN12]. Fla. Stat. ch. 766.207 (2002). For example, a plaintiff whose capacity to enjoy life has been diminished by 50% would be able to recover no more than \$125,000 in non-economic damages through the arbitration.

[FN13]. Fla. Stat. ch. 766.209 (1995).

[FN14]. I recognize the problems associated with using the term "tort reform," and its loaded meaning in the popular press. See, e.g., Alfred P. Carlton, Tort Wars: Simple Messages, Complex Issues, ABA J., Mar. 2003 at 6. I will nonetheless use the term liberally throughout this paper, as its loaded meaning is by now so well known to the average reader that the term will not likely cause significant problems of comprehension.

[FN15]. Fla. Stat. ch. 766.112 (2002).

[FN16]. Wayne J. Guglielmo, Tort Reform Battles: Sometimes the Force is with You, Med. Econ., July 26, 1999, available at <http://www.memag.com>.

[FN17]. Greg Groeller & Robyn Suriano, Lawmakers Leery of Award Limits, Orlando Sentinel, Sept. 22, 2002, at A19.

[FN18]. 2003 Fla. Laws ch. 416.

[FN19]. *Id.*

[FN20]. 2003 Fla. Laws ch. 416, § 54.

[FN21]. *Id.*

[FN22]. Joni James, Deal Struck on Medical Malpractice Insurance, Miami Herald, Aug. 8, 2003, at 1A.

[FN23]. Id.

[FN24]. 2003 Fla. Laws ch. 416, § 54(2)(b).

[FN25]. Id.

[FN26]. Id. § 54(3)(a).

[FN27]. Id.

[FN28]. Id. § 56.

[FN29]. Id.

[FN30]. Id.

[FN31]. Id.

[FN32]. Id.

[FN33]. Id.

[FN34]. Id. § 6.

[FN35]. Id. §§ 7, 8.

[FN36]. Id. § 11.

[FN37]. Id. §§ 14, 15.

[FN38]. Id. § 17.

[FN39]. Mary Ellen Klas, Duel Continues on Eve of Malpractice Law, Palm Beach Post, Sept. 13, 2003, at 1A.

[FN40]. See Fla. Const. art. I, § 21 ("The courts shall be open to every person for redress of any injury, and justice shall be administered without sale, denial or delay.").

[FN41]. Robert A. Clifford, Runaway Juries? The Facts Say No, Nat'l L.J., Feb. 21, 2000, at 15.

[FN42]. Id. ("It may be handy for corporations and insurance companies to calculate the cost of maiming or killing people, but there are those in our society who believe that the scales of justice are more important than the wheels of commerce.").

[FN43]. See Richard H. Middleton, Beating Back Tort 'Reform,' Nat'l Law Journal, Aug. 7, 2000, at A19.

[FN44]. 281 So. 2d 1 (Fla. 1973).

[FN45]. Id. at 4.

[FN46]. Id.

[FN47]. Smith v. Dep't of Ins., 507 So. 2d 1080, 1087 (Fla. 1987). In an odd twist, the Academy of Florida Trial Lawyers and representatives from the insurance industry teamed up to challenge the 1986 legislation. The Trial Lawyers challenged it on the basis of limitations it placed on plaintiffs' recoveries, while the insurance industry was most concerned with tighter controls placed on the industry by the legislature.

[FN48]. Id. at 1088 (emphasis in original).

[FN49]. Id.

[FN50]. Smith, 507 So. 2d at 1089. Specifically, the court stated:  
This reasoning fails to recognize that we are dealing with a constitutional right which may not be restricted simply because the legislature deems it rational to do so. Rationality only becomes relevant if the legislature provides an alternative remedy or abrogates or restricts the right based on a showing of overpowering public necessity and that no alternative method of meeting that necessity exists. Here, however, the legislature has provided nothing in the way of an alternative remedy or commensurate benefit and one can only speculate, in an act of faith, that somehow the legislative scheme will benefit the tort victim.

Id.

[FN51]. Id. at 1091.

[FN52]. See id. at 1088.

[FN53]. Fla. Stat. ch. 627.737 (1974).

[FN54]. Lasky v. State Farm Ins. Co., 296 So. 2d 9, 14 (Fla. 1974). Specifically, the court stated:

In exchange for his former right to damages for pain and suffering in the limited category of cases where such items are preempted by the act, he receives not only a prompt recovery of his major, salient out-of-pocket losses--even where he is at fault--but also an immunity from being held liable for the pain and suffering of the other parties to the accident if they should fall within this limited class where such items are not recoverable.

Id.

[FN55]. Smith, 507 So. 2d at 1088.

[FN56]. See N. Fla. Women's Health & Counseling Servs., Inc. v. State, No. SC01-843, 2003 WL 21546546, at \*10 (Fla. July 10, 2003).

[FN57]. Id.

[FN58]. Id.

[FN59]. Id.

[FN60]. 2003 Fla. Laws ch. 416.

[FN61]. Id. § 1.

[FN62]. See, e.g., Governor Jeb Bush, Exec. Order No. 02-241 (Aug. 28, 2002).

[FN63]. See, e.g., Bush Creates Task Force on Medical Malpractice Insurance, Naples Daily News, Aug. 29, 2002, available at <http://>

web.naplesnews.com/02/08/florida/d820153a.htm (last visited Mar. 26, 2004). See also Tim Stapleton, *The Perfect Storm: The Current Medical Malpractice Crisis*, Florida Chapter of the American College of Cardiology, Oct. 2001, available at <http://www.accfl.org/articles/artcl-storm.htm> (last visited Mar. 26, 2004) (estimating the increases at 25% per year in 2001 and 2002).

[FN64]. <http://www.fha.org/> See Richard S. Biondi et al., Florida Hospital Association, *Medical Malpractice Analysis 11* (Nov. 7, 2002) (on file with author). The FHA's data reflecting written premiums of \$650 million is the highest level of written premiums reported in the literature for 2001 and exceeds the Governor's Task Force on Healthcare Professional Liability Insurance estimates, which placed the value at around \$570.7 million. See John C. Hitt et al., *Report of the Governor's Select Task Force on Healthcare Professional Liability Insurance 62-63* (2003), available at <http://www.fha.org/acrobat/DOHLargeFinalBook.pdf> (last visited Mar. 26, 2004).

[FN65]. *Id.*

[FN66]. *Id.* In its calculation of a per-doctor average, the FHA data estimates the number of doctors in Florida to be 39,576, somewhat higher than the Bureau of Labor Statistics (BLS), which places the number of doctors in Florida at 20,980 during 2001. See 2001 State Occupational Employment and Wage Estimates, Florida, at [http://www.bls.gov/oes/2001/oes\\_fl.htm](http://www.bls.gov/oes/2001/oes_fl.htm) (last visited Mar. 26, 2004). Taking the lower number given by the BLS, the per-doctor premium can be estimated at \$30,981.

[FN67]. *Medical Malpractice Insurance Rates*, Hearing Before the Subcomm. on Health of the House, Comm. on Energy and Commerce, 107th Cong. Exhibit A (2002) (statement of Travis Plunkett, Legislative Dir. Consumer Fed'n of Am.), available at [http://www.consumerfed.org/Med\\_Mal\\_House\\_testimony.pdf](http://www.consumerfed.org/Med_Mal_House_testimony.pdf) (last visited Mar. 26, 2004). Data on the number of doctors was taken from the Statistical Abstract of the United States; medical care inflation data was taken from the Bureau of Labor Statistics; and data on premium levels was taken from the National Association of Insurance Commissioners' Report on Profit by Line by State. *Id.*

[FN68]. See John Dorschner, *Doctor, Lawyer Battle Costly*, *Miami Herald*, Nov. 5, 2002, at C1.

[FN69]. Liz Freeman, *Insurance Squeeze Tightens for Another SW Florida Surgeon*, *Naples Daily News*, Sept. 9, 2002, available at <http://web.naplesnews.com/02/09/naples/d799065a.htm> (last visited Mar. 26, 2004).

[FN70]. *Id.*

[FN71]. Liz Freeman, *Hospitals Warn Area Medical Care May Be Impacted by High Insurance Rates*, *Naples Daily News*, Aug. 13, 2002, available at <http://www.naplesdailynews.com/02/08/naples/d802404a.htm> <http://web.naplesnews.com/02/08/naples/d802404a.htm> (last visited Mar. 26, 2004).

[FN72]. *Id.*

[FN73]. Stapleton, *supra* note 63.

[FN74]. *Id.*

[FN75]. See *The St. Paul Companies, Inc., Annual Report Form 10-K For the Fiscal Year Ended December 31, 2001*, Mar. 29, 2002, at 6.

[FN76]. Letter from Coalition to Ensure Patient Access (CEPA) to the Honorable J. Dudley Goodlette, Chair, Medical Liability Insurance Workgroup 1 (Nov. 8, 2002), available at [http://www.leg.state.fl.us/publications/2003/house/reports/med\\_liability/pdfs/44%20Organizations.pdf](http://www.leg.state.fl.us/publications/2003/house/reports/med_liability/pdfs/44%20Organizations.pdf) (last visited Mar. 26, 2004).

[FN77]. Dorschner, *supra* note 68.

[FN78]. *Id.* (The comment made about doctors' inability to pass through the costs to their patients was attributed to Bill Sage, a law professor at Columbia University).

[FN79]. 2003 Fla. Laws ch. 416, § 1.

[FN80]. See Governor Jeb Bush, Exec. Order No. 02-241 (Aug. 28, 2002).

[FN81]. *Id.*

[FN82]. *Id.*

[FN83]. *Id.*

[FN84]. See, e.g., Phil Galewitz, Panel Urges \$250,000 Malpractice Award Cap, Palm Beach Post, Jan. 17, 2003, at 1A.

[FN85]. *Id.*

[FN86]. *Id.*

[FN87]. Freeman, *supra* note 71.

[FN88]. *Id.*

[FN89]. Governor's Select Task Force on Healthcare Professional Liability Insurance, Jan. 29, 2003, available at <http://www.doh.state.fl.us/myflorida/DOH-Large-Final%20Book.pdf> (last visited Mar. 26, 2004).

[FN90]. 2003 Fla. Laws ch. 416, § 1.

[FN91]. *Id.*

[FN92]. U.S. General Accounting Office, Medical Malpractice: Implications of Rising Premiums on Access to Health Care, GAO-03-836 (Aug. 2003).

[FN93]. *Id.* at 17-18.

[FN94]. Donna Wright, Bush Told of Doctor Exodus: Florida's Malpractice Crisis, Bradenton Herald, Jan. 17, 2003 at A1.

[FN95]. *Id.*

[FN96]. Statement of Senator Edward M. Kennedy in Opposition to the Medical Malpractice Amendment: Greater Access to Affordable Pharmaceuticals Act of 2001, July 26, 2002, available at <http://www.senate.gov/7Ekennedy.statements/02/07/2002730306.html>. He states that national data from the AMA shows that in states with caps on non-economic damages, there are 233 doctors per 100,000 persons, while states without caps average just 223 doctors per 100,000; states without caps have 29 ob/gyn's per 100,000 residents, while states with caps have just

27.4 per 100,000).

[FN97]. See, e.g., Freeman, *supra* note 69; Kris Hundley, Malpractice Insurance Crisis Hits Home, *St. Petersburg Times*, Aug. 17, 2002, available at [http://www.sptimes.com/2002/08/17/Business/Malpractice\\_insurance.shtml](http://www.sptimes.com/2002/08/17/Business/Malpractice_insurance.shtml) (last visited Mar. 26, 2004); Press Release, Florida Hospital Association, Medical Liability Insurance Crisis Forces Hospitals to Close, Reduce Services Statewide, New Data Shows (Jan. 2, 2003) (on file with author) (chronicles hospital department closures due to high medical malpractice costs over the three years to 2003).

[FN98]. Letter from Florida Academy of Family Physicians, to J. Dudley Goodlette, Chair, Medical Liability Insurance Workgroup (Nov. 6, 2002), available at [http://www.leg.state.fl.us/publications/2003/house/reports/med\\_liability/pdfs/FL%20Academy%20of%20Family%20Physicians.pdf](http://www.leg.state.fl.us/publications/2003/house/reports/med_liability/pdfs/FL%20Academy%20of%20Family%20Physicians.pdf) (last visited Mar. 26, 2004).

[FN99]. Medical Malpractice: A Continuing Problem with Far-Reaching Implications: Hearing Before the House Subcomm. on Ways and Means, GAO/T-HRD-90-24, at 10 (Apr. 26, 1990) (statement of Charles A. Bowsher, Comptroller General of the United States).

[FN100]. *Id.*

[FN101]. Public Citizen, *Bush Administration Grandstanding on Medical Malpractice, Failing Patients in Need of Better Medical Care*, available at [http://www.citizen.org/pressroom/print\\_release.cfm?ID=1165](http://www.citizen.org/pressroom/print_release.cfm?ID=1165) (July 25, 2002) (quoting Sidney Wolfe, M.D., director of Public Citizen's Health Research Group).

[FN102]. Greg Groeller, *Bush Touts Award Cap on Medical Malpractice*, *Orlando Sentinel*, Jan. 17, 2003, at A1 (quoting President George W. Bush).

[FN103]. 2003 Fla. Laws ch. 416, § 1.

[FN104]. *Fla. Stat. ch. 766.201 (2002)*. The statute, enacted in 1988 as Chapter 88-1, § 48, is the legislative findings and intent for the 1988 medical malpractice reform measures that were enacted.

[FN105]. See Groeller, *supra* note 102.

[FN106]. *Id.*

[FN107]. John Hillman, *AMA Pushes for Federal Med-Mal Legislation*, *Best's Ins. News*, Aug. 14, 2002 (via BestWire).

[FN108]. John Dorschner, *Many Miami-Area Doctors Forgo Malpractice Insurance Due to Rates, Jury Awards*, *Miami Herald*, Feb. 3, 2002, at 1E.

[FN109]. See Tanya Albert, *Malpractice Awards Pushing Insurance Premiums Higher, Juries Are Awarding Higher Dollar Amounts in Malpractice Cases, Hitting Physicians in the Pocketbook*, *AMNews*, Mar. 5, 2001, available at <http://www.ama-assn.org/amednews/2001/03/05/prl10305.htm>.

[FN110]. *Id.*

[FN111]. *Id.*

[FN112]. Dorschner, *supra* note 108.

[FN113]. See Albert, *supra* note 109.

[FN114]. Stapleton, *supra* note 63.

[FN115]. Robert P. Hartwig, Trends in Medical Malpractice: Behind the Chaos, Presentation of the Insurance Information Institute (Apr. 25, 2003), available at [http://server.iii.org/yy\\_obj\\_data/binary/695301\\_1\\_0/medmal.pdf](http://server.iii.org/yy_obj_data/binary/695301_1_0/medmal.pdf).

[FN116]. *Id.*

[FN117]. Florida Medical Association, The Medical Liability Insurance Crisis: Fact and Fiction, Jan. 31, 2003 (Letter to the Governor's Task Force on Medical Malpractice Liability), available at <http://www.fma.org>.

[FN118]. See Letter from Richard S. Biondi, (WHO IS HE??) to the Governor's Task Force on Health Care Professional Liability State of Florida (Jan. 8, 2003), available at [www.healfhealth.org/heal\\_FLhealthcare/presentationLancedeHavenSmith.html](http://www.healfhealth.org/heal_FLhealthcare/presentationLancedeHavenSmith.html).

[FN119]. *Id.*

[FN120]. Florida Medical Association, The Medical Liability Insurance Crisis: Fact and Fiction, Jan. 31, 2003. (Letter to the Governor's Task Force on Medical Malpractice Liability).

[FN121]. See Edward L. Holloran III, Medical Malpractice Litigation in Florida: Discussion of Problems and Recommendations, 26 *Nova L. Rev.* 331, 335 (2001).

[FN122]. *Id.*

[FN123]. See Association of Florida Trial Lawyers, Medical Malpractice Situation Analysis 1 (2003) (Report to the Governor's Task Force).

[FN124]. Rachel Zimmerman & Christopher Oster, Insurer's Missteps Helped Provoke Malpractice "Crisis": Lawsuits Alone Didn't Cause Premiums to Skyrocket; Earlier Price War a Factor, *Wall St. J.*, June 24, 2002, at A1.

[FN125]. *Id.*

[FN126]. *Id.*

[FN127]. See Association of Florida Trial Lawyers, *supra* note 123, at 2.

[FN128]. See *id.* at 3.

[FN129]. *Id.* (emphasis in original).

[FN130]. Closed Claims data from the Florida Department of Insurance Closed Claims Database; Consumer Price Indices from the United States Department of Labor, Bureau of Labor Statistics.

[FN131]. Hitt et al., *supra* note 64.

[FN132]. *Id.* at 132.

[FN133]. *Id.* at 128.

[FN134]. Hitt et al., *supra* note 64.

[FN135]. Florida Agency for Workforce Innovation: Florida Research and Economic Database (FRED), available at <http://fred.labormarketinfo.com>.

[FN136]. Cite

[FN137]. Cite

[FN138]. See Hitt et al., *supra* note 64, at 132.

[FN139]. *Id.*

[FN140]. Raghu Ramachandran, Did Investments Affect Medical Malpractice Premiums? *Ins. Inv. Research* (Brown Brothers Harriman, New York, N.Y.), Jan. 2003.

[FN141]. *Id.* at 2.

[FN142]. *Id.* at 3.

[FN143]. *Id.* at 4.

[FN144]. *Id.* at 3.

[FN145]. Ramachandran, *supra* note 140, at 4.

[FN146]. *Id.*

[FN147]. *Id.*

[FN148]. *Id.*

[FN149]. *Id.*

[FN150]. Ramachandran, *supra* note 140, at 5.

[FN151]. *Id.* at 4.

[FN152]. See Plunkett, *supra* note 66. See also Richard A. Opiel, Jr., Bush Enters Fray Over Malpractice, *N.Y. Times*, Jan. 17, 2003, at A24 (quoting Frank A. Sloan, economics professor at Duke University: "[Medical malpractice] is the most cyclical health policy there is .... There are periods of time when premiums stop going up, and then nobody's interested, then again we get a crisis and everyone says juries are terrible.").

[FN153]. See Plunkett, *supra* note 66.

[FN154]. National Consumer Groups Applaud Congress' Call for Major Investigation of Insurance Industry, *US Newswire*, July 3, 2002, available at <http://www.usnewswire.com/topnews/first/0703-119.html> (quoting Susanna Montezemolo of the Consumers' Union: "The primary causes of these crises are severe underwriting problems and the cyclical nature of the medical malpractice insurance industry. Congress should focus on these issues, rather than ineffective tort 'reform' efforts.").

[FN155]. Zimmerman & Oster, *supra* note 124, at A8.



[FN156]. Id. The company is cited as having a 20% national market share for medical malpractice insurance during 1985, and is therefore used as the market-leading insurer in this example.

[FN157]. Id.

[FN158]. The St. Paul Companies, Inc., 1996 Report 10K-405 to the Securities Exchange Commission 6 (1996).

[FN159]. Id.

[FN160]. Zimmerman & Oster, *supra* note 124.

[FN161]. Id. (quoting Donald J. Fager, president of Medical Liability Mutual Insurance Co.).

[FN162]. Id. (quoting Bob Sanders, an actuary with Millman USA).

[FN163]. Joe Niedzielski, Conning: Upheaval Due in Medical Malpractice, *Nat'l Underwriter*, Sept. 15, 1997, at 39. This article claims that as early as 1997, the medical malpractice insurance industry was predicting poor performance. Favorable loss developments from 1987 to 1993, and high returns on investments allowed premiums to stay artificially low in comparison to paid losses, and insurers could remain profitable through investment returns. Id.

[FN164]. Kennedy, *supra* note 96.

[FN165]. Id.

[FN166]. Id.

[FN167]. The St. Paul Companies, Inc., 2000 Annual Report, at 28.

[FN168]. Id. at 27.

[FN169]. The St. Paul Companies, Inc., 1996 Report 10K-405 to the Securities Exchange Commission 49 (1996).

[FN170]. Id. at 49.

[FN171]. See The St. Paul Companies, Inc., Annual Report Form 10-K For the Fiscal Year Ended December 31, 2001, Mar. 29, 2002, at 6.

[FN172]. Marie Suszynski, More Than 1,000 Rally in Florida for Federal Med-Mal Bill, *BestWire*, July 16, 2002. The company's statewide market share measured by total premiums collected was estimated at 18.8% in 2001. See also FPIC Insurance Group, Inc., *Tough Questions, Honest Answers: Annual Report for the year 2001*, at 48 (57% of the company's malpractice insurance business consisted of policies written in the state).

[FN173]. FPIC Insurance Group, Inc., *Tough Questions, Honest Answers: Annual Report for the year 2001*, at 6.

[FN174]. Id. at 9.

[FN175]. Id. at 63.

- [FN176]. See *id.*
- [FN177]. Plunkett, *supra* note 67, at 1-2.
- [FN178]. *Id.* at 3.
- [FN179]. *Id.* at 3.
- [FN180]. Public Citizen, Florida's Real Medical Malpractice Problem: Bad Doctors and Insurance Companies, Not the Legal System, at 9-10, available at <http://www.citizen.org/documents/FLAreport.pdf> (Sept. 2002).
- [FN181]. Linda T. Kohn et al., To Err is Human: Building a Safer Health System 1-2 (2000).
- [FN182]. Harvard Medical Practice Study, Patients, Doctors and Lawyers: Medical Injury, Malpractice Litigation, and Patient Compensation in New York (1990).
- [FN183]. Michael J. Berens, Infection Epidemic Carves Deadly Path, *Chi. Trib.*, July 21, 2002, at C1.
- [FN184]. *Id.*
- [FN185]. Academy of Florida Trial Lawyers, Medical Malpractice: Situation Analysis, at 6, available at <http://www.aftl.org>.
- [FN186]. William M. Sage, M.D., Putting the Patient Back in Patient Safety, 287 *J. Am. Med. Ass'n* 3003 (2002).
- [FN187]. Dean Baquet & Jane Fritsch, New York's Public Hospitals Fail, and Babies are the Victims, *N.Y. Times*, Mar. 5, 1995, at 1 (explaining the hospital's decision to use midwives instead of untrained interns for births).
- [FN188]. Tort Reform Only Part of Solution for Liability Crisis, *AAFP Direct*, May 17, 2002, at 1, available at [http://www.aafp.org/ad/afpentireMay\\_17\\_2002.html](http://www.aafp.org/ad/afpentireMay_17_2002.html).
- [FN189]. Mark Crane, Medical Mistakes, Must Doctors Take the Rap? Looking Beyond the IOM Report, *Med. Econ.*, Nov. 20, 2000, available at <http://www.memag.com>.
- [FN190]. *Id.*
- [FN191]. *Id.*
- [FN192]. Harvard Medical Practice Study, *supra* note 182. This book claims that only one in eight medical errors resulting in death or serious injury ever gives rise to a lawsuit.
- [FN193]. Fla. Stat. ch. 458.301-458-3.51, 627.357 (2002).
- [FN194]. The Guidelines are issued by the Board of Medicine in Fla. Admin. Code Ann. r. 64B8-8.001 (2004).
- [FN195]. See Fla. Stat. ch. 458.301 (2002):  
The Legislature recognizes that the practice of medicine is potentially dangerous to the public if conducted by unsafe and incompetent practitioners. The Legislature finds further that it is difficult for the public to make an informed choice when selecting a physician.

and that the consequences of a wrong decision could seriously harm the public health and safety. The primary legislative purpose in enacting this chapter is to ensure that every physician practicing in this state meets minimum requirements for safe practice. It is the legislative intent that physicians who fall below minimum competency or who otherwise present a danger to the public shall be prohibited from practicing in this state.

[FN196]. See *supra* note 194.

[FN197]. *Id.*

[FN198]. *Id.*

[FN199]. See Fla. Stat. ch. 458.301 (2002).

[FN200]. Public Citizen, *supra* note 180, at 8.

[FN201]. *Id.* at 6.

[FN202]. *Id.*

[FN203]. 2000 State Occupational Employment and Wage Estimates, Florida, at [http://www.bls.gov/oes/2000/oes\\_fl.htm](http://www.bls.gov/oes/2000/oes_fl.htm) (last visited Mar. 26, 2004).

[FN204]. An average of the number of doctors practicing in Florida between 1998 and 2000, according to Bureau of Labor Statistics data, is just under 14,000. As a percentage of this average, the 2,974 doctors with multiple paid claims represent only 21.2%. See Bureau of Labor Statistics data, at <http://www.bls.gov>. Statistics on the number of doctors in Florida prior to 1998 were not available from the BLS.

[FN205]. Florida Department of Insurance, Closed Claims Database, at <http://www.fldfs.com/Data/Liability/index.htm>.

[FN206]. Public Citizen, *supra* note 178, at 7.

[FN207]. *Id.*

[FN208]. *Id.*

[FN209]. Dan Lonkevich, Medical Malpractice Reform Inches Ahead, Nat'l Underwriter--Life & Health, Nov. 10, 1997, at 32.

[FN210]. United States Department of Labor, Bureau of Labor Statistics, Consumer Price Index series (1982-84 = 100.0), available at <http://www.bls.gov>.

[FN211]. David M. Katz, Health Care Growth Spawns New Risks, Nat'l Underwriter--Life & Health, Nov. 10, 1997, at 49.

[FN212]. *Id.*

[FN213]. See Lonkevich, *supra* note 209, at 32.

[FN214]. U.S. Census Bureau, Statistical Abstract of the United States: 2002, at 91.

[FN215]. See *supra* note 79.

[FN216]. See Plunkett, *supra* note 67, at Exhibit B. Accord Insurance Information

Institute, Hot Topics and Insurance Issues: Medical Malpractice, Jan. 2003, available at [http:// www.iii.org/media/hottopics/insurance/medicalmal/content.print/findings](http://www.iii.org/media/hottopics/insurance/medicalmal/content.print/findings) ("Medical malpractice premiums contribute about 1 percent to the overall cost of health care").

[FN217]. Id. at Appendix B.

[FN218]. See Plunkett, supra note 67, at 3.

[FN219]. See Smith v. Dep't of Ins., 507 So. 2d 1080, 1088 (Fla. 1987). For a discussion of the constitutional standard of restricting access to the courts by capping non-economic damages, see Section V(B) of this Comment.

[FN220]. This figure accords with a sum of written premiums gathered by the Governor's Task Force. See Hitt et al., supra note 64, at 62-63.

[FN221]. Id.

[FNa1]. J.D. 2004.  
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