

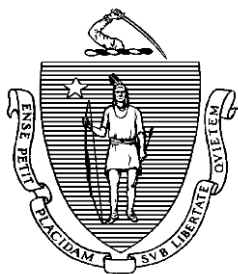
MEDICAL MALPRACTICE INSURANCE IN THE MASSACHUSETTS MARKET

Compendium of Testimony & Related Information

Investigation and Study of the Costs of Medical Malpractice Insurance for Health Care Providers

*A report to the Joint Committee on Financial Services,
Joint Committee on Health Care Financing
the Senate Committee on Ways and Means,
and House Committee on Ways and Means
of the Massachusetts General Court,
and the Secretary of the Commonwealth*

December 31, 2008



NONNIE S. BURNES
COMMISSIONER OF INSURANCE

DIVISION OF INSURANCE

Compendium of Testimony & Related Information

Investigation and Study of the Costs of Medical Malpractice Insurance for Health Care Providers

Section	Document
1.0	Chapter 305 of the Acts of 2008, section 39
2.0	Hearing Notice
3.0	Proof of Publication; Boston Globe – 9/12/08
4.0	Testimony - Industry/Trade Groups
4.1	Written Testimony of R. Brewer of Medical Professional Mutual Insurance Company (ProMutual)
4.2	Written Statement of Medical Protective Company (MedPro)
4.3	Materials from MATA; “MATA Testimony” [1], Statement of Jay Angoff w/ supporting material [2], Medical Malpractice Reform Opposition Sheet [3], Article from <i>Monitor</i> re: Healthcare Professional Liability (w/ accompanying graph) [4], <i>The Truth About Medical Malpractice Litigation</i> [5], <i>Patient Justice</i> [6], <i>Where have all the doctors gone?</i> [7], <i>Highly Regarded New Studies Obliterate Common Myths About Medical Malpractice</i> [8], Statement of Joanne Doroshov of Center for Justice & Democracy (“CJ&D”) [9]
4.4	Francis C. O’Brien of Property Casualty Insurers Assoc. of America (PCI) (dated 10/3/08)
4.5	Francis C. O’Brien of PCI (dated 10/7/08)
4.6	Supplemental Statement of F. O’Brien of PCI (dated 10/14/08)
4.7	Written Statement of James T. Harrington of the Massachusetts Insurance Federation, Inc.
4.8	Written Testimony of Massachusetts Medical Society; <i>Physician Workforce Study, Executive Summary 2008</i>
5.0	Testimony - Healthcare Providers
5.1	Dr. Darlyne Johnson sent <u>via</u> e-mail to K. Beagan
5.2	Dr. Veronica Ravinkar sent <u>via</u> e-mail to K. Beagan
5.3	Written Statement of Nurses United for Responsible Services
5.4	Written Statement of Dr. Marylou Buyse of Massachusetts Association of Health Plans (“MAHP”); <u>via</u> e-mail and fax

6.0	Testimony - Other	
	6.1	Written Statement of Sen. Richard T. Moore (dated 10/1/08 to Commissioner)
	6.2	Written Statement of Matt Rearwin; <i>Massachusetts Fixed the "Malpractice Crisis: and Punishes the Victims</i>

7.0	Other Information	
	7.1	Review of Florida Committee Substitute for Senate Bill 2-D; 11/6/03 (Deloitte)
	7.2	Florida Medical Malpractice Financial Information, Closed Claim Database and Rate Filings; 10/1/04 (Deloitte)
	7.3	<i>The Million-Dollar Challenge</i> (article by Kevin M. Bingham)

8.0	Transcripts	
	8.1	Transcripts: Public Informational Hearing on 10/3/08
	8.2	Transcripts: Public Informational Hearing on 10/8/08

Chapter 305 of the Acts of 2008

AN ACT TO PROMOTE COST CONTAINMENT, TRANSPARENCY AND EFFICIENCY IN THE DELIVERY OF QUALITY HEALTH CARE.

SECTION 39. Notwithstanding any general or special law to the contrary, the division of insurance shall conduct an investigation and study of the costs of medical malpractice coverage for health care providers, as defined in section 193U of chapter 175 of the General Laws. The investigation and study shall include, but not be limited to, an examination and analysis of the following: (1) the availability and affordability of medical malpractice insurance; (2) the factors considered by medical malpractice insurers when increasing premiums; (3) options for decreasing premiums including, but not limited to, establishing a reinsurance pool with additional stop loss coverage, subsidizing premium payments of providers practicing in certain high-risk specialties or in specialties for which the cost of premiums represents a disproportionately high proportion of a health care provider's income, subsidizing premium payments of providers who do not qualify for group coverage rates and pay higher premiums for commercial market insurance and prorating premiums for providers who practice less than full-time; and (4) funding mechanisms that would facilitate the implementation of recommendations arising out of the study which may include, but shall not be limited to, charges borne by the health care industry or other entities. The division shall hold at least 2 public hearings to take testimony relating to the investigation and study, 1 of which shall be held outside the metropolitan Boston area. The division shall report its findings and recommendations to the clerk of the house of representatives who shall forward the same to the house and senate committee on ways and means and the joint committee on health care financing on or before January 1, 2009.



DEVAL L. PATRICK
GOVERNOR

TIMOTHY P. MURRAY
LIEUTENANT GOVERNOR

COMMONWEALTH OF MASSACHUSETTS
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DIVISION OF INSURANCE

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DANIEL O'CONNELL
SECRETARY OF HOUSING AND
ECONOMIC DEVELOPMENT

DANIEL C. CRANE
DIRECTOR

NONNIE S. BURNES
COMMISSIONER OF INSURANCE

NOTICE OF HEARING

Pursuant to Chapter 305, §39 of the Acts and Resolves of 2008, the Commissioner of Insurance is conducting an investigation and study of the costs of medical malpractice insurance for health care providers, as defined in G.L. c. 175, §193U. As part of the investigation and study, public hearings will take place on October 3, 2008 at 10:00 a.m. at the offices of the Division of Insurance, One South Station, Boston 02110, and on October 8, 2008 at 11:00 a.m. in the Council Chamber of Worcester City Hall, 455 Main Street, Worcester, MA.

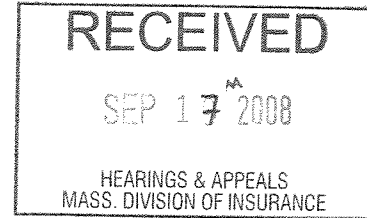
The purpose of the hearings is to receive oral and written statements that will assist in the examination and analysis of, among other things, 1) the availability and affordability of medical malpractice insurance; 2) the factors medical malpractice insurers consider when increasing premiums; 3) options for decreasing premiums including, but not limited to, establishing a reinsurance pool with additional stop loss coverage, subsidizing premium payments of providers practicing in certain high-risk specialties or in specialties for which the cost of premiums represents a disproportionately high proportion of a health care provider's income, subsidizing premium payments of providers who do not qualify for group coverage rates and pay higher premiums for commercial market insurance, and prorating premiums for providers who practice less than full-time; and 4) funding mechanisms that would facilitate the implementation of recommendations arising out of the study which may include, but not be limited to, charges borne by the health care industry or other entities.

This matter has been assigned docket number M2008-01. Any person who wishes to make an oral statement is requested to file a Notice of Intent to Comment with the Division of Insurance on or before October 1, 2008. All other persons who wish to make oral statements will be heard after those who notify the Division of Insurance in advance. Written comments may be submitted at either hearing and thereafter until the record of the hearing is closed. All submissions must be sent to: Docket Clerk, Hearings and Appeals, Division of Insurance, One South Station, Boston, Massachusetts, 02110-2208, and must refer to Docket No. M2008-01.

September 9, 2008

Nonnie S. Burnes
Commissioner of Insurance

Ad Number 2000013976
ID: Notice of Hearing/M2008-01
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End Date: 9/12/2008



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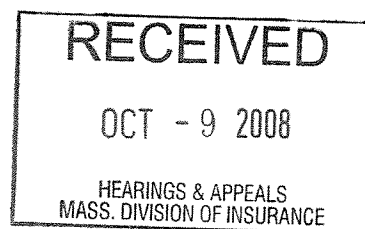
September 9, 2008

Nonnie S. Burnes
Commissioner of Insurance

M2008-01
Oct. 3, 2008

October 3, 2008

The Honorable Nonnie S. Burnes
Commissioner
Division of Insurance
One South Station
Boston, MA 02110-2208



**Re: October 3, 2008, Hearing on Medical Malpractice Insurance
Docket No. M2008-01**

Dear Commissioner Burnes:

Please accept this letter as the written testimony of Medical Professional Mutual Insurance Company, (dba, "ProMutual"), and its subsidiary, ProSelect Insurance Company ("ProSelect"), in response to the Notice of Hearing issued by the Massachusetts Division of Insurance to investigate the costs of medical malpractice liability insurance in the Commonwealth. This notice was issued in response to recently enacted legislation.

While we commend the Legislature for its efforts to improve health care delivery in the Commonwealth and to make health care more accessible to the citizens of Massachusetts, we maintain that the present medical liability insurance system prescribed by the Legislature is not in need of substantial change as it accommodates legitimate and competing interests, while ensuring that coverage is available and affordable.

Background

ProMutual writes medical malpractice coverage for physicians, dentists, certified nurse mid-wives, and hospitals in the Commonwealth. ProSelect writes these coverages for caregivers in Connecticut, Maine, New Hampshire, New Jersey, Pennsylvania, Rhode Island and Vermont. In Massachusetts, ProSelect writes such coverage for nursing homes and also writes excess coverage for various health care providers. ProMutual maintains the largest market share within the segment of commercial insurance carriers of medical malpractice premium in Massachusetts, and together with ProSelect, is the largest writer of this form of insurance in New England. In 1994, the Legislature established ProMutual under St. 1994, c 330. Its predecessor, the Massachusetts Medical Malpractice Joint Underwriting Association (JUA), was created by the Legislature in 1975 in response to an availability crisis at that time.

My testimony does not address all of the issues listed in the hearing notice, but focuses on several key areas where our input might be valuable. It is hoped that these comments will be of use to you and the Legislature.

Availability

By virtue of Massachusetts law, there is essentially no issue relating to the availability of medical malpractice insurance in the Commonwealth. Under M.G.L. c. 175 s 193U, the so-called “take-all-comers” statute, every medical malpractice insurer must “make available to every health care provider every primary medical malpractice insurance coverage, as defined in the plan or rules of operation of the medical malpractice reinsurance plan, which it provides to any health care provider.” In other words, by law, every physician, dentist, certified nurse mid-wife, and hospital is able to obtain coverage from an admitted carrier in the state. While the law serves a good purpose, it must be kept in mind that the cost of this requirement is reflected in the rates charged for medical malpractice insurance.

Factors Considered When Adjusting Rates

The current regulatory system for adjusting rates in Massachusetts affects all commercial insurance carriers and was designed to support a competitive market while ensuring that there are important checks and balances so that rates are not excessive, inadequate, or unfairly discriminatory. It is a system that is sensitive to the needs of medical providers, who are the most affected by its process. All carriers are required to file their rates with the Division of Insurance, where filings are independently reviewed by the State Rating Bureau.

There is also a legal requirement that is unique to ProMutual as a result of its enabling statute, St. 1994, c. 330. Prior to making a filing, ProMutual must give notice of its rates to the Massachusetts Medical Society, Massachusetts Hospital Association, Massachusetts Dental Society, or the American College of Nurse Mid-wives (Massachusetts chapter), as applicable. In addition, ProMutual’s Board of Directors, which is comprised of a majority of practicing health care providers, reviews the rates in advance.

ProMutual is in the enviable position of having a 30-year history of providing medical malpractice insurance in Massachusetts, both under the name ProMutual and its predecessors. Because of this history, we have the experience to determine the proper rate for a particular risk while maintaining the financial strength to protect each insured. ProMutual sets its rates based on actuarially accepted methods, using documented claim payments data and an estimate of the projected need going forward.

Affordability

The Legislature has suggested that alternative mechanisms to reduce premiums be considered. However, there are already ways in which health care providers can pay premiums lower than the filed rate. ProMutual offers reduced premiums in the form of loss free credits for insureds who are claim free, pro-rated premiums for providers who practice part-time, and credits for policyholders who take advantage of certain risk

management programs offered by us. Approximately 87% of ProMutual policyholders have some form of credit, which collectively average 16%.

Effective risk management to prevent losses from occurring plays an important role in keeping rates as low as possible. We are proud of our long history of risk management and physician education and we intend to continue our emphasis in this area.

We also have a history of declaring policyholder dividends when financial results allow. In 2008 we declared a 5% dividend for our physician insureds. This is a good way in which a company can reward its policyholders for bringing about good results and can offset their premiums as well.

As a mutual company, ProMutual is ultimately responsible to its owners who are our Massachusetts policyholders. This is important in that it serves to remind us that we must take the best interests of these policyholders seriously at all times. While being a mutual insurer is not unique to us, it serves as another check and balance when determining how to charge a fair price for the coverage we afford.

Other Comments

Before considering any changes to the current system, it is worth noting that a large segment of the medical malpractice market is unregulated, that is, comprised of captives and risk retention groups. These entities are not regulated in terms of their ability to set rates for their own groups; nor are they bound by the statutory requirement to take all comers. Any change to the existing balanced system of setting rates could hurt the regulated market and threaten the ability of traditional insurers to compete effectively against the unregulated market segment.

Additionally, as a way to consider other means that might decrease premiums, the Legislature could engage in efforts at meaningful tort reform. We suggest there are ways to reduce costs without impeding the rights of the victims of medical malpractice errors and, to that end, we continue to recommend eliminating joint and several liability and further reducing the rate of judgment interest.

Conclusion

We understand the frustration of health care providers and the effect that the high cost of medical malpractice liability claims has on their practices. We will continue to devote our efforts to keeping premiums as low as possible, while also ensuring the ongoing financial strength of the company.

We hope that you agree that the present system is effective and not in need of any change because it ensures that medical malpractice insurance is available and affordable. We hope that you will encourage the Legislature to proceed cautiously when considering making changes to the regulated market in the Commonwealth.

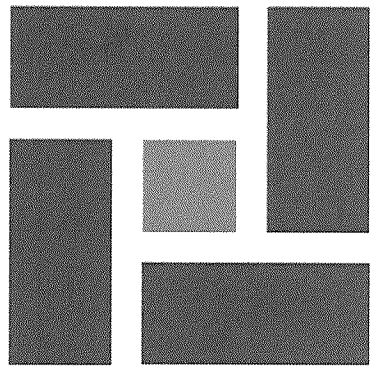
October 3, 2008, Hearing on Medical Malpractice
Docket No. M2008-01
Page 4 of 4

Thank you for considering our comments today and we hope that you will call upon us if additional information is needed.

Sincerely,

A handwritten signature in black ink, appearing to read "Richard W. Brewer". The signature is fluid and cursive, with the first name "Richard" being more prominent.

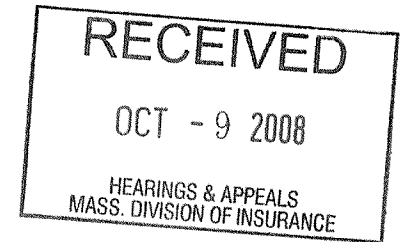
Richard W. Brewer
President and CEO



MEDICAL PROTECTIVE

Strength. Defense. Solutions. Since 1899.

a Berkshire Hathaway Company



Massachusetts Department of Insurance
Hearing to Investigate Medical Malpractice Insurance

October 8, 2008

M2008-01
October 8 2008

Considerations for Today's Discussion

- ☐ Availability of Medical Malpractice Insurance
- ☐ Affordability of Medical Malpractice Insurance
- ☐ Factors Influencing Rate Increases
- ☐ Options for Decreasing Premiums



Availability of Medical Malpractice Insurance

Availability of Medical Malpractice Insurance

☐ Market Conditions

- Mkt. Concentration & Competitiveness
- Competitor Strengths/Weaknesses

☐ Capital Constraints

- Financial Condition
- Factors Influencing Deployment

☐ Legal Environment

- Tort Law
- Recent Judicial Rulings

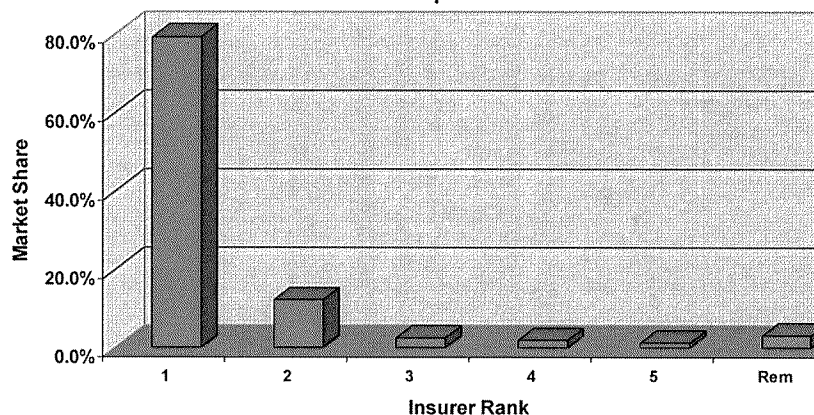
☐ Regulatory Environment

- Rating Law & Related Provisions
- Oversight of Rate Adequacy & Solvency

Availability - MA Market Concentration

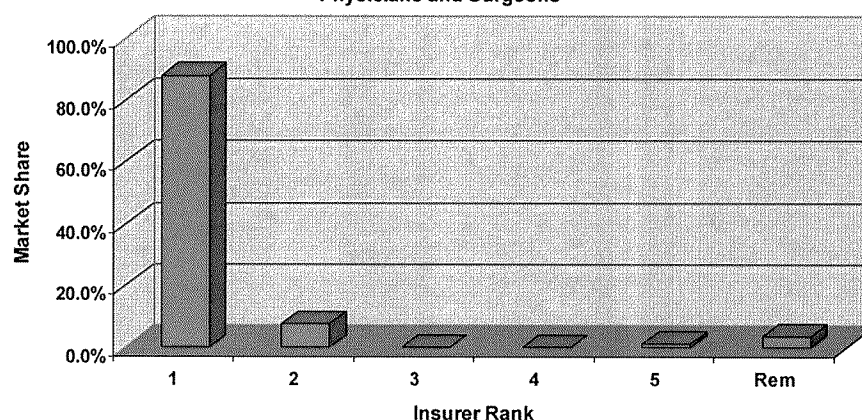
2007 Mkt.: \$118M ~ 39% 9 insurers

Hospitals



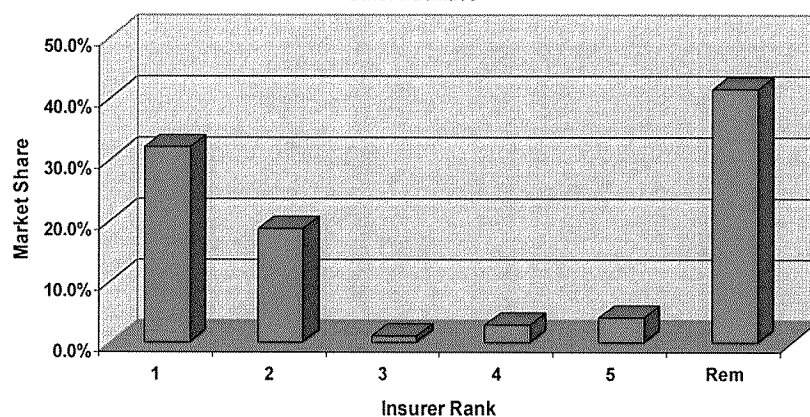
2007 Mkt.: \$142M ~ 47% 9 insurers

Physicians and Surgeons



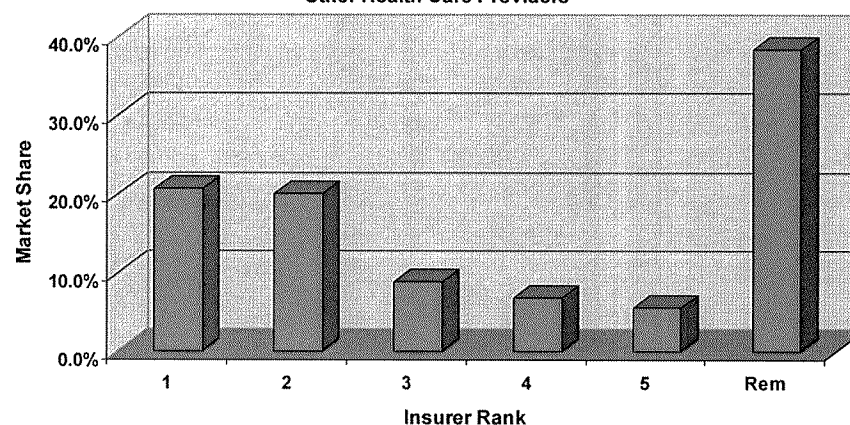
2007 Mkt.: \$10M ~ 4% 11 insurers

Other Facilities



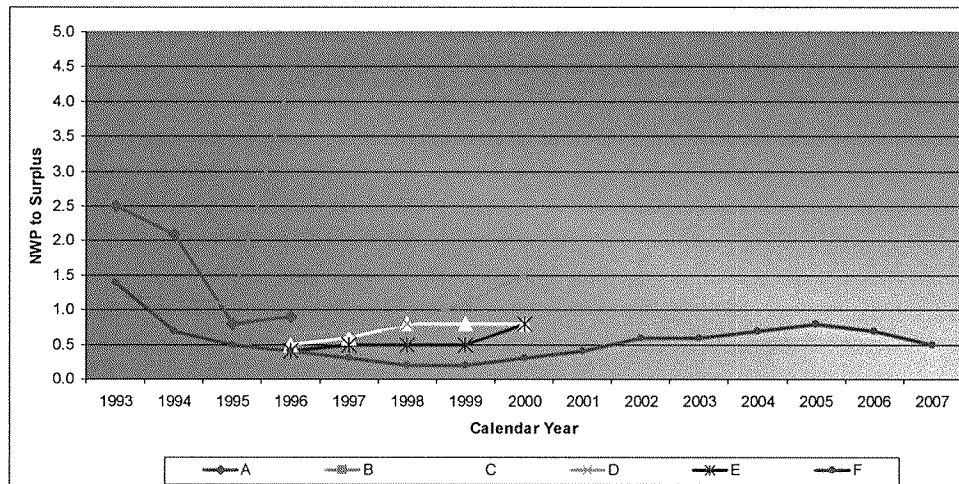
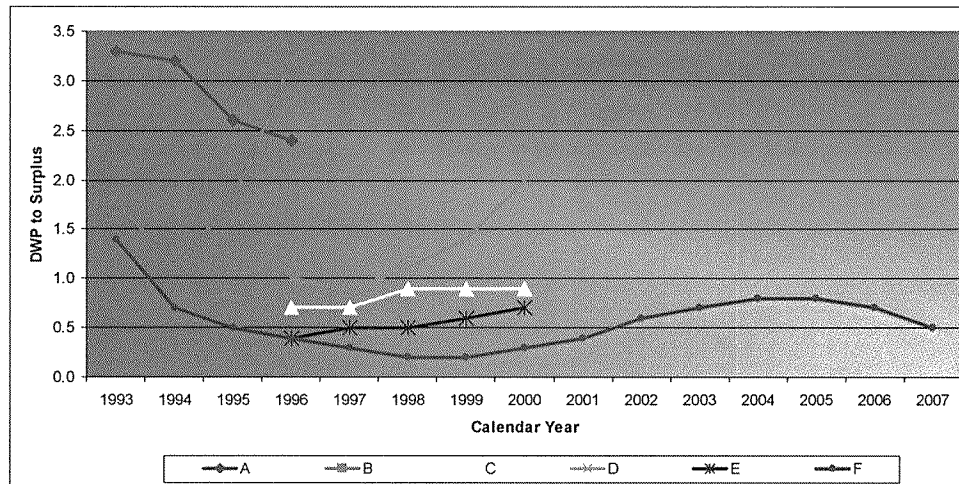
2007 Mkt.: \$30M ~ 10% 15 insurers

Other Health Care Providers



* No. of insurers by segment based on minimum of \$100K DWP

Capital - Fin'l Condition & Deployment



- Fin'l condition often measured by surplus (relative to premium)
- Direct Premium to Surplus represents total leverage
- Net Premium to Surplus represents net leverage after reins.
- Strict adherence to ratios can be deceiving
- Illustration provides insight into the ratios of once prominent insurers prior to demise...in contrast to the leading writer in the state
- Numerous factors must be considered in evaluation of fin'l strength and appropriate level of capital

Availability - Legal Environment

- ☐ Statute of Limitations
- ☐ Contributory or Comparative Negligence
- ☐ Joint and Several Liability
- ☐ Vicarious Liability
- ☐ Expert Testimony
- ☐ Damage Caps
- ☐ Collateral Source
- ☐ Pre-Judgment Interest Provisions
- ☐ Claim Screening Requirements

Liability expanded by Supreme Court decision
in *Dias v. Brigham*

In Med Mal cases, a jury is instructed that
if it finds the defendant liable, it is not to award
the plaintiff more than \$500K for pain and suffering
...unless it determines that there is substantial or
permanent loss or impairment...or other special
circumstances which warrant finding such limitation
would deprive the plaintiff of just compensation

Availability - Legal Environment

MA Supreme Court decision in Dias v. Brigham (12/23/2002) concluded that (1) vicarious liability could be imposed on a medical group without proof of ability to direct or control an employed physician's actions, and (2) genuine issue of material fact, whether physician was acting as employee of group at the time he treated patient, precluded summary judgment.

A leading med mal writer in MA noted, in its 2004 rate filing, that it ... "responded to SJC-08379 commencing with our July 1, 2003 rates by increasing the per physician/dentist/nurse midwife charge.

** Charges for partnerships and corporations increased 50-100% as a result*

Availability - Legal Environment

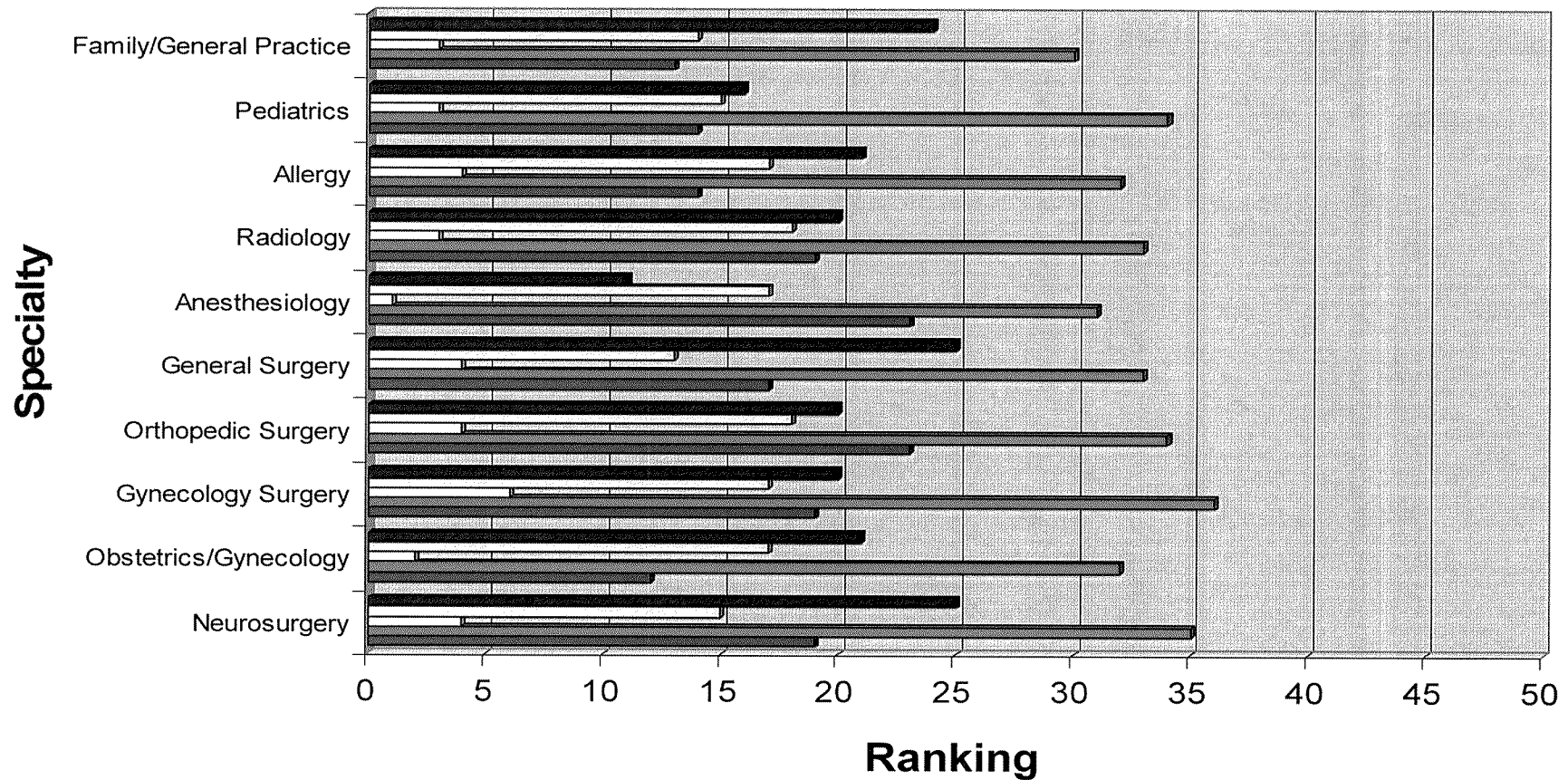
MA Supreme Court decision in Coombes v. Florio (12/10/2007) concluded that a physician owes reasonable care to everyone foreseeably put at risk by his failure to warn a patient of a treatment's side effects. The Court reasoned that as a drug's side effects influence abilities like driving, the foreseeable risk of injury is not limited to the patient. Florio argued that if the Court imposed such a duty on physicians, the fear of litigation would weigh upon the physician's decisions about what medications to prescribe.

Will this decision influence the delivery of health care and the potential exposure to litigation ?



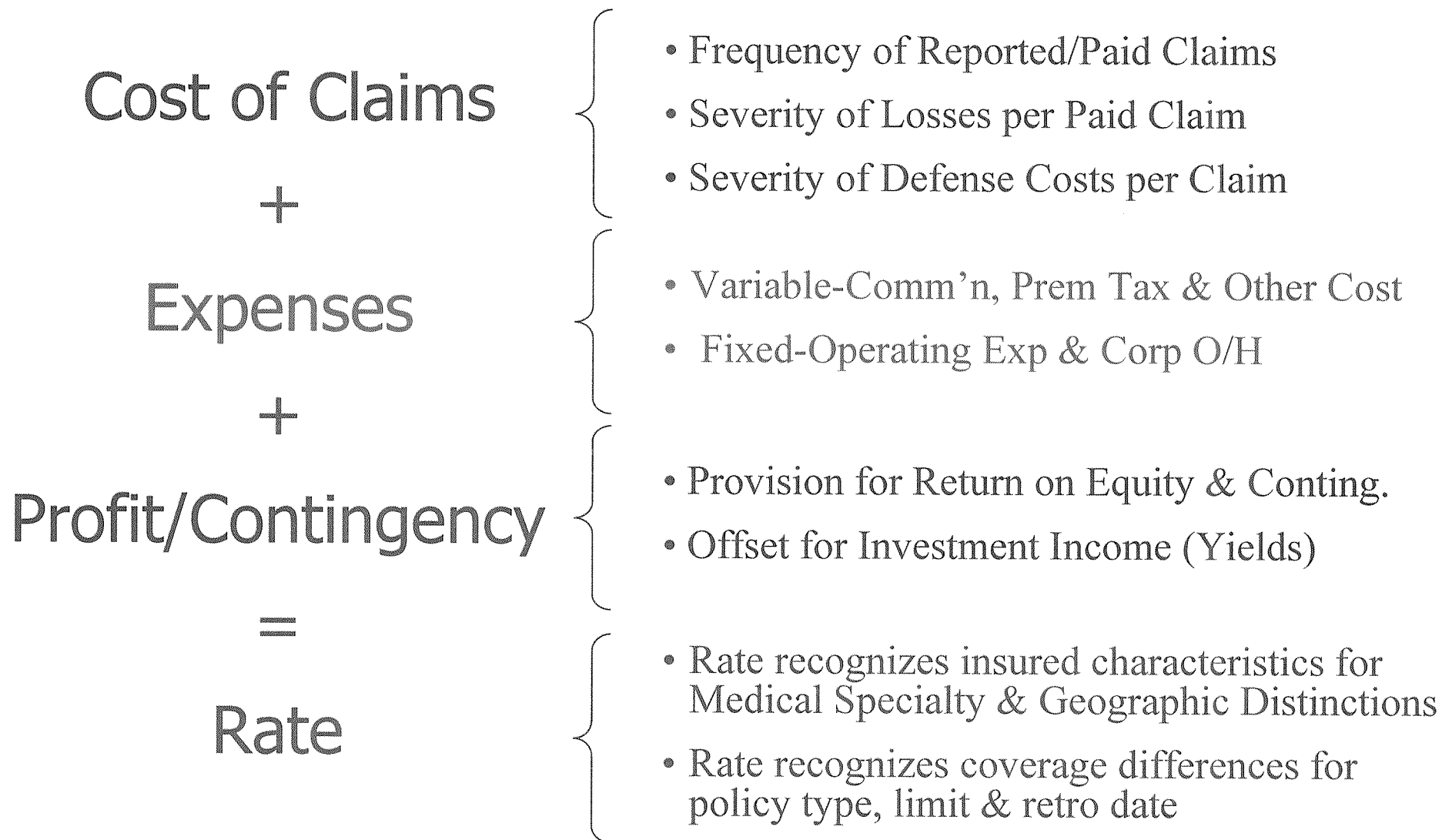
Affordability of Medical Malpractice Insurance

Affordability - Rate Level Comparison



Massachusetts
 Maine
 Connecticut
 New Hampshire
 Rhode Island

Affordability - Ratemaking 101





Factors Influencing Rate Increases

Ratemaking Components

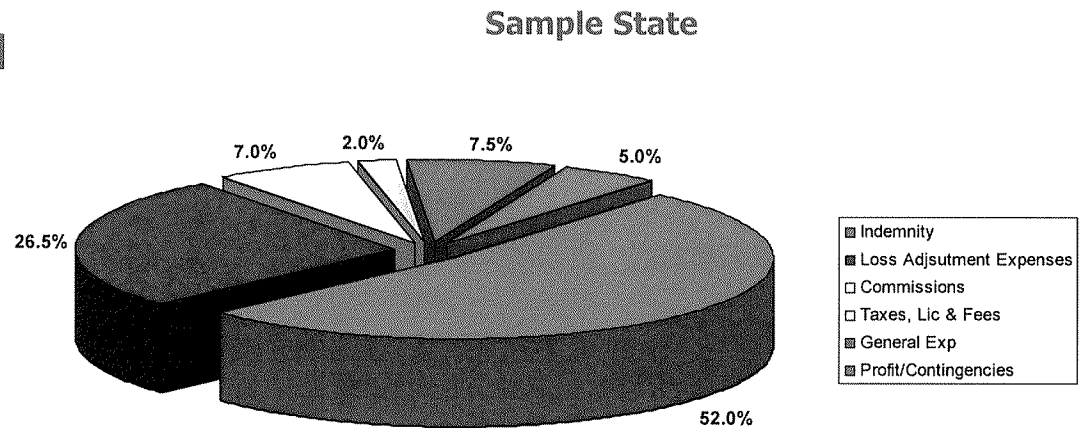
- ☐ Large volume of historical claim experience

- ☐ Projections based on development patterns and state specific legal environment

- ☐ Variable expenses derived from state specific costs

- ☐ Fixed expenses allocated to each state

- ☐ Profit and contingencies reflect consideration for products offered and unique characteristics of the state

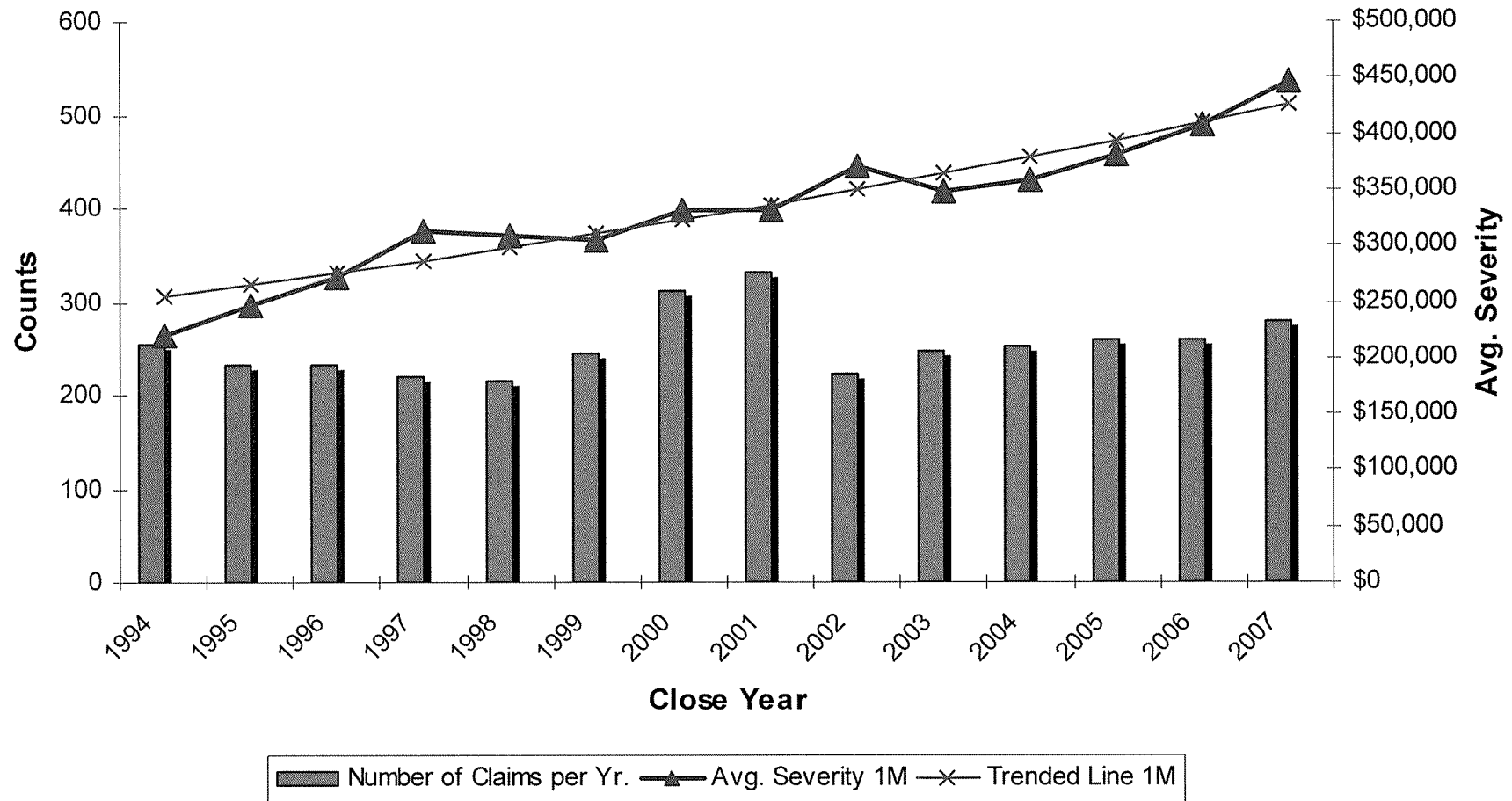


Ratemaking - Indemnity

- ☐ **Largest individual component of the rate**
- ☐ **Lacking sufficient data, insurers must rely on external data sources**
 - **National Practitioners Data Bank (Federal data source)**
 - **Competitors' rate filings**
 - **State data calls or similar aggregate data**
- ☐ **Rate level influenced by quality and quantity of data available**

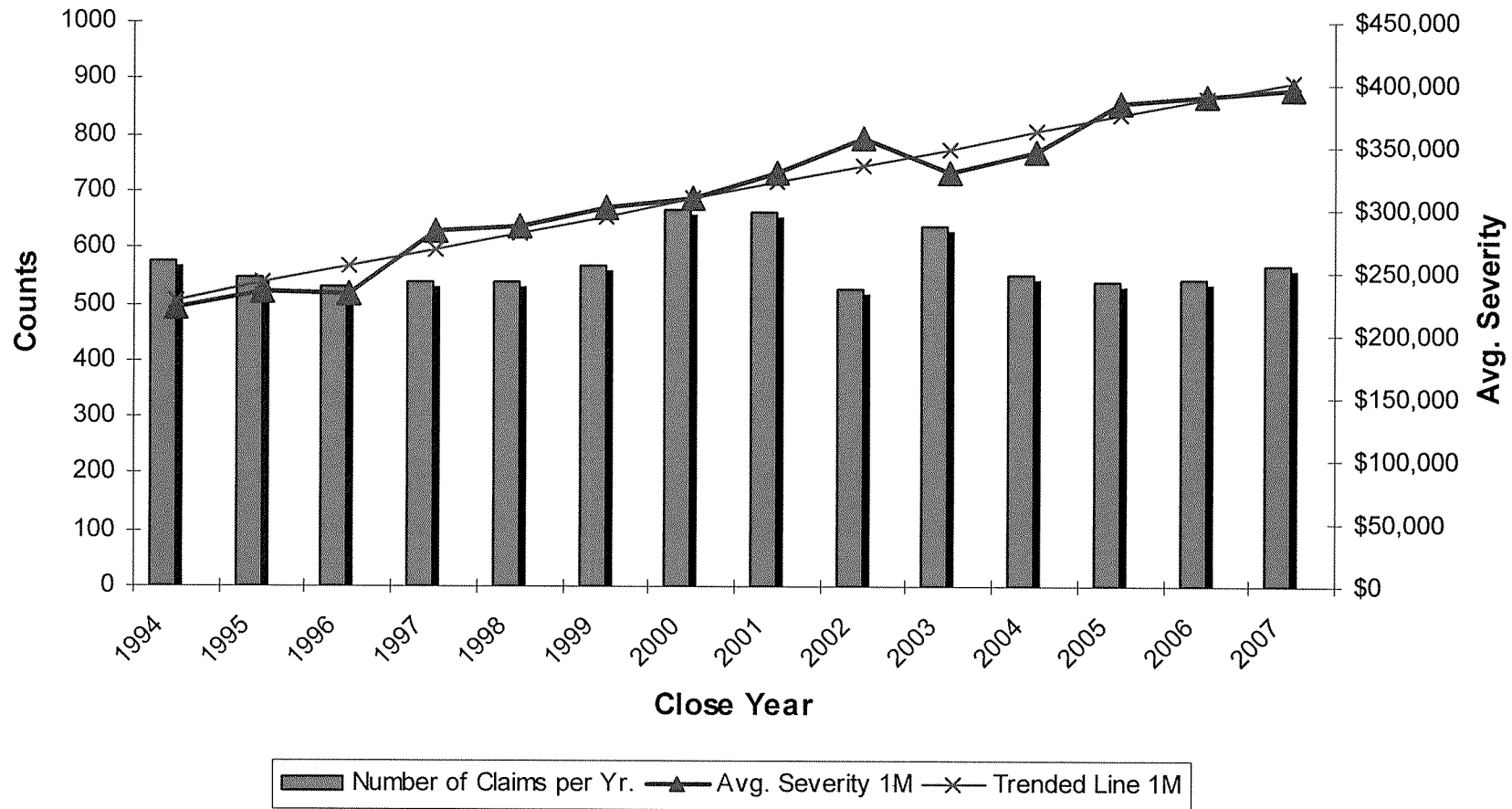
MA Indemnity Severity - NPDB

Massachusetts NPDB Payments Capped at 1M



NE Indemnity Severity - NPDB

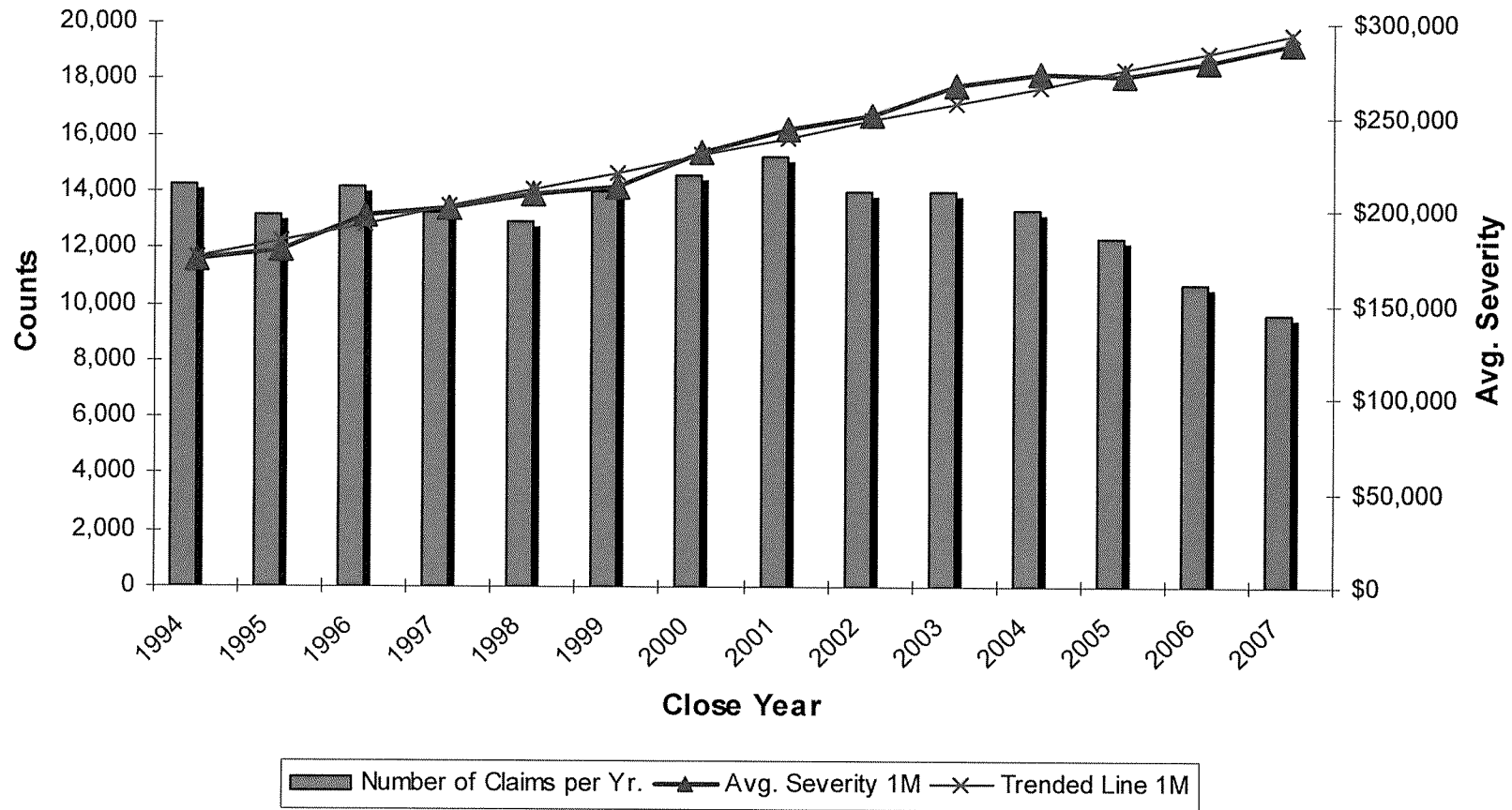
NE NPDB Payments Capped at 1M



* Data aggregated from CT, NH, ME, MA, RI, VT

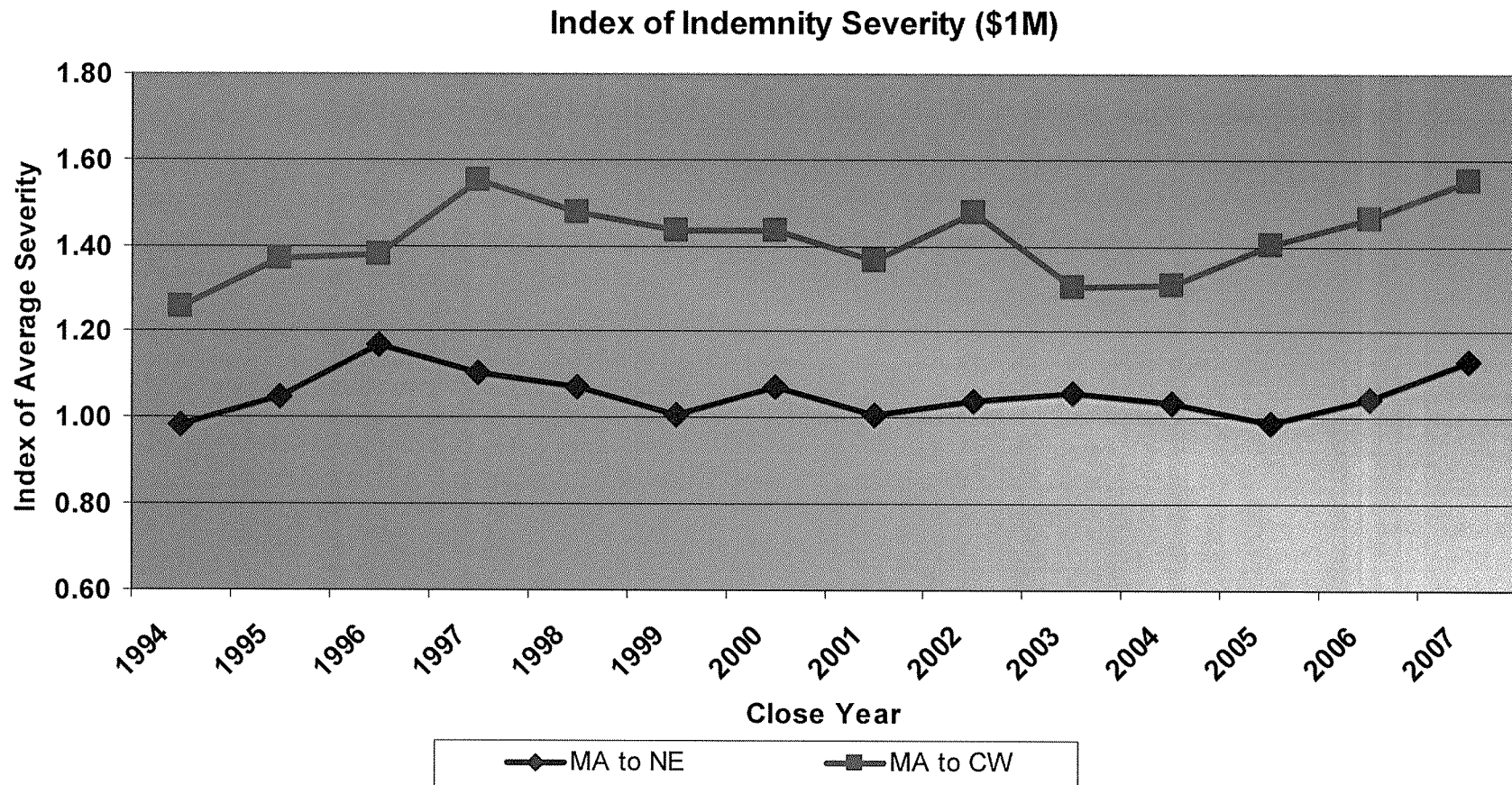
CW Indemnity Severity - NPDB

Countrywide Less MA NPDB Payments Capped at 1M



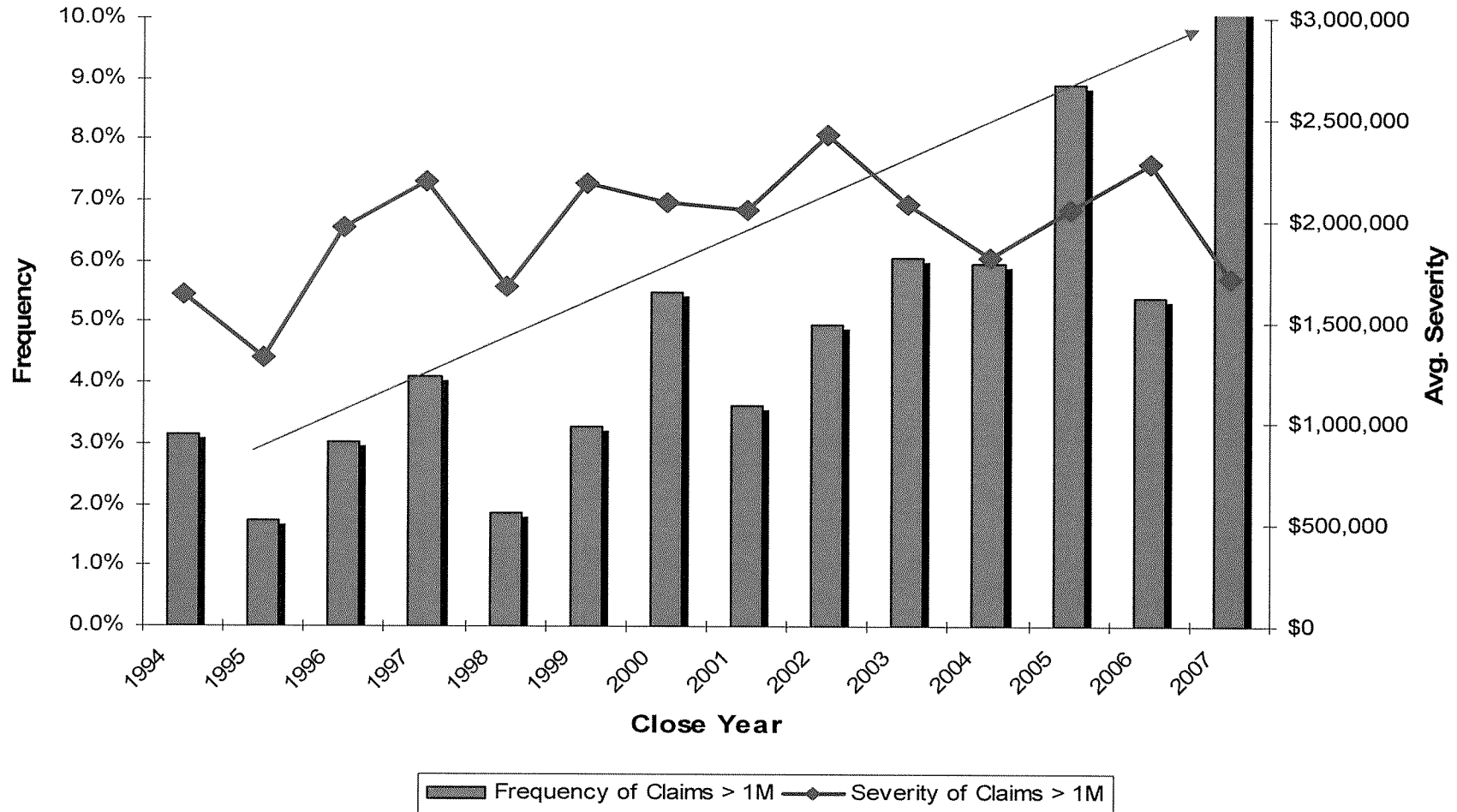
* Countrywide data aggregated less MA

Index Indemnity Severity - NPDB



Indemnity Severity Volatility

Massachusetts NPDB Payments at Total Limits



Factors Influencing Rate Increases

☐ Indemnity

- Inflationary pressure (medical costs, wages, etc.)
- Volatility (influences predictability)
- Changes in frequency of paid claims
- Legislative changes & judicial rulings
- Quality & quantity of data

☐ Loss Adjustment Expenses

- Legal environment (process & time)
- Expertise and experience of defense attorneys
- Changes in frequency of reported claims

☐ Operating Expenses



Options for Decreasing Premiums

Options for Decreasing Premiums

- ☐ **Direct subsidization of rates**

- ❖ New Jersey provides subsidy for “high risk” classifications
- ❖ Maryland Rate Subsidy Plan available to all insureds

- ☐ **Comprehensive Tort Reform**

- ❖ Reforms similar to MICRA
- ❖ Texas reforms of 2005 provide insight

- ☐ **Compensation fund**

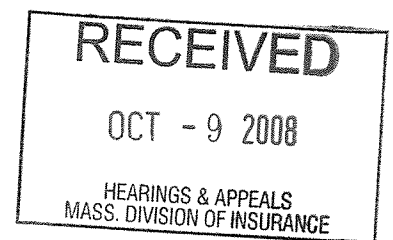
- ❖ Provide coverage excess of a defined primary limit
- ❖ Fund assumes liability and absorbs volatility in xs layer

**Outline of Statement of Jay Angoff
before
The Massachusetts Division of Insurance
on
The Costs of Medical Malpractice Insurance for Health Care Providers,
Docket No. M2008-01**

I. The medical malpractice rate level

A. Medical malpractice rates are excessive, both in Massachusetts and countrywide. See Exhibits A and B.

1. Net income is at an all-time high
2. Loss ratios and combined ratios are at all-time lows
3. Surplus is at an all-time high
4. RBC ratios are at all-time highs
5. Premium to surplus ratios are at all-time lows
6. Reserve redundancies are at all-time highs



B. Possible ways to bring down the medical malpractice rate level

1. Non-regulatory or de-regulatory approach:
 - a. Publicize new entrants
 - b. Disseminate comparative price information
 - c. Authorize malpractice carriers to raise and lower rates at will
2. Regulatory approach:
 - a. Establish standards that actuaries must follow in calculating rates
 - b. Limit the ability of carriers with surplus exceeding a certain level to raise rates

(1) Allow a return only on "used and useful" surplus

(2) Prohibit insurers with surplus exceeding a specified level from including a contingencies factor in their rates

(3) Establish maximum surplus standards

c. Authorize the commissioner to order refunds if she finds rates excessive

d. Authorize private parties to challenge rates as excessive and obtain refunds of excessive rates

II. How the medical malpractice rate is distributed among specialties

A. Physicians' income v. physicians' malpractice premiums. See Exhibit C.

1. Differences in premium by specialty

2. Differences in income by specialty

3. General rule: low-income specialties pay low malpractice premiums, high-income specialties pay higher malpractice premiums

4. But certain exceptions:

a. High-income specialties, low malpractice premiums: E.g., dermatologists and cardiologists

b. Moderate-income specialties, high malpractice premiums: Ob-gyn's.

B. Possible ways to improve equity among specialties

1. What is equity?

2. Redistribute premium among specialties:

a. Low-premium specialties subsidize high-premium specialties?

b. High-income specialties subsidize low-income specialties?

c. High-income, low-premium specialties subsidize low-income, high-premium specialties?

d. Ob-gyn's

C. Subsidize malpractice rates from outside malpractice system?

1. Subsidize out of health insurers' surplus exceeding a specified level?
2. Subsidize out of other property/casualty insurers' surplus exceeding a certain level?
3. Essential to prevent pass-through to health insurance policyholders: otherwise low-income people subsidize high-income people.
4. Same problem with general revenue funding of portion of malpractice premiums.

III. Conclusion

- A. Due to high profits and decreasing rates, little pressure to look at issue now
- B. Division is wise to look at issue now.

EXHIBIT A**Financial Key Data, 2003-2007
Pro Mutual**

	2003	2004	2005	2006	2007
Net Income (\$000's omitted)	21,540	25,266	39,691	63,994	108,892
Return on Premium	11.3%	9.6%	11.3%	18.7%	34.4%
Return on Surplus	6.3%	6.7%	9.5%	12.7%	18.0%
Surplus (\$000's omitted)	342,767	378,461	417,962	504,689	602,815
RBC Ratio	246%	250%	250%	333%	446%
P:S ratio	0.55	0.69	0.84	0.67	0.52
Loss Ratio	96.5	59.7	58.9	58.3	44.8
2-yr Loss Dev.	-2.8%	-10.2%	-15.1%	-16.7%	-28.5%

Source: 2007 Annual Statement, Five Year Historical Data pages.

EXHIBIT B**Key Financial Data, 2003-2007
The Doctors Company**

	2003	2004	2005	2006	2007
Net Income (\$000's omitted)	-50,066	32,396	77,579	137,639	156,554
Return on Premium	NM	7.0%	17.0%	27.9%	30.3%
Return on Surplus	NM	8.0%	15.4%	21.0%	19.5%
Surplus (\$000's omitted)	350,189	405,583	503,180	655,987	804,192
RBC ratio	432%	501%	728%	933%	1156%
P:S ratio	0.96	1.13	0.9	0.75	0.64
Loss Ratio	0.69	0.54	0.40	0.27	0.34
2 yr. Loss Dev	40.1%	40.8%	14.6%	-16.0%	-21.8%

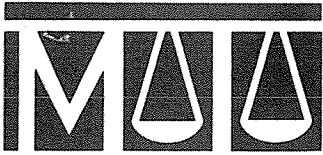
Source: 2007 Annual Statement, Five Year Historical Data pages.

EXHIBIT C**Malpractice Premium by Specialty**

Specialty	Mature Claims-Made Premium \$1 million/\$3million Limits**	Premium as % of Net Income	Avg. Net Income*
Neurosurgery	\$129,009	25.2%	\$512,294
Ob-Gyn Surgery	\$108,088	42.5%	\$254,426
Cardiac & Thoracic Surgery	\$97,628	22.1%	\$442,097
Emergency Surgery	\$59,275	24.7%	\$239,587
Orthopedic Surgery	\$59,275	15.5%	\$382,561
Colon/Rectal Surgery	\$50,209	14.3%	\$352,000
Urology	\$50,209	15.2%	\$330,225
Gastroenterology	\$39,050	10.5%	\$370,157
Radiology (Interventional)	\$33,472	8.3%	\$405,544
Cardiology	\$33,472	10.2%	\$329,303
Pediatrics	\$19,863	11.5%	\$173,450
Internal Medicine	\$19,863	11.5%	\$173,406
Family practice	\$16,852	10.5%	\$160,985
Dermatology	\$10,233	3.4%	\$298,799

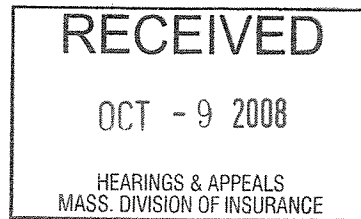
*Source: American Medical Group Assn., 2007 Physician Compensation Survey (2007).

**Medical Protective premium for Missouri territory including St. Louis, filed March 31, 2004.



Mary Jane McKenna, President

Chris A. Milne
President - Elect
Kimberly E. Winter
Treasurer
Andrew Abraham
Secretary
Paul F. Leavis
Immediate Past - President



Jennifer L. Comer
Executive Director
Sheila Sweeney
Director of Development & PR
Michele L. Burns
Member Services Director
Susan W. Simpson
Office Manager

MASSACHUSETTS ACADEMY OF TRIAL ATTORNEYS

TESTIMONY FOR THE DIVISION OF INSURANCE INVESTIGATION AND STUDY OF THE COSTS OF MEDICAL MALPRACTICE INSURANCE FOR HEALTH CARE PROVIDERS DOCKET NO. M2008-01

The Massachusetts Academy of Trial Attorneys (MATA) respectfully requests that the Commissioner of Insurance recommend that no steps be taken which would have a negative impact on the rights of patients who are innocent victims of medical negligence.

Too often, representatives of the insurance industry have misrepresented the impact that claims asserted by the innocent victims of medical negligence have on premiums and have asserted that the rights of patients should be taken away or limited by various tort reform measures such as caps on damage awards. In fact, medical malpractice verdicts and settlements have very little effect on premiums. The economic markets have much more of a profound effect on premiums. The cost of malpractice insurance is rarely studied carefully. The best studies suggest that there is no major premium crisis and that limiting the rights of patients' is not the answer to this perceived issue. The documents attached to this statement provide a careful analysis of malpractice premiums.

Currently in the medical malpractice insurance industry, projected and actual payouts have declined. The losses of the leading medical malpractice insurers have dropped nearly 50% over the last three years. Insurers are paying out only 39 cents for each premium dollar they receive. While payouts are decreasing, surplus is increasing. In 2006, surplus was 43% greater than

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2003, greatly exceeding mandated surplus levels. Despite this good news for the insurers, doctors did not necessarily see decreases in their rates. Insurance companies continued to pad their profits and drive up the cost of healthcare. Even mutual insurers, whose sole duty is to their owner/policyholders, are failing to issue dividends. Only three of the 15 leading insurers issued dividends to doctors in 2006.

According to the April 2008, *Medical Liability Monitor*, things are definitely on the upswing for both insurers and doctors. It declares, "the insurance environment for Healthcare Professional Liability, (medical malpractice insurance) seems to be one of stability, calm and improvement." It also states that, "For 2008, we can expect rate reductions that are a reflection of significantly reduced claim frequency." The article attributes the vitality of the medical malpractice insurance industry to six major influences: "reinsurance changes, lower frequency of claims, companies reaping the rewards of tight underwriting, surplus money from previous rate increases, insurance companies flush with cash and decreased numbers of plaintiff attorneys in the field."

Furthermore, a recent study done in Massachusetts on malpractice premiums published in *Health Affairs*, definitively states that in Massachusetts there is no premium crisis. It supports that MA premiums reflect national and regional averages as reported by the AMA. Most premiums were lower in 2005 than in their peak in 1990, including most specialties. In 2006 rates rose 5 percent and in 2007 no rates increased and five high risk specialties decreased including OB/GYN. The study supports that rates are cyclical and mirror the market and also that claims have significantly decreased.

As you consider the availability and affordability of medical malpractice insurance and the various factors considered by medical malpractice insurers, MATA respectfully requests that the Commissioner not consider any argument that would take away the right of patients. This study should be limited to taking a careful look at the premiums for physicians over an extended time period to identify market trends and their effects and whether there has been a history of overcharging doctors by insurers and the extent to which the insurance industry has profited through this practice. In looking at the fluctuation of rates over a significant time period, it is easy to see the cyclical nature of the industry and the correlation of its cycles to the performance of the investment industry and Wall Street. If the market is down, premiums go up. If the market is up, insurance company profits go up and rates go flat or decrease.

Skyrocketing Insurance Premiums Are Caused by Insurance Industry Overcharging Doctors and Market Conditions

Expensive insurance premiums are the result of industry overcharging, not pay-outs in medical malpractice cases. A 2005 study conducted by former Missouri Insurance Commissioner Jay Angoff found that insurance companies have been price-gouging doctors by drastically raising their insurance premiums, even though claims payments have been flat, or in some cases decreasing. According to the annual statements of the 15 largest insurance companies, the amount malpractice insurers collected in premiums increased by 120.2 percent between 2000 and 2004, while their claims payouts rose by only 5.7 percent. Thus, they increased their premiums by 21 times the increase in their claims payments.

According to Americans for Insurance Reform: “Not only has there been no ‘explosion’ in medical malpractice payouts at any time during the past 30 years, but payments (in constant dollars) have been extremely stable and virtually flat since the mid-1980s.”

Payouts in medical malpractice cases have dropped over the last four years. After adjusting for inflation, the number of payments over \$1 million has dropped by percent since 1991.

According to Public Citizen, malpractice payouts have remained flat for more than a decade.

Even insurance industry officials and their allies admit that medical malpractice “reform” will not lead to lower insurance rates.

- American Insurance Association: “Insurers never promised that tort reform would achieve specific premium savings.”
- Both the President of the Physician Insurers Association of America and the General Counsel to the American Tort Reform Association have stated that premiums increased, in part, to make up for lost investments.
- President of First Professional Insurance Company: “No responsible insurer can cut its rates after a [medical malpractice tort ‘reform’] bill passes.”
- GE Medical Protective told the Texas Insurance Commissioner that caps had a negligible impact on rates.

MATA respectfully requests that the Commissioner consider proposals that would require insurance companies to pass on any savings to doctors in the form of lower insurance premiums.

Premiums Are Actually Declining

Whether there is a crisis or any need to assist physicians in their payments of medical malpractice insurance, is an issue that should be carefully analyzed in the study. Careful analysis over the long term reveals that premiums are actually decreasing.

According to the Medical Liability Monitor, premiums for internists, general surgeons and ob/gyn’s combined have decreased in Massachusetts since 2004 by 9.2%. For ob/gyn’s alone they have decreased 12.4%.

Limiting the Rights of Patients does not Reduce Premiums

Medical malpractice premiums in a number of states actually increased even after medical malpractice caps were enacted.

- A month after passing malpractice caps, South Carolina’s two largest insurers increased rates by as much as 22 percent, after increasing their rates by 27 percent the year before.
- After Texas passed rate caps in 2003, the Joint Underwriting Association requested a 35 percent jump in premiums for physicians and 68 percent increase for hospitals. In addition, GE Medical Protective, the nation’s largest medical malpractice insurer, announced a 19 percent increase in doctors’ premiums. When the request was denied,

they announced intentions to use a legal loophole, avoiding state regulation, and increased premiums 10 percent – without approval.

There has been numerous tort reform measures proposed by the insurance industry and other special interest groups that they claim will decrease medical malpractice premiums. These proposals have included health courts, a no-fault system, changing the criteria for expert testimony, binding arbitration and other changes to the law and Constitution. Please see the enclosed attachment outlining these proposals and why they are bad for Massachusetts citizens. A recent study published by the New England Journal of Medicine states that the vast majority of claims and resources are dedicated to cases involving bona fide medical error resulting in patient harm. This conclusion emanated from an extensive study from the Harvard hospital system with involvement of academics, clinicians and insurers and rebuffs the industry's claim that most cases are frivolous. None of these attempts to limit the rights of Massachusetts citizens will lower the costs of medical malpractice insurance. They do not address the root cause and they will only hurt patients who have been harmed through no fault of their own.

The Number of Doctors is Increasing

According to the American Medical Association's own statistics, the number of physicians in the United States has increased by 40 percent since 1990. In fact, the number of emergency room doctors has nearly doubled; the number of neurosurgeons has increased by more than 20 percent; and the number of OB-GYNs has increased by nearly 25 percent. Meanwhile the medical malpractice filings they are allegedly running away from have fallen in number since 1998.

- The number of emergency physicians in the United States has increased. The number of emergency room doctors has nearly doubled - from 14,243 in 1990 to 27,864 in 2004.
- The number of neurosurgeons in the United States has increased. The number of neurosurgeons has increased by more than 20 percent – from 4,358 in 1990 to 5,288 in 2004.
- The number of OB/GYNs has increased in the United States. The number of OB-GYNs has increased by nearly 25 percent – from 33,697 in 1990 to 42,059 in 2004.
-

There is No “Explosion” in Pay-Outs

The recently touted “explosion” in medical malpractice payouts is a myth. The average verdict size is relatively low and has remained stable since the mid-1980s. Americans use the civil justice system as a last resort; with only 2 percent of potential plaintiffs going to court after all other efforts have failed.

Medical Negligence Cases are Not Threatening Access to Health Care

According to the Congressional Budget Office, malpractice costs amount to less than 2 percent of overall health care spending. Even a 25-30 percent reduction in malpractice costs wouldn't lower health insurance premiums by half a percent.

Malpractice cases aren't threatening health care...medical negligence is. As many as 98,000 patients die each year in hospitals alone as a result of medical negligence. As the Institute of Medicine noted, "preventable medical errors in hospitals exceed attributable deaths to such feared threats as motor-vehicle wrecks, breast cancer, and AIDS." They also noted that this medical negligence costs the economy between \$17 billion and \$29 billion per year.

So-Called "Defensive Medicine" is a Myth

The methodology used to calculate the cost of "defensive medicine" has been debunked by the CBO and the GAO. Supporters of medical malpractice "reform" often refer to the cost of so-called "defensive medicine" – the additional procedures that doctors supposedly order solely because of litigation concerns – to bolster their case for limiting access to the civil justice system. In 1999 the GAO wrote, "[this study] cannot be extrapolated to the larger practice of medicine. Given the limited evidence, reliable cost savings estimates cannot be developed."

A Fair Analysis

The fact of the matter remains that the data prepared by those who have carefully looked at these issues demonstrates the falsity of a major component used by special interest groups who wish to immunize wrongdoers from accountability by stripping patients of their legal rights. The citizens of the Commonwealth of Massachusetts are much more likely to obtain better quality and access to healthcare than states that restrict the ability of injured patients to hold negligent doctors accountable.

This study should be limited to a review of the premiums for physicians over an extended time period, whether there has been a history of overcharging doctors by insurers, the extent to which the market influences premiums, and the extent to which the insurance industry has profited through its practices, and whether there is already a downward trend in premiums.

In order to reduce malpractice premiums, insurance reform is needed, not tort reform. Some insurance reform ideas are outlined in Jay Angoff's testimony, other ideas include: compressing rates amongst different medical specialties; meaningful experience rating; three strikes rule for physicians, anti-kickback and anti-trust legislation for insurers and medical societies; removing the \$20,000 charitable cap for hospitals. Malpractice premiums will not drop significantly until there is insurance industry reform.

MASSACHUSETTS ACADEMY OF TRIAL ATTORNEYS

MEDICAL MALPRACTICE REFORM OPPOSITION SHEET

The Massachusetts Academy of Trial Attorneys ("MATA") states its strong belief that making major changes to medical malpractice law would substantially hurt citizens of Massachusetts.

MATA specifically opposes the following:

1. Eliminating traditional joint and several liability for defendants in malpractice actions (Section 1);
2. The reduction of future damages by collateral sources of future benefits (Section 2);
3. Requiring medical malpractice tribunal testimony to be from physicians board-certified in the same specialty as the defendant physician and actively practicing in the same specialty, and require that experts whose statements are used at tribunal must testify at trial
4. Requiring expert witnesses in malpractice actions to be physicians currently board certified in the same specialty as the defendant physician
5. Providing immunity from discovery for apologies and admissions of error by medical providers
6. Allowing the medical malpractice tribunal to require cases to submit to binding arbitration
7. Reduction in the amount of non-economic damages
8. Health Courts
9. No-fault system

These provisions, supported by the medical malpractice insurance carriers, have the claimed intent of reducing future malpractice insurance premiums by reducing the amount collected by victims of medical errors. Available data however, have established that limiting malpractice verdicts has no effect on reducing future insurance company premiums for physicians and healthcare providers.

1. Eliminating traditional joint and several liability for defendants in malpractice actions.

Eliminating joint and several liability in medical malpractice would be an unwarranted step toward the abrogation of the long established doctrine of joint and several liability among tortfeasors in Massachusetts. No such special protection in the medical malpractice area is warranted, and efforts to provide this special and unorthodox protection should be resisted.

The joint tortfeasor rule in Massachusetts is both a vital basis of our tort system and a long established rule. It provides that when two or more persons cause harm or loss, each of them is responsible for the whole loss to the plaintiff. However, in Massachusetts,

the existing law further provides that, as between joint tortfeasors, either may recover any amount paid to the plaintiff over their pro rata share from the other joint tortfeasor. In this regard, the burden of collecting damages in a proportionate fashion from joint tortfeasors correctly and appropriately lies with the tortfeasors, rather than the injured plaintiff.

The proposed legislation radically alters Massachusetts joint tortfeasor law by further burdening victims of malpractice with the new and additional requirement of establishing proportionate fault, a concept never found in our joint tortfeasor statute. The theoretical and practical result of this proposed change would be an explosion of litigation and a delay in the resolution of claims: resolution of each claim would require additional litigation and judicial resources to determine the degree of proportionate fault. Unfortunately, the complexity and nature of medical malpractice actions render this a difficult and often impossible task. Medical injuries are often the result of cumulative actions, where multiple caregivers render substandard care. In these circumstances, the overlapping and interweaving care often makes it exceedingly difficult, and indeed often impossible, to determine the precise percentage of each caregivers' negligence that caused the injury.

Passage of bills abrogating joint and several liability for the medical profession would also prevent injured Massachusetts patients and consumers from being fairly compensated in circumstances where one or more defendants failed to carry adequate liability insurance. Instead, the burden of loss would be shifted from the responsible party to the injured party. Passage of this provision would not predictably lower premiums charged to physicians, but would, instead, lead to an increased financial burden for the citizens of Massachusetts, lead to increased litigation and increased expenditure of judicial resources, and preclude Massachusetts patients and consumers from being fairly compensated for their injuries.

2. Reduction of Future Damage Award by Collateral Sources of Potential Future Benefits (Section 2).

This would create a right for a defendant found negligent in a medical malpractice action to have the jury verdict reduced by an amount *expected* to be compensable by a future collateral source. Since 1986, verdicts in malpractice cases have been offset, or reduced, by amounts actually received from a collateral source prior to the verdict. This provision, if enacted, would require the Court to predict what benefits will be replaceable, compensable or indemnifiable in the future, for how long, and subject to what limitations, and then reduce the amount given to a victim of medical error by this figure. This task would be impossible to accurately execute and would be akin to crystal ball predictions of future policy decisions not in effect at the time of the decision. Reducing amounts paid to victims of medical errors by some amount that might be paid in the future by some other benefit provider is grossly unfair and invites mischief.

3. Requiring medical malpractice tribunal testimony to be from physicians board-certified in the same specialty as the defendant physician and

actively practicing in the same specialty, and require that experts whose statements are used at tribunal must testify at trial.

This would amend Chapter 231, Section 60B by adding the following additional requirements to plaintiffs attempting to bring a malpractice case before the medical malpractice tribunal:

1. That experts used at the tribunal be board certified in the same major areas of clinical service as the defendant physician;
2. That experts used at the tribunal be actively practicing in the same specialty as the defendant physician; and
3. That any expert whose statement is used in the tribunal must testify at trial.

These changes would substantially alter current practice, unduly restrict medical malpractice patients at the tribunal stage of the proceeding and unfairly deprive patients who have been harmed by medical errors of the right to exercise necessary judgment when choosing which consulting experts will testify at trial.

Common law decisions interpreting the current tribunal requirements allow expert statements upon proof of proper understanding of the medical issues involved in the standard of care, with the absence of board certification in the defendant's specialty affecting the weight rather than the admissibility of the evidence. This is an appropriate standard which should not be altered. Frequently, malpractice actions involve care at the intersection of two or more specialties, such as radiology and orthopedic surgery, or internal medicine and infectious diseases. Often a malpractice action will arise as a result of a doctor going beyond his certified specialty in providing treatment, or failing to consult an appropriate specialist when the condition required such. Requiring that a patient put forth an expert board certified in the same specialty as the defendant does not take into account these crossover scenarios and unnecessarily restricts medical malpractice claimants. It also incorrectly assumes that a defendant will be board certified in his specialty, which is often not the case.

Requiring an expert to be "actively" practicing is opposed by MATA not only for the reasons listed above but also because it would unjustly remove a substantial portion of otherwise qualified medical professionals from testifying about the standard of care. Professionals who, by virtue of very recent retirement, have the time and inclination to testify and, most importantly, are not under pressure from hospitals, insurers, and the medical community not to testify, would be unnecessarily excluded.

The requirement that statements provided by experts at a tribunal "shall be admissible at trial" and that, "said experts shall be required to testify at trial" misunderstands the role of the tribunal in the discovery and screening process and ignores the practical consequences of our current trial system. The function of the medical malpractice tribunal, as described in paragraph one of "Section 60B, is to screen potentially meritorious claims from those that merely involve an unfortunate medical result and to impose a requirement of a bond on claims in the latter category. In order to

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be admissible at trial, statements by experts supplied to the tribunal should be required to meet the same burdens as other out of court statements.

The requirement that tribunal experts testify at trial is unfair. A tribunal statement is typically made at the beginning of a case, prior to any discovery. It is incorrect to assume that the quality and content of information available prior to the tribunal is the same as that which has been discovered by the time of trial. In practice, additional medical records frequently turn up, doctors and nurses testify to fact contrary to what is recorded in the medical records, and new theories of liability arise. To hold the plaintiff to the requirement that he produce at trial the expert who provided a statement at the beginning of a matter would unduly and unfairly restrict plaintiffs and would have the effect of preventing them from presenting their best case, based on all available information, to a jury at trial in a situation where defendant healthcare providers are often able to identify two and three experts on the same issue. Finally, this ignores the obvious practical considerations of an expert relocating, becoming infirm, or having commitments or scheduling conflicts that prevent him from testifying at a scheduled trial.

4. Requiring expert witnesses in malpractice actions to be physicians currently board certified in the same specialty as the defendant physician.

A change to existing limitations utilized for expert witness would substantially alter current practice, unduly restrict victims of medical malpractice, and unfairly prejudice victims who have been harmed by medical errors of the right to exercise necessary judgment when choosing which consulting expert will testify at trial.

Common law decisions interpreting the current limitations placed on expert testimony allows experts to offer testimony and statements upon proof of proper understanding and familiarity of the medical issues involved in the standard of care. An expert's absence of board certification in the defendant's specialty under existing law affects the weight given to that expert's testimony rather than the admissibility of the evidence. This is an appropriate standard which should not be altered. Frequently, malpractice actions involve care at the intersection of two or more specialties, such as radiology and orthopedic surgery, or internal medicine and infectious disease. Often a malpractice action will arise as a result of a doctor going beyond his certified specialty in providing treatment, or failing to consult an appropriate specialist when the condition required such. Requiring a victim to put forth an expert who is board certified in the same specialty as the defendant does not take into account these crossover scenarios. Limiting expert testimony to one specialty also limits the jury or fact finders ability to from the expertise of other specialists, who are often necessary to the medical issues at dispute in a given case. Additionally, the proposed bill incorrectly assumes that a defendant will be board certified in his specialty, which often is not the case.

Interestingly, the proposed bill is inconsistent and unduly prejudicial to both physicians and patients involved with malpractice actions. Experts outside of the defendant's specialty are often used by both sides of malpractice litigation to help

persuade the jury and finder of fact of their position. Allowing this bill will accordingly limit physicians and patients' ability to present expertise from other specialties that are relevant, helpful, and in many cases necessary for a just result.

5. Providing immunity from discovery for apologies and admissions of error by medical providers.

A patient has the ethical and legal right to full disclosure of facts surrounding adverse outcomes and medical mistakes. This position has been advocated by national patient safety advocate, Dr. Lucien Leape, a professor at Harvard University School of Public Health. There is a growing trend in favor of apologies because of data which suggests that apologies reduce claims due to dissipation of the anger associated with lack of full disclosure by medical providers. The fact that the making of the apology is the right thing to do and will decrease the likelihood of a claim being brought should be motivation enough to give it.

However, these proposals seek to provide immunity from discovery for the apology and any admissions of error made by the medical provider. In cases where the medical provider apologizes and admits to error or wrongdoing, it is clear that the patient has suffered harm due to medical malpractice. In the event of a subsequent claim, a clearly meritorious plaintiff will be saddled with an additional, unfair and unwarranted burden by losing rights afforded by well-settled rules of discovery and evidence. To further tie the hands of the victim's lawyer by foisting immunity upon apologies and admissions of wrongdoing by medical providers is artificial and unjust. To shield an apology and admission of error from discovery in a subsequent lawsuit penalizes a clear victim of medical negligence by creating a further obstacle to uncovering the truth and successfully resolving the claim. Rather, the victim's attorney must continue to have the opportunity to fully inquire of the defendant medical provider about what the standard of care was which applied to the treatment in question and whether there was compliance with that standard. Any previous admissions should be fully admissible on the issue of non-compliance with the standard of care or should be fair game for impeachment of testimony which is inconsistent with the previous admission. An apology cannot be neatly separated from the reason given for the apology. To shelter the apology and related admission is a slippery slope which will result in blanket immunity objections from defense counsel, which will hamper effective and fair discovery. Full disclosure in the form of an honest recognition and acknowledgement of mistake or wrongdoing is the patient's right, and where it occurs, the patient should not lose their right to fully inquire about the error in discovery and use any such evidence in the prosecution of their claim.

As Dr. Leape has noted, FULL disclosure about events which occurred to a person or to a member of the family is not an option, it is an ethical imperative. Attempting to shield information about what actually happened to a patient or a member of the family from full disclosure is fundamentally inconsistent with this imperative and the Massachusetts Academy of Trial Attorneys opposes any efforts to do so.

6. Allowing The Medical Malpractice Tribunal to Require Case to Submit to Binding Arbitration

This would allow the medical malpractice tribunal “where it determines the circumstances of the case may be resolved more appropriately, may also refer any case to mediation or arbitration.” This simple sentence would have the devastating affect of stripping plaintiffs in medical malpractice actions of their right to a trial with a jury of their peers. This arbitrary elimination of ones right to a jury trial should not be allowed. Tribunal panel members are typically doctors and lawyers who volunteer to sit for a number of cases on a given day. Their task is to determine if the cases presented put forth the minimal amount of evidence necessary to proceed. To give the panel, at the infancy stage of a case and before the parties have had the opportunity to conduct any discovery, the ability to require that cases be decided by arbitration as opposed to a jury trial, is unjust and unfair.

There is no data or other evidence to suggest that forceful arbitration of malpractice actions will have any affect on insurance premiums. It also provides no requirements or standards to be applied by the tribunal members when making such determinations. MATA strongly opposes this attempt to arbitrarily take away the right to a jury trial from victims of medical errors.

7. Reduction in Amount of Non-Economic Damages

The current law requires that a jury can only award more than \$500,000 in non-economic damages if it first establishes that “substantial or permanent impairment of bodily function or substantial disfigurement, or other special circumstances in the case which warrant a finding that the imposition of such a limitation ... would deprive the plaintiff of just compensation for the injuries sustained.” This cap has been in effect, without any limit change, since 1986. There is no justification for reducing the amount at this time or making it a “hard” cap. As with all damage caps, it would deprive the most severely injured individuals of compensation for their injuries. It would also have a disproportionate effect on women and children, whose damages from personal injuries can be largely non-economic.

Non-economic damages compensate victims for very real, but not easily quantifiable, losses sustained when they suffer a serious injury, such as loss of mobility, paralysis, loss of bodily functions, blindness, disfigurement, severe and chronic pain, loss of consortium, or loss of reproductive capacity. These are conditions which can deprive a person of the ability to engage in many of the normal activities of day to day living. There is no justification for reducing an amount recoverable for non-economic damages that was established and has been in place for the past 20 years.

There is **no** empirical data to link larger awards for non-economic damages to increased insurance premiums. There is also no data to suggest that juries routinely misuse the current cap or award non-economic damages excessively. This would, of course, have no effect on large awards based upon large medical expenses or future lost earning capacity calculations.

The existing judicial system has many safeguards against excessive jury verdicts, including motions for judgment notwithstanding the verdict, for remittitur and appeals. It would unnecessarily further reduce the ability of a person harmed by medical negligence to recover fair compensation for their injury.

8. Health Courts are Unconstitutional

Health courts would be an expensive, bureaucratic nightmare. They would exchange a patient's constitutional right to a jury trial for a schedule of pre-determined outcomes that would be handed out by judges more interested in appeasing special interests than rendering justice to the injured patients standing before them. And health courts would not protect patients from wrongdoers, but instead, would shield doctors and hospitals from accountability for their careless, harmful acts. Health courts truly are an unfair proposition for patients.

Health Courts Would be Expensive and Bureaucratic. Health courts would place a huge financial burden on already struggling state treasuries and American taxpayers. States would have to contribute significant dollar amounts to first create a health court system and then to cover all of the administrative costs associated with its operation. Health courts would also be a bureaucratic nightmare for injured patients. Navigating through the red tape of a health court system would make it more complicated and frustrating for an injured patient to be compensated for a doctor or hospital's wrongdoing than under the current system.

Health Courts Would Eliminate a Patient's Constitutional Right to a Jury Trial. In health courts, decisions about liability and compensation would be made by biased, medically-trained judges, rather than by a fair and impartial jury. Despite the constitutional guarantee to a jury trial and the fact that, for hundreds of years juries have justly and effectively decided cases on varying levels of complexity, health courts would eliminate juries altogether. In their place, health courts would use quasi-judges to hand out pre-determined, one size-fits-all liability and compensation outcomes.

One Size Does Not Fit All When it Comes to Liability and Compensation Determinations. Health court judges would not consider the unique facts and circumstances of each case. Instead, decisions about liability and compensation would be pre-determined and selected from a schedule of fixed outcomes and amounts. Health courts would unfairly treat all injured patients the same, regardless of individual circumstances. For example, the financial and professional ramifications of losing a finger are much greater for a pianist than for a librarian; thus providing the same compensation outcome for each would be highly unjust.

Health Court Judges Would be Biased. Health court judges, who might not even be lawyers, would be hand-picked by politicians who would face heavy pressure from insurance companies and the medical industry to select only those individuals that would accommodate their interests over the interests of injured patients. Moreover, such

political appointees tend to favor the political viewpoint of their appointer. Depending on the political climate, this could be disastrous for injured patients, who are less influential.

Health Courts Would Protect Wrongdoers from Accountability. Health courts would make doctors and hospitals completely unaccountable when they carelessly injure patients, and they would eliminate any incentive for doctors and hospitals to provide the standard of care necessary to keep patients safe. Because health courts would rely on pre-determined liability and compensation outcomes, wrongdoers would not have to take responsibility for their bad acts. Moreover, health courts would further shield doctors and hospitals from culpability by eliminating requirements to report adverse events to the appropriate authorities.

9. No-fault System

Increases the cost of health care, at least one percent, by taxing every health care insurer. This cost would have to be passed on to employers who bear much of the burden of health care insurance and individual policy holders and would result in higher co-pays and deductibles in health insurance policies.

To the extent that data gathering and reporting – to be used to identify patterns of care giving rise to injuries, and that this is touted as a benefit of this legislation, this data is ALREADY known by the Board of Registration in Medicine, the medical insurers, and some is known to the Department of Public Health. The Betsey Lehman institute was created for this same purpose and would provide the same function and benefit. The problem is that the patterns of practice would not be made known to the public, even though the data would be collected at public expense.

This proposal completely guts the Massachusetts Wrongful Death Act, by completely denying compensation to husbands and wives, and children for injury to family member or death of their family member.

The Corporation would have carte blanche to inspect all of a person's medical records. This runs afoul of federally enacted HIPPA regulations, recent court decisions protecting privacy of medical records, and public policy of a right of privacy of medical information.

This proposal has serious constitutional concerns, because it takes away a person's rights to access to the courts and trial by jury. This private corporation would have the power to take away a person's right go to court to seek fair compensation for their injuries, even if they wanted to go to use the courts. This is unprecedented in Massachusetts in the history of a person's civil rights.

The injured person would still have to prove causation.

Healthcare Professional Liability: Is 29 Years of Volatility Finally Over in Medical Malpractice?

by Philip E. Dyer

The insurance environment for Healthcare Professional Liability (medical malpractice insurance) seems to be one of stability, calm and improvement. Yet it remains important for both hospitals and doctors to exercise discretion.

Hospitals are seeing increased insurance competition, current carriers are improving their bottom line and more companies are entering the market. Existing carriers have also become more aggressive in both pricing, terms and conditions. More and more hospitals are seeing reductions in premiums, and some are even negotiating successful reductions in their deductibles at the same time.

The picture is also improving for physicians, perhaps to an even greater degree. Carriers appear to be more aggressive in soliciting new business as well as reducing premiums (and some declaring dividends and increasing credits) for existing insureds.

For 2008, we can expect rate reductions that are a reflection of significantly reduced claim frequency. This is a dramatic change when compared to the previous four years in this line of insurance, known for turbulence, dramatic premium increases, reductions in ability to provide coverage, and even non-renewals due to stepped up underwriting criteria.

Industry analysts argue that the major influences on the current marketplace are six-fold: reinsurance changes, lower frequency of claims, companies reaping the rewards of tight underwriting, surplus money from previous rate increases, insurance companies flush with cash, and decreased numbers of plaintiff attorneys in the field.

ONE: Reinsurance Changes

Healthcare professional liability insurance companies are affected through the purchase of reinsurance in the domestic, Bermuda and London marketplace. Historically, with its high volatility, high severity and lengthy turnaround time for results, malpractice insurers were at the

dictates that this produces a large number of insurance companies chasing a very limited reinsurance market.

There are anecdotes that the aftermath of Hurricane Katrina seems to have changed the reinsurance scenario.

Reinsurers that had typically exposed their capital to property insurance risks in the Gulf Coast States were no longer willing to participate in that arena. In order to continue to utilize their capital they seem to have shifted to lines with less volatility. A hurricane risk to property in the Gulf States seemed more volatile than medical malpractice. With increased competition in reinsurance come reduced costs to the insurance companies. This is then passed on to hospitals and doctors.

TWO: Frequency of Claims Has Dropped Dramatically

Estimates of the drop in frequency compared to high points of previous years, ranged from a drop of 30 percent to a drop of more than 50 percent in the number of claims reported. Hospitals that have seen frequency as high as three to four claims per 100 beds are now seeing frequency as low as one and a half claims per 100 beds. Doctors with median frequency in the 10-12 claims per 100 physicians per year are now seeing frequency as low as four to six claims per 100 physicians per year. This has a direct effect to lower premiums; however, the severity of claims continues to increase. Most experts consistently show that the severity of medical professional liability claims continues to rise at six to seven percent per year, and the costs of defense are rising 15+ percent, per year.

THREE: Companies Are Reaping the Rewards of Previous Years

The years 2000 through 2005 were difficult days for malpractice insurance, with impacts on both carriers and consumers. With a deteriorating loss picture (increasing frequency and severity), companies had to make tough choices. Besides dramatically raising premiums (compounded premium increases more than 100 percent in some states) and cur-

existing business with strict criteria.

With the improvements in 2005 and 2006, loss development appears to only be 'favorable' with additional reductions in loss reserves for the companies.

FOUR: Companies Have Money to Spare

With clean books of business, robust premiums and a favorable claims environment, there is a great deal of room for companies to be aggressive and lower rates. Companies find that increasing profits allow them to increase their surplus (stockholders equity). This increases the opportunity for dividends and reduced premiums. It also creates opportunities for aggressive new business appetites.

FIVE: The Healthcare Delivery System Is Better at Preventing Claims and the Incentive to Do So Is Pervasive

The last five years have generated an industry-led and regulator-enhanced ethos of patient safety that has been remarkably successful. There are now as many as 10 major hospital analytical/rating schemes on patient safety that have generated national recognition and standards, and similar activities have increased the priority at the physician/provider insurers. Even the restaurant rating organization Zagat is looking at rating physicians. In addition, not only has the system created an environment that has embraced patient safety and prevention, the providers themselves have seen the financial incentive of claims prevention, healthcare cost reductions (welcomed by the payors and employers) and the more societal improvements in patient satisfaction and wellness.

SIX: The Trial Bar Cannot Afford to Bring Cases that Have Little or No Settlement Value

With 'transparency' of the records of providers and institutions creating a stiffening of resolve to aggressively defend claims, and the cost to 'work-up' a case dramatically increasing for plaintiff attorneys, there is a diminished

Is Healthcare Professional Liability Stable?

➤ continued from page 6

incentive/reward for plaintiff attorneys that are not experts in this field to take medical malpractice cases. This has reduced the number of plaintiff attorneys who actively take medical malpractice cases. What remain are experts in this discipline who may 'triage' 100 cases brought to them down to less than five or six that warrant further investigation and possible claim.

Have We Finally Reached a 'Nirvana' of Stability in Medical Malpractice?

Insurance companies in this discipline for this period of time are typically reluctant to trust the current situation. Years of

experience have dictated that favorable conditions in medical malpractice are transient. However, these incumbent insurers are being forced to react to those newer players seeking advantage in the marketplace. This presents insurance buyers with both opportunities and reasons to be cautious. Some of the potential long-term trends are unprecedented and could provide a permanent stability, yet only the future will tell; does past experience tell us otherwise and not to trust the current market? Time will tell.

Phil Dyer is vice president of the Professional Liability Division at Kibble & Prentice, A USI Company.

Consumer, Patient Groups Reject State-Subsidized Malpractice Insurance

➤ continued from page 1

Reports, sent a similar letter to Gov. Paterson.

The group letter states, "since the last task force meeting in December, there has been absolutely no communication with the patient safety and consumer members of the task force," yet press accounts are reporting that a "major reform proposal" will be unveiled shortly. Say the consumer and patient groups, "We are particularly distressed that lobbyists for doc-

tors and hospitals seem to have participated fully in crafting some sort of indemnity system—something never discussed at the task force meetings and of which we know absolutely nothing." Reports have indicated this could include having Medicaid "assume the burden of subsidizing malpractice." The groups called this "completely wrong-headed. In light of the state's current fiscal crisis, it would be a budget-busting bailout for the state's most dangerous doctors."

Vicarious Liability Spreads with Ostensible Partnerships

➤ continued from page 8

effects on critical access in rural areas. Pilot programs in the planning stage will scrutinize how gainsharing affects disease management under Medicare and skilled nursing facilities operating on prospective payment systems.

Opponents of gainsharing argue that the quality of care will suffer because a less aggressive treatment or followup action will result. The American Association of People with Disabilities has consistently been the voice of caution. Medical device companies are also concerned that their products will be the first cut under gainsharing. Additionally, gainsharing critic Representative Pete Stark (D-CA) will now chair the Ways and Means Health Subcommittee instead of Nancy Johnson. Stark has been quoted as saying he will continue to oppose gainsharing.

The Doctrine of Loss of Chance

Failure to diagnose has long been a leading cause of action in medical malpractice cases. This has been particularly true for claims against primary care physicians in cases involving cancer. Raising the stakes to greater levels of liability for doctors is the growing legal threat called "loss of chance."

The loss of chance doctrine seeks to compensate a plaintiff for injuries resulting from the diminished likelihood that the outcome would have been better had some act or omission of medical care not occurred. Typically, the plaintiff represents that the injuries caused by a disease or condition, usually cancer, become more severe the longer a diagnosis is delayed and thus the prospect (or "chance") of a cure or longer life decreases.

The doctrine of loss of chance was introduced into

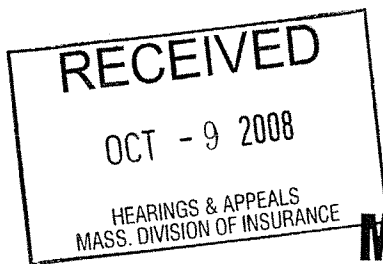
was faced with a contract breach by a landowner who went back on his promise to allow a farmer to use the land. In *Taylor v. Bradley*, the court ruled that the farmer was being deprived of his chance for profit. The doctrine subtly moved forward with approval through American treatises and case law and is becoming a growing category of medical malpractice litigation.

Usually a doctor is held liable for diagnostic delay or failure only if that failure is found to be a substantial factor in a patient's injury or death. However, courts in an increasing number of states have adopted the doctrine of loss of chance. Under this doctrine, the doctor can be held liable for depriving the patient of a significant chance of a better outcome, including survival. A common expression of the doctrine allows for the full recovery of damages if a patient had a 50 percent or greater chance of a better outcome and allows a proportional recovery of damages if a patient's chance of a better outcome was less than 50 percent.

Those judges adopting loss of chance say that they believe it to be a fairer doctrine. Twenty-two states recognize some form of the principle, and a number of states have cases pending that may lead to the doctrine's adoption. States have adopted a wide range of different percentage criteria and a threshold for a loss of chance constituting a recoverable injury that varies from "substantial" to "appreciable."

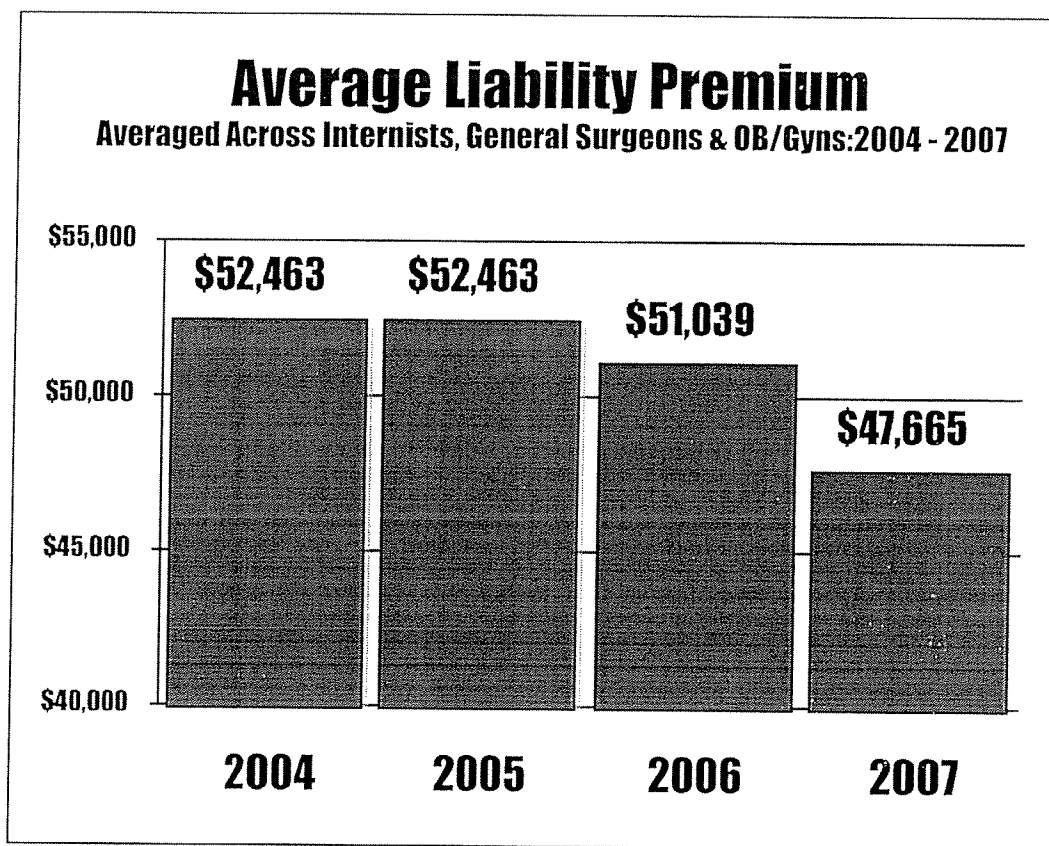
A few state courts have held that the loss of chance to survive in alleged medical malpractice cases is not actionable. In some of these states, new cases are pending to seek a reversal of the previous decision.

Leona Egeland Siadek is vice president of public relations



Medical Malpractice Insurance

Have Premiums Been Skyrocketing?

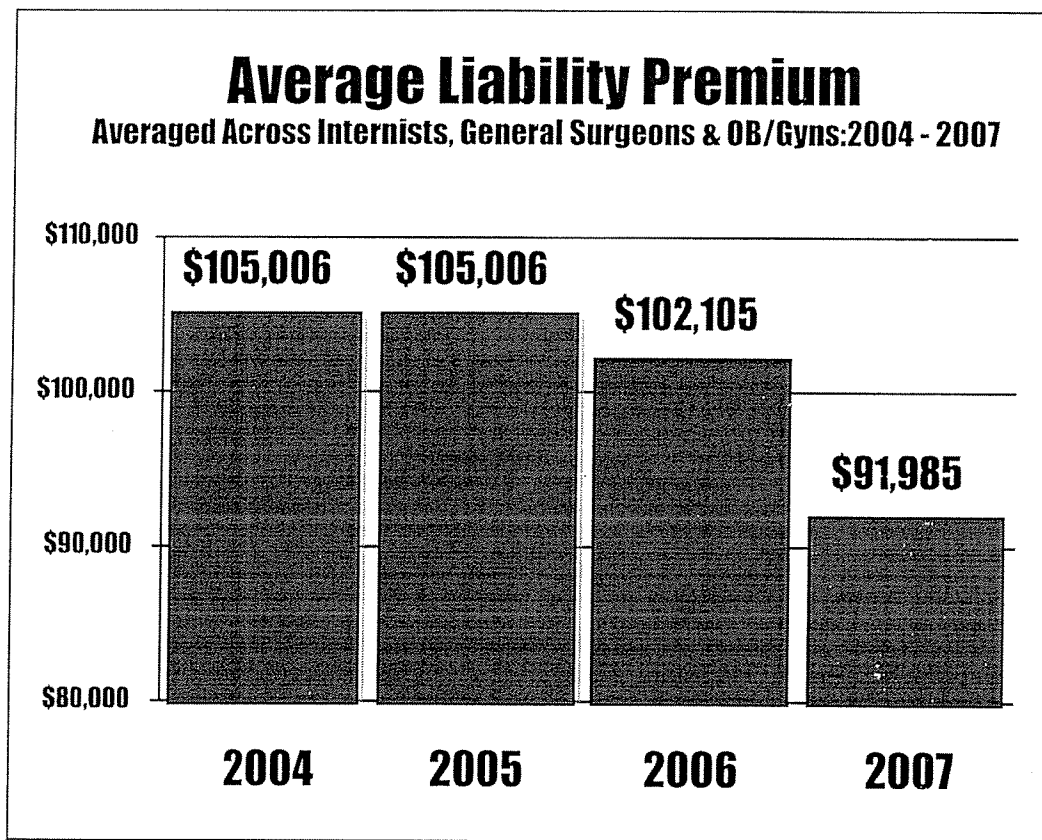


Following The Nationwide Insurance Cycle Premiums In Massachusetts Have Dropped 9.2% Since 2004.

Derived from data provided by Medical Liability Monitor (Oct 2004, 2005, 2006, 2007) A state's average premium is calculated as the unweighted mean value of premiums for all companies for which data is provided across all regions.

Medical Malpractice Insurance

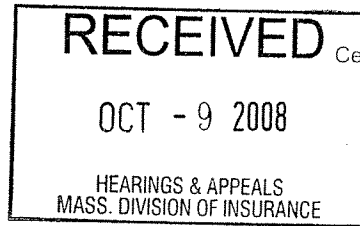
Have OB/Gyn Premiums Been Skyrocketing?



**Following The Nationwide Insurance Cycle
OB/Gyn Premiums In Massachusetts Have
Dropped 12.4% Since 2004.**

Derived from data provided by Medical Liability Monitor (Oct 2004, 2005, 2006, 2007) A state's average premium is calculated as the unweighted mean value of premiums for all companies for which data is provided across all regions.

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MYTHBUSTER!

THE TRUTH ABOUT MEDICAL MALPRACTICE LITIGATION

MEDICAL MALPRACTICE CASES REPRESENT A TINY PERCENTAGE OF TORT CASES FILED EACH YEAR. In 2004, medical malpractice cases accounted for an average of only four percent of tort cases in 13 states reporting.¹

CONTRARY TO POPULAR MYTH, FEW INJURED PATIENTS FILE LAWSUITS.

- Between 44,000 and 98,000 Americans die each year (and 300,000 are injured) due to medical errors in hospitals alone. Yet eight times as many patients are injured as ever file a claim; 16 times as many suffer injuries as receive any compensation.²
- At the highest level, the estimated number of medical injuries (in hospitals and otherwise) is more than one million per year; approximately 85,000 malpractice suits are filed annually. "With about ten times as many injuries as malpractice claims, the only conclusion possible is that injured patients rarely file lawsuits."³

FAR FROM BEING "BROKEN," THE CURRENT MEDICAL MALPRACTICE SYSTEM WORKS WELL.

The Harvard School of Public Health recently found that the current system works: legitimate claims are being paid, non-legitimate claims are generally *not* being paid, and "portraits of a malpractice system that is stricken with frivolous litigation are overblown."⁴ The authors found:

- Sixty-three percent of the injuries were judged to be the result of error and most of those claims received compensation; on the other hand, most individuals whose claims did not involve errors or injuries received nothing.
- Eighty percent of claims involved injuries that caused significant or major disability or death.
- "The profile of non-error claims we observed does not square with the notion of opportunistic trial lawyers pursuing questionable lawsuits in circumstances in which their chances of winning are reasonable and prospective returns in the event of a win are high. Rather, our findings underscore how difficult it may be for plaintiffs and their attorneys to discern what has happened before the initiation of a claim and the acquisition of knowledge that comes from the investigations, consultation with experts, and sharing of information that litigation triggers."
- "Disputing and paying for errors account for the lion's share of malpractice costs."
- "Previous research has established that the great majority of patients who sustain a medical injury as a result of negligence do not sue. ... [F]ailure to pay claims involving error adds to a larger phenomenon of underpayment generated by the vast number of negligent injuries that never surface as claims."

THE VAST MAJORITY OF TRUE MEDICAL MALPRACTICE CASES SETTLE; "FRIVOLOUS" CASES DO NOT SETTLE.

- In the Harvard closed claims study, only fifteen percent of claims were decided by trial verdict.⁵ Other research shows that 90 percent of cases are settled without jury trial, with some estimates indicating that the figure is as high as 97 percent.⁶

- According to a Bureau of Justice report that examined medical malpractice insurance claims in seven states, between 2000 and 2004, about 95 percent of medical malpractice insurance claims settled prior to trial.⁷
- As Duke Law professor Neil Vidmar, who has extensively studied medical malpractice litigation, recently testified in the U.S. Senate, “Research on why insurers actually settle cases indicates that the driving force in most instances is whether the insurance company and their lawyers conclude, on the basis of their own internal review, that the medical provider was negligent....An earlier study by Rosenblatt and Hurst examined 54 obstetric malpractice claims for negligence. For cases in which settlement payments were made there was general consensus among insurance company staff, medical experts and defense attorneys that some lapse in the standard of care had occurred. No payments were made in the cases in which these various reviewers decided there was no lapse in the standard of care.”⁸
- Vidmar testified, “In interviews with liability insurers that I undertook in North Carolina and other states, the most consistent theme from them was: ‘We do not settle frivolous cases!’ The insurers indicated that there are minor exceptions, but their policy on frivolous cases was based on the belief that if they ever begin to settle cases just to make them go away, their credibility will be destroyed and this will encourage more litigation.”⁹
- Vidmar further testified, “Without question the threat of a jury trial is what forces parties to settle cases. The presence of the jury as an ultimate arbiter provides the incentive to settle but the effects are more subtle than just negotiating around a figure. The threat causes defense lawyers and the liability insurers to focus on the acts that led to the claims of negligence.”¹⁰

THE NUMBER OF MEDICAL MALPRACTICE PAYMENTS IS DECLINING.

- According to Public Citizen’s analysis of National Practitioner Data Bank (NPDB) data, between 1991 and 2005, the total number of malpractice payments made on behalf of doctors declined 15.4 percent (with judgments and settlements).¹¹
- Public Citizen’s analysis also found that between 1991 and 2005, the number of malpractice payments per 100,000 Americans dropped more than ten percent.¹²

MEDICAL MALPRACTICE PAYOUTS ARE FAR SMALLER THAN COMMONLY BELIEVED AND COMPENSATE FOR SERIOUS INJURIES.

- **Verdicts and Payouts.**
 - In 2001, the latest year studied by the U.S. Department of Justice, median awards in medical malpractice cases (jury and bench trials) was \$422,000.¹³ In jury trials, the median was \$431,000.¹⁴
 - According to Public Citizen’s analysis of National Practitioner Data Bank (NPDB) data, “the annual average payment for a medical malpractice verdict has not exceeded \$1 million in real dollars since the beginning of the NPDB. The average payment for a medical malpractice verdict in 1991 was \$284,896. In 2005, the average was \$461,524. Adjusting for inflation, however, shows that the average is actually declining. The 2005 average adjusted for inflation is only \$260,890 — a decline of 8 percent since 1991.”¹⁵
 - Public Citizen also found that the total number of malpractice payments made on behalf of doctors, including judgments and settlements, declined 15.4 percent from 2001-2005 (from 16,588 in 2001 to 14,033 in 2005) and “the number of payments per 100,000 people in the U.S. also fell since 2001 – from 5.82 to 4.73 – a decline of 18.6 percent. Since 1991, the number of payments per 100,000 people declined more than 10 percent.”¹⁶
 - According to a Bureau of Justice report that examined medical malpractice insurance claims in seven states between 2000 and 2004, most medical malpractice claims were closed without any compensation provided to those claiming a medical injury.¹⁷
 - Vidmar testified “research evidence indicates that outlier verdicts seldom withstand post verdict proceedings.... Post-trial reductions have been documented in a number of studies. I and two colleagues found that some of the largest malpractice awards in New York ultimately resulted in settlements between five and ten percent of the original jury verdict. A

study that I conducted on medical malpractice awards in Pennsylvania and a study of Texas verdicts found similar reductions. . . . My recent research on medical malpractice verdicts in Illinois found that, on average, final payments to plaintiffs were substantially lower than the jury verdicts. This does not mean that the original verdict was too high. Rather, needing money immediately and wanting to avoid a possibly lengthy appeal process the plaintiffs settled for the health providers' insurance policy limit. Generally speaking, the larger the award, the greater the reduction in the settlement following trial.¹⁸

- **Total Payouts.** Total medical malpractice payouts, for injuries and deaths caused by medical negligence in the nation, have recently hovered between \$5 billion and \$6 billion annually.¹⁹ This is less than half of what Americans pay for dog and cat food each year.²⁰
- **Severity of injuries.**
 - Public Citizen's analysis of NPDB statistics shows that patients do not win large jury awards for insignificant claims and that payments usually correspond with injury severity. In 2005, more than 64 percent of payments involved death or significant injury, less than one-third were for insignificant injury, and less than three percent were for million-dollar verdicts.²¹
 - According to Duke University Law Professor Neil Vidmar, "the magnitude of jury awards in medical malpractice tort cases positively correlated with the severity of the plaintiffs' injuries, except that injuries resulting in death tended to result in awards substantially lower than injuries resulting in severe permanent injury, such as quadriplegia. I and two colleagues conducted a study of malpractice verdicts in New York, Florida, and California. We also found that jury awards of prevailing plaintiffs in malpractice cases were correlated with the severity of the injury."²²
- **Punitive damages.**
 - In medical malpractice cases in 2001, the most recent year studied by the U.S. Department of Justice, punitive damages were awarded in only 4.9 percent of cases with plaintiff winners.²³
 - In medical malpractice cases between 1963 and 1993 studied by professors Koenig and Rustad, punitive verdicts were largely proportional to compensatory awards, with the median ratio of punitive damages to compensatory damages awarded at trial 1.21 to 1.²⁴ They also found that punitive damages were only levied in instances of outrageous behavior.²⁵ In addition, judges changed 42 percent of punitive verdicts after trial. Nearly ten percent (26 out of 270) of cases involving punitive damages were reversed by appellate courts.²⁶ Moreover, the "vast majority of punitive dollars were uncollectible due to post-trial reversals, settlements, and defendant insolvency."²⁷

CONTRARY TO POPULAR NOTIONS, IT IS DIFFICULT FOR PATIENTS TO WIN MEDICAL MALPRACTICE CASES BEFORE JURIES.

- In 2001, the latest year studied by the U.S. Department of Justice, patients won before judges 50 percent of the time, while only winning 26.3 percent of cases before juries, dropping from 30.5 percent in 1992.²⁸
- According to the Harvard School of Public Health, patients "rarely won damages at trial, prevailing in only 21 percent of verdicts as compared with 61 percent of claims resolved out of court."²⁹
- Duke University Law professor Neil Vidmar testified before Congress, "Interviews with North Carolina jurors who decided medical malpractice cases showed that jurors viewed the plaintiffs' claims with great skepticism. Jurors expressed their attitudes in two main themes: first, too many people want to get something for nothing, and second, most doctors try to do a good job and should not be blamed for a simple human misjudgment. This does not mean that in every case jurors held these views. Sometimes, evidence of the doctor's behavior caused jurors to be angry about the negligence. However, even in these latter cases the interviews indicated that the jurors had approached the case with open minds."³⁰

JURIES ARE COMPETENT AND ABLE TO HANDLE MEDICAL MALPRACTICE

CASES. Consistent empirical studies show juries to be competent, effective, and fair decision makers able to handle complex cases.³¹

LITIGATION IMPROVES PATIENT SAFETY. The *New England Journal of Medicine* confirmed in a breakthrough article by George J. Annas, J.D., M.P.H., that litigation against hospitals improves the quality of care for patients.³² The author wrote, “In the absence of a comprehensive social insurance system, the patient’s right to safety can be enforced only by a legal claim against the hospital. ... [M]ore liability suits against hospitals may be necessary to motivate hospital boards to take patient safety more seriously.... Anesthesiologists were motivated by litigation to improve patient safety. As a result, this profession implemented 25-years-ago a program to make anesthesia safer for patients and as a result, the risk of death from anesthesia dropped from 1 in 5000 to about 1 in 250,000.”

A SMALL PERCENTAGE OF DOCTORS ARE RESPONSIBLE FOR MOST MALPRACTICE PAYMENTS.

- From 1991 to 2005, only 5.9 percent of doctors were responsible for 57.8 percent of malpractice payments. Each of those doctors made at least two payments.³³
- Since the creation of the National Practitioner Data Bank in 1990, the large majority of doctors – 82 percent – never made a malpractice payment.³⁴

FEAR OF LITIGATION IS NOT THE MAIN REASON DOCTORS DO NOT REPORT ERRORS.

- According to a recent study by Dr. Thomas Gallagher, a University of Washington internal-medicine physician and co-author of two studies published in the *Archives of Internal Medicine*, “Comparisons of how Canadian and U.S. doctors disclose mistakes point to a ‘culture of medicine,’ not lawyers, for their behavior.”³⁵ In Canada, there are no juries, non-economic awards are severely capped and “if patients lose their lawsuits, they have to pay the doctors’ legal bills... yet “doctors are just as reluctant to fess up to mistakes.” Moreover, “doctors’ thoughts on how likely they were to be sued didn’t affect their decisions to disclose errors.” The authors believe “the main culprit is a ‘culture of medicine,’ which starts in medical school and instills a ‘culture of perfectionism’ that doesn’t train doctors to talk about mistakes.”³⁶
- Research by George J. Annas, J.D., M.P.H. “found that only one quarter of doctors disclosed errors to their patients, but “the result was not that much different in New Zealand, a country that has had no-fault malpractice insurance” [i.e., no litigation against doctors] for decades. In other words, “There are many reasons why physicians do not report errors, including a general reluctance to communicate with patients and a fear of disciplinary action or a loss of position or privileges.”³⁷

MEDICAL MALPRACTICE CLAIMS AND PREMIUMS ARE A TINY PERCENTAGE OF THE TOTAL COSTS OF HEALTH CARE IN THIS COUNTRY.

- Medical malpractice payouts are less than one percent of total U.S. health care costs. All “losses” (verdicts, settlements, legal fees, etc.) have stayed under one percent for the last 18 years. Moreover, medical malpractice premiums are less than one percent of total U.S. health care costs as well. Dropping for nearly two decades, malpractice premiums have stayed below one percent of health care costs.³⁸
- The Congressional Budget Office found that “Malpractice costs account for less than 2 percent of [health care] spending,” and that all the provisions of the federal medical malpractice bill, including a \$250,000 cap on non-economic damages, “would lower health care costs by only about 0.4 percent to 0.5 percent, and the likely effect on health insurance premiums would be comparably small.”³⁹

NOTES

¹ *Examining the Work of State Courts, 2005, A National Perspective from the Court Statistics Project* (2006) at 29.

² National Academy of Sciences Institute of Medicine, "To Err is Human" (1999); Harvard Medical Practice Study (1990). In 2004, HealthGrades, Inc., which rates hospitals for insurers and health plans, concluded, from a study of Medicare records for all fifty states from 2000-2002, that the Institute of Medicine's high figure of 98,000 was too low and that a figure of 195,000 annual deaths was more accurate. (Testimony of Neil Vidmar of Duke Law School before The Senate Committee on Health, Education, Labor and Pensions, Hearing on "Medical Liability: New Ideas for Making the System Work Better for Patients," June 22, 2006 at 5.)

³ David A. Hyman and Charles Silver, "Medical Malpractice Litigation and Tort Reform: It's the Incentives, Stupid," 59 Vand. L. Rev. 1085, 1089 (May 2006) (citing Brian Ostrom, Neal Kauder & Neil LaFontain, *Examining the Work of State Courts* (2003) at 23).

⁴ David M. Studdert, Michelle Mello, et al., "Claims, Errors, and Compensation Payments in Medical Malpractice Litigation," *New England Journal of Medicine*, May 11, 2006.

⁵ David M. Studdert, Michelle Mello, et al., "Claims, Errors, and Compensation Payments in Medical Malpractice Litigation," *New England Journal of Medicine*, May 11, 2006.

⁶ Testimony of Neil Vidmar, Russell M. Robinson, II Professor of Law, Duke Law School before The Senate Committee on Health, Education, Labor and Pensions, "Hearing on Medical Liability: New Ideas for Making the System Work Better for Patients," June 22, 2006 at 17. (citations omitted).

⁷ Bureau of Justice Statistics, U.S. Department of Justice, "Medical Malpractice Insurance Claims in Seven States, 2000-2004," NCJ 216339 (Mar. 2007) at 7.

⁸ *Ibid.* at 17-18, 22.

⁹ *Ibid.* at 23.

¹⁰ *Ibid.* at 21.

¹¹ Public Citizen, Congress Watch, *The Great Medical Malpractice Hoax: NPDB Data Continue to Show Medical Liability System Produces Rational Outcomes*, (January 2007) at 2. (This report analyzes data in the National Practitioner Data Bank Public Use File, dated 31 December 2005.)

¹² *Ibid.* at 4.

¹³ "Tort Trials and Verdicts in Large Counties, 2001," U.S. Department of Justice, Bureau of Justice Statistics, 206240 (November 2004), at 4.

¹⁴ "Tort Trials and Verdicts in Large Counties, 2001," U.S. Department of Justice, Bureau of Justice Statistics, 206240 (November 2004), at 7.

¹⁵ Public Citizen, Congress Watch, *The Great Medical Malpractice Hoax: NPDB Data Continue to Show Medical Liability System Produces Rational Outcomes*, (January 2007) at 5, 9. (This report analyzes data in the National Practitioner Data Bank Public Use File, dated 31 December 2005.)

¹⁶ *Ibid.* at 2-5.

¹⁷ Bureau of Justice Statistics, U.S. Department of Justice, "Medical Malpractice Insurance Claims in Seven States, 2000-2004," NCJ 216339 (Mar. 2007) at 1.

¹⁸ Testimony of Neil Vidmar, Russell M. Robinson, II Professor of Law, Duke Law School before The Senate Committee on Health, Education, Labor and Pensions, "Hearing on Medical Liability: New Ideas for Making the System Work Better for Patients," June 22, 2006 at 13.

¹⁹ See, Americans for Insurance Reform, *Stable Losses/Unstable Rates, 2004*, <http://www.insurance-reform.org/StableLosses04.pdf>.

²⁰ The Pet Food Institute puts these figures at \$13 to \$14 billion annually over the past few years. See, http://www.petfoodinstitute.org/reference_pet_data.cfm

²¹ Public Citizen, Congress Watch, *The Great Medical Malpractice Hoax: NPDB Data Continue to Show Medical Liability System Produces Rational Outcomes*. (January 2007) at 2.

²² Testimony of Neil Vidmar, Russell M. Robinson, II Professor of Law, Duke Law School before The Senate Committee on Health, Education, Labor and Pensions, "Hearing on Medical Liability: New Ideas for Making the System Work Better for Patients," June 22, 2006 at 10.

²³ Bureau of Justice Statistics, U. S. Department of Justice, "Selected Findings, Civil Justice Survey of State Courts, 2001, Punitive Damage Awards in Large Counties, 2001," NCJ 208445 (March 2005) at 3.

²⁴ Thomas Koenig & Michael Rustad, "Reconceptualizing Punitive Damages in Medical Malpractice: Targeting Amoral Corporations, Not 'Moral Monsters,'" 47 *Rutgers L. Rev.* 975, 1009 (1995).

²⁵ *Ibid.* at 15, 50-51.

²⁶ *Ibid.* at 15, 24, 43.

²⁷ *Ibid.* at 15, 43.

²⁸ Bureau of Justice Statistics, U.S. Department of Justice, "Tort Trials and Verdicts in Large Counties, 2001," NCJ 206240 (Nov. 2004) at 4, 7.

²⁹ David M. Studdert, Michelle Mello, et al., "Claims, Errors, and Compensation Payments in Medical Malpractice Litigation," *New England Journal of Medicine*, May 11, 2006.

³⁰ Testimony of Neil Vidmar, Russell M. Robinson, II Professor of Law, Duke Law School before The Senate Committee on Health, Education, Labor and Pensions, "Hearing on Medical Liability: New Ideas for Making the System Work Better for Patients," June 22, 2006 at 8.

³¹ For an extensive list of studies demonstrating the competence of juries, see, e.g., Testimony of Neil Vidmar, Russell M. Robinson, II Professor of Law, Duke Law School before The Senate Committee on Health, Education, Labor and Pensions, "Hearing on Medical Liability: New Ideas for Making the System Work Better for Patients," June 22, 2006 at 10 ("The overwhelming number of the judges gave the civil jury high marks for competence, diligence, and seriousness, even in complex cases ... Systematic studies of jury responses to experts lead to the conclusion that jurors do not automatically defer to experts and that jurors have a basic understanding of the evidence in malpractice and other cases. Jurors understand that the adversary system produces experts espousing opinions consistent with the side that called them to testify. Moreover, jurors carefully scrutinize and compare the testimony of opposing experts. They make their decisions through collective discussions about the evidence.... We also found that jury awards of prevailing plaintiffs in malpractice cases were correlated with the severity of the injury.")(citations omitted); Peters Jr., Philip G., "Doctors & Juries," U of Missouri-Columbia School of Law Legal Studies Research Paper No. 2006-33 Available at SSRN: <http://ssrn.com/abstract=929474> ("Four important findings emerge from the data. First, negligence matters. Plaintiffs rarely win weak cases. They have more success in toss-up cases, and fare best in cases with strong evidence of medical negligence. Second, jury verdicts are most likely to square with the opinions of experts hired to evaluate the jury's performance when the evidence of provider negligence is weak. This is the very set of cases that most worries critics of malpractice litigation. Juries agree with expert reviewers in 80 to 90 percent of these cases - a better agreement rate than physicians typically have with each other. Third, jury verdicts are much more likely to deviate from the opinion of an expert reviewer when there is strong evidence of negligence. Doctors consistently win about 50 percent of the cases which experts believe the plaintiffs should win. Fourth, the poor success of malpractice plaintiffs in these cases strongly suggests the presence of factors that systematically favor medical defendants in the courtroom. The most promising explanations for that advantage are the defendant's superior resources, the social standing of physicians, social norms against 'profiting' from an injury, and the jury's willingness to give physicians the "benefit of the doubt" when the evidence of negligence is conflicting.") See also, Marc Galanter, "Real World Torts: An Antidote to Anecdote," 55 *Md. L. Rev.* 1093, 1109, note 45 (1996), citing Michael J. Saks, *Small-Group Decision Making and Complex Information Tasks* (1981); Robert MacCoun, "Inside the Black Box: What Empirical Research Tells Us About Decisionmaking by Civil Juries," in *Verdict: Assessing the Civil Jury System* 137 (Brookings Institution, Robert E. Litan ed., 1993); Christy A. Visser, "Juror Decision Making: The Importance of Evidence," 11 *Law & Hum. Behav.* 1 (1987); Richard O. Lempert, "Civil Juries and Complex Cases: Let's Not Rush to Judgment," 80 *Mich. L. Rev.* 68 (1981).

³² George J. Annas, J.D., M.P.H., "The Patient's Right to Safety - Improving the Quality of Care through Litigation against Hospitals," *New England Journal of Medicine*, May 11, 2006.

³³ Public Citizen, *The Great Medical Malpractice Hoax*, at 12.

³⁴ *Ibid.*

³⁵ Carol M. Ostrom, "Lawsuit fears aren't reason for docs' silence, studies say," *Seattle Times*, August 17, 2006, citing from Thomas Gallagher, M.D., et al, "Choosing your Words Carefully: How Physicians Would Disclose Harmful Medical Errors to Patients," *Archives of Internal Medicine*, Aug. 14, 2006.

³⁶ *Ibid.*

³⁷ George J. Annas, J.D., M.P.H., "The Patient's Right to Safety - Improving the Quality of Care through Litigation against Hospitals," *New England Journal of Medicine*, May 11, 2006.

³⁸ See, Americans for Insurance Reform, "Think Malpractice is Driving Up Health Care Costs? Think Again," <http://www.insurance-reform.org/pr/AIRhealthcosts.pdf>

³⁹ Congressional Budget Office, *Limiting Tort Liability for Medical Malpractice* 1, 6 (Jan. 8, 2004).



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PATIENT JUSTICE

Patients Are Better Off in States Without Barriers to Justice

January 2008

Executive Summary

In state after state, patients continue to be told that the silver bullet for improving healthcare is to enact severe and arbitrary limits on patient access to the legal system. The argument made by insurance and medical industry lobbyists is that, in essence, allowing the epidemic of medical errors to go unchecked by legal accountability will improve the quality of healthcare.¹

We set out to test this theory and determine if so-called tort “reform” corresponds to improvements in the healthcare system. Our investigation shows the opposite to be the case. Using data collected for a comprehensive state-by-state evaluation of healthcare by the non-profit, nonpartisan Commonwealth Fund,² we have determined that states without caps on medical malpractice lawsuits tend to have *better* healthcare than those with these arbitrary limits.³

According to our analysis, states with limits on patient access to the legal system have worse overall healthcare on the Commonwealth Fund’s composite measurement than those without arbitrary legal restrictions. In a ranking of all 50 states plus the District of Columbia, the average rank of overall state health system performance for those states without caps on medical liability damages is higher at 21.3 than those with arbitrary limits, which have an average rank of 28.9. This demonstrates that patients in states without limits on their access to the legal system are better off than those with such barriers.

Moreover, states with caps more often rank among the worst in the Commonwealth Fund’s healthcare measures. For instance, 69% of states with the poorest overall health system performance (bottom quarter), 79% of states with the worst access to care, and 84% of states with

¹ This claim has been made by numerous special interests that advocate for severe and arbitrary limits on patient access to the courts, including the American Tort Reform Association (http://www.atra.org/wrap/files.cgi/7964_howworks.html), Pacific Research Institute (http://www.pacificresearch.org/publications/id.2932/pub_detail.asp), and Texans for Lawsuit Reform (<http://www.tortreform.com/node/1>).

² The Commonwealth Fund, “Aiming Higher: Results from a State Scorecard on Health System Performance,” June 2007. See http://www.commonwealthfund.org/usr_doc/StateScorecard.pdf?section=4039.

³ The 20 states (plus the District of Columbia) without caps are: Alabama, Arizona, Arkansas, Connecticut, Delaware, District of Columbia, Iowa, Kentucky, Maine, Minnesota, New Hampshire, New Jersey, New York, North Carolina, Oregon, Pennsylvania, Rhode Island, Tennessee, Vermont, Washington, and Wyoming. The 30 states with caps are: Alaska, California, Colorado, Florida, Georgia, Hawaii, Idaho, Illinois, Indiana, Kansas, Louisiana, Maryland, Massachusetts, Michigan, Mississippi, Missouri, Montana, Nebraska, Nevada, New Mexico, North Dakota, Ohio, Oklahoma, South Carolina, South Dakota, Texas, Utah, Virginia, West Virginia, and Wisconsin.

the poorest quality of care have limits on patient access to the courts. Evidence from this study shows that the proposition that so-called tort “reform” is achieving its touted goal of improving patient care is highly dubious. Patients fare worse in states with limits on access to their legal accountability system.

This data demonstrates the falsity of a major component used by special interests who desire to immunize wrongdoers from accountability by stripping patients of their legal rights. According to this analysis, Americans are much more likely to obtain better quality and access to healthcare and are significantly more likely to have health insurance in states that do not restrict the ability of injured patients to hold negligent doctors and hospitals accountable.

Methodology

Using healthcare rankings developed by The Commonwealth Fund, a non-profit healthcare research foundation, this report compares states that have imposed limitations on patient access to the civil justice system through arbitrary limits on medical malpractice cases with those that have not. The Commonwealth Fund rankings measure overall health system performance, access to healthcare, and quality of healthcare by dividing all 50 states plus the District of Columbia into quartiles based on each state’s performance. According to the Commonwealth Fund, performance is measured in “access, quality, avoidable hospital use and costs, equity, and healthy lives.”⁴ Texas Watch utilized the Commonwealth Fund’s measures as a benchmark to compare states with caps on medical liability damages with those that do not impose these arbitrary limitations.

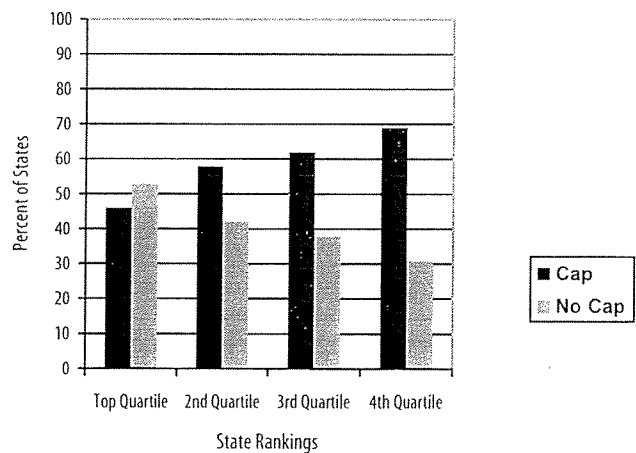
Results

Overall Health System Performance

When the Commonwealth Fund rankings of states are combined with information about which states have limits on physician and hospital accountability, it becomes clear that states without limits typically ranked higher. The difference is particularly clear among states that provide the poorest healthcare (those in the bottom quartile), where 69% of the states have caps on medical liability damages. This trend continues across the states in the overall health system performance rankings, as states with caps comprise an increasing percentage as the overall performance worsens, while states without caps comprise a decreasing percentage.

Texas, which has been applauded by special interests pushing a corporate immunity agenda across the country, is ranked 49th among states in overall health system performance.

Overall Health System Performance

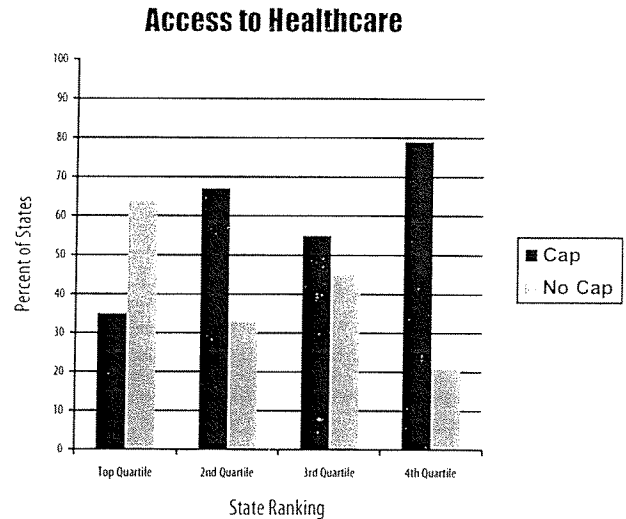


⁴ See Footnote 2 at pg. 3.

Access to Healthcare

The Commonwealth Fund report also ranks states according to access to healthcare. The report concludes that “access to health care is the foundation and hallmark of a high performance health system, [and] the foremost factor in determining whether people have access to care...is having insurance.”⁵ For numerous years, Texas has ranked at or near the bottom of states for percent of residents covered by health insurance,⁶ and in the Commonwealth’s assessment of access, Texas ranks dead last yet again.

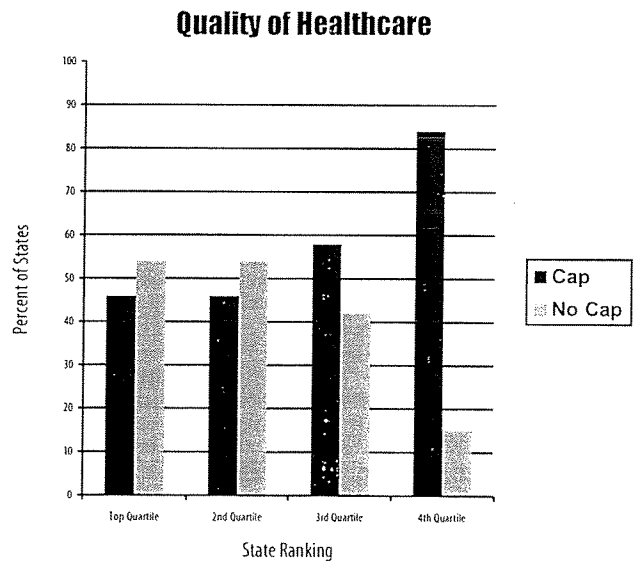
In the access rankings, states with caps comprise a mere 36% in the top quartile while they represent a whopping 79% of states in the bottom quartile. The report further subdivides the access rankings to indicate which states have the highest percentages of insured adults and insured children. In both of these categories, states with caps comprise an astounding 85% in the bottom quartile – meaning that states with caps are significantly more likely than states without caps to have high percentages of uninsured adults and children.



Quality of Healthcare

The Commonwealth Fund uses numerous factors to measure health care quality, including adult preventative care, child mental health care, and hospital quality. Of states with the highest quality of healthcare (those in the 1st tier), only 46% have caps, while of states with the poorest quality of healthcare (those in the 4th tier), 84% - nearly twice as many – have caps.

This clearly indicates that states with caps fare worse in terms of quality in the healthcare arena, directly contradicting assertions that caps on medical malpractice claims lead to improved healthcare.



Conclusion

This analysis clearly demonstrates that assertions by special interests that stripping patients of their legal rights will lead to better care is groundless. Advocates of restricting patient rights simply

⁵ See footnote 2 at pg. 18.

⁶ U.S. Census Bureau, “Household Income Rises, Poverty Rates Decline, Number of Uninsured Up,” August 28, 2007. See http://www.census.gov/Press-Release/www/releases/archives/income_wealth/010583.html.

cannot get around the simple fact that patients are better off in states that do not limit the legal rights of patients.

While a number of factors go into determining the quality of care that patients receive, we believe that holding negligent doctors and careless hospitals accountable goes a long way toward improving overall patient care.

Rather than relying on flimsy conclusions made by insurance-backed interest groups and industry lobbyists, we encourage lawmakers in states across the nation to address the epidemic of medical errors by strengthening patient safety standards and ensuring fair and open access to the legal system.

About Texas Watch

Founded in 1998, Texas Watch is a citizens group based in Austin, Texas, which is dedicated to open access to the legal system for all Texans, fair markets for consumers, and strong accountability measures for wrongdoers. With 10,000 citizen members, Texas Watch actively advocates for real insurance and legal reforms that strengthen protections for families, patients, consumers, workers, and small business owners. To learn more about Texas Watch, visit www.TexasWatch.org.

Appendix

Table 1 Information

Overall Health System Performance

- Top Quartile
 - Cap: 6/13 = 46%
 - No Cap: 7/13 = 53%
- Second Quartile
 - Cap: 7/12 = 58%
 - No Cap: 5/12 = 42%
- Third Quartile
 - Cap: 8/13 = 62%
 - No Cap: 5/13 = 38%
- Fourth Quartile
 - Cap: 9/13 = 69%
 - No Cap: 4/13 = 31%

Table 2 Information

Access to Healthcare

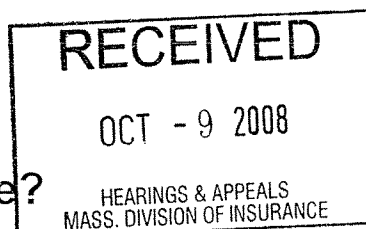
- Top Quartile
 - Cap: 5/14 = 35%
 - No Cap: 9/14 = 64%
- Second Quartile
 - Cap: 8/12 = 67%
 - No Cap: 4/12 = 33%
- Third Quartile
 - Cap: 6/11 = 55%
 - No Cap: 5/11 = 45%
- Fourth Quartile
 - Cap: 11/14 = 79%
 - No Cap: 3/14 = 21%

Table 3 Information

Quality of Healthcare



- Top Quartile
 - Cap: 6/13 = 46%
 - No Cap: 7/13 = 54%
- Second Quartile
 - Cap: 6/13 = 46%
 - No Cap: 7/13 = 54%
- Third Quartile
 - Cap: 7/12 = 58%
 - No Cap: 5/12 = 42%
- Fourth Quartile
 - Cap: 11/13 = 84%
 - No Cap: 2/13 = 15%

JOSEPH B. MARTIN



The Boston Globe

Where have all the doctors gone?

Email | Print | Single Page | Text size   By Joseph B. Martin

May 27, 2008

THE QUESTION OF whether there are enough doctors to care for patients, particularly if the nation moves toward a new scheme for universal health coverage, is the elephant in the room of the presidential campaign debate on health reform.

Fifteen to 20 years ago there were worries about too many doctors, particularly in some specialties. Now, the Association of American Medical Colleges is requesting medical schools to increase enrollments by 30 percent over the next seven to 15 years.

Serious shortages are expected in fields like general surgery, particularly in smaller urban centers and rural districts, and in neuro-ophthalmology, where doctors, unlike ophthalmologists, have a tough time making enough to pay off school debts.

And with an aging population there will be an increasing demand for geriatric medicine as well.

But the gravest concern is about the lack of primary care doctors to work in settings where the patient load is high and the pay is less.

Indeed, Massachusetts is finding that there are not enough primary care venues to deliver care to all the enrollees in the new universal healthcare plan.

Let's step back and put this medical supply-and-demand equation in context. Every year US medical schools graduate about 15,000 students. They welcome another 6,500 foreign medical graduates into first year post-graduate residency slots; most of these international graduates will remain in the United States, unfortunately depriving their home countries of the work force required to deliver adequate medical care there.

Where do all the new doctors go? The current view is that they are hitting the ROAD: Radiology, Ophthalmology, Anesthesiology, and Dermatology. In all these specialties the pay is better and lifestyle issues permit regular work hours, a point often of great importance to women graduates, who now make up a full 50 percent of the graduating doctors.

I've done some checking on doctors' career plans based on their residency match. They show some distinct trends. At both Harvard and the University of Rochester medical schools, for

example, 16-27 percent of the graduates chose internal medicine, 10-15 percent pediatrics, 4-11 percent obstetrics and gynecology and 7-11 percent general surgery. Sadly, at the low end of the spectrum, less than 5 percent went into primary care and family medicine.

This march into more lucrative medical specialties is severely crimping the ranks of needed primary care doctors at the very moment the demand for primary care is on the rise.

So what can be done to deliver the quality of care expected by patients? How will healthcare increasingly focus on the importance of prevention and public health measures - encouraging parents to vaccinate their children, supporting major initiatives to stop smoking, developing regimens for weight control that actually work, and turning the focus from treatment to preventing and managing chronic diseases?

The solution entails more than simply producing more doctors; it requires educating doctors and care givers in new collaborative ways. Those who are trained need the right training and the right jobs with the right pay commensurate with the contributions made.

But most important, new models of healthcare delivery must be developed - with a new focus on team work, where, for example, doctors, nurses, pharmacists, and social workers form efficient groupings to consider patient-centered care. Teamwork and new ways of delegating treatment will take the load off of the hard-pressed primary care physician.

Also needed to be addressed is the disparity in reimbursement where doing procedures pays well but thinking deeply about a patient's problems has financial limitations. Reimbursements should be based on quality of care, not quantity.

Bottom line: the new requirements in medical care require new thinking in how to deliver that care.

And new thinking is what is needed in an election year featuring a major debate on healthcare. This debate needs to move beyond the issue of access and coverage to how the delivery system can be restructured to provide the best healthcare possible at an affordable cost.

So let the real debate over health reform begin.

Dr. Joseph B. Martin, professor of neurobiology and former dean of Harvard Medical School, is chairman of the New England Healthcare Institute. ■



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HIGHLY REGARDED NEW STUDIES OBLITERATE COMMON MYTHS ABOUT MEDICAL MALPRACTICE

Two just-published studies from the March 2008 Journal of Empirical Legal Studies find:

1. The supply of OB/GYNs in a state has no relationship to either doctor's malpractice premiums or a state's liability laws.¹

"[M]alpractice insurance premium levels and the presence of liability-limiting tort reforms in a state do not significantly affect the supply of OB/GYNs at the state level. These results are at odds with assertions of an exodus of OB/GYNs from states with high and rapidly rising insurance premiums. They also undercut suggestions that caps on noneconomic damages and other tort reforms help states attract and retain high-risk specialists by providing relatively good insulation from malpractice judgments."

"Our results suggest that most OB/GYNs do not respond to liability risk by relocating out of state or discontinuing their practice, and that tort reforms such as caps on noneconomic damages do not help states attract and retain high-risk specialties."

"Overall, the results provide no evidence that liability pressure, as measure by malpractice premiums, is associated with the supply of OB/GYNs per capita in a state."

2. Patients are *less* likely to file malpractice claims in underserved areas, and *less* likely if their medical procedures are considered risky.²

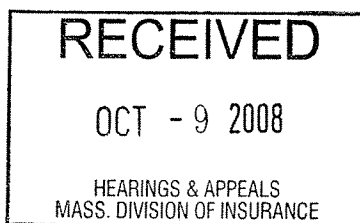
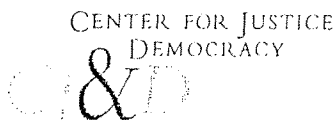
"Two factors negatively associated with claiming are 1. The prevalence of risky medical diagnoses [obstetric/gynecology procedures, cardiac procedures, and orthopedic procedures fall into this risk group] and 2. physicians per capita."

"[T]he risk factor was *negatively* associated with high claim rates, perhaps suggesting an association with quality of care and malpractice claims."

"The negative association between the rates of high risk procedures, and the rates of malpractice claims, was true for both inpatient and outpatient claims."

¹ Y. Tony Yang, David M. Studdert, S.V. Subramanian, Michelle M. Mello, "A Longitudinal Analysis of the Impact of Liability Pressure on the Supply of Obstetrician-Gynecologists, *Journal of Empirical Legal Studies*," Vol. 5, Issue 1, 21-53 (March 2008)

² Kevin D. Hart, Philip G. Peters, "Cultures of Claiming: Local Variation in Malpractice Claim Frequency," *Journal of Empirical Legal Studies*, Vol. 5, Issue 1, 77-107 (March 2008)(analyzed annual claims from 62 New York counties over a 14-year period).



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**Statement of Joanne Doroshow
Executive Director, Center for Justice & Democracy
Co-founder of Americans for Insurance Reform
Before the Boston Bar Association
McDermott, Will & Emery Conference Center (28 State Street, 34th Floor)
November 19, 2003**

I appreciate the opportunity to address the Boston Bar Association on the Governor's proposal to establish an "Avoidability-Based Administrative Compensation Scheme for Obstetrical Injury" in the state of Massachusetts.

The Center for Justice & Democracy (CJ&D) is a national consumer rights organization dedicated to educating the public about the importance of the civil justice system. Americans for Insurance Reform, a project of CJ&D, is a coalition of over 100 consumer and public interest groups representing more than 50 million people. Among our members are MassPIRG and the New England Patients' Rights Group. We have also worked closely with Massachusetts residents who have been the victims of medical malpractice, including John McCormack who lost his 13-month-old daughter Taylor while she was awaiting surgery to repair a malfunctioning shunt in her skull.

AIR advocates strengthening state oversight of insurance industry practices instead of trying to solve insurance problems on the backs of injured patients. Increased insurance regulation is the only real solution to ending the periodic insurance "crises" that hit this country every 10 years or so and inevitably lead to frenetic calls for legislative limits on patients' rights to sue. The proposal before you today is simply one more variation of this recurring pattern.

I would like to address both the premise of this proposal and its merits as articulated in the outline presented to us.

A PHONY PREMISE – A BOGUS "CRISIS"

Since the premise behind this proposal is to avoid an impending medical malpractice insurance "crisis" in Massachusetts, it is critical to understand why insurance rates are skyrocketing for some doctors in some states.

The Insurance Cycle, Not the Legal System, is Driving Up Rates

Insurers make most of their money from investment income. During years of high interest rates and/or excellent insurer profits, insurance companies engage in fierce competition for premium

dollars to invest for maximum return. Insurers severely underprice their policies and insure very poor risks just to get premium dollars to invest. This is known as the “soft” insurance market.

But when investment income decreases — because interest rates drop or the stock market plummets or the cumulative price cuts make profits become unbearably low — the industry responds by sharply increasing premiums and reducing coverage, creating a “hard” insurance market usually degenerating into a “liability insurance crisis.”

A hard insurance market occurred in the mid-1970s, precipitating rate hikes and coverage cutbacks, particularly with medical malpractice insurance and product liability insurance. A more severe crisis took place in the mid-1980s, when most liability insurance was impacted. At that time, numerous studies, including those conducted by the National Association of Attorneys General under the direction of the Massachusetts Attorney General¹ and state commissions in New Mexico, Michigan and Pennsylvania², confirmed that the crisis was not caused by the legal system but rather by the insurance cycle and mismanaged underwriting by the insurance industry. Even the insurance industry admitted this internally. In 1986, Maurice R. Greenberg of American International Group told an insurance audience in Boston that the industry’s problems were due to price cuts taken “to the point of absurdity” in the early 1980s. Had it not been for these cuts, Greenberg said, “[T]here would not be ‘all this hullabaloo’ about the tort system.”³

Business Week magazine also explained in a January 1987 editorial:

Even while the industry was blaming its troubles on the tort system, many experts pointed out that its problems were largely self-made. In previous years the industry had slashed prices competitively to the point that it incurred enormous losses. That, rather than excessive jury awards, explained most of the industry’s financial difficulties.⁴

Again today, the country is experiencing another so-called insurance “crisis,” or “hard market,” this time impacting property as well as medical malpractice lines with rates going up 100 percent or more for some.

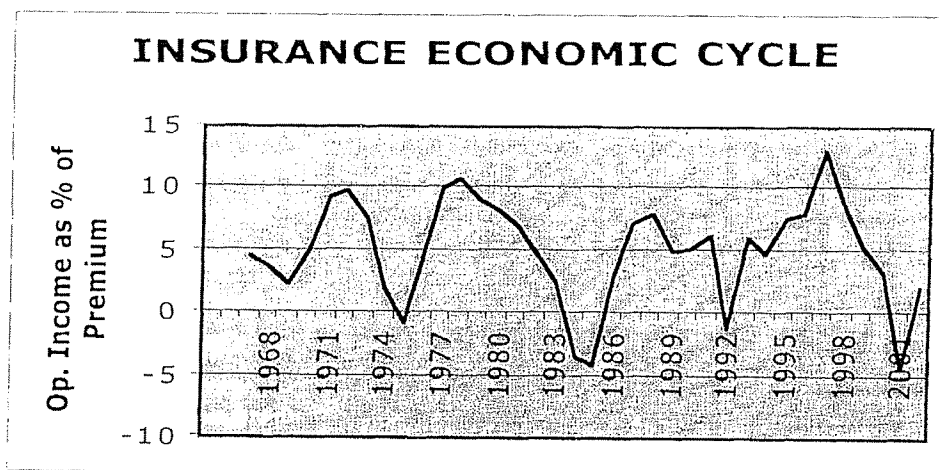
¹ Francis X. Bellotti, Attorney General of Massachusetts, et al., *Analysis of the Causes of the Current Crisis of Unavailability and Unaffordability of Liability Insurance* (Boston, MA: Ad Hoc Insurance Committee of the National Association of Attorneys General, May 1986).

² See, e.g., New Mexico State Legislature, Report of the Interim Legislative Workmen’s Compensation Comm. on Liability Insurance and Tort Reform, Nov. 12, 1986; Michigan House of Representatives, Study of the Profitability of Commercial Liability Insurance, Nov. 10, 1986; Insurance Comm. Pennsylvania House of Representatives, Liability Insurance Crisis in Pennsylvania, Sept. 29, 1986.

³ Greenwald, “Insurers Must Share Blame: AIG Head,” *Business Insurance*, March 31, 1986.

⁴ “What Insurance Crisis?” *Business Week*, January 12, 1987.

The following chart shows the national cycle at work, with premiums stabilizing for 15 years following the mid-1980s crisis. (The 1992 data point was not a classic cycle bottom, but reflected the impact of Hurricane Andrew and other catastrophes in that year.)



Prior to late 2000, the industry had been in a soft market (characterized by low rates) since the mid-1980s. The strong financial markets of the 1990s had expanded the usual six- to ten-year economic cycle. No matter how much they cut their rates, the insurers wound up with a great profit year when investing the float on the premium in this amazing stock and bond market. (The "float" occurs during the time between when premiums are paid into the insurer and losses paid out by the insurer —e.g., there is about a 15-month lag in auto insurance and a 5 to 10 year lag in medical malpractice.) Further, interest rates were relatively high in recent years as the Fed focused on inflation.

But in 2000, the market started to turn with a vengeance and the Fed cut interest rates again and again. This took place well before September 11th. The terrorist attacks sped up the price increases, collapsing two years of anticipated increases into a few months and leading to what some seasoned industry analysts see as gouging.⁵ However, the increases we are witnessing are mostly due to the cycle turn, not the terrorist attack or any other cause. This is a classic economic cycle bottom.

In hard market periods, as we are currently experiencing, insurers will increase reserves as a way to justify price increases. In fact, the current insurance "crisis" rests significantly on a jump in loss reserves in 2001. Historically, reserves have been later "released" to profits during the "softer" market years. For example, according to a June 24, 2002, *Wall Street Journal* front page investigative article, St. Paul, which until 2001 had 20 percent of the national med mal market, pulled out of the market after mismanaging its reserves. The company set aside too much money in reserves to cover malpractice claims in the 1980s, so it "released" \$1.1 billion in reserves,

⁵ "[T]here is clearly an opportunity now for companies to price gouge — and it's happening. . . . But I think companies are overreacting, because they see a window in which they can do it." Jeanne Hollister, consulting actuary, Tillinghast-Towers Perrin, quoted in "Avoid Price Gouging, Consultant Warns," *National Underwriter*, Jan. 14, 2002.

which flowed through its income statements and appeared as profits. Seeing these profits, many new, smaller carriers came into the market. Everyone started slashing prices to attract customers. From 1995 to 2000, rates fell so low that they became inadequate to cover malpractice claims. Many companies collapsed as a result. St. Paul eventually pulled out, creating huge supply and demand problems for doctors in many states.⁶

However, lawmakers and regulators (and the general public) are now being told by insurance and medical lobbyists that doctors' insurance rates are rising, and companies are pulling out of the market, due to increasing claims by patients, rising jury verdicts, and exploding tort system costs in general. The insurance industry argues and, worse, convinces doctors and some lawmakers to believe that patients who file medical malpractice lawsuits are being awarded more and more money, leading to unbearably high losses for insurers. Medical malpractice insurers state that to recoup money paid to patients, insurers are being forced to raise insurance rates or, in some cases, pull out of the market altogether.

In fact, none of this is true. Americans for Insurance Reform has released a new study, *Stable Losses/Unstable Rates*, showing that since 1975, medical malpractice paid claims per doctor in this country have tracked medical inflation very closely (slightly higher than inflation from 1975 to 1985 and flat since). In other words, payouts have risen almost precisely in sync with medical inflation. Moreover, contrary to what the insurance and medical lobbies have alleged, the years 2001 and 2002 saw no "explosion" in medical malpractice insurer payouts or costs to justify sudden rate hikes. In fact, rather than exploding, inflation-adjusted payouts per doctor dropped from 2001 to 2002. These data confirm that neither jury verdicts nor any other factor affecting total claims paid by insurance companies that write medical malpractice insurance have had much impact on the system's overall costs over time.

Second, while payouts closely track medical inflation, medical malpractice premiums are quite another thing. They do not track costs or payouts in any direct way. Since 1975, the data show that in constant dollars, per doctor written premiums — the amount of premiums that doctors have paid to insurers — have gyrated almost precisely with the insurers' economic cycle. Moreover, medical malpractice insurance premiums rose much faster in 2002 than was justified by insurance payouts. This hike is similar to the rate hikes of the past, which occurred in the mid-1980s and mid-1970s and were not connected to actual payouts.

Where's the Crisis?

On August 29, 2003 — the Friday before Labor Day weekend — the General Accounting Office report *Medical Malpractice: Implications of Rising Premiums on Access to Health Care* was released to the public. The report had been requested by congressional Republicans. The GAO report examined claims by the American Medical Association (AMA) and state medical societies that a widespread health care access "crisis" exists as a result of doctors' medical malpractice insurance problems. The AMA has labeled 19 states as so-called "crisis" states. Massachusetts is considered by the AMA to be a "problem" state. It is this designation that has apparently led

⁶ Christopher Oster and Rachel Zimmerman, "Insurers' Missteps Helped Provoke Malpractice 'Crisis,'" *Wall Street Journal*, June 24, 2002.

to the current proposal. Yet, *Massachusetts has more physicians per capita than any other state in the country,*⁷ and ranks seventh of the fifty states in the number of OB/GYNs per capita.⁸

Similarly, the one so-called “crisis” state in New England, Connecticut, ranks second in the nation in the number of OB/GYNs per capita and fourth in physicians per capita, and the other alleged “crisis” state in the Northeast, New York, ranks third in the nation in the number of OB/GYNs and second in physicians per capita.⁹ These and other findings with regard to states that have been designated as in “crisis” by the AMA should raise significant questions as to whether OB/GYNs in Massachusetts are, in fact, experiencing any sort of “crisis” as a result of the state’s legal system.

GAO found claims about a current or impending crisis to be false or widely exaggerated. To the extent there are a few access problems, many other explanations can be established. In fact, the health care access problems that GAO could confirm were isolated and the result of numerous factors having nothing at all to do with the legal system. Specifically, GAO found that these pockets of problems “were limited to scattered, often rural, locations and in most cases providers identified long-standing factors in addition to malpractice pressures that affected the availability of services.”

With regard to obstetrics practices in two high profile so-called “crisis” states – Nevada and West Virginia – GAO found:

In Nevada, 34 OB/GYNs reported leaving, closing practices, or retiring due to malpractice concerns; however, confirmatory surveys conducted by the Nevada State Board of Medical Examiners found nearly one-third of these reports were inaccurate—8 were still practicing and 3 stopped practicing due to reasons other than malpractice. Random calls [GAO] made to 30 OB/GYN practices in Clark County found that 28 were accepting new patients with wait-times for an appointment of 3 weeks or less.

....

In West Virginia, although access problems reportedly developed because two hospital obstetrics units closed due to malpractice pressures, officials at both of these hospitals told [GAO] that a variety of factors, including low service volume and physician departures unrelated to malpractice, contributed to the decisions to close these units. One of the hospitals has recently reopened its obstetrics unit.

As far as what the insurance industry is actually experiencing, newly-released data shows that insurance company profits, including those of medical malpractice insurers, are booming and insurance analysts are privately raving about it. According to the September 15, 2003, *Business Insurance* article entitled “Market Conditions Still Ripe for Insurer Profitability; Buyers to See

⁷ See U.S. Census Bureau, *Statistical Abstract of the United States: 2002*, Table 147, <http://www.census.gov/prod/2003pubs/02statab/health.pdf>.

⁸ *New York State Conference of Blue Cross and Blue Shield Plans, The Facts About . . . New York's Physician Supply*, at http://files.veranet.net/1163/physician_supply0603.pdf (last visited Nov. 18, 2003).

⁹ *New York State Conference of Blue Cross and Blue Shield Plans, The Facts About . . . New York's Physician Supply*, at http://files.veranet.net/1163/physician_supply0603.pdf (last visited Nov. 18, 2003).

Rate Hikes Ease," 14 property/casualty insurers saw a 35.9 percent increase in net income, to \$7.5 billion, in the first half of 2003. Only Hartford booked an \$888 million first-half loss, reflecting a \$3.91 billion pretax charge for asbestos reserves in the first quarter.

By far the largest insurer reporting was American International Group, a major medical malpractice writer. AIG's net income increased by 30.3% in the first half of 2003, and it had a shockingly low combined ratio of 92.7%. That means it is making a lot of money even before adding in investment income.

Here's what some insurance analysts had to say about the first half 2003 results, according to *Business Insurance*:

"I think the industry did fantastic, and my expectation is that we'll see more of the same in the second half." — Chris Winans, senior property/casualty analyst, Lehman Bros.

There have been some "amazing cash flow numbers." — Stephan Petersen, Cochran, Caronia & Co.

"Underwriting margins should remain good and, in fact, likely improve modestly because *price increases have been exceeding claims inflation* for the most part." (emphasis added) — Jay Cohen, Merrill Lynch.

"I think it's going to continue to get better. I don't see any clouds on the horizon." — James Inglis, Philo Smith & Co.

In addition to undermining insurers' arguments that they are suffering gigantic losses due to claims and payouts — an assertion that underlies their principal argument for this proposal and other "tort reform" — this new data has additional significance: It may be signaling the end of the hard market. Americans for Insurance Reform spokesperson J. Robert Hunter, Director of Insurance for the Consumer Federation of America, said, "As in previous insurance cycles, the insurers are raking in the dollars, belittling their results as 'inadequate,' hiding much of their spoils in massive reserve hikes and, quietly, starting to compete again, setting the stage for the soft market, and lower prices, ahead."

Insurance Industry Reform is the Only Answer to Prevent Future Insurance "Crises"

So what can we do? First, wait for the hard market to end before even considering taking away patients' rights. Rates will stabilize soon. As Hunter put it in an April 2003 report by the Consumer Federation of America, "This classic turn after two years of skyrocketing premiums is good news for the hard-pressed buyers of commercial insurance. While there may be some increases yet ahead for some specific commercial buyers, the end of the hard market is clearly at hand for most business consumers."

Second, the causes and solutions to these insurance problems lie with the insurance industry, not the legal system. Unless fundamental changes in insurance industry practices are made, the cyclical price-gouging of policy holders will never end.

In July 2002, AIR sent letters to all 50 state insurance commissioners, including Massachusetts, outlining a number of steps that each state should immediately pursue. AIR wrote:

In view of the excessive rate increases, price-gouging and tight underwriting that have hit certain lines of insurance this year, including the homeowners and medical malpractice lines, and recent reports about the questionable business and accounting practices of some insurers that are intensifying the impact of the economic cycle of the insurance industry,¹⁰ Americans for Insurance Reform believes it is imperative that insurance regulators take immediate steps to impose a new regime of corporate responsibility and accountability on this industry whose business practices are wreaking havoc on the American economy. This letter details our recommendations for investigations, audits, and reforms.

The following were AIR's recommendations:

1. Investigations and Audits

There must be a full and thorough investigation of the insurance companies' data to determine if there are errors and over-reserving in the data. In particular, we are asking that you order an investigation to determine:

The extent to which the extraordinarily high profitability of the insurance industry during much of the 1990s . . . is related to the performance of interest rates and the stock market during those periods;

The extent to which today's rate increases are an attempt to recoup money that insurers lost in the stock market or in other poorly-performing assets;

The extent to which insurers are adversely affected by today's low interest rates;

Whether insurers' estimates of their future claims payments, which are the basis for rate increases, are unreasonably high today; and

Whether it is proper, or lawful, for insurers to seek substantial rate increases despite having hugely increased their surplus—the money they have “in the bank,” with policyholder-supplied funds, particularly if the insurer is overcapitalized.

In addition, we urge you to institute, or seek statutory authority to institute, annual, rather than the typical once-every-three-years, audits of insurance companies operating in your

¹⁰ For example, on June 24, 2002, the *Wall Street Journal* ran a front-page investigative story that reported, among other things: “Following a cycle that recurs in many parts of the business, a price war that began in the early 1990s led insurers to sell malpractice coverage to obstetrician-gynecologists at rates that proved inadequate to cover claims. . . . Some of these carriers had rushed into malpractice coverage because an accounting practice widely used in the industry made the area seem more profitable in the early 1990s than it really was. A decade of short-sighted price slashing led to industry losses of nearly \$3 billion last year.” Moreover, “[i]n at least one case, aggressive pricing allegedly crossed the line into fraud.”

state. These annual audits, we believe, should ascertain whether the companies are engaging in questionable accounting practices and whether their business and investment practices, by failing to take into account cyclical economic downturns, present unacceptable financial risks for insurance consumers and shareholders.

2. Specific Reforms. The state insurance commissioner should:

Regulate excessive pricing. One cause of the cycle is the lack of regulatory action to end excessive and inadequate rates during the different phases of the cycle. Please start now by regulating the excessive prices being charged by insurers today in your state. At least hold the necessary hearings to determine if the prices are not excessive.

Advise your legislators that the solution to prevent shock rate increases such as we are now experiencing is insurance reform, not “tort reform.”

Freeze particularly stressed rates until the examination of the prices and remarkable jumps in loss reserves can be fully analyzed. For instance, medical malpractice and homeowner rates should be frozen. A roll back of unjustified rate increases that have already taken effect should then be in order. (The manner in which insurance rate rollbacks can be written and implemented to comply with all Constitutional requirements is explained in *Calfarm Ins. Co. v. Deukmejian*, 48 Cal. 3d 805 (1989), and *20th Century Ins. Co. v. Garamendi*, 8 Cal. 4th 216 (1994). These cases substantially upheld Prop 103, the California insurance reform initiative that rolled back auto insurance rates by 20%.)

Require that risks with poorer experience pay more than good risks in lines of insurance where such methods are not in use today. For example, require medical malpractice insurers to use claims history as a rating factor, and to give that factor significant weight. Auto insurers use an individual’s driving record as a rating factor; workers’ compensation insurers use the employer’s loss experience as a rating factor— so-called “experience mod.” Malpractice insurers should do the same. In addition, you should require all medical malpractice insurers to offer all “good” doctors— i.e., all doctors meeting an objective definition of eligibility based on their claims history, their amount of experience and perhaps other factors — the lowest rate.

Reduce the percentage of assets that insurers can invest in stocks or other risky assets. Insurers should not be permitted to raise their rates in order to recoup losses on stocks or other risky assets. The less risky their investments, the more secure policyholders are, and the more stable are rates.

Create a standby public insurer to write risks when the periodic cycle bottoms and hard markets occur, such as a medical malpractice insurer funded by a start-up loan from the state to compete with the existing malpractice carriers. Several states have created such carriers to write workers’ compensation, and in many states such carriers have helped bring down workers’

comp rates. Similarly structured medical malpractice insurers should have similar success.

More strongly regulate auto and homeowners insurance to prevent shock price increases and insecurity for policyholders. For example, you must prevent insurers, like State Farm, from overreacting by not writing new business in some states and by adopting draconian underwriting rules for renewal business. If the rate increases are shown to be high due to corporate policy (such as State Farm holding down prices as a marketing strategy), prices should not be allowed to go up suddenly but be spread over at least a three-year period to avoid "sticker shock" for your state's citizens.

Ask NAIC to stop implementation of the deregulation of commercial rates and forms which NAIC is unwisely pushing at this time. Oppose the implementation of such deregulation in your state.

Clearly, insurance rate regulation has helped to slow rate increases in some states, particularly in the medical malpractice lines. Nowhere has this been more evident than in California, a state that in 1988 passed the strongest insurance reform law in the country.

In September 2003, the California Insurance Commissioner ordered the state's second largest medical malpractice insurer, SCPIE Indemnity, to slash its proposed rate increase for doctors by 36 percent after an eight-month regulatory investigation of the firm's rate request. The investigation was conducted pursuant to California's 1988 insurance reform law, Proposition 103, which created a "prior approval" regulatory system that requires insurers to justify rate hikes and allows the public to challenge excessive rate requests. The ruling was in response to the first-ever consumer group challenge to a medical malpractice insurance rate hike request, brought by the Foundation for Taxpayer and Consumer Rights (FTCR), a California nonprofit organization.

SCPIE requested a 15.6 percent hike but the Commissioner allowed only a 9.9 percent increase. According to the FTCR, "the net impact is a \$16 million savings for the insurer's 9,000 physicians in 2003 and an additional \$7.2 million of savings in next year's premiums."

In other states with strong insurance regulatory laws, malpractice insurers are now withdrawing requests for dramatic increases, or seeing those requests denied. For example, under a new Kentucky directive that requires insurers to seek prior approval if they hope to raise premiums more than 25 percent, ProNational Insurance Co. withdrew its request for a 57 percent increase after a hearing by the state Insurance Commissioner and her subsequent request that ProNational reconsider its request. In New York, insurers asked for a 19 percent increase in malpractice premiums, but the state Insurance Department approved an increase of less than half that size, averaging 8.5 percent. A spokesperson for the department explained: "Basically, we didn't see any justification for that big of an increase."

On the other hand, trying to remedy insurance problems by addressing the legal system has never worked. The Center for Justice & Democracy's 1999 study, *Premium Deceit—the Failure of "Tort Reform" to Cut Insurance Prices*, found that tort law limits enacted since the mid-1980s

have not lowered insurance rates in the ensuing years. Some states that resisted enacting any “tort reform” experienced low increases in insurance rates or loss costs relative to the national trends, and some states that enacted major “tort reform” packages saw very high rate or loss cost increases relative to the national trends. In other words, there was no correlation between “tort reform” and insurance rates.

More recently, Weiss Ratings, an independent insurance-rating agency, found that between 1991 and 2002, states with caps on non-economic damage awards saw median doctors’ malpractice insurance premiums rise 48 percent -- *a greater increase than in states without caps*. In states without caps, median premiums increased only 36 percent. Moreover, according to Weiss, “median 2002 premiums were about the same” whether or not a state capped damage awards.

But don’t just take our word for it. The following quotes from the American Tort Reform Association and the American Insurance Association (AIA) confirm this as well:

- “We wouldn’t tell you or anyone that the reason to pass tort reform would be to reduce insurance rates.” Sherman Joyce, president of the American Tort Reform Association, *Liability Week* (July 19, 1999).
- “[M]any tort reform advocates do not contend that restricting litigation will lower insurance rates, and ‘I’ve never said that in 30 years.’” Victor Schwartz, *Liability Week* (July 19, 1999).
- “Insurers never promised that tort reform would achieve specific savings.” Debra Ballen, AIA executive vice president, March 13, 2002 news release.

In sum, volcanic eruptions in insurance premiums for doctors have occurred three times in the last 30 years – in the mid-1970s, again in the mid-1980s, and now today. The cause is always the same: a drop in investment income for insurers compounded by underpricing in prior years. Each time, insurers have tried to cover up their mismanaged underwriting by blaming lawyers and the legal system. This is completely without basis.

Eventually, as in the late 1980s, the insurance cycle will flatten out on its own, rates will stabilize and availability will improve. The flattening of rates will have nothing to do with tort law restrictions enacted in particular states, but rather to modulations in the insurance cycle everywhere. Trying to solve a widespread insurance problem by addressing the legal system and taking away patients’ rights has failed in the past. It will fail again. Only effective insurance reforms will stop this and future cyclical insurance crises.

THE FALLACY OF THE WORKERS’ COMPENSATION MODEL

For 30 years, the insurance industry and other special interests have been trying to force the sick and injured to waive their Seventh Amendment right to trial by jury and have their disputes resolved outside the court system. In some ways, this proposal is no different. But basing it on the disastrous workers’ compensation model is a truly terrible idea.

Workers’ compensation is rife with problems. Employers who pay into it, employees who rely on it, analysts who look at it, and scholars who study it all have a long list of complaints about how it doesn’t work. It is a heavily bureaucratic adversarial system that shortchanges injured

workers, even while employers are struggling throughout the nation with rapidly rising workers' compensation insurance rates. And to the extent that rate reductions have taken place, they inevitably have come at the expense of the injured, where lawmakers have slashed benefits and pushed many of the injured entirely out of the system.

Workers' Compensation – Bad for the Injured; Payday for Insurers

The theory behind programs like workers' comp is that in return for giving up the right to use the civil justice system, those who are injured should be able to avoid lengthy delays in receiving care or compensation and should have this right without having to litigate in an adversarial proceeding. The truth, however, is that workers' comp has utterly failed to deliver on any of those promises.

The basic reason is that once codified, any kind of statutory administrative system is at the whim of industry money and the regular influence-peddling that reaches legislators. Indeed, over the years, lawmakers in virtually every state have steadily chipped away at workers' comp benefit levels and definitions of workplace injuries. As a result, increasing numbers of workers, particularly those with permanently disabling injuries, are finding themselves barely able to survive. Some of this "chipping away" took place in Massachusetts in 1991, when disability benefits were significantly reduced. There is no reason to believe that patients' benefits would not be subjected to similar reductions.

The problems with workers' comp have been around for years, making it even more astounding that lawmakers should consider workers' comp any sort of model program. According to the 1972 Report of the National Commission on State Workmen's Compensation Laws, headed by John F. Burton, Jr., "When Congress enacted the Occupational Safety and Health Act of 1970, they declared that 'in recent years serious questions have been raised concerning the fairness and adequacy of present workmen's compensation laws.'" Two years later, the commission found that "State workmen's compensation laws are in general neither adequate or equitable."

It seems things have only gotten worse in the subsequent 31 years. As in the past, workers' compensation today does a terrible job compensating many of those injured on the job. Benefits, even if they were initially adequate, fall over time as insurers, employers or, in this case, hospitals and health care providers, will inevitably pressure legislators to reduce compensation. *Consumer Reports*, which was highly critical of workers' comp in a 2000 report, described this pattern:

In the early 1990s, state legislatures across the nation, at the behest of insurance carriers and the business community, passed reform laws designed to improve the system. They did--for insurers and businesses. Workers-comp insurance, once the money-loser of the industry, grew fat with profits. And businesses saw premiums drop substantially from 1992 to 1996, a development that public officials say stimulates job growth.

The old system needed changing, many agree. But instead of targeting insurance bureaucracies and employer fraud--two key problems that still exist--the new laws have generated profits for insurers and savings for employers mainly at the expense of injured workers. Those laws clamped down on benefits, raised eligibility requirements, and put

medical treatment mainly in the hands of insurance companies, which can delay or deny medical care or income payments.¹¹

A 2001 study by the Rand Corporation's Institute for Civil Justice estimated that partially disabled workers injured in one state — California — generally have received less than 60 percent of their pre-injury income over a five-year period and less than 50 percent of pre-injury earnings over a ten-year period.¹² And in a June 2002 report, the nonprofit National Academy of Social Insurance found that for every \$100 in wages, workers' comp benefits had declined by 39% to \$1.03 in 2000, the eighth consecutive year that benefits had dropped as a percentage of wages.¹³

What's more, because of the inadequacy of benefits, it is when injuries are most severe, as in the case of serious brain damage or other catastrophic injury, that the system fails most completely. Virginia has had a somewhat similar program in place for the last 15 years, covering babies who are brain-damaged at birth. This proposal is described in more detail at the end of this statement. According to a series of investigative reports in the *Richmond Dispatch*, the program prevents many catastrophically-injured children from receiving adequate benefits: "Children born in Virginia with catastrophic neurological injuries are promised lifetime medical care by the birth-injury program. But these children and their families also have been forced to absorb stunning disparities in program benefits because of shifting priorities and cost reductions over which they had no control or voice. . . . 'The program can end up providing very little,' said Christina Rigney, referring to the minimal benefits her family received in the face of her son's traumatic birth and brief life."¹⁴

In medical malpractice cases, the problems would be especially acute if non-economic damages were limited, as they are under workers' comp. Non-economic damages compensate injured consumers for intangible but real injuries, like infertility, permanent disability, disfigurement, pain and suffering, loss of a limb, or other physical impairment. Abolishing or limiting non-economic damages will have a disproportionate effect on patients who do not have high wages — like women who work inside the home, children, or the poor, who are thus more likely to receive a greater percentage of their compensation in the form of non-economic damages if they are injured.

Further, to "obtain sign off" from malpractice insurers, the proposal acknowledges that it must "guarantee" no higher premiums and, to do so, must create a schedule of damages that "seem reasonable" to insurers and convince insurers that there will not be a "dramatically larger number of injuries eligible for compensation." Given the well-known Harvard study that found that 78% of victims of preventable errors in hospitals do not make malpractice claims,¹⁵ and the fact that

¹¹ "Workers Comp: Falling Down on the Job," *Consumer Reports*, Feb. 2000.

¹² *Trends in Earnings Loss from Disabling Workplace Injuries in California*, Rand Institute for Civil Justice, 2002.

¹³ *Workers' Compensation: Benefits, Coverage and Costs*, National Academy of Social Insurance, June 2002.

¹⁴ Bill McKelway, "Danville Has High Birth-Injury Rate; Critics Say Virginia Law Shields Doctors from Lawsuits," *News Virginian*, June 1, 2003.

¹⁵ Harvard Medical Study Group, *Patients, Doctors and Lawyers: Medical Injury, Malpractice Litigation, and Patient Compensation in New York*, 1990.

this system should theoretically compensate all such patients, a schedule of damages that seems “reasonable” to insurers who must guarantee no premium increase will have to be terrifyingly measly, particularly for the most severely injured.

After the changes to the workers’ comp laws in the 1990s, “workers-comp carriers had become the envy of the insurance industry, with annual operating profits of 20 percent.”¹⁶ How did they do that? According to *Consumer Reports*:

The new laws not only reduced benefits but also made them harder to collect. In many states, the burden is now on the workers to prove by a preponderance of the evidence that their injuries occurred as a result of their job and not poor health habits, aging, or a pre-existing medical condition. To win a claim, says [a] workers-comp attorney . . . , a worker practically has to be “convicted of injury on the job.” The result is that ill and injured workers now must fight a series of battles: first, to get medical care; next, to withstand exams by insurance-company doctors who have an incentive to find excuses not to pay; then, to get a fair assessment of any permanent disability; and finally, to win a hearing if there’s a dispute.¹⁷

Meanwhile, workers’ compensation programs have saved employers and their insurance carriers billions of dollars. According to John Burton, Dean of the School of Management and Labor Relations at Rutgers University and Chairman of the National Commission on State Workers’ Compensation Laws, in much of the 1990s insurer profits increased dramatically and employers’ workers’ comp costs dropped, while benefit payments to workers decreased substantially. Burton found that in 1995 alone, insurers took in over \$124 for every \$100 of net expenses. Similarly, the AFL-CIO discovered that in 1998 the average profit on workers’ compensation insurance was 7 percent, as compared with 3.7 percent and – 0.7 percent for auto insurance and homeowners’ insurance, respectively.¹⁸ As for employer savings, the National Academy of Social Insurance reports that employer workers’ comp costs had fallen by 42 percent relative to wages between 1993 and 2000.¹⁹

Litigation Will Not Be Reduced – But Patients Will Be Greatly Disadvantaged.

This proposal not only will not reduce litigation, it will do little to reduce patients’ burdens while forcing them to litigate in forums that are unfair to patients.

The workers’ comp system is instructive. This was a system that was basically conceived as “no-fault.” Yet the adjudicatory burdens on the injured are substantial. As far back as 1972, the National Commission on State Workers’ Compensation Law stated, “The no-fault concept and prescribed benefits, it was assumed, would reduce the need for litigation. The complexities of the law and doubts about the sources and nature of impairments have dashed these expectations. . . . Substantial litigation results from efforts to determine which injuries or

¹⁶ “Workers Comp: Falling Down on the Job,” *Consumer Reports*, Feb. 2000.

¹⁷ *Ibid.*

¹⁸ AFL-CIO Workers Compensation Comparison Tables, 2001.

¹⁹ *Workers’ Compensation: Benefits, Coverage and Costs*, National Academy of Social Insurance, June 2002.

diseases are work-related and compensable. There are both legal and medical questions in each claim." The Commission also found that passive agency administration resulted in excessive litigation, delay and expense.

When the American Bar Foundation looked at no-fault proposals in medical malpractice cases in the mid-1980s, during the last insurance "crisis," they noted, "While claiming that the main advantage of a no-fault mechanism is a streamlined recovery which presumably takes less time, less money and less hassle to receive the payback, no-fault proponents face the great problem of actually defining what is a compensable event." In these cases, a broad definitional category could be unworkable, since it is often impossible to tell whether a patient's injury was physician or hospital induced or a natural condition.²⁰

The Massachusetts proposal is extremely vague in terms of what exactly an injured patient must prove to obtain compensation. However, using the legislative language of HB 1704, on which there were hearings last week, there could actually be *additional* burdens of proof placed on the injured beyond what is typically required in a medical malpractice case. In terms of causation, proving an "act or omission" that resulted in an injury, illness, or impairment is, essentially, no different than having to prove negligence. Any act or omission that causes such an injury would be, by definition, outside the normal standard of care.

Moreover, under the standards contained in HB 1704, there could also be an additional burden of proof on the injured patient that would not apply to them in a medical malpractice case: proving that the injury, illness, or impairment "is not within the range of medical outcomes ordinarily expected as foreseeable results of the patient's condition or of appropriately selected and administered treatment." This second burden seems particularly draconian when, say, a doctor fails to diagnose a condition, such as when the doctor misreads test results or fails to do appropriate tests. For example, if a doctor fails to diagnose a tumor that he or she should have, and that tumor then causes paralysis, the injured patient might still have a hard time with the second requirement, since it is foreseeable that a tumor in a certain area would result in paralysis (even though the doctor's negligence resulted in leaving the tumor untreated).

Where there are power and resource disparities between the parties, requiring patients to prove causation and other issues before an administrative tribunal, even one that did not consist of a biased panel controlled by health care and insurance professionals as proposed here, is very unfair to the patient. This is particularly true in the context of medical malpractice actions because the disputing parties are extremely ill-matched. The parents of catastrophically injured children who are in need of medical care, who are disabled or perhaps in pain, and who may have major medical expenses, are in a substantially weaker position than the medical establishment.

For example, a recent story about a child denied benefits under Virginia's birth-injury compensation program, which functions much as this proposed system would, described the lopsided scene as follows: "Using material she tracked on the Internet and assessments from her daughter's pediatrician, Sue Ann Sochor found herself opposed at a hearing in March by a

²⁰ Taylor, "Alternatives to Tort Liability, An Overview," *Legal Liability and Quality Assurance in Newborn Screening*, American Bar Foundation, 1985.

lawyer from the Richmond based Hirschler Fleischer firm, a neurologist hired by the program and other experts paid by the program.”²¹

Even neutral administrative tribunals do not offer the normal protections provided by the court system to neutralize imbalances between parties, *e.g.*, procedural and substantive rights like the right to know and rebut evidence through discovery, cross-examination and argument, civil rules of procedure, and an impartial judge who is guided by the substantive law. Rules of evidence and procedure are relaxed or not applied at all. When the *New England Journal of Medicine* compared alternative compensation systems with jury trials in medical malpractice cases in the late 1970s, they found that the protection against bias and influence that a jury provides and the accuracy attained by complete and careful presentations in court would not be offset by any gains in efficiency an alternative system might provide.²²

Some jury critics have said that jurors are unable to handle the evidence and law in medical malpractice and other complex cases, and that so-called “expert” tribunals, as envisioned here, are preferable. However, judges, who every day observe how juries function, have roundly rejected this suggestion. In March 2000, the *Dallas Morning News* and Southern Methodist School of Law sent questionnaires to every federal trial judge in the United States, its territories and protectorates – over 900 judges. About 65 percent (594) of the federal judges responded.²³

The paper reported, “The judges’ responses reflect a high level of day-to-day confidence in the jury system. . . . Only 1 percent of the judges who responded gave the jury system low marks. . . . Ninety-one percent believe the system is in good condition needing, at best, only minor work. . . . **Overwhelmingly . . . judges said they have great faith in juries to solve complicated issues.** . . . Ninety-six percent said they agree with jury verdicts most or all of the time. **And nine of 10 judges responding said jurors show considerable understanding of legal and evidentiary issues involved in the cases they hear.**”²⁴

Another problem will be the inability of patients to find attorneys to help them. Using workers’ comp as a guide, attorneys who represent injured workers receive far less compensation than lawyers practicing in the tort system, reducing the number of attorneys willing to practice in this field and increasing the work of those who do. One can expect defendants to take advantage of this to the detriment of the injured, low-balling settlement offers that would grossly undercompensate patients.

²¹ Bill McKelway, “Old Rules Deny New Benefits; Children Rejected for Brain-Injury Program,” *Richmond Times Dispatch*, June 5, 2003.

²² Schwartz (M.D.), Komesar (J.D.), “Doctors, Damages and Deterrence,” *New England Journal of Medicine*, (June 8, 1978).

²³ Allen Pusey, “Judges Rule in Favor of Juries: Surveys by Morning News, SMU Law School Find Overwhelming Support for Citizens’ Role in Court System,” *Dallas Morning News*, May 7, 2000.

²⁴ *Ibid.* (emphasis added).

In sum, as former Judge Harry Edwards of the U.S. Court of Appeals for the D.C. Circuit once noted, “inexpensive, expeditious and informal adjudication is not always synonymous with fair and just adjudication.”²⁵

Medical Errors Will *Increase* Under this Proposal as the Deterrence and Disclosure Functions of the Civil Justice System Are Disrupted

In the sensationalized debate over medical malpractice lawsuits, there is typically little discussion of perhaps their most critical function — making patients safer. Time and again, history has shown that lawsuits against health care providers create an economic incentive for them to practice safer. By the same token, when disputes are resolved without trial and without a public record, wrongdoers can prolong misconduct and suppress for years information about dangerous practices.

For example, under Virginia’s Birth-Related Neurological Injury Compensation Program (discussed in greater detail below), which operates much as this proposed program apparently would, “[b]ecause the cases do not come to trial, there is no examination of the doctor and what occurred at birth, nor is there testimony from nurses or neurologists about a doctor’s action.”²⁶ National birth-injury experts have reportedly expressed fear about Virginia becoming a safe harbor for bad doctors due to this law.

Our judicial system recognizes that there are duties inherent in certain types of relationships, such as between a health care provider and a patient, and that anyone who breaches its duties ought to be subject to liability. When a controversy is resolved informally by an administrative tribunal, it has no legally binding effect on other controversies. There can be no expectation that others will follow the announced principle. Removing claims from the tort system like this circumvents rules about standards of conduct which have evolved over the years to protect patients who have no way to protect themselves. It disrupts the important functions of the tort system: deterrence of unsafe practices and the disclosure of dangers to the public, and the evolution of written precedents, which develop individual rights and responsibilities by others.

Workers’ comp, on which this proposal is based, is a good example of how safety can be compromised when tort suits are eliminated. Professor Richard Abel has written that because the workers’ compensation system is consciously designed not to reflect the full costs of accidents, it is an ineffective deterrent against workplace dangers.²⁷ The 1972 National Commission on State Workmen’s Compensation Laws also found problems with workers’ compensation systems’ impact on deterrence.

²⁵ Harry Edwards, “Hopes and Fears for Alternative Dispute Resolution,” 21 Willamette L. Rev. 425 (1985).

²⁶ Bill McKelway, “Brain Injuries Spur No Action; Case Review, Required by Law, Is Not Being Done, Va. Study Found,” *Richmond Times Dispatch*, Jan. 14, 2003.

²⁷ Abel, “The Real Tort Crisis – Too Few Claims,” 48 Ohio L.J. 443, 456 (1987) *See also* “Exceptions to the Exclusive Remedy Requirements of Workers’ Compensation Statutes,” Harvard L. Rev. 1647 (1983).

According to the Rand, researchers in 1982 expressed misgivings about the adequacy of the financial incentive which such systems provide for safety.²⁸ In particular, worker compensation incentives are inadequate for both insureds and self-insureds because the employer incurs less than the full economic and non-economic costs of an injury.

Moreover, workers rather than wrongdoers still bear a large portion of wage losses resulting from their injuries (in addition to pain and suffering), when the losses exceed the statutory limit. Under the negligence system, the wrongdoer would bear this cost. Thus, to the extent that insurance reduces the deterrent impact of financial liability, its effect is greater under workers' compensation than under negligence.²⁹

In the mid-1980s, Ashford and Johnson found that employers bear less of the accident costs under workers' compensation than under negligence (9 percent vs. 13 percent). They suggest that while workers' compensation programs may allow more injured workers to receive some payments, this has been achieved primarily at the expense of non-negligent workers who otherwise could expect greater recovery under negligence rules. It has not been at the expense of employers, who pay less under workers' compensation than under negligence, and who likewise might be seen as enjoying a subsidy financed by non-negligent workers. It is, of course, also at the expense of workers who are injured since employers have failed to take safety precautions because of limited liability under the workers' compensation system.

Under workers comp., the trend has always been to blame workers for job injuries and do little to eliminate or reduce job hazards. According to the Massachusetts Coalition for Occupational Safety and Health (MassCOSH), "49 Massachusetts workers . . . died as a result of a workplace injury or illness in 2002. Most of these workers died from acute, traumatic injuries. For each worker who is killed on the job, there are 10 more who die from occupational disease — most whose names do not appear on this list and whose faces will never be known. In Massachusetts last year, an estimated 490 workers died from occupational disease, another 1,565 were diagnosed with cancer caused by workplace exposures, and 50,000 workers were seriously injured. . . . During the 17-year period, 1986-2002, 273 out of 351 cities and towns have had a worker killed on the job, most of these from acute traumatic injuries. This represents over two-thirds of all the municipalities in Massachusetts."³⁰

Lawsuits are often the only means for the public and government regulators to learn about dangerous and unsafe practices. In other words, lawsuits protect us all, whether or not we ever go to court. Moreover, the amount of money saved as a direct result of this deterrence function — injuries prevented, health care costs not expended, wages not lost, etc. — is incalculable. Some have estimated this savings to be perhaps a trillion dollars a year.

²⁸ Victor, "Workers' Compensation and Workplace Safety, The Nature of Employer Financial Incentives," Rand, The Institute for Civil Justice (1982).

²⁹ Ashford, Johnson, "Negligence vs. No-Fault Liability: An Analysis of the Workers' Compensation Example," 12 Seton Hall L. Rev. 747 (1982).

³⁰ MassCOSH, *Dying for Work in Massachusetts: The Loss of Life and Limb in Massachusetts Workplaces*, at <http://www.masscosh.org/workersmemoriaexecsum.htm> & <http://www.masscosh.org/deathssummaries.htm> (last visited Nov. 17, 2003).

Many academic scholars have written that the influence of jury verdicts in civil cases, of which there are relatively few, is vastly disproportionate to their number. Jury verdicts provide “signals” or warnings that certain types of practices will not be tolerated. According to the Rand Institute for Civil Justice, “The jury’s decision in any particular case indicates the potential costs of engaging in behavior similar to the defendant’s . . . Punitive damages are designed to punish a defendant for grossly inappropriate actions and, in so doing, to deter future such actions by signaling that their consequences can be severe.”³¹

In medical malpractices cases, the *New England Journal of Medicine* reported in the late 1970s that replacing the tort system “might well abolish the deterrent signal or distort clinical decision making.”³² They found that fault systems that assess damages against the negligent doctor sends “signals” to other doctors that discourage future carelessness and reduce future damages. At best, such systems satisfy isolated individuals. They do not prevent or deter abuses.

Examples of cases around the country where patients or their families have been able to sue and have won improvements to existing safety standards by filing civil actions include the following:

Serious trauma patients not taken to trauma centers.

FACTS: on December 20, 1992, his best friend rushed 20-year-old Jason Griffith to an Ohio community hospital after being accidentally shot in the chest. Although Griffith was losing massive amounts of blood, his attending doctor — a fifth-year resident in general surgery — waited more than five hours before taking him to surgery. Griffith went into shock ten days later and ultimately suffered cardiopulmonary arrest and brain damage. He required constant care until his death in January 1994. His parents filed suit against the hospital and the doctors who treated him. The case settled for \$2.5 million two days after the trial began.³³

FACTS: On May 3, 1997, 37-year-old Joyce Lyons sustained abdominal injuries from a car accident on a rural road in Ohio. Lyons was admitted to Mary Rutan Hospital, subjected to a CT scan, and kept overnight. The following morning, Lyons’ condition had worsened from internal bleeding, which required emergency surgery. Lyons was then flown by helicopter to a trauma center where she was operated on immediately. On May 12, after suffering complications, she underwent additional surgery; she died nine

³¹ Erik Moller et al., *Punitive Damages in Financial Injury Jury Verdicts* (Rand Institute for Civil Justice, Doc. No. MR-888-ICJ, 1997); see also Marc Galanter, “Real World Torts: An Antidote To Anecdote,” 55 Md. L. Rev. 1093 (1996); William M. Landes & Richard A. Posner, *The Economic Structure of Tort Law* (1987); Richard L. Abel, “The Real Tort Crisis – Too Few Claims,” 48 Ohio St. L.J. 443 (Spring 1987).

³² Schwartz (M.D.), Komesar (J.D.), “Doctors, Damages and Deterrence,” *New England Journal of Medicine*, (June 8, 1978).

³³ Mark D. Somerson, “Lawsuits Might Move Trauma System Forward,” *Columbus Dispatch*, June 1, 1997 (discussing *Griffith v. Booher*, No. 94CVA-09-6799 (Franklin County Ct. of Common Pleas, Ohio, settlement May 21, 1997)); see also Bruce Cadwallader, “Mount Carmel Lawsuit Settled; Insurers to Pay \$2.5 Million in Pickerington Man’s Death,” *Columbus Dispatch*, May 27, 1997; Bruce Cadwallader, “Mount Carmel East Lawsuit Trial Begins,” *Columbus Dispatch*, May 21, 1997; Mark D. Somerson, “Lawsuit Highlights Trauma Care Issue; Parents: Son Died for Lack of Timely Care,” *Columbus Dispatch*, April 27, 1997.

days later. Lyons' husband filed a negligence suit against Mary Rutan and the doctors there who treated his wife. The jury awarded \$5 million.³⁴

EFFECT: On July 27, 2000, after nearly a decade of active opposition, Ohio enacted legislation that mandates that patients with serious trauma be transported to selected, certified trauma hospitals. The Griffith and Lyons cases "put a face to the numbers of 'preventable deaths' in Ohio, and I believe gave the Governor and sponsors of the legislation the leverage needed to enact this legislation."³⁵

HMO forced psychiatrists to prescribe psychiatric drugs.

FACTS: On April 10, 2000, Dr. Thomas Jensen filed a lawsuit against Kaiser Permanente, California's largest health maintenance organization, after he was fired for refusing to prescribe medications for mental health patients whom he did not personally examine. Kaiser required psychiatrists to prescribe anti-depressant drugs for depression and anxiety at the recommendation of non-medical psychotherapists, such as social workers, family therapists, and social-work interns.³⁶

EFFECT: The lawsuit prompted state regulators to investigate Kaiser's prescription policy. Faced with an onslaught of negative publicity arising from Jensen's lawsuit, Kaiser eliminated the practice in August 2000. Kaiser now requires psychiatrists to rely on their own examination of patients before writing prescriptions.³⁷

Failure to properly monitor patient.

FACTS: Marilyn Hathaway suffered brain damage after an anesthesiologist failed to monitor her cardiopulmonary status during surgery. In 1983, Hathaway sued the physician for medical negligence. The jury awarded \$5 million in damages.³⁸

³⁴ Kathryn L. Koehler, "Delay In Performing Surgery Cost Patient's Life; Late Operation Could Not Prevent Complications," *Ohio Lawyers Weekly*, Feb. 28, 2000 (citing *Lyons v. Clarkston*, No. 978CVC-08-7796 (Franklin County Ct. of Common Pleas, Ohio, verdict Sept. 3, 1999)); see also Tim Doulin & Joe Hoover, "Family of Crash Victim Is Awarded \$5 Million," *Columbus Dispatch*, Sept. 4, 1999; Mark D. Somerson, "Crash Victim's Care on Trial," *Columbus Dispatch*, Aug. 23, 1999.

³⁵ Letter from Gerald Leeseberg, dated Nov. 16, 2000 (Leeseberg is the attorney for the Griffith and Lyons families); see also Misti Crane, "Trauma Cases, Hospitals to be Matched," *Columbus Dispatch*, July 28, 2000; Mark D. Somerson, "Trauma System Would Save Hundreds of Lives," *Columbus Dispatch*, Sept. 7, 1997.

³⁶ Tony Fong, "Kaiser Sued Over Policy on Medicine; S.D. Psychiatrist Says Doctors Must Prescribe Drugs to Unseen Patients," *San Diego Union Tribune*, April 13, 2000; Sharon Bernstein & Davan Maharaj, "Kaiser Drug Policy Prompts State Inquiry," *Los Angeles Times*, April 12, 2000.

³⁷ "Kaiser Permanente has Reached a Settlement with Thomas Jensen, M.D. of San Diego," *Managed Care Week*, Vol. 10, No. 32, Sept. 11, 2000; Sharon Bernstein, "Kaiser Settles Doctor's Suit Over Drug Policy," *Los Angeles Times*, August 26, 2000; Tom Abate, "Kaiser to End Controversial Prescriptions," *San Francisco Chronicle*, May 3, 2000; Davan Maharaj, "Kaiser Tightens Rule On Writing Prescriptions," *Los Angeles Times*, May 3, 2000; "California Investigates Kaiser Prescriptions Policy," *BestWire*, April 17, 2000; Tom Abate, "State Probing Kaiser's Protocol for Depression; Prescriptions Allegedly Given without Exams," *San Francisco Chronicle*, April 13, 2000.

³⁸ *Frank v. Superior Court of the State of Arizona*, 150 Ariz. 228 (1986).

EFFECT: "After having to pay repeated medical malpractice claims arising from faulty anesthesia practices ... Arizona's malpractice insurance companies took action. For example, the Mutual Insurance Company of Arizona, which insures over 75 percent of the state's physicians, began levying a \$25,000 surcharge on insurance premiums for anesthesiologists against whom claims had been made because constant monitoring of the patient was not performed during general anesthesia. As a result of litigation, adequate anesthesia monitoring during surgery has become a standard medical practice in Arizona."³⁹

Staffing problem endangered patients.

FACTS: On January 26, 1998, Dr. Roberto C. Perez suffered severe brain damage after a nurse, who had been working over 70 hours a week and was just finishing an 18-hour shift, injected him with the wrong drug. Perez had been admitted to Mercy Hospital in Laredo, Texas, two weeks earlier after a fainting spell and was almost ready to be discharged. His family filed a medical malpractice suit, arguing that hospital administrators knew since 1994 that staffing problems existed yet failed to do anything about the nursing shortage. The case settled before trial, with the hospital paying \$14 million.⁴⁰

EFFECT: As part of the settlement, Mercy Hospital agreed that no nurse in the ICU would be allowed to work more than 60 hours per week.⁴¹

Bacterial infection spread to hospital roommate.

FACTS: In 1983, 72-year-old Julius Barowski contracted a bacterial infection from a fellow patient after undergoing knee replacement surgery. His condition required 11 hospitalizations and 9 surgeries; his leg lost all mobility. As the infection spread, he suffered excruciating pain and was institutionalized for depression until his death one year later. Barowski's representative filed suit, alleging that the hospital breached its own infection control standards. The jury awarded \$500,000.⁴²

EFFECT: "The Widmann ruling and similar cases have had a catalytic impact in health care facilities around the country. Facilities are much more attentive to the clinical importance of cleanliness in all its dimensions — hand-washing, routine monitoring of infection risks, and more vigorous reviews of hospital infection control protocols."⁴³

³⁹ Harvey Rosenfield, *Silent Violence, Silent Death* 57 (1994) at 56 (citing James F. Holzer, "The Advent of Clinical Standards for Professional Liability," *Quality Review Bulletin*, Vol. 16, No. 2 (Feb. 1990)).

⁴⁰ *Perez v. Mercy Hospital*, No. 98 CVQ 492-D3 (341st Judicial Dist., Webb County Ct., Tex., settlement Oct. 28, 1999); *Perez v. Mercy Hospital*, No. 98 CVQ 492-D3 (341st Judicial Dist., Webb County Ct., Tex., fourth amended original petition, filed Oct. 22, 1999) (on file with CJ&D).

⁴¹ *Perez v. Mercy Hospital*, No. 98 CVQ 492-D3 (341st Webb County Ct., Tex., settlement Oct. 28, 1999); *Perez v. Mercy Hospital*, No. 98 CVQ 492-D3 (341st Judicial Dist., Webb County Ct., Tex., release and settlement agreement, Oct. 28, 1999) (on file with CJ&D).

⁴² *Widmann v. Paoli Memorial Hospital*, No. 85-1034 (E.D. Pa., verdict Dec. 9, 1988); see also Harvey Rosenfield, *Silent Violence, Silent Death* 57 (1994), at 55-6.

⁴³ Harvey Rosenfield, *Silent Violence, Silent Death* 57 (1994) at 55-6.

Tube misinsertion caused death.

FACTS: Rebecca Perryman was admitted to Georgia's DeKalb Medical Center after suffering from kidney failure. While undergoing dialysis, a catheter inserted in her chest punctured a vein, causing her chest cavity to fill with blood. Perryman suffered massive brain damage and lapsed into a coma. She died two weeks later. Perryman's husband Henry filed suit against DeKalb and its Radiology Group, as well as the doctor who failed not only to spot the misplaced catheter in Perryman's chest x-ray but also to quickly respond to the victim's excessive bleeding. DeKalb and the Radiology Group settled before trial for an undisclosed amount; a jury awarded \$585,000 against the doctor.⁴⁴

EFFECT: "After the award, the radiology department instituted new protocol for verifying proper placement of catheters."⁴⁵

Nurses feared consequences of challenging doctors' actions.

FACTS: On April 30, 1979, Jennifer Campbell suffered permanent brain damage after becoming entangled in her mother's umbilical cord before delivery. Although a nurse had expressed concern when she noticed abnormalities on the fetal monitor, the obstetrician failed to act. Despite the doctor's unresponsiveness, the nurse never notified her supervisor or anyone else in her administrative chain of command. The child developed cerebral palsy, requiring constant care and supervision. Evidence revealed that the hospital lacked an effective mechanism for the nursing staff to report negligent or dangerous treatment of a patient. In addition, the nursing supervisor testified that an employee could be fired for questioning a physician's judgment. The jury awarded the Campbells over \$6.5 million.⁴⁶

EFFECT: "Because of this verdict and its subsequent publicity, hospitals throughout North Carolina have adopted a new protocol that allows nurses to use their specialized training and judgment on behalf of patients, without risking their jobs."⁴⁷

Verdicts and settlements in medical malpractice cases have forced improvements in health care and led to the elimination of many unsafe practices, saving millions of people from injury or death. When a controversy is resolved outside the court system, it has no legally binding effect on other controversies. There can be no expectation that others will follow the announced principle. Removing claims from the tort system, such as proposed here, will ultimately circumvent rules about standards of conduct that have evolved over the years to protect patients who have no way to protect themselves.

⁴⁴ *Perryman v. Rosenbaum et al.*, No. 86-3453 (DeKalb County Super. Ct., Ga., verdict June 5, 1991).

⁴⁵ Thomas Koenig & Michael Rustad, *In Defense Of Tort Law* (2001) (citing letter from W. Fred Orr III, Henry Perryman's attorney, dated April 26, 1994).

⁴⁶ *Campbell v. Pitt County Memorial Hospital, Inc.*, 84 N.C. App. 314 (1987); see also Laura Mahlmeister, "The Perinatal Nurse's Role in Obstetric Emergencies: Legal Issues and Practice Issues in the Era of Health Care Redesign," *J. of Perinatal & Neonatal Nursing* (Dec. 1996); Harvey Rosenfield, *Silent Violence, Silent Death* 57 (1994).

⁴⁷ Harvey Rosenfield, *Silent Violence, Silent Death* (1994) at 57.

Secrecy about Errors and Injuries Will Continue Under the Proposed System

Massachusetts may provide the best proof in the country that litigation and liability risks are *not* the reasons for secrecy about medical errors. Massachusetts hospitals have some of the strongest protections from liability in the nation, since nearly all fall under the state's charitable immunity laws that cap their liability at \$20,000.⁴⁸ Yet, even though they run little risk of liability for errors, "statistics suggest, and leading experts confirm, that doctors and hospitals around Boston — widely considered the medical capital of the world — are vastly underreporting their mistakes to regulators and the public."⁴⁹ According to a February 2003 *Boston Magazine* article:

In 2001, Massachusetts hospitals reported 982 serious incidents, or medical errors, to state regulators, up from 636 five years earlier, but still an average of just three reports per day. In New York state, by comparison, hospitals submitted nearly 30,000 reports, or 82 per day. In fairness, that disparity is mostly due to the different ways the states define a medical error: New York studies every little complication; Massachusetts, only major incidents. Still even New York is criticized for disclosing fewer medical errors than actually occur, and with a population only three times that of Massachusetts, it is reporting more than 30 times as many. One doctor who was a member of a Massachusetts oversight committee says statistics show there should be 10 reports of medical errors per 100 hospital beds each year. In fact, hospitals in this state are disclosing roughly three. Even when they are reported, one Harvard School of Public Health professor says, many medical errors are barely investigated because of a lack of resources.⁵⁰

It is misguided to think that fear of litigation is the only, or even principal, reason that doctors and hospitals do not report errors. According to *Boston Magazine*, "doctors, either out of shame, a fear of being sued or disciplined, or anxiety about their reputations, rarely talk openly about their errors. . . . The biggest challenge is finding a way to break the culture of silence in hospital corridors that has long crippled efforts to cut medical errors, just as the blue wall of silence has stifled police investigations."

This "white wall of silence" would not just stop the day Massachusetts adopted the proposed system. In fact, under the similar birth-injury program in place in Virginia, obstetricians are not even asked to explain what happened, and the family may never learn anything about what caused a catastrophic injury. Not a single case in the program's 15-year history has produced a disciplinary action against a hospital or doctor, even though those cases "pose a high risk for findings of negligence against doctors, nurses and hospitals."⁵¹ One mother of a daughter with cerebral palsy and other severe disabilities testified before the Virginia House that the program

⁴⁸ Mass. Gen. Laws ch. 231, § 85K (2003).

⁴⁹ Doug Most, "The Silent Treatment," *Boston Magazine*, Feb. 2003.

⁵⁰ *Ibid.*

⁵¹ Bill McKelway, "Brain Injuries Spur No Action; Case Review, Required by Law, Is Not Being Done, Va. Study Found," *Richmond Times Dispatch*, Jan. 14, 2003.

"has evolved from a model of care for severely disabled children to . . . safe haven for physicians and hospitals who, in some cases, are directly responsible for these catastrophic injuries."⁵²

It should also be noted that the proposal outline states that the National Practitioner Databank, which seeks to record incidents of negligence in the practice of medicine, "pollutes" the medical industry's attitude and encourages secrecy. In every other context — corporate America, government, and any other industry — openness and letting the light shine on wrongdoing is seen as an important step in bringing about fairness and positive change. While this proposal outline expresses almost no concern about increasing patient safety, it is still astounding that the drafters would go so far as to refer to disclosure of wrongdoing as polluting.

Pre-Dispute Notice Provisions are Fundamentally Unfair to Patients

Under this proposal, pregnant women would have to sign an agreement to waive their rights to sue in the event their child is injured at birth, or be turned away. This is in direct violation of AMA policy, which has said in the context of pre-dispute binding managed care arbitration that such agreements are fundamentally unfair to patients.

The AMA view was most recently articulated in a 1998 report released jointly by the AMA, the American Bar Association and the American Arbitration Association, which studied such mandatory binding arbitration agreements, entitled *Health Care Due Process Protocol*.⁵³ As a result of this study, the American Arbitration Association affirmed in its Health Care Policy Statement that it will not participate in arbitration between a patient and health care provider if the patient was forced to give up their rights before malpractice occurred.⁵⁴

In the report's recommendations, the organizations jointly found that any alternative resolution process (ADR), like arbitration, must abide by due process considerations and must be fundamentally fair. Specifically, they found:

The agreement to use ADR should be knowing and voluntary. Consent to use an ADR process *should not be a requirement for receiving emergency care or treatment*. In disputes involving patients, binding forms of dispute resolution *should be used only where the parties agree to do so after a dispute arises*. (emphasis added).

Case Study: Virginia's Birth-Related Neurological Injury Compensation Fund

Virginia's Birth-Related Neurological Injury Compensation Program, in place for 15 years, is similar to what is being proposed for Massachusetts and provides some examples Massachusetts would face should this proposal be adopted.

⁵² Bill McKelway, "Panel Approves Bill on Birth Injuries; Would Expand Benefits and Notification Rights," *Richmond Times Dispatch*, Jan. 29, 2003.

⁵³ American Arbitration Assoc., American Bar Assoc. & American Medical Assoc., *Health Care Due Process Protocol* 15 (1998) (emphasis added).

⁵⁴ American Arbitration Assoc., *Health Care Policy Statement*, at <http://www.adr.org/index2.1.jsp?JSPssid=16235&JSPsrc=upload/livesite/focusArea/Healthcare/HEALTH%20CARE%20POLICY%20STATEMENT.htm> (last visited Nov. 17, 2003).

The Virginia program was established in the mid-1980s, during this country's last so-called "insurance crisis," as another misguided attempt to reduce skyrocketing insurance rates for doctors. Like the Massachusetts proposal, this program was set up as an injury compensation system for catastrophically injured newborns. It is the exclusive remedy for children delivered by a participating OB/GYNs and hospital. All claims go before an administrative panel, established within the workers comp. system. The panel is "aided" by an "expert" panel of three doctors who determine if the injury is a covered birth-related neurological injury.

This program has been a tremendous failure on every level. It has hurt patients, has done nothing to help doctors with their insurance problems and has allowed the state to become a safe harbor for negligent and reckless doctors who should not be practicing medicine at all. Virginia's Joint Legislative Audit and Review Commission has suggested "abandoning or overhauling" the program⁵⁵ and "ridding the board of its heavy presence of medical professionals,"⁵⁶ and has found that the program could not be made fiscally sound.⁵⁷ In testimony before the Virginia Legislature, one parent called the program "a generous system of care gone awry, of state-sanctioned impunity for doctors and hospitals, and of the struggle families face caring for society's weakest children."⁵⁸

Although by no means an exhaustive list of the program's shortcomings, the following are some of its more notable problems:

- *Prevents patients from receiving adequate compensation and understanding the medical errors and negligence responsible:* "Children born in Virginia with catastrophic neurological injuries are promised lifetime medical care by the birth-injury program. But these children and their families also have been forced to absorb stunning disparities in program benefits because of shifting priorities and cost reductions over which they had no control or voice. . . . 'The program can end up providing very little,' said Christina Rigney, referring to the minimal benefits her family received in the face of her son's traumatic birth and brief life. 'We believed there was negligence involved, but nothing ever came of it.'" Her son died three years after he was severely injured due to oxygen loss during birth. Because of the birth injury law, the family couldn't file a malpractice suit, the obstetrician was never even asked to explain what happened, and the family could learn nothing from illegible notes that failed to account for long periods of time. Families of two other brain-injured infants he delivered faced the same limits on their ability to learn what happened, or seek to show he was negligent. He is facing a lawsuit,

⁵⁵ Bill McKelway, "Study Faults Program for Brain-Injured; Shortcomings Found in Care for Children," *Richmond Times Dispatch*, Nov. 13, 2002; Liz Szabo & Elizabeth Simpson, "Birth Injuries Get 'Minimal Review; State Report Says Board Must Hold Doctors Accountable,'" *Virginian-Pilot*, Nov. 15, 2002.

⁵⁶ Bill McKelway, "Brain-Injury Program's Outlook Dim; Cost Savings for Doctors Meant Less for Children," *Richmond Times Dispatch*, Nov. 16, 2002.

⁵⁷ Bill McKelway, "Brain-Injury Program's Outlook Dim; Cost Savings for Doctors Meant Less for Children," *Richmond Times Dispatch*, Nov. 16, 2002.

⁵⁸ Bill McKelway, "Danville Has High Birth-Injury Rate; Critics Say Virginia Law Shields Doctors from Lawsuits," *News Virginian*, June 1, 2003.

however, for a fourth case in which a woman giving birth bled to death after delivering a healthy baby.⁵⁹

- *Has allowed Virginia to become a safe harbor for bad doctors:* National birth-injury experts have reportedly expressed fear about Virginia becoming a safe harbor for bad doctors because of a lack of disciplinary actions under this law. "The birth-injury cases ... are not reported to national databases that track actions against doctors and measure physicians' insurability. With no court action, settlement or disciplinary actions, a doctor's involvement in birth-injury cases can go undetected."⁶⁰
- *Cannot adjust to new medical research:* The program has been unable to adjust to current medical understanding because definitions of which injuries are covered have not changed in 15 years, despite important advances in understanding the causes of brain damage in babies. The program has rejected claims because it used out-dated criteria for assessing birth injuries. "Decisions in the [Virginia program's] cases can mean the difference between lifetime care for some of society's most-disabled children and no guarantees that medical expenses will be covered. Many families have had to opt for institutionalizing their children."⁶¹
- *Families of infants who died minutes after birth denied any compensation:* Until recently, the program provided for lifetime care but nothing for wrongful death (a new provision to provide up to \$100,000 to deceased children went into effect in July 2003). That led to perverse situations such as a recent case where the obstetrician and hospital successfully argued before the administrative body that an infant who lived only minutes qualified for the program, protecting them from any liability other than the care provided during the deceased infant's 30-minute lifetime.⁶²
- *Had not led to reduced malpractice insurance rates:* Doctors claim that the program has failed to protect them from unacceptable malpractice insurance rate increases.⁶³

CONCLUSION

This proposal follows in the tradition of building a system based upon pleasing insurers rather than upon concern that those who are injured receive adequate compensation. The outline of this proposal shows little concern for what is best for patients or, particularly, the most severely injured patients.

⁵⁹ Bill McKelway, "Danville Has High Birth-Injury Rate; Critics Say Virginia Law Shields Doctors from Lawsuits," *News Virginian*, June 1, 2003.

⁶⁰ Bill McKelway, "Brain-Injury Program's Outlook Dim; Cost Savings for Doctors Meant Less for Children," *Richmond Times Dispatch*, Nov. 16, 2002.

⁶¹ Bill McKelway, "Old Rules Deny New Benefits; Children Rejected for Brain-Injury Program," *Richmond Times Dispatch*, June 5, 2003.

⁶² Bill McKelway, "Deceased Infant Put into Program; Ruling Blocks Suits Over Death of Baby," *Richmond Times Dispatch*, June 27, 2003.

⁶³ See, e.g., Novelda Sommers, "Peace of Mind is Pricey; Some Malpractice Insurance Soars," *Daily Press* (Newport News, VA), June 5, 2003.

One thing is for sure. This proposal will protect negligent or reckless health care providers from liability exposure, compel victims to resort to processes where more powerful interests prevail, and disrupt critical functions of the tort system, namely deterrence of unsafe practices, disclosure of dangers to a wider public, and authoritative expansions of respect for human life through written public precedents. And it will do nothing to help doctors' insurance problems. It is a terrible idea.



**Property Casualty Insurers
Association of America**

Shaping the Future of American Insurance

2600 South River Road, Des Plaines, IL 60018-3286

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OCT - 9 2008

HEARINGS & APPEALS
MASS. DIVISION OF INSURANCE

**STATEMENT ON MEDICAL MALPRACTICE INSURANCE ISSUES
IN DIVISION OF INSURANCE DOCKET NO. M2008-01
OCTOBER 3, 2008**

The Property Casualty Insurers Association of America (PCI) submits these comments on some of the medical malpractice insurance issues that are raised by the notice of hearings in this matter. PCI is a national insurance company trade association with more than 1,000 major insurers that provide insurance to policyholders in all property/casualty lines. In Massachusetts, PCI members accounted for more than 52% of medical malpractice premiums written in 2007. ProMutual, the largest medical malpractice insurer in Massachusetts, is a PCI member.

Medical malpractice is a very difficult line of insurance, characterized by cycles of "hard" and "soft" markets. In hard markets, rates go up; in soft ones, rates fall. Other lines of insurance also experience similar cycles of hard and soft markets, but the swings in malpractice rates are generally more extreme than in other lines. Currently, malpractice rates in Massachusetts are relatively stable. PCI believes that the present rate filing and review process -- under which companies file competitive rates and those are subject to review and disapproval by the Division of Insurance -- is working well, and there should be no fundamental change in that process.

We note that prior to the formation of ProMutual by the Massachusetts Legislature in 1994, there was no insurance market in the state. The only provider of coverage for the 20 years before that was the state-created and controlled joint underwriting association. No private insurer would sell in the market. While this structure did ensure that all providers could obtain coverage, it did not prevent large rate increases or the periodic medical malpractice crisis, nor could providers avail themselves of the benefits of competition. With the establishment of ProMutual, competition was allowed to begin. Under the competitive rating system, new entrants have periodically come into Massachusetts, and that has benefited medical providers by giving them choices of insurers, rates and coverage. Undoubtedly, competition has served to constrain rate increases during the recent hard market in this line in Massachusetts.

One issue about which the hearing notice seeks comment is the availability of medical malpractice insurance. Availability of coverage is not a problem. Medical practitioners are guaranteed access to any insurer underwriting the specialty in which they practice through the take-all-comers requirement contained in the statute creating ProMutual. That requirement was undoubtedly needed as the market transitioned into a competitive one, but it also certainly limits the number of insurers willing to do business in the state. However, at some point, the Legislature should revisit the take-all-comers requirement to determine if there is a more effective way of ensuring that all providers can obtain coverage.


The hearing notice also seeks commentary on options for decreasing premiums. There are two areas of the tort laws that should be revised, and these changes would reduce premiums for medical practitioners. The first involves modifying the current law that imposes joint and several liability in medical malpractice cases. Secondly, the statute prescribing the pre-judgment interest rate for medical malpractice cases should be further revised so that rate is determined by the market rather than by some artificial number prescribed by the Legislature. The Legislature did lower the statutorily prescribed rate in medical malpractice cases a couple of years ago, but it is still set at a level significantly above the market rate, which simply adds unnecessary costs to the system.

A number of other states have enacted comprehensive tort reform (generally including liability caps) in the malpractice arena over the last twenty years, and those have served to reduce premiums and/or moderate their increases during hard markets. PCI seriously doubts there is the political appetite for such broad reforms. However, with the changes in joint and several liability and the pre-judgment interest rate we have suggested, Massachusetts doctors could obtain some premium relief.

Finally, we note that the hearing notice invites comments on a number of ways in which the premiums of certain types of providers might be subsidized. In general, PCI opposes the prescription of subsidies because they distort the economics and incentives in market-based insurance pricing. Rather than shift dollars around among providers -- which means that some will pay more than their actuarially indicated costs -- efforts at reform should focus on cost-drivers, including the tort system.

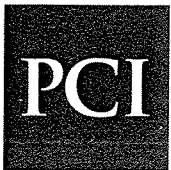
We appreciate the opportunity to comment on some of the issues in this matter, and we stand ready to assist the Division any way we can in completing its study and report.

Respectfully submitted,

A handwritten signature in dark ink, appearing to read "Francis C. O'Brien". The signature is fluid and cursive, with a large initial "F" and a stylized "O'Brien".

Francis C. O'Brien
Vice President, Regional Manager and Counsel

Jerry

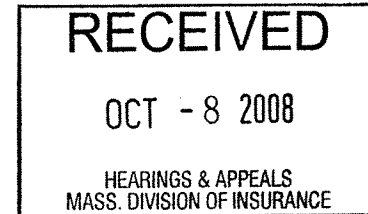


**Property Casualty Insurers
Association of America**

Shaping the Future of American Insurance

40 Court Street, Suite 700, Boston, MA 02108

October 7, 2008



The Honorable Nonnie S. Burnes
Commissioner of Insurance
Commonwealth of Massachusetts
Division of Insurance
One South Station
Boston, MA 02110-2208

Attn: Docket Clerk, Hearings and Appeals re Docket No. M2008-01 Medical
Malpractice Insurance Hearing

Dear Commissioner Burnes:

During the course of the hearing on October 3 held pursuant to the provisions of Chapter 305, Section 39 of the Acts and Resolves of 2008 (medical malpractice insurance), former Missouri Insurance Commissioner Jay Angoff testified on behalf of the Massachusetts Academy of Trial Attorneys. During the course of his statement, Commissioner Angoff made a number of statements and suggestions which, if implemented, would engender significant opposition on the part of PCI and its member companies. Several of these points were mentioned in PCI's oral statement at the hearing.

In PCI's view, the most objectionable statement made by Commissioner Angoff during the course of the hearing was his suggestion that in the event that a public policy decision is made to subsidize the medical malpractice insurance premiums of certain specialties, a source of funding for such subsidies which could be targeted is the surplus of property and casualty carriers.

Commissioner, I can hardly begin to suggest to you just how bad of an idea this is. In addition to the potential retaliatory tax consequences, such a suggestion flies in the face of any sort of reasonable solvency regulation. While we are hopeful that such a suggestion could never be seriously considered in the commonwealth, its implications are so profound that PCI felt the need to register its specific concerns with this suggestion at this very early stage.

Very truly yours,

A handwritten signature in cursive script, reading "Frank O'Brien", is written over a circular stamp. The signature is in dark ink and is slanted slightly to the right.

Francis C. O'Brien
Vice President, Regional Manager and Counsel

FCO:am

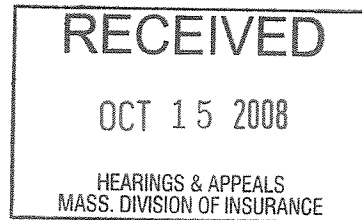


**Property Casualty Insurers
Association of America**

Shaping the Future of American Insurance

2600 South River Road, Des Plaines, IL 60018-3286

October 14, 2008



The Honorable Nonnie S. Burnes
Commissioner of Insurance
Commonwealth of Massachusetts
Division of Insurance
One South Station
Boston, MA 02110-2208

Attn: Docket Clerk, Hearings and Appeals re Docket No. M2008-01 Medical
Malpractice Insurance Hearing

Dear Commissioner Burnes:

Enclosed please find a supplemental statement of PCI regarding medical malpractice
insurance issues in the Division of Insurance Docket No. M2008-01.

Thank you for your attention to this matter.

Very truly yours,

A handwritten signature in cursive script, reading "Francis C. O'Brien".

Francis C. O'Brien
Vice President, Regional Manager and Counsel

FCO:am

cc Nancy Allen
Jean Farrington



**Property Casualty Insurers
Association of America**

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HEARINGS & APPEALS
MASS. DIVISION OF INSURANCE

**SUPPLEMENTAL STATEMENT ON
MEDICAL MALPRACTICE INSURANCE ISSUES
IN DIVISION OF INSURANCE DOCKET NO. M2008-01
OCTOBER 14, 2008**

The Property Casualty Insurers Association of America (PCI) submits this supplemental statement for the record in this matter. PCI submitted a statement at the initial hearing held on October 3, 2008, and we also submitted a letter following that hearing in response to some suggestions made by one of the witnesses.

In order to fully understand the factors affecting medical malpractice insurance costs and rates, policymakers must take into account the periodic expansion of liability in this area by the courts. Judicial decisions which create or expand the liabilities of medical providers directly affect the claims insurers incur and thus the premiums medical providers must pay. In the last year alone, the Massachusetts Supreme Judicial Court has expanded tort liability for medical providers in two areas:

Expansion of Duty to Warn. In *Coombes v. Florio*, 450 Mass. 182 (2007), a badly-divided Court ruled that a doctor can be held liable for injuries to third parties caused by a patient of the doctor when the patient was not warned about the effects of prescribed medication. As Chief Justice Marshall said in dissent: “. . . [This] opinion would establish for the first time in this Commonwealth a physician’s duty to prevent harm to nonpatients, and would do so in sweeping terms. . . . [The opinion] conflates the ‘duty to warn’ with the much more comprehensive ‘duty of care,’ and *thus vastly enlarges the field of physician liability.*” Id. at 201, 202 (Emphasis supplied).

Adoption of Loss of Chance Doctrine. This summer, the Court issued two rulings in which it adopted a new theory of injury in medical malpractice wrongful death cases, *Matsuyama v. Birnbaum*, 452 Mass. 1 (2008) and *Renzi v. Paredes*, 452 Mass. 38 (2008). In *Matsuyama*, the Court held that Massachusetts law permits the recovery for “loss of chance” in medical malpractice wrongful death actions. Under this doctrine, the physician is liable for damages where the physician’s negligence reduces or eliminates a patient’s prospect for achieving a more favorable medical outcome. The Court acknowledged that it was expanding the scope of the wrongful death statute: “Although wrongful death did not traditionally encompass loss of chance of survival, we conclude that claims for loss of chance of survival are sufficiently akin to wrongful death claims as to be cognizable under the wrongful death statute.” Id. at 23.

The *Renzi* decision, which was issued the same day as *Matsuyama*, not only affirmed the adoption of the loss of chance doctrine, but also held that loss of chance damages are recoverable even where the defendants are not liable for causing the decedent’s wrongful death. The Court did, however, send the case back for a new trial of the issue of damages alone because the trial judge had not given the jury proper

instructions on apportionment method of calculating damages, consistent with the formula the Court had set forth in *Matsuyama*.

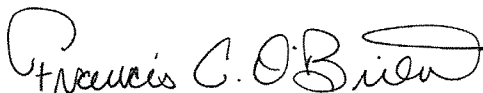
Judicial creation and/or expansion of tort liability is a persistent problem for medical providers in Massachusetts and for their insurers. These decisions add costs to the medical system, lead to higher medical malpractice premiums and create uncertainty and volatility for the insurers and their policyholders about future costs and premiums. PCI believes that these changes in tort law are best left to the Legislature. In this regard, Chief Justice Marshall's comments about the effects of the *Coombes* decision are particularly apt:

"Finally, I fail to see how the unwarranted extension of judicial power suggested by the concurring opinions is cured by Justice Ireland's invitation to fix the result reached today. Ante at 192 (Ireland, J., concurring)('I would leave to the Legislature the task of determining whether to impose further limits on doctors' liability.'). The invitation reverses the appropriate roles of the legislative and judicial branches. . . . One need not be clairvoyant to understand the inevitable result of today's enlargement of liability: a significant increase in third-party litigation against doctors and an attendant increase in expenses at a time when our health care system is already overwhelmed with collateral costs."

Coombes, 205-206.

We request that the Division's report to the Legislature in this matter include a discussion of the effects on medical malpractice claims, and thus on the premiums paid by medical providers, of judicial expansion of tort liability.

Respectfully submitted,

A handwritten signature in black ink, reading "Francis C. O'Brien". The signature is fluid and cursive, with the first name "Francis" and last name "O'Brien" clearly legible.

Francis C. O'Brien
Vice President, Regional Manager and Counsel

The Massachusetts Insurance Federation, Inc.

Two Center Plaza, 8th Floor
Boston, MA 02108
Tel: 617-557-5538
Fax: 617-557-5675

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HEARINGS & APPEALS
MASS. DIVISION OF INSURANCE

James T. Harrington
Executive Director

MEDICAL MALPRACTICE COSTS: MASSACHUSETTS DIVISION OF INSURANCE DOCKET NO. M2008-01

The Massachusetts Insurance Federation is pleased to submit comments on some of the issues in this proceeding concerning medical malpractice costs. The Federation is a single state trade association comprised of insurers writing all principal lines of property/casualty coverage in the Commonwealth.

One of our members is ProMutual, the largest medical malpractice insurer in the state, and one of the largest in the country. ProMutual was created by an act of the Legislature in 1994 to replace the joint underwriting association that was established legislatively in 1975 in response to a crisis of availability in medical malpractice insurance. For the 20 years following its creation, the JUA was the only market in Massachusetts for doctors, hospitals and other providers who were not covered by a hospital captive. The JUA ensured providers a market, but did not protect them against dramatic increases in rates such as what occurred in the mid-to-late 1980s. Because the JUA statutory scheme also provided for the fixing-and-establishing of medical malpractice rates by the Commissioner, no insurance companies were willing to do business in the state. Accordingly, medical providers did not have the ability to shop around for different coverage or lower rates. That all changed when ProMutual was created by the Legislature. Massachusetts now has a competitive medical malpractice insurance market, which by all indications is working well. Since that time, companies have entered and departed the market and have offered lower rates than ProMutual. This change has been good for the market, as well as for medical providers by giving them alternatives.

There is another aspect of the current market that also must be taken into account. ProMutual has become a sizable and, financially, very strong company. It writes at conservative premium-to-surplus ratios. No action should be recommended in the Division's report to the Legislature in this matter, and no action should be taken by the Legislature, that would in any way jeopardize the current financial strength or health of ProMutual. Such adverse action would include any move away from the current rate review process for medical malpractice insurers, back to one with more rigid state controls. The current rate regulatory system is working well, and it should be left as is.

The American International Group
Amica Mutual Insurance
Atlantic Charter
The Chubb Group
CNA Insurance Company
Encompass Insurance Company
Fireman's Fund

Hanover Insurance Company
The Liberty Mutual Group
Metlife Auto & Home
The OneBeacon Insurance Co.
Premier Insurance Company
Progressive Insurance
ProMutual Group

Quincy Mutual Fire Insurance Co.
Safety Insurance Group
The Guard Insurance Group
The Travelers Group
USAA
Zurich North America

The American Insurance Association

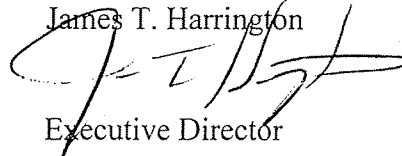
National Association of Mutual
Insurance Companies
Reinsurance Association of America

Property Casualty Insurers
Association of America

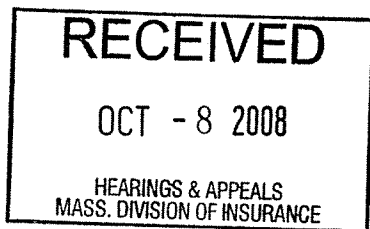
Finally, I wish to note our support of and agreement with the recommendations of ProMutual in its statement in this proceeding that there are at least two areas where the tort laws need to be modified – modification of the joint and several liability requirement and a further reduction in the pre-judgment interest rate. These changes would take costs out of the system and would help lower premiums.

I appreciate the opportunity to participate in this proceeding.

James T. Harrington

A handwritten signature in black ink, appearing to read 'J. T. Harrington', written over the printed name.

Executive Director



MASSACHUSETTS MEDICAL SOCIETY

Every physician matters, each patient counts.

Testimony of the Massachusetts Medical Society in the matter of Investigation and Study of the Costs of Medical Malpractice Insurance for Health Care Providers

Docket No. M2008-01

October 7, 2008

On behalf of the Massachusetts Medical Society and its over 20,000 physicians, residents and students, we appreciate the opportunity to submit these comments. Plainly put, the cost of professional liability premiums is having a serious detrimental effect on the ability of the Commonwealth to recruit and retain physicians. This in turn exacerbates an already severe shortage of practicing physicians which undermines the access that has been potentially achieved with Chapter 58. In hard numbers, since 1992 Massachusetts professional liability premium have risen 138.3%, while practice expenses have increased 81.9%, the consumer price index has increased 54.1% and Medicare reimbursements have only increased by 20%. The reimbursement trend represents less than 1% per year compounded with other payers tying reimbursement to these numbers. This situation is not sustainable.

Today, the Medical Society issued its 2008 Physician Workforce Study. A copy of the executive summary is included for the record. The number of physician specialties found to be in short supply has doubled to a total of 12 in just three years. Oncology, neurology and dermatology were included in the study for the first time this year, urology was added last year. Neurosurgery has been classified as facing critical or severe labor market conditions in all seven MMS surveys. Eight of the specialties have been found to be facing critical or severe shortages in at least four of the seven years of the studies. The report also found that there continues to be difficulty in recruiting. The survey of practicing physicians indicated that recruitment times averaged more than one year for 11 of the 18 specialties: 26 months for dermatology, 24 neurology, 23 gastroenterology, 22 vascular surgery, 22 neurosurgery, 21 urology, 19 general surgery, 17 orthopedics and cardiology, 14.5 family medicine and 13 months for internal medicine.

In addition, driven by the fear of potentially devastating economic and professional consequence of medical liability lawsuits, physicians nationwide are engaging in the practice of defensive medicine. Defensive medicine can come in diverse forms, including the pursuit of clinically unnecessary laboratory or radiographic information, prescriptions for unneeded medications such as antibiotics, medically unnecessary referrals to specialist, the performance of invasive procedures to exclude or confirm

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diagnoses, and the avoidance of high-risk procedures, or in certain circumstances, the avoidance of high-risk patients entirely.

While the nature and prevalence of the defensive medical practices have been widely debated, most agree that the costs are exorbitant. In fact some estimates report that the practice of defensive medicine costs the American in excess of \$170 billion dollars annually, which would account for up to 12% of all health care expenditures.¹ In a study published last year by the Pacific Research Institute, the total impact of the current tort system on medical expenditures was estimated to be \$124 billion annually, with an additional \$38 billion in reduced access to healthcare.² A study conducted as early as 1987 estimated that expenditures resulting from defensive practices comprised over 15% of all health care dollars spent.³ Tillinghast (2000) estimated the cost of defensive medicine at \$70 billion national and \$253 per Massachusetts citizen which would translate to approximately \$1.5 billion in unnecessary costs. As the Commonwealth grapples with increased health care costs as an employer, a social welfare agency a connector and a government trying to make Massachusetts attractive to employer, this is \$1.5 billion in waste that should be eliminated.

In a survey conducted by the Medical Society this year relative to defensive medicine researchers found the following:

The current medical liability environment appears to add significantly to the costs of health care

The cost of professional liability insurance and the risk associated with medical malpractice suits present significant financial concerns for Massachusetts physicians. (One third of the respondents and a majority of neurosurgeons and obstetrician/gynecologists characterized the liability insurance premiums as "very burdensome financially")

Medical liability concerns have lead Massachusetts physicians to reduce the scope of their practices in ways that have clearly affected patients' access to health care. More than one quarter of physicians in the sample and half of orthopedic surgeons, ob/gyns and general surgeons reported that they reduce the number of high risk services or procedures they performed. More than one quarter of physicians also reported reducing the number of high risk patients they saw; this was most common among ob/gyn and those in surgical subspecialties.

In 2008, the Massachusetts Supreme Judicial Court has issued three decisions which have increased physicians' concerns about their potential liability. In the *Coombes v. Florio* case, the SJC decided the defendant physician could potentially be liable to a third party

¹ Carroll. Going on the Offensive against Defensive Medicine. *Managed Care Magazine*. March 2005.

² McQuillan, LJ, Abramyan H, Archie A. JACKPOT JUSTICE: The True Cost of America's Tort System. Pacific Research Institute, 2007.

³ Reynolds RA, Rizzo JA, Gonzalez ML. *The Cost of Medical Professional Liability*. JAMA 257(20): 2776-2781, May 22/29, 1987.

for failure to warn his patient of the risk of driving while under the medication prescribed by the defendant. This narrowly decided decision had strong dissents, including that of Chief Justice Marshall who states "'Today's result impedes not only the work of doctors. It impedes the work of our courts. On remand, the trial judge is left the unenviable task of divining from the vague generalizations of the concurring opinions the outer limits of a novel duty of physicians to third-party nonpatients. Because I agree with the trial judge that the physician's liability does not extend to the third-party decedent in this case, I would uphold the grant of summary judgment in Dr. Florio's favor, and not leave it to trial judges to puzzle their way through this thorny issue of public policy.

Judge Cordy added. "The opinion of Justice Ireland (and the two Justices who join him) would recognize a new duty vastly expanding the potential liability of a physician to persons with whom the physician has had no contact or relationship. This duty is not compelled by our precedents, nor does it reflect 'existing social values and customs and appropriate social policy,

Later in 2008 the SJC created a new doctrine of loss of chance for medical malpractice cases. These decisions, in the *Matsuyama v. Birnbaum* and *Renzi v. Paredes*, conclude that Massachusetts common law permits recovery for a "loss of chance" for a better medical outcome in a medical malpractice. These cases are still under analysis but are reverberating through the medical community as physicians grapple to understand exactly what potential liabilities they owe, to whom and under what standard of care.

Earlier this year the Medical Society issued the following statement:

The Medical Society said it "remains committed to reducing the cost of professional liability insurance," and said the cost of liability insurance for physicians is one of the major factors in the deteriorating physician practice environment in the state. According to the Medical Society, liability premiums for physicians have risen 132 percent in the 13-year period ending in 2005.

As costs rose, the Society said, recruitment and retention of physicians has become more difficult, leading to shortages of physicians in many specialties. Among the shortages are neurosurgeons, vascular surgeons, anesthesiologists, cardiologists, and gastroenterologists, as well as psychiatrists and primary care physicians. (As noted above in our testimony, additional specialties have been added.)

In addition, physicians wary of litigation have limited their areas of practices and services and engaged in "defensive medicine," a practice that cost billions annually in Massachusetts and raises the cost of health care for all.

In response, the Medical Society has proposed a number of ways to address the issue of medical professional liability in the Commonwealth, with the goal of promoting "solutions that benefit all stakeholders, patients and providers alike."

Toward that goal, the Society testified in support of the following proposed legislation:

- *House Bill 1370 and Senate Bill 987, "An Act Relative to Health Professionals Statements of Regret," identical legislation that would make health professionals*

statements of regret, apology, or concern regarding an unanticipated outcome inadmissible as evidence in any subsequent legal proceeding. The Society said such legislation is "aimed at expediting the often lengthy process of resolving malpractice claims by fostering better communications between the parties - communication that could obviate the need for costly litigations in some cases."

- *House Bill 1445 and Senate Bill 988, "An Act Relative to Expert Witnesses in Actions for Medical Malpractice," identical legislation that would help assure that physicians claiming to be expert witnesses are indeed experts in the area of medicine in which they are testifying. "This legislation," said the Society, "would require that a witness in a medical malpractice trial be board-certified in the same specialty as the doctor on trial. As medicine becomes more complicated and specialized, it is important that the expert physician have at least the same area of expertise as the physician named in the litigation. This will improve the fairness of the legal system and ultimately help to reduce costs."*
- *House Bill 1447, "An Act Relative to Timely Notice," would require the provision of a "notice of intent to file a claim" 182 days prior to beginning a malpractice action against a provider. The objective of this legislation is to provide a window of time during which the parties have an opportunity to thoroughly review the case and if a patient has been avoidably injured, offer a fair settlement prior to beginning legal action.*

Last October, the Medical Society testified before the Joint Committee on Financial Services, urging strong support of House Bill 985, An Act Relative to Patient Care Access," legislation that would provide medical liability reforms that have proven successful in other states. The Society said that such reforms would help to eliminate billions of dollars in the cost of defensive medicine, improve the practice environment for physicians in the state, and ultimately enhance patient access to medical care. Among the provisions of that legislation are:

- *Replacing the current system of "joint and several" liability with the requirement that a defendant be liable only for the amount of damages for which they were responsible.*
- *Indexing the prejudgment interest rate to Treasury Bill rates, replacing the current rate that is four percent higher.*
- *Requiring that an expert witness in an action against a physician be, at a minimum, board certified in the same specialty as the defendant physician.*
- *Allowing the payment of future damages in periodic payments in awards of \$50,000 or more rather than in a lump sum.*
- *Consideration of collateral sources in awards, such as health or disability insurance.*
- *Requiring insurers and risk management organizations that provide coverage to report to the Betsey Lehman Center for Patient Safety and Medical Error Prevention at the DPH the top categories of losses, claims or actions, so that this information could be used to develop evidence-based best practices to reduce medical errors and enhance patient safety.*

While we recognize that the legislative action is separate from the mandate before the Division, we do think attention should not be diverted from some of the benefits that legislation can have in mitigating premium increases. Given the political sensitivity of both the cost of and access to care, the information we have provided should provide strong impetus for providing fundamental liability reform.

The current environment must be improved as a cost and access question and as a key element of increasing patient safety and improving outcomes. Overall, the current liability system is profoundly dysfunctional for the patient and provider and undermines the integrity of our health care system. As Michelle Mello of the Harvard School of Public Health has stated: "For compensation, deterrence, corrective justice, efficiency and collateral effects, the system gets low or failing grades."

There are multiple means to achieve such a transformation. The most comprehensive approach advocates investing in a baseline culture of safety at every healthcare enterprise fostering open communication and analysis of every miss or near miss with loop closure to prevent reoccurrence, followed by best practice dissemination to improve patient safety universally. Further when an adverse event occurs, this approach includes a full disclosure to the patient and, there is an appropriate, sincere apology for avoidable injuries followed by an offer to provide fair and timely economic compensation for our errors. Disputes regarding offered compensation may be resolved through mediation or arbitration. Litigation through the court system with its tremendous time and overhead inefficiencies and adversarial nature is available as a last resort.

This comprehensive approach could fundamentally transform the system from a "culture of secrecy" to a system of open disclosure and full transparency, one that embraces patients' safety and discourages defensive medicine,, from a culture of "blame and deny" to one of apology and healing, from a culture which isolates patients and providers involved in incidents to a system of supportive assistance, from a process which thwarts patient safety to one which embraces it and from a system that encourages defensive medicine to one of evidence-based medicine. It is a system that compensates a greater number of patients much more quickly and equitably while dramatically reducing the costly overhead of litigation. This comprehensive approach is consistent with recommendations in the Joint Commission's Report "Healthcare at the Crossroads" and the Sorry Works! Coalition. This reform will increase access, decrease professional liability premiums, decrease the cost of defensive medicine and increase patient safety.

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Physician Workforce Study

Executive Summary - 2008

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The Massachusetts Medical Society 2008 Physician Workforce Study

Executive Summary

I. Introduction

The Massachusetts Medical Society has studied physician labor markets in Massachusetts over a seven-year period (2002-2008). The results provide a comprehensive picture of the current and past conditions in physician labor markets in Massachusetts.

The Massachusetts Medical Society's (MMS) seventh workforce study has identified 12 physician specialties that meet the classification for critical or severe conditions* in the labor market.

The MMS has evaluated the status of the current physician workforce through both primary and secondary research. This research included a survey of practicing physicians, presidents of medical staffs¹, department chiefs in teaching hospitals, medical groups, residency and fellowship program directors, and public opinion polls.

II. Physician Shortages

In all seven MMS surveys, neurosurgery has been classified as facing critical or severe labor market conditions. In three of the seven years, the labor market for this specialty was categorized as being in a most critical condition. Without question, this specialty continues to operate with the most stressed labor markets among those surveyed.

Five additional specialties have typically operated in very stressed labor markets: anesthesiology, cardiology, gastroenterology, general surgery, and orthopedics. Of these, anesthesiology has experienced either critical or severe labor market conditions in six of the past seven MMS surveys. Among the remaining four, labor market conditions were classified as either critical or severe in five of the seven survey years.

Two specialties, internal medicine and family medicine, face critically stressed labor markets. Over the first four survey years, labor market conditions for these specialties

* Specialties categorized as "severe" are experiencing a *very high* degree of stress where demand for labor exceeds supply while "critical" specialties are experiencing the *highest* possible degree of stress as established by our criteria.

¹ The primary purpose of surveying Medical Staff Presidents is to determine how they are meeting the unique needs of their community populations. In our survey we received 25 responses from medical staff presidents, of these 23 (92%) were operating in small- or medium-sized community hospital settings. Thus in interpreting analyses with these data, this point should be kept in mind.

were soft, but during the past three years they have turned dramatically. Both are classified as critical in 2008.

One must conclude that patient demands on these specialties have outstripped supply. Furthermore, with the continued implementation of Chapter 58, a landmark healthcare reform law establishing mandatory health insurance enrollment for all Massachusetts residents, it seems very clear that these labor markets will face even greater stress. Addressing these deteriorating physician labor markets is a policy area in which the MMS can play a key role in working collaboratively with medical schools, hospitals, employers, payers, and the state and federal government.

Table 1
Physician Specialties Classified as Facing Critical or Severe Shortages
2002-2008 Survey Years

Specialty	2008	2007	2006	2005	2004	2003	2002
Anesthesiology	--	Severe	Severe	Critical	Severe	Critical	Critical
Cardiology	--	Critical	--	Severe	Severe	Critical	Severe
Dermatology*	Severe	*	*	*	*	*	*
Emergency Medicine	Severe	--	Severe	--	--	--	Severe
Family Medicine	Critical	Severe	Severe	--	--	--	--
Gastroenterology	--	Severe	Severe	Severe	--	Critical	Severe
General Surgery	Severe	--	Severe	Severe	Severe	Severe	--
Internal Medicine	Critical	Critical	Critical	--	--	--	--
Neurology*	Severe	*	*	*	*	*	*
Neurosurgery	Severe	Critical	Severe	Severe	Critical	Critical	Severe
OB/GYN	--	--	--	--	--	--	--
Oncology*	Severe	*	*	*	*	*	*
Orthopedics	Severe	--	Severe	Severe	Severe	Severe	--
Pediatrics	--	--	--	--	--	--	--
Psychiatry	Severe	Severe	Severe	--	--	--	--
Radiology	--	--	Critical	--	Severe	Critical	Critical
Urology**	Severe	Severe	**	**	**	**	**
Vascular Surgery	Severe	Critical	Severe	--	--	Severe	--

* 2008 data only

** 2007, 2008 data only

Of the 12 specialties operating in critical or severe labor markets, four that have only recently been added to the MMS survey, dermatology, neurology, oncology and urology, satisfied the previously established criteria for tightness in their existing labor markets. Dermatology, neurology, and oncology were added to the survey this year and urology was added to the survey last year. In each of the past two survey years, urology has been operating within severe labor market conditions.

The labor market conditions for two specialties—obstetrics/gynecology (OB/GYN) and pediatrics—have behaved quite differently from all other specialties surveyed. In none

of the survey years were their labor market conditions sufficiently stressed to be categorized as critical or severe.

Table 2
Physician Specialties Categorized as Critical or Severe in 2008

Specialty	2008
Dermatology	Severe
Emergency Medicine	Severe
Family Medicine	Critical
General Surgery	Severe
Internal Medicine	Critical
Neurology	Severe
Neurosurgery	Severe
Oncology	Severe
Orthopedics	Severe
Psychiatry	Severe
Urology	Severe
Vascular Surgery	Severe

III. Additional Findings

Snapshot of 2008 Findings – Across MMS Physician Workforce Study Surveys and Opinion Polls

Practicing Physicians Survey Responses

- In 2008 more than half (55%) of practicing physicians reported that, over the past three years, the amount of time needed to recruit physicians has increased. Forty percent reported that retaining existing physician staff had become more difficult.
- The percentage of family medicine physicians who are no longer accepting new patients has steadily increased over the past three years from 25% in 2006 to 35% in 2008. Internal medicine physicians' closed new patient panels increased over the past three years as well from 31% in 2006 to 48% in 2008. These results were similar to the results from a separate poll conducted with physician offices where 42% of internists and 35% of family medicine physicians were not accepting new patients in 2008.
- Recruitment times averaged more than one year for the following specialties: internal medicine (13 months), family medicine (14.5 months), cardiology (17 months), orthopedics (17 months), general surgery (19 months), urology (21 months), neurosurgery (22 months), vascular surgery (22 months),

gastroenterology (23 months), neurology (24 months), and dermatology (26 months).

- Thirty percent (30%) of practicing physicians responded that physician supply problems have made it necessary to alter the services they provide.
- The ability of a physician to refer patients to specialists continues to be a problem with over 70% of physicians reporting difficulty.
- Roughly one-half (44%) of the physicians surveyed responded that their practice is being altered or limited because of the fear of being sued. More than half of the physicians in the following specialties said they had altered or limited their practice because of the fear of being sued: neurosurgery (76%), urology (75%), emergency medicine (66%), OB/GYN (57%), family medicine (53%), general surgery (51%), and orthopedics (51%).
- For the period 2004-2008, approximately one out of four physicians reported that professional liability fees represented over 15% of the total practice operating costs. The top five specialties reporting professional liability costs exceeding 15% of total operating costs in 2008 were: OB/GYNs (85%), neurosurgeons (60%), emergency medicine (40%), general surgeons (40%), and orthopedic surgeons (35%).
- While more than eight out of ten (83%) physicians surveyed reported that they find their medical careers either very rewarding or rewarding, forty-seven percent (47%) of physicians responded that they are very dissatisfied or dissatisfied with the current practice environment. If given the choice, only 51% of physicians would choose to practice medicine again as their profession.
- One-half (50%) of the physicians reported being very dissatisfied or dissatisfied with the number of hours they are able to spend on patient care versus administrative tasks.
- Compared to their colleagues in other states, 62% of the physician respondents rate their current income level as very uncompetitive or uncompetitive. Eighty-five percent (85%) believe that over the next five years, their salary levels will either decline or remain the same.
- Eighty-four percent (84%) of physicians are maintaining or increasing their work hours, and almost half (44%) are very dissatisfied or dissatisfied with the number of hours they work versus their ability to pursue home life.
- Forty-two percent (42%) of physicians are considering changing their profession due to the current practice environment. One in three (33%) family

medicine physicians were planning a career change, an increase over the one in four (25%) who were planning a career change in 2007. The percentage of internal medicine physicians contemplating a career change has also increased from 26% in 2007 to 29% in 2008. Percentages for these two primary care specialties were at or above the sample mean in both 2007 and 2008.

- In addition to primary care, many specialties reported percentages that were higher than the sample mean (29%) for physicians contemplating a career change in 2008. These include: emergency medicine (53%), orthopedics (48%), urology (42%), radiology (40%), neurosurgery (38%), general surgery (37%), oncology (36%), OB/GYN (32%), and dermatology (31%).
- About one-fifth (18%) of physician respondents are planning or considering a move out of Massachusetts if the practice environment does not change.

Community and Teaching Hospital Survey Responses²

- Sixty-nine percent (69%) of teaching hospitals and 96% of community hospitals are currently experiencing difficulty filling physician vacancies.
- Fifty-two percent (52%) of community hospitals reported that physician supply problems necessitated altering the provision of services, and 70% report adjusting professional staffing due to physician supply problems.
- Thirty-three percent (33%) of teaching hospitals reported physician supply problems necessitated altering the provision of services, and 49% report adjusting professional staffing patterns.
- Massachusetts employs a large number of international medical graduates (IMGs), and is highly dependent on IMGs to fill its physician labor market needs. The questionnaire used in conducting the 2008 survey of department chiefs in teaching hospitals collected information on the number of new hires by physician specialty over a six-month period (March – August 2007) and the sources of those new hires. Of these new hires, slightly more than 23% were IMGs. Reliance on these IMGs to meet the staffing needs of teaching hospitals has been rising somewhat over the past two years.
- Fifteen of the 18 physician specialties in teaching hospitals had job vacancy rates higher than the 2.9% statewide average for all job industries in 2007. These include: dermatology, vascular surgery, radiology, neurology, family

² The primary purpose of surveying Medical Staff Presidents is to determine how they are meeting the unique needs of their community populations. In our survey we received 25 responses from medical staff presidents, of these 23 (92%) were operating in small- or medium-sized community hospital settings. Thus in interpreting the analysis with these data, this point should be kept in mind.

medicine, gastroenterology, pediatrics, emergency medicine, internal medicine, OB/GYN, urology, oncology, neurosurgery, anesthesiology, and general surgery. The 7.3% overall job vacancy rate for the 18 physician specialties included in this year's survey is 2.5 times the statewide average for all jobs and would rank among the very highest in the state for major occupational groups .

- More than half of medical staff presidents at community hospitals reported that there were shortages in internal medicine (56%). Specialties where close to half of medical staff presidents reported shortages included general surgery (48%), family medicine (44%), and psychiatry (44%).

Medical Directors of Medical Groups Survey

- About 60% of medical directors of medical groups reported the need to alter services due to physician supply problems, an increase over the 33% reported in 2006.
- Over one-half (53%) of medical directors reported that physician supply problems have made it necessary to adjust staffing patterns.
- Three-quarters of the medical directors (77%) responded that over the past three years their ability to retain their existing staff of physicians has become more difficult.

Residency/Fellowship Program Directors Survey

- Slightly more than one-half (52%) of residents pursued the next step in their medical careers outside Massachusetts.
- Residency and fellowship program directors rate salary level (6%) and the on-call work schedule (11%) as the least likely reason residents plan to begin their career in Massachusetts. Intellectual (85%) and research (85%) opportunities top the list of professional reasons residents plan to stay in the Commonwealth.

Physician Office Telephone Survey

- *Family Medicine/General Practitioner(GP)*
Among those who are accepting new patients, the average wait time for an appointment is 36 days, similar to last year's figure of 34 days.

- *Internal Medicine*
Among the offices accepting new patients, the average wait time for an appointment is 50 days, which is similar to last year's figure of 52 days.
- *Cardiology*
Among offices that are taking on new patients, the average wait time is 30 days, which is similar to recent figures (29 last year and 28 percent in 2006), and is still below 34 days in 2005.
- *Gastroenterology*
Among offices that are accepting new patients, the average wait time for an appointment is 39 days. Though this is up from 36 days last year, it is close to the figures of 2006 and 2005 (41 and 42 days, respectively).
- *Obstetrics/Gynecology*
Among those who are accepting new patients, the average wait time for an appointment is 44 days, which is similar to 46 days last year and up from 34 and 35 days in 2006 and 2005, respectively.
- *Orthopedic Surgery*
Among those who are accepting new patients, the average wait time for an appointment is 21 days, which has remained fairly consistent except for a small dip in 2006 (18 days).

Public Opinion Telephone Survey

- The impact of Massachusetts health care reform legislation is evident from the decrease in the number of Massachusetts residents who report being uninsured since the law was passed. Just 2% of residents report having no insurance in the 2008 study, down from 6% in 2007.
- Other survey findings, however, suggest that the impact of health care reform has not been universally positive on Bay State residents. Specifically, more residents report having difficulty obtaining the care they need (24%, up from 16% last year). The most common explanations for difficulty obtaining care are cost, long waits for appointments, and difficulty finding the right doctor or health plan.
- Cost is still the biggest health issue facing Massachusetts according to residents interviewed. Almost one-half (46%) of state residents identify cost of health care or insurance as the single most important health issue facing Massachusetts.

- For the most part, residents (88%) are satisfied with the health care they received over the past year. As has been the case in the past, residents with higher incomes and more education say they are satisfied more often than those with lower incomes and less education.
- There is strong resistance to tying insurance copayments to insurers' internal quality and cost rating---76% of residents oppose this proposal. Similar opposition was recorded last year.
- Only one-third of residents are aware that the state and insurers have started posting quality and cost information of physicians and medical groups on the Internet. Notably, two-thirds of residents indicated they will access the information next time they need to choose a physician.
- Seventy percent of residents say they are satisfied with the amount of information available regarding the quality of care provided by specific doctors and medical groups.
- As has been the case in past studies, less than one-fifth (14%) of residents favor requiring patients to pay a larger portion of their medical costs via larger co-pays and deductibles. Three-quarters are opposed to increasing co-pays and deductibles; 56% are *strongly* opposed, while 19% say they are *somewhat* opposed.

IV. Evaluating Physician Recruitment

There is considerable evidence to support the view of a seriously inadequate labor pool from which to recruit. Among established physicians, the factors include noncompetitive salaries, early retirement, dissatisfaction with the work environment, and high professional liability fees. Among physicians just beginning their medical careers, one half of the residents and fellows trained in Massachusetts medical schools prefer to pursue their careers elsewhere³.

³ See analysis in section 4 of the full version of this report, *Survey Results Regarding the Opinions of Programs Directors of Residency/Fellowship Programs*.

Chart 1: Percent Reporting that the Current Pool of Applicants is Inadequate to Fill Vacant Positions

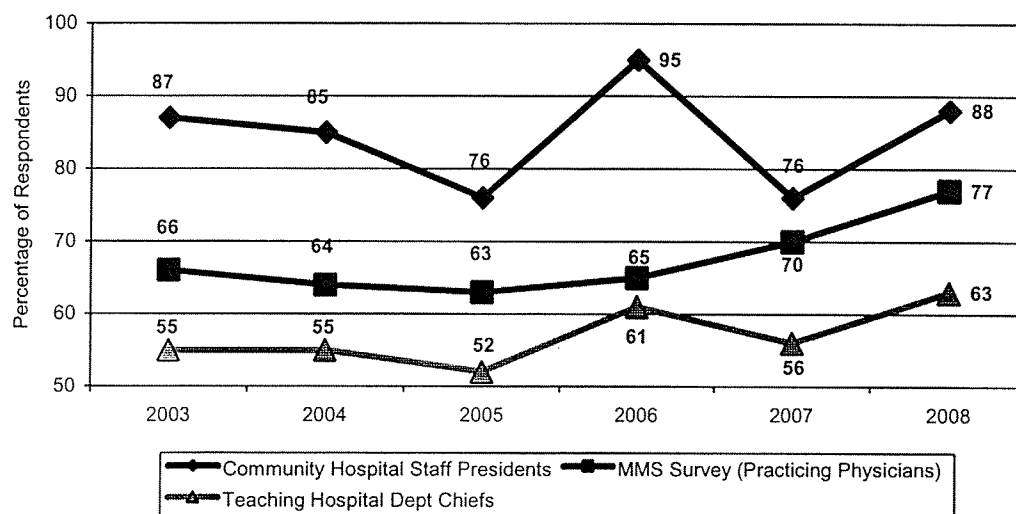
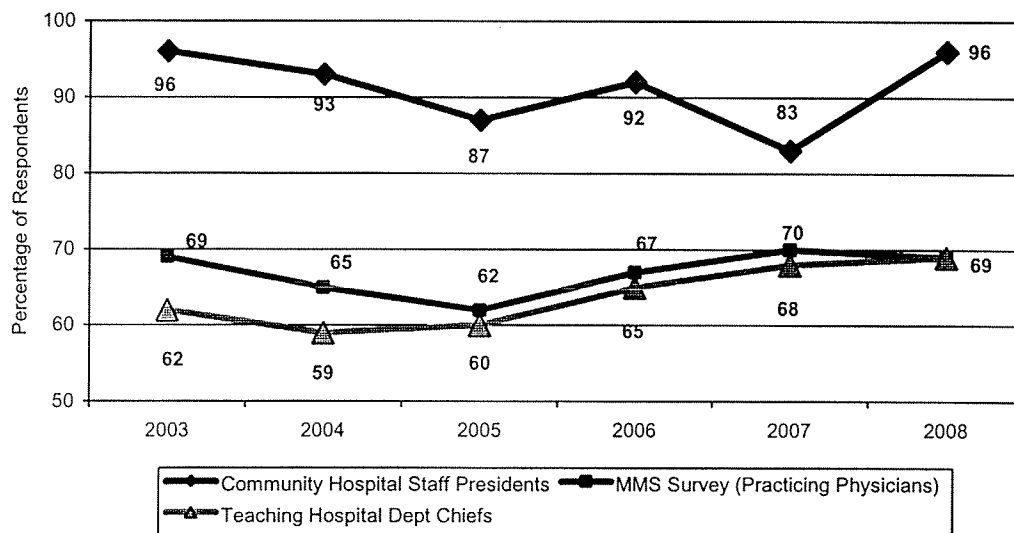


Chart 2: Percent Responding That They are Experiencing Difficulties Filling Physician Vacancies

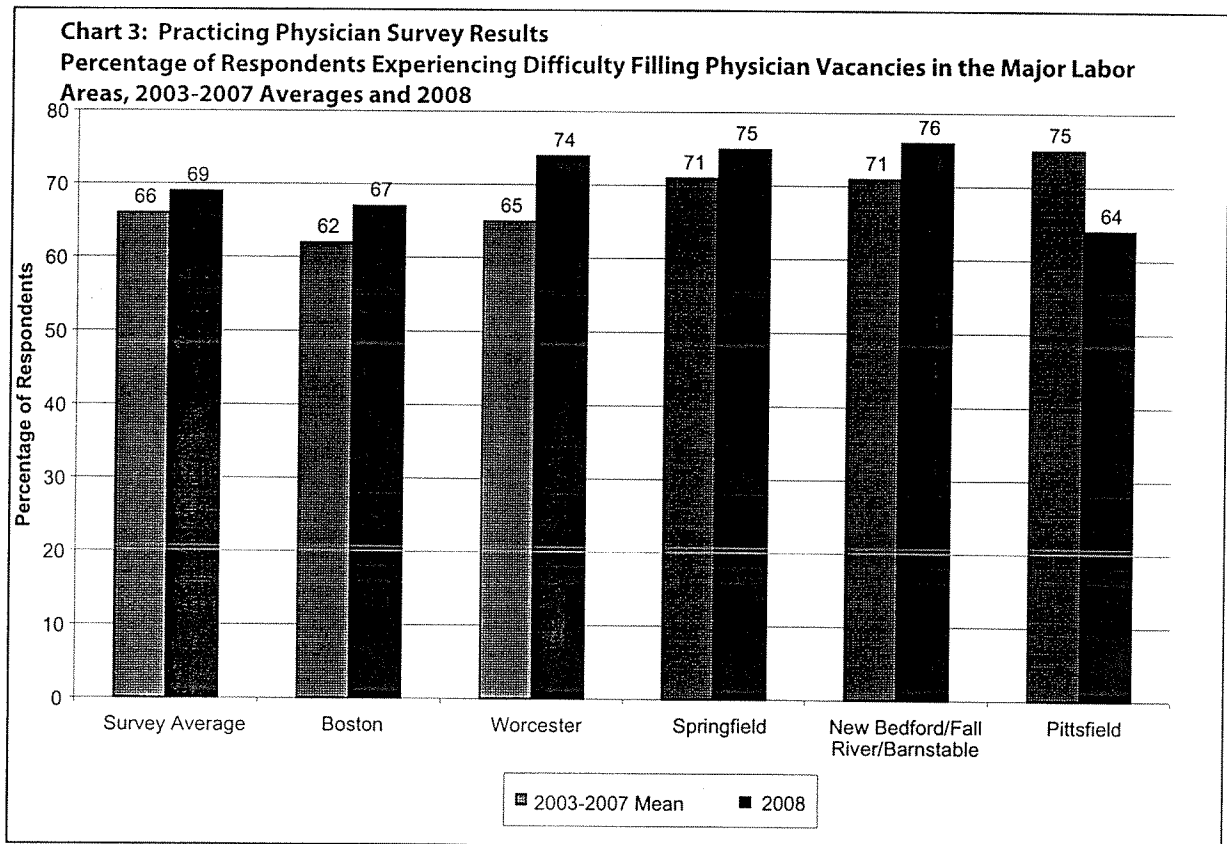


Community hospitals report that they are facing especially severe problems in terms of the inadequacy of the current pool of physicians and the degree of difficulty in recruiting physicians. Given the constant financial pressures, therefore, community hospitals find themselves confronted by competitive disadvantages.

V. Regional Disparities across the Principal Urban Labor Markets in Massachusetts

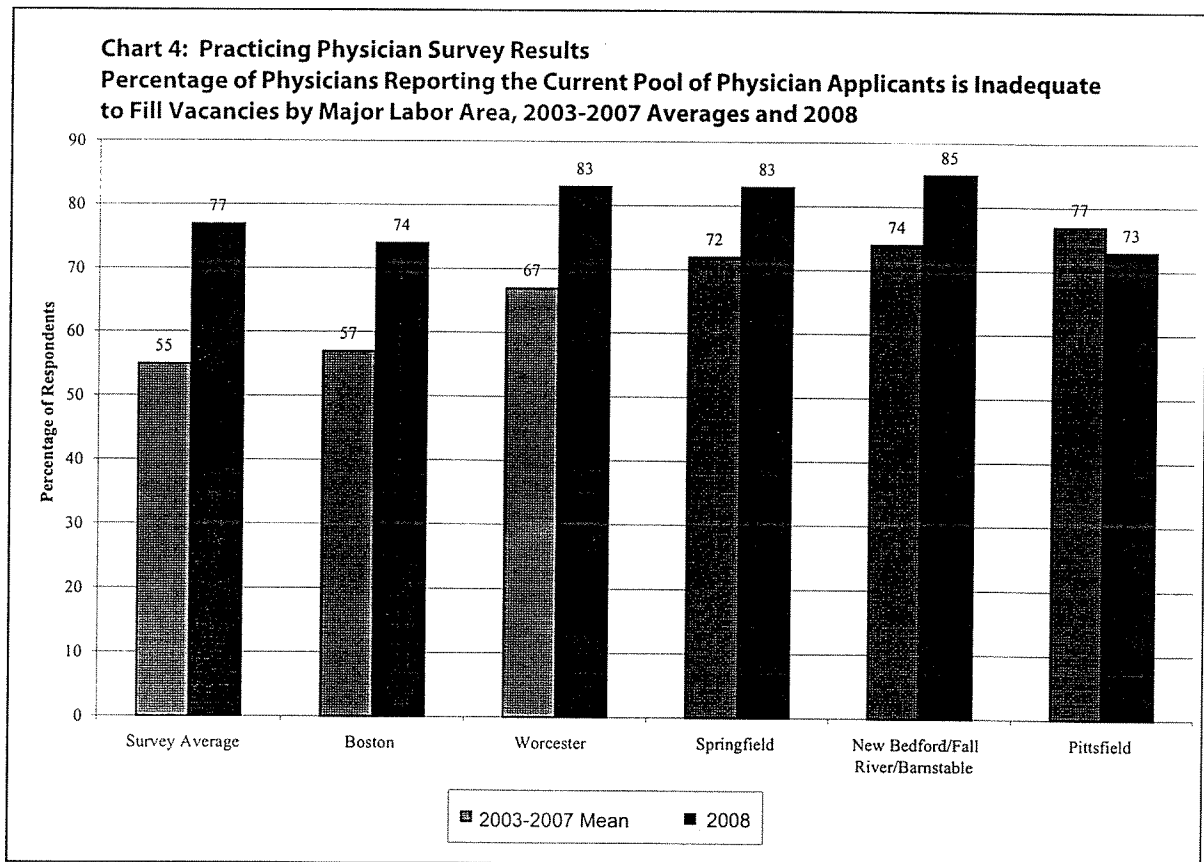
The geographic distribution of medical care facilities and health care professionals and the state of local physician labor markets clearly impact the provision of medical care. In analyzing the findings of the practicing physician surveys, we disaggregated the survey data into the following five labor market areas based on the locations of the facilities and physicians:

- Boston metropolitan area
- New Bedford/Fall River/Barnstable County (Cape Cod)
- Pittsfield (Berkshire County)
- Springfield urban area
- Worcester urban area



In 2008, difficulties in filling physician vacancies were quite severe in five labor areas. The percentage of physicians reporting difficulties in filling physician vacancies ranged from a low of 64% in Pittsfield to highs of 74 to 76% in Worcester, Springfield, and New Bedford/Fall River. The fraction of physicians reporting difficulties in filling vacancies in 2008 was above the 2003-2007 average in four of the five labor areas.

In a closely related question, the surveyed physicians were asked to indicate whether the current pool of applicants was adequate to fill existing vacancies. The percent of physicians reporting that the pool is inadequate are displayed in the following chart for each of the five local labor areas.



These survey results should be considered in relation to those shown in the preceding table. A substantial majority of the responding physicians in 2008 in each of the five urban areas reported that the current pool of applicants was inadequate to fill the existing number of vacancies. The percentage share of responding physicians reporting such an inadequate pool ranged from 73% in Pittsfield to a high of 85% in the New Bedford/Fall River/Barnstable area. In each area, except Pittsfield, the share of physicians with an inadequate pool has been rising.

Conclusions and Policy Considerations

The Massachusetts Medical Society's seventh annual Physician Workforce Study again identifies serious concerns in many specialties, including primary care. The following policy recommendations address many of the key findings from the 2008 MMS Physician Workforce Study in an effort to improve the physician practice environment and reduce physician labor market shortages at a time when demand for healthcare services is on the rise in Massachusetts.

Physician Workforce Development and Improvement in Patient Care

Work with stakeholders to create a practice environment that:

- Easily enables physicians to be current with technological support such as EHRs, registries and timely accurate data for improving care
- Streamlines the process for establishing a practice, including assisting those trained out of the US as appropriate,
- Reduces barriers to the recruitment and retention of physicians. This includes reducing medical debt and easing the impact of the high cost of housing.

Physician Practice Satisfaction and Improvement with Patient Care

Work with stakeholders to create a practice environment that:

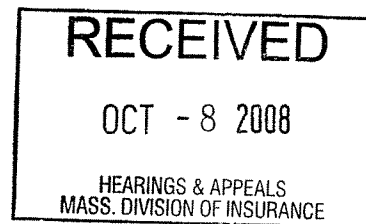
- Significantly reduces administrative burden allowing for more patient care
- Enables better coordination of care across specialties and between inpatient and outpatient settings
- Encourages a healthy balance of work and non-work activities, including implementation of appropriate support for practice viability and improvement to the current professional liability environment

Several researchers have outlined detailed demand-side approaches to the workforce crisis.⁴ These can differ significantly from the supply-side priorities outlined above. While both approaches merit serious consideration, it is important to note again that the implementation of Chapter 58 and the rapid aging of the population render demand-side management extremely difficult at best. For these reasons, an approach using toolsets from both the demand side and the supply side has the highest likelihood of yielding the desired result – a physician workforce that is large enough to effectively and efficiently meet the health care needs of the population. It should be noted that Chapter 58 does try to address some of these issues. Successful implementation is critical.

While there are a number of worrisome findings in this report, we do report several positive findings. Most residents and fellows are believed to be drawn to the research opportunities in Massachusetts healthcare, and there is a favorable pull in terms of

⁴ Goodman DC, Fisher ES. Physician workforce crisis? Wrong diagnosis, wrong prescription. N Engl J Med. 2008 Apr 17;358(16):1658-61. <http://content.nejm.org/cgi/content/full/358/16/1658>

clinical opportunities. Also, the youngest physicians surveyed, (those under age 40) were the least likely to report dissatisfaction with the practice environment. Therefore, policies aimed at younger physicians and building on the unique and positive aspects of practice in Massachusetts are important to consider including outstanding teaching institutions and residency programs with the top researchers and clinicians in the country. It is important to note that despite a negative practice environment, the majority of physicians surveyed for this report still find the career of medicine rewarding. However, concerns with the balance of hours between practice and administrative duties and the tradeoffs between work and income need to be taken seriously since they have a strong independent effect on the probability of physician making a career change and moving out of state.⁵



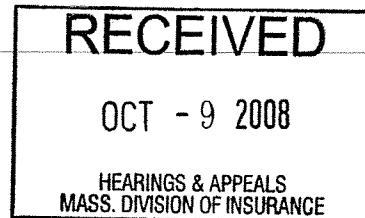
⁵ See analysis in section 5 of the full version of this report, *A Multivariate Statistical Analysis of the Plans of Physicians to Change Careers or Relocate Outside of the State*

Allen, Nancy (DOI)

From: Beagan, Kevin (DOI)
Sent: Thursday, October 09, 2008 9:05 AM
To: drdollj@aol.com
Cc: Allen, Nancy (DOI); Farrington, Jean (DOI); Mancini, Matthew (DOI); Condon, Gerald (DOI)
Subject: RE: Med Mal

Thank you for submitting your thoughts to add to the record. We all know how important an issue this is for health care in Massachusetts. I am adding your e-mail to the docket file associated with the hearing that has been held on medical malpractice. Please feel free to submit any other thoughts you may have to my attention as the Division of Insurance develops its report on medical malpractice.

Kevin Beagan
Director, State Rating Bureau
(617) 521-7323



From: drdollj@aol.com [mailto:drdollj@aol.com]
Sent: Wednesday, October 08, 2008 9:58 PM
To: Beagan, Kevin (DOI)
Subject: Med Mal

Dear Mr Beagan;

I am an OB/GYN on the South Shore of Massachusetts. I am writing to discuss the state of medicine and malpractice in the state of Massachusetts. I have been in practice for almost 19 years. This is the first job I had after Yale Medical school and residency in Philadelphia. I was recruited to South Shore Hospital. Despite the fact that I grew up in Ct I wanted to come here. Medicine has changed enormously over the past 18 years. It has gone from a delightful, rewarding, exciting way to make a living to constant worries about insurance companies, malpractice insurance, patient dissatisfaction. Besides the insurance companies and the lawyers I have patients telling me how to practice medicine. I had a patient on the way into the OR for an emergency cesarean section ask me what kind of closure i was gong to do on her Uterus--one or two layers!?!?!?!?! I asked her what she thought i should do and she said "two". She didn't ask me if I thought the baby would live or die!!!!!! I am seriously considering stopping OB in the next few years. I don't believe that the ACOG is a good enough advocate for me as far as malpractice concerns go. It is a difficult task to convince law makers (ie lawyers) who consider us a paycheck to change malpractice laws. It is hard for anyone to feel compassionate toward doctors that make more than an average salary. However we handle people's lives in our hands everyday and everyday our hands are tied tighter and tighter behind our backs!!!

One solution that i have thought about for the malpractice problem is a fund for damaged children that are not malpractice. WE in medicine know that all babies are not born perfect and that most times it has nothing to do with the doctor. However someone must take care of that child!!! If there were a fund that is contributed to by the insurance companies and the practitioners then there would be money for these unfortunate children without it being someone's "fault". I for one would contribute gladly to something like this. I also think that malpractice trials should be attended by doctors not plumbers or secretaries, etc. I know that doctors do not have the best track record of policing ourselves but we could with the help of lawyers (that hurt) devise a court system that is fair --to the doctor and to the injured family.

I have tried on several occasions to speak with someone in the Deval Patrick office but I have been blown off everytime. I realize that no one but us cares about the state of medicine and malpractice but soon there will be no doctors to worry about. At South Shore Hospital there will probably be 10-12 doctors leaving OB in the next 10 years. Eight doctors have already left for many reasons including dissatisfaction with medicine. Well, I can't leave right now because I am a single parent with 2 adopted children. I want them to be proud of me and

the work i do. However if I am constantly unhappy or afraid that something bad will happen everyday--what will they think about my job then????????????????

Please consider a some new ways of dealing with this problem. When the atty general came to speak at South Shore Hospital I told him I would volunteer to be on a task force to try to fix the problem. I got a typical "thanks for being a good citizen" follow up phone call and never heard from them again. I think that there are people out there that could be helpful in some way. as I stated earlier pretty soon there won't be any OB/GYNs to worry about. I hope that the insurance executives and lawyers are taking courses on how to deliver a baby safely!!!!

For whatever it is worth ...Darlyne Johnson MD

Doll

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Allen, Nancy (DOI)

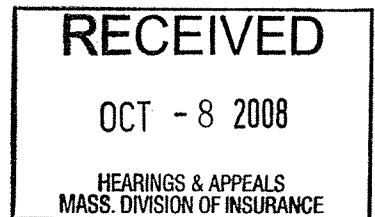
From: Beagan, Kevin (DOI)
Sent: Wednesday, October 08, 2008 3:10 PM
To: Maureen_Donovan@sshosp.org; Veronica_Ravnikar_MD@sshosp.org
Cc: Allen, Nancy (DOI); Farrington, Jean (DOI)
Subject: FW: Response: Hearing in Worcester / Malpractice Insurance

Importance: High

I am adding your e-mail to the docket file associated with the hearing that has been held on medical malpractice. Thank you for submitting your thoughts to add to our files.

Kevin Beagan
(617) 521-7323

From: Maureen_Donovan@sshosp.org [mailto:Maureen_Donovan@sshosp.org] **On Behalf Of** Veronica_Ravnikar_MD@sshosp.org
Sent: Wednesday, October 08, 2008 2:54 PM
To: Beagan, Kevin (DOI)
Subject: Response: Hearing in Worcester / Malpractice Insurance
Importance: High



To: Kevin Patrick Beagan

As a provider of OB/GYN healthcare and as a chair of a regional Level III OB Unit on the South Shore, I definitely support reform in malpractice premiums for obstetricians in the state.

Many OB/GYN's are giving up OB practice entirely even though many would still gladly see OB patients in the office. If these physicians were to be given a break on their premiums, they would provide access to OB care in their respective communities. Other individuals in their group would do the delivery or a hospital based laborist. Furthermore, the accessibility of obstetricians in various practices would be much more stable. Patients are forced at times to change practices in the middle of their pregnancies when OB providers have to give up the OB insurance due to excess cost. Access to OB care is dwindling and getting worse. South Shore Hospital is a regional provider of OB/GYN healthcare in southeastern Massachusetts. It has the capacity of providing full OB care to the South Shore (including high-risk OB). The issues noted above definitely limit growth and contribute to the difficulty to staff and recruit OB physicians.

It would help if OB malpractice insurance were discounted when an individual only practices OB in the office since the hospital would then provide the coverage for the delivery. Finally, there is also the factor of individuals desiring to work entirely as OB/GYN but on a part-time basis. Practices have difficulty supporting such individuals if their premiums are not prorated.

In summary, there has to be modification for obstetrics malpractice insurance for the hospital based laborist, for the OB/GYN who does only office OB and for the provider who wishes to work part-time.

Sincerely,

Veronica

Veronica A. Ravnikar, M.D.
Chairperson of Department OB/GYN and
Associate Clinical Professor Harvard Medical School
South Shore Hospital
55 Fogg Road
S. Weymouth, MA 02190-2455

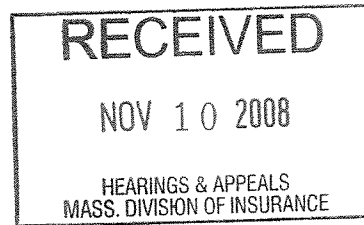
Administrative office:
781-340-4203 Maureen
781-340-3597 Fax
781-340-8123 Pager #7963

Patient office:
781-682-5201 Paulette
781-340-3782 Fax

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Nurses United for Responsible Services
P.O. Box 920711
Needham, Massachusetts 02492
617 332-0422

November 7, 2008



Honorable Nonnie Burnes, Commissioner
Division of Insurance
One South Station
Boston, MA 02110-2208

Dear Commissioner Burnes:

Nurses United for Responsible Services (NURS) is an organization that represents Advanced Practice Psychiatric Nurses (Psychiatric and Mental Health Clinical Nurse Specialists and Psychiatric Nurse Practitioners) in Massachusetts. Since 1975, NURS has been instrumental in the passage of five pieces of legislation involving third party reimbursement for psychotherapy; hospital medical staff privileges; authorization to sign involuntary commitment evaluations; prescriptive authority; and guardianship assessments. By expanding our scope of practice, we have ensured that people in the Commonwealth have greater access to quality behavioral health care. Our expertise in both medication management and psychotherapy enables us to provide a cost-effective and seamless form of treatment to our patients. Pursuant to Chapter 305, §39 of the Acts and Resolves of 2008, please consider this communiqué a response to your investigation and study of the costs of medical malpractice insurance for health care providers, as defined in G.L. c. 175, §193U for which public hearings took place on October 3 and October 8, 2008. In light of this investigation into the medical malpractice insurance issue in Massachusetts, we are weighing in with our perspective on **Docket No. M2008-01** and with another important insurance-related issue that affects our practice as well.

Our annual rates for malpractice insurance have gone up considerably in the last 15 years. Our current rates are almost 13 times more than they were in 1994. The enclosed pie chart, compiled in late 2006, is already out of date as there has been another 10% increase since then. In addition, as our scope of practice has expanded, we have been forced to meet increasingly more costly licensing, supervision and continuing education requirements. And for the average Advanced Practice Psychiatric Nurse in full time private practice, operating expenses can easily be as high as 42% of gross income, taxes another 19% of gross earnings (33% of net earnings), leaving only 39% as retained income.

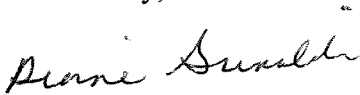
The other side of the insurance issue is that while we provide competent and much needed behavioral health care, the compensation we receive from insurance carriers for the services we provide is unfortunately not commensurate with our professional expertise and liability. Our rates of reimbursement are considerably less than those of other disciplines that provide the same services. While we recognize that nurses do not assume the enormous malpractice insurance cost burden that physicians carry, our increasing costs in this area are emblematic of a much larger problem: it is just one of the many professional expenses that continue to escalate in a context of inadequate third party

reimbursement, making independent practice less and less attractive at a time when many mental health practices have waiting lists and patients cannot get appointments.

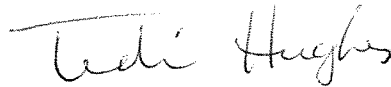
Advanced Practice Psychiatric Nurses are in a position to fill the gap in behavioral health services. However, if there continues to be a discrepancy between our professional expenditures (only one of which is malpractice insurance) and our third party reimbursement rates, it will not be economically feasible for nurses to prepare for or remain in the Advanced Practice Psychiatric Nursing role. This trend would signal a tragic loss of a valuable resource for consumers of behavioral health care in Massachusetts.

Thank you for your consideration of our ideas, which we hope will guide you in your thinking and decision making regarding insurance concerns relevant to the above. We hope you will include NURS in any ongoing working group that is established as a result of your investigation into the medical malpractice issue in Massachusetts.

Sincerely,



Diane Grimaldi,
Co-Chair NURS

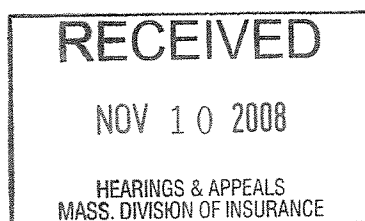


Tedi Hughes,
Co-Chair NURS



Sharon Reynolds,
Chair Legislative, Committee

cc: Nancy Allen, Docket Clerk, Hearings and Appeals, Division of Insurance

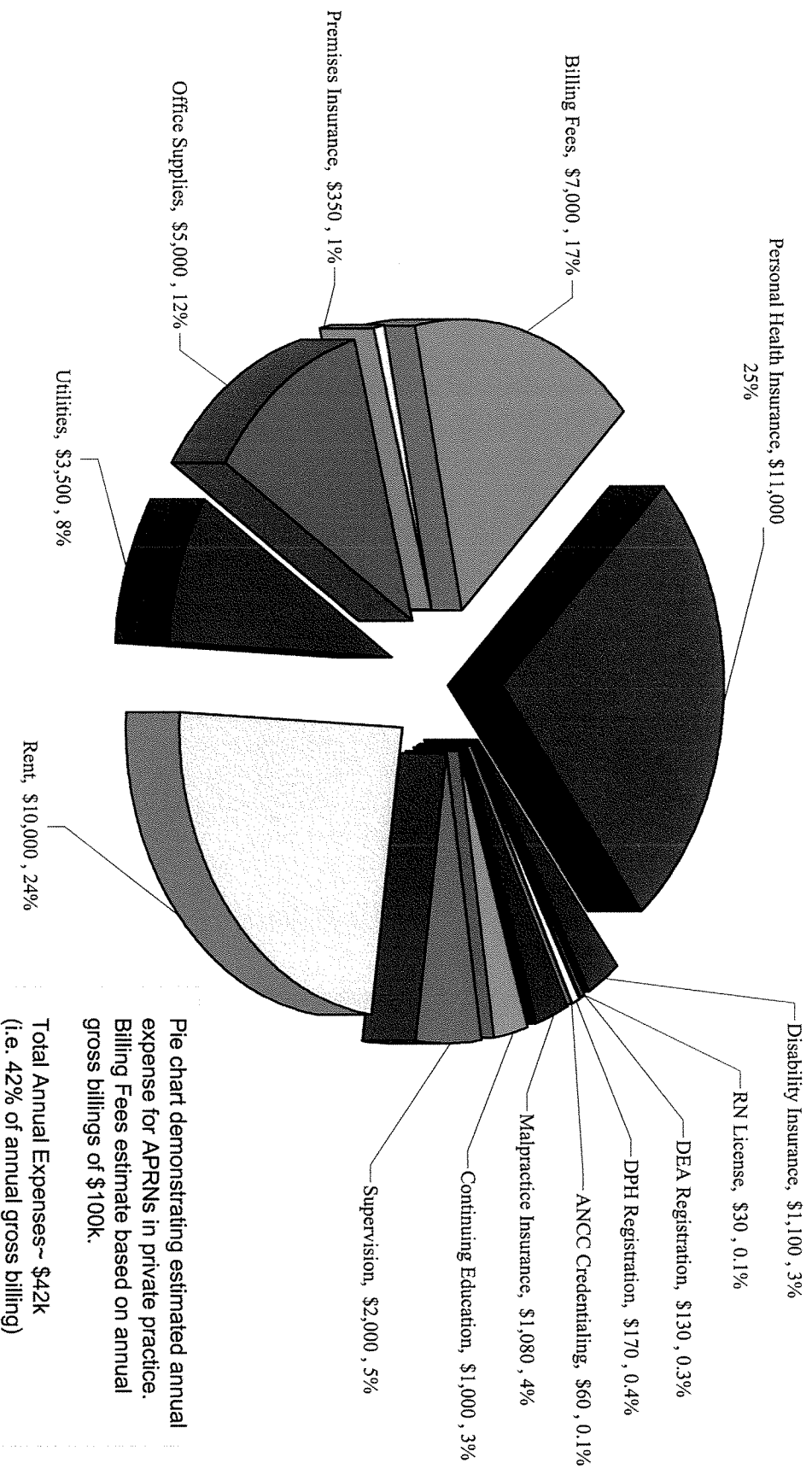


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HEARINGS & APPEALS
MASS. DIVISION OF INSURANCE

Annual Expenses Estimate
APRNs in Private Practice

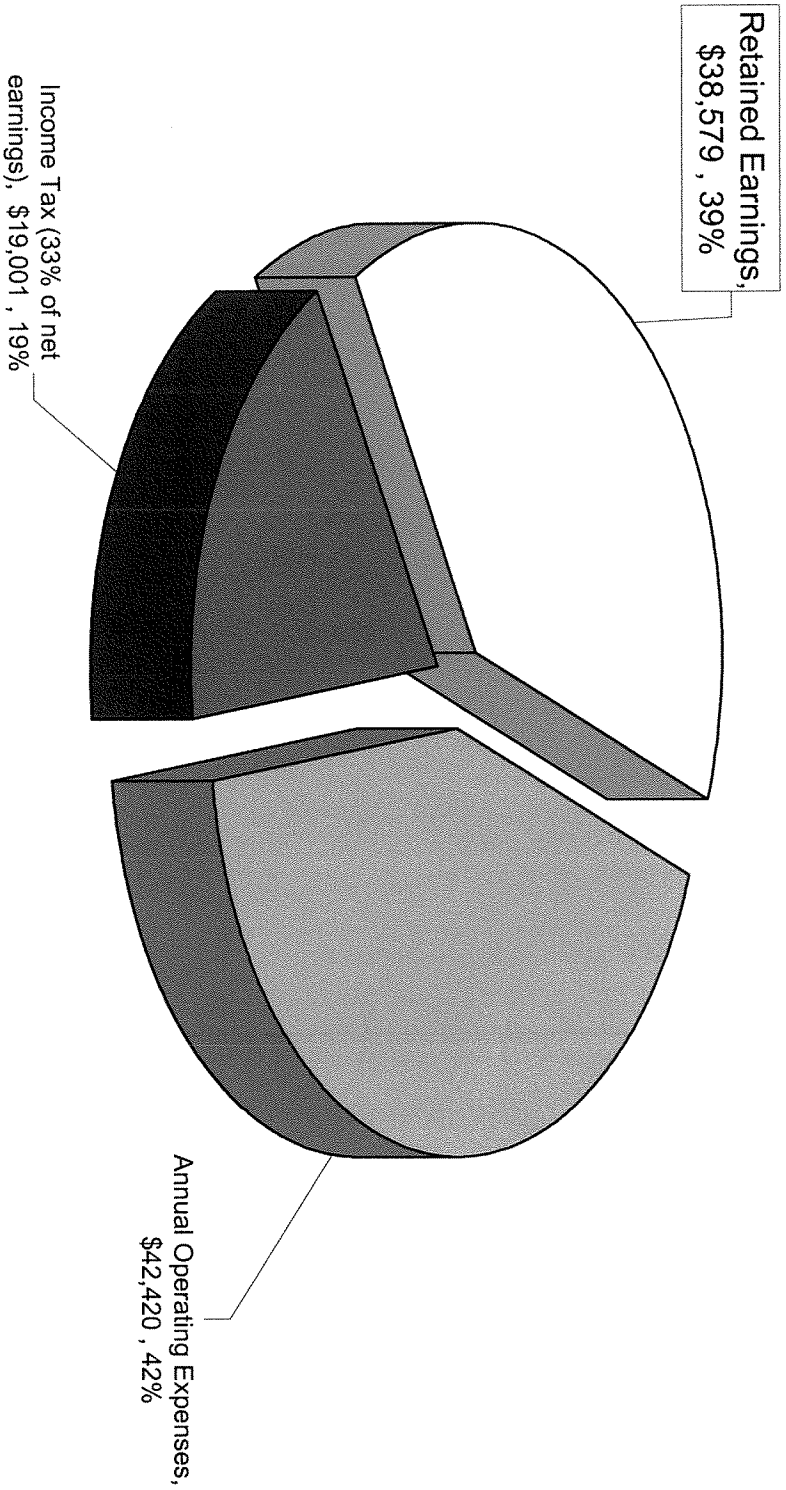


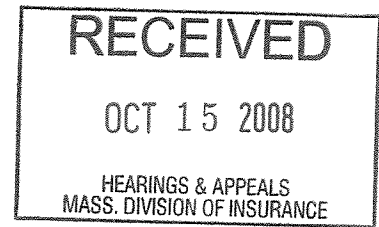
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HEARINGS & APPEALS
MASS. DIVISION OF INSURANCE

**APRNs in Private Practice
Retained Earnings Estimate**
(based on \$100K annual gross income)





October 15, 2008

Nonnie S. Burnes, Commissioner
Massachusetts Division of Insurance
One South Station
Boston, MA, 02110-2208

Re: Investigation and Study of the Costs of Medical Malpractice Insurance for Health Care Providers
Docket No. M2008-01

Dear Commissioner Burnes:

I am writing on behalf of the Massachusetts Association of Health Plans (MAHP), which represents 12 health plans operating in Massachusetts that provide health care coverage to approximately 2.3 million Massachusetts residents, with regard to the Division's Investigation and Study of the Costs of Medical Malpractice Insurance for Health Care Providers – Docket No. M2008-01. In particular, we are writing to express our opposition to any proposals to assess health insurers to fund the recommendations included in the final report.

The primary cause of the medical malpractice crisis is the tremendous increase in large jury awards. According to Jury Verdict Research, nationally the average medical malpractice jury award in 1994 was \$1.19 million. By 1999, the average was \$3.5 million, and by 2003 the average had risen to \$4.7 million. In 2007, the Bureau of Justice Statistics issued a Special Report in which it reviewed 2000-2004 closed claim data available from a number of states. Its analysis of that data showed that 8.5 percent of paid claims in Massachusetts resulted in payouts at or above \$1 million.

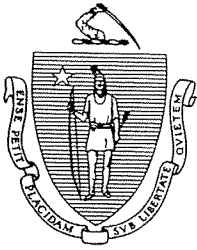
These costs have an impact on health insurance premiums. PricewaterhouseCoopers' 2006 report, *The Factors Fueling Rising Healthcare Costs*, prepared for America's Health Insurance Plans, noted that approximately 10 percent of the costs of medical services are attributed to the cost of litigation and defensive medicine. Medical practice driven by the fear of litigation is too often an unfortunate substitute for evidence-based medicine. The result is billions of dollars of medically unnecessary tests and procedures ordered in an effort to avert potential lawsuits.

Any effort to reform the medical malpractice insurance system by assessing health insurance carriers represents the wrong approach. Such an approach would seek to solve issues in the medical malpractice insurance market by shifting costs onto the health insurance industry. However, it would do nothing to address the underlying factors fueling rising medical malpractice insurance rates, but would increase the cost of health insurance and threaten to undermine the continued success of Health Care Reform. With employers and individuals grappling with rising health care costs and the impact the downturn in the economy will have on them still unknown, now is not the time to be adding to their health care costs.

For all these reasons we urge the Division to reject any proposals to assess health insurers to fund the medical malpractice insurance market and to exclude such recommendations from the final report.

Sincerely,

Marylou Buyse, M.D.
President



COMMONWEALTH OF MASSACHUSETTS

MASSACHUSETTS SENATE

STATE HOUSE, BOSTON 02133-1053

SENATOR RICHARD T. MOORE
WORCESTER AND NORFOLK DISTRICT
ROOM 111

TEL. (617) 722-1420

FAX (617) 722-1944

richard.moore@state.ma.us

www.senatormoore.com

CHAIRMAN:

JOINT COMMITTEE ON HEALTH CARE FINANCING

COMMITTEES ON:

BILLS IN THIRD READING

POST AUDIT AND OVERSIGHT

HIGHER EDUCATION

BONDING, CAPITAL EXPENDITURES & STATE ASSETS

October 1, 2008

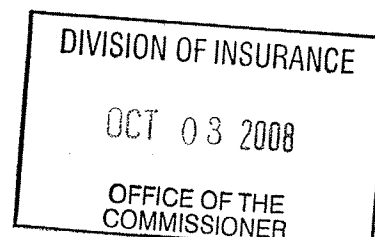
Nonnie Burnes
Commissioner of the Division of Insurance
One South Station, 5th Floor
Boston, MA 02110

Dear Commissioner Burnes,

I am writing to express my concerns with the medical malpractice system that is currently in place within the Commonwealth. We have witnessed medical malpractice insurance costs skyrocket over the past couple of decades, but few efforts have been made to curtail these rising premiums. As a result the state faces the challenge of successfully recruiting and retaining physicians. Equally disturbing is that these rising costs and physicians shortages are only one part of the problem. We also face inequitable compensation for patients who have sustained similar injuries and a system that discourages the disclosure of medical errors thereby putting the patient's safety at risk.

Fortunately, however, there is a reform model that offers a solution to how we can transform the system to address all of these issues. This type of reform model, which has been implemented in both Michigan and Illinois, is commonly referred to as an "early disclosure and compensation" program.

The chief purpose of this model is to remove the barriers that preclude transparency in the medical system, promote equitable and timely compensation to patients who are injured by preventable medical errors, improve patient safety by recognizing adverse events, and reduce the cost of health care. Although it often starts with an apology, it is not simply a program advocating apologies in the aftermath of a medical error. The model is a patient centered reengineering of the way physicians and hospitals deliver health care. The quality of health care we deliver can be improved by opening the lines of



communication with patients, compensating them for avoidable events, and systematically learning from adverse events.

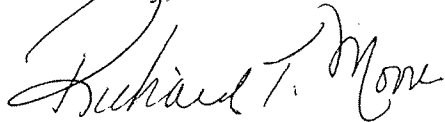
The following is a brief outline of the model's formula:

- 1) The hospital (through a variety of quality assurance mechanisms and self-reporting) identifies all adverse events.
- 2) Each adverse event undergoes intensive and rapid review to determine the root causes and whether any error occurred.
- 3) If an error occurred, the hospital provides an apology to the patient.
- 4) If no error occurred, the hospital still explains the event in full to the patient.
- 5) Whether or not an error occurred, the hospital provides for continuous contact with the patient to address issues of continued care and manage future concerns.
- 6) If an error occurred, the hospital determines if compensation is appropriate, and if so, provides the patient with an offer of compensation. The patient is encouraged to have legal representation.
- 7) All root cause analyses are incorporated back into the hospital to make internal process improvements and prevent future adverse events.

Along with this letter, I have included a report entitled "*Restoring Trust and Value in Our Health Care System: Achieving Real Medical Liability Reform with an Early Disclosure and Compensation Model.*" This was prepared for me by Dr. Peter Smulowitz who researched this model while completing his Master of Public Health degree at Harvard School of Public Health. In his report he offers a very thorough discussion of this model and its proven successes as well as the challenges that it faces. I believe that it will serve as an excellent roadmap as the Division of Insurance prepares its recommendations to the Legislature.

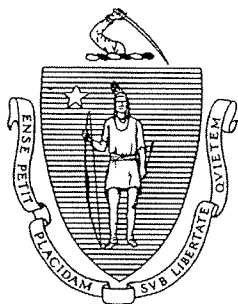
Your careful and thorough consideration of this matter is greatly appreciated.

Sincerely,

A handwritten signature in cursive script that reads "Richard T. Moore". The signature is written in dark ink and is positioned above the printed name.

RICHARD T. MOORE

Senate Chair, Committee on Health Care Financing



RESTORING VALUE AND TRUST IN OUR HEALTH CARE SYSTEM:

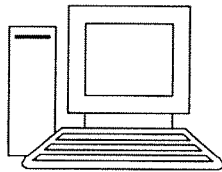
ACHIEVING REAL MEDICAL LIABILITY REFORM WITH AN EARLY DISCLOSURE AND COMPENSATION MODEL

*A Brief for the Joint Committee on Health Care
Financing of the Massachusetts General Court*

By Peter B. Smulowitz, MD, MPH

With an Introduction by
Senator Richard T. Moore
Senate Chair, Committee on Health Care Financing

March 11, 2008



This document is available online at
www.senatormoore.com/health

INTRODUCTION

March 11, 2008

The Insurance Information Institute states:

“Medical malpractice insurance covers doctors and other professionals in the medical field for liability claims arising from their treatment of patients.”

“The cost of medical malpractice insurance began to rise at the beginning of this decade, after a period of essentially flat prices. Rate increases were precipitated in part by the growing size of claims, particularly in urban areas. Among the other factors driving up prices was a reduced supply of available coverage as several major insurers exited the medical malpractice business because of the difficulty of making a profit.”

“New research suggests that premium increases may be moderating but for any turnaround to take root significant reforms in the delivery of medical care that focus on patient safety need to occur, industry observers say.”

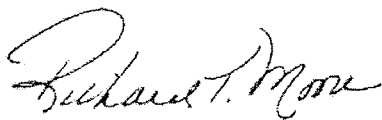
In addition to reforms in the delivery of medical care that focus on patient safety, this report suggests that reforms of the medical malpractice system in Massachusetts must also focus on the injured patient.

The present medical malpractice system in the Commonwealth:

- Fails to adequately compensate most of those who are injured in the medical care delivery system undermining patient trust in the health care system;
- Discourages disclosure and discussion of patient safety that could improve the quality and safety of the health care system and increases the cost of care;
- Continues to have a large impact and influence on the practice of medicine and the state's competitive position to recruit and retain physicians at a time when state policy seeks to expand access to health care.

We are grateful to Dr. Smulowitz for his review of this important area of concern and for his suggestions for improving the professional liability system by placing patients first.

Sincerely,



RICHARD T. MOORE

Senate Chairman

Joint Committee on Health Care Financing

ABOUT THE AUTHOR

Dr. Peter Smulowitz is an emergency physician at Beth Israel Deaconess Medical Center in Boston and St. Luke's Hospital in New Bedford. He recently completed his Master of Public Health Degree at the Harvard School of Public Health. Dr. Smulowitz attended medical school at the University of California, Irvine College of Medicine, and went on to residency in emergency medicine at Beth Israel Deaconess Medical Center, Harvard Affiliated Emergency Medicine Residency.

Dr. Smulowitz has a primary interest in health policy and public health. He is cultivating policy and research interests in areas including emergency department utilization, medical liability, disparities in care amongst minorities and elders in the emergency department, and universal health care. He authored this brief while completing his Master in Public Health, and continues to work with Senator Richard T. Moore on a variety of projects to improve the financing and delivery of health care in the Commonwealth.

RESTORING VALUE AND TRUST IN OUR HEALTH CARE SYSTEM:

ACHIEVING REAL MEDICAL LIABILITY REFORM WITH AN EARLY DISCLOSURE AND COMPENSATION MODEL

Executive Summary

Peter B. Smulowitz, MD, MPH

Introduction

Now more than ever, Massachusetts is in dire need of medical liability reform. The implementation of Chapter 58 is certain to increase the demand for physician services, and the financial viability of universal health care in the Commonwealth depends on reducing the cost of delivering care. Yet, Massachusetts ranks highest among states reporting medical malpractice insurance claims to a central state agency, with almost 20% of insurance payouts over \$1 million.¹ Furthermore, the increase in professional liability fees is one of the key factors driving the Commonwealth's perpetual shortage of practicing physicians, particularly in primary care where they will be needed most with the enactment of Chapter 58.² Hence, successful liability reform is certain to play an important role in securing the viability of Massachusetts' landmark health care reform.

Medical liability reform has been on the nation's legislative agenda for decades. It is no doubt a heated issue, and has needlessly pitted physicians at odds with trial attorneys. What has been lost in the rhetoric and turf wars is that the system does not accomplish the task of equitably compensating patients, nor does it make the practice of medicine any safer. Meaningful liability reform legislation has met significant resistance, in part because previous attempts at reform focused on the financial aspects of medical malpractice rather than on improving compensation or safety for patients. The chief purpose of this brief is to introduce the legislature to a unique model that has the potential to alter the landscape of liability reform, improve patient safety, and reduce the cost of providing health care in the Commonwealth.

Recently, the medical and patient advocacy communities have been promoting a relatively simple idea based on early disclosure to patients of medical errors, apologizing for these errors, and providing timely and fair compensation to patients outside the traditional tort system. This model was most notably put into successful practice by the University of Michigan in 2001, and was implemented in even more comprehensive fashion by the University of Illinois in 2006. Despite successful small scale experience with this model within Massachusetts, its widespread implementation continues to meet

¹ Cohen T, Hughes K. Medical malpractice insurance claims in seven states, 2000-2004. Bureau of Justice Statistics Special Report, March 2007.

² Massachusetts Medical Society Physician Workforce Study, Executive Summary 2007. Available at http://www.massmed.org/Content/NavigationMenu/NewsandPublications/ResearchReportsStudies/PhysicianWorkforceStudy/2007Workforce_ExecSummary.pdf

resistance from the rigid cultural norms and financial interests of the legal and malpractice professions, as well as by health care professionals wary of increased liability exposure. Based on the data and anecdotal information to be presented in this brief, there are no major reasons why this “early disclosure”³ model could not be further utilized in Massachusetts. There are some obstacles, which will be discussed in detail, that should not prevent a trial of demonstration projects in the Commonwealth.

It should be noted that apologizing for and disclosing medical errors is not a novel concept, and that these terms are often viewed as empty catch phrases in the malpractice insurance and risk management industry. Thus, the point of this brief is not to expound upon the virtues of apology or disclosure, though there are many. The goal of this brief is to demonstrate the failure of the status quo, as well as the promise of a model that seeks to improve patient safety and reduce malpractice claims by opening the lines of communication with patients, compensating them for avoidable events, and systematically learning from adverse events.

While Massachusetts – without encouragement from the legislature – is still a long way from instituting a comprehensive model like that of the University of Michigan, an encouraging narrative comes from CRICO/RMF, the Harvard hospitals’ captive insurer and risk management organization. In 2006 a working group of experts developed a consensus statement defining the institution’s responsibility to respond to an adverse event or medical error. This responsibility rests on open disclosure of incidents to patients and families with a commitment to open, timely, and sustained communication and care, and on a commitment to change the systems to prevent future errors. The authors then summarize:

We are making a moral argument here, not a business case or an evidence-based clinical guideline... We are committed to full disclosure because it is the right thing to do. The patient and family have the right to know what happened. In addition, honest communication promotes trust between the patient and provider, so that the primary focus of the clinician-patient relationship remains patient care. Further, open discussion about errors can promote patient safety by encouraging clinicians to seek systems improvements that minimize the likelihood of recurrence.⁴

While these are logical conclusions that are the due diligence of any health care organization, the reality is that medical errors and adverse events are shrouded in secrecy, and patients are all too rarely included in any discussion of injuries or adverse events sustained during their medical care. The legislature itself has a moral imperative to stimulate meaningful medical liability reform, and to promote

³ The University of Michigan model utilizes early disclosure as well as the consideration of compensation to patients, hence it is not purely an “early disclosure” model. However, this term is routinely used in reference to these mixed disclosure and compensation models, so for the sake of simplicity this brief will utilize the term “early disclosure” to refer to the entire disclosure and compensation program.

⁴ When Things Go Wrong: Responding to Adverse Events. A Consensus Statement of the Harvard Hospitals. Massachusetts Coalition for the Prevention of Medical Errors 2006. Available from www.macoalition.org

the adoption of early disclosure programs in a coordinated fashion throughout the Commonwealth.

Discussion

The first section of this brief will discuss the failure of the traditional medical liability system, and how it does not achieve any of the key social goals we have set forth for a successful tort system. These failures include:

1. Inadequate compensation to patients: only a minority of patients who sustain an injury as a consequence of medical errors actually receive compensation. Many patients never find out that a medical error occurred, and many minor injuries never receive compensation because it is too expensive to file a claim for a minor injury. Furthermore, patients who do receive compensation for their injury only receive 36 cents of every dollar awarded.
2. Failure to improve patient safety: the current system based on a standard of negligence places blame on individual physicians, yet medical errors are most commonly a consequence of system errors. The tort system entices physicians and hospitals to hide medical errors, not share them with patients. Hence, the system does not deter medical errors, and it carries no incentive to improve the systematic delivery of medical care. Furthermore, mandatory reporting of medical errors is virtually impossible under the current system.

The next section of the brief introduces the University of Michigan's and the University of Illinois' early disclosure program. It will also provide a comparison of this early disclosure model to the health court model developed by the Harvard School of Public Health and the advocacy group Common Good. While both models may achieve the desired aims of improving patient safety and more equitably compensating patients, I favor the early disclosure model for a number of reasons:

1. Cost: the cost associated with developing and operating a health court system far exceeds that of implementing early disclosure programs. Implementation of a health court on only a pilot basis is projected to cost the Commonwealth approximately \$1.3 million dollars over five years.⁵ The major up-front cost to implement a disclosure program is the cost required for a hospital or insurer to revise its risk management structure (though in many hospitals, and certainly in hospitals where the demonstration projects would be implemented, the essential framework is already in place), while in the long term costs are expected to decline. In the University of Michigan's experience, overall costs steadily fell by almost 64% as a result of the disclosure of medical errors and improvements in patient safety.⁶ While a

⁵ From the office of Senator Robert O'Leary. Budget for proposed project: Alternative medical liability demonstration. 2007.

⁶ Boothman R. The benefits of an open and honest dialogue: The University of Michigan Health System's medical malpractice claims experience. Beyond the Blame Game: A forum on professional liability in medicine. March 27, 2007. Waltham, MA.

pilot disclosure program could theoretically cost the state nothing, it is possible that a grant per institution could support the improvement of an organization's risk management structure.

2. Inklusivity: the health court system in practice is severely limited by the necessity to consent patients prior to receiving clinical care. This excludes patients receiving care in some of the areas most fraught with risk, such as the emergency department and cases requiring emergency surgery or other emergent interventional procedures. On the other hand, early disclosure programs do not require consent, and can be utilized for cases involving any medical specialty.
3. Retaining the right to trial by jury: the health court system is also limited by the need for the state to pass authorizing legislation to establish the system as the exclusive legal remedy for all covered patients and providers. Once patients consent to utilizing the health court system, they no longer retain the right to trial by jury. The early disclosure programs make every attempt to arbitrate cases outside the courtroom, but patients unsatisfied with the outcome still retain the right to jury trial.

The brief will then discuss some of the obstacles to the implementation of an early disclosure program. The University of Michigan Health System benefits from being a "closed" medical care system, where all providers are part of one health care system and are represented by a single malpractice insurer. It is theoretically simpler to arbitrate a case and offer financial compensation to a patient when only one malpractice insurer is involved. In Massachusetts, there are apt to be cases where an adverse event is a result of the actions of a number of health care providers, each of whom may have different malpractice insurers. Developing a cohesive strategy in these cases for offering compensation to patients will require leadership from each hospital's Chief Risk Officer, as well as cooperation amongst the few malpractice insurers involved. Such cooperation necessitates a culture change within the risk management circles, which is vital for successful implementation of an early disclosure program. The other major obstacle is certain to be resistance from plaintiff and defense attorneys, sectors of the malpractice industry, hospital administrators, as well as health care providers, where change will not be welcomed even though the long term consequences may in fact be beneficial to all parties.

The brief will conclude by outlining some of the guidelines for demonstration projects in Massachusetts, as well as concurrent legislation that will provide for a more favorable environment for these projects. The demonstration projects should follow the essential principles developed at the Universities of Michigan and Illinois⁷, and should include the following:

⁷ McDonald T, Chamberlin W. Full disclosure and rapid remedy: More than just saying sorry. Creating a comprehensive program for responding to adverse patient events. *Journal of Management and Marketing in Health Care*. In Press.

1. Hospitals should develop a curriculum to train health care providers and utilize a type of "Patient Communication Consult Service" (refer to section on the University of Illinois) in order to appropriately and rapidly respond to adverse events by communicating the event to the patient and family.
2. Hospitals should employ a Chief Risk Officer, whose unique role is to: monitor for adverse events and patient injuries; stimulate an intensive institutional review of each case to determine the root cause and whether an error occurred; provide support and training for health care providers involved in such events; and initiate communication with the patient and/or family to provide disclosure of the event, an explanation of the circumstances, and an offer of apology if appropriate.
3. The Chief Risk Officer should work along with the malpractice insurer to develop an offer of compensation when appropriate. Additionally, for all events deemed to be errors (or even suspected of being errors prior to intensive review), hospitals should begin by holding all hospital bills for that patient.
4. Each hospital must develop a procedure for collecting and analyzing information on each event so as to develop protocols for reducing the occurrence of future similar events when possible. Each hospital must also report these events (and the response to these events) to DPH for review, analysis, and dissemination to other hospitals in the Commonwealth.

Finally, while the brief itself only touches upon the moral fabric of this topic, one cannot emphasize enough how much could be gained from a system whereby health care providers can communicate more openly with patients after a medical error, and where they can -without the risk of a lawsuit- apologize for the mistake and any injury incurred. Dr. Aaron Lazare, through conversation and his enlightening book *On Apology*,⁸ taught me an immense amount about the power of apology. Simple words of apology have the promise of soothing patients who have been hurt or ignored by the health care system, and of restoring the bond between patients and physicians. However, apologies are incomplete without an adequate acknowledgement of the offense, an expression of genuine remorse, and an offer of appropriate reparations including a commitment to make changes in the future.⁹ Thus, an early disclosure program that involves an apology, a full disclosure of the events, and compensation in the event of a mistake (and alternatively, at least an open and frank discussion between patient and provider after an adverse event that did not involve a mistake), has the potential to re-establish trust in our health care system.

⁸ Lazare A. *On Apology*. Oxford. Oxford University Press, Inc. 2004.

⁹ Ibid

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ACKNOWLEDGEMENTS

This brief was done for Senator Richard T. Moore, Senate Chair of the Committee on Health Care Financing of the Massachusetts Legislature. I wish to thank Senator Moore, his Chief of Staff Jonathan Daigle, Caroline Fisher (General Counsel/Health Policy Advisor), and Timothy Hoppe (Legislative and Budget Director) for their interest in this issue and assistance with an issue of potential impact on the citizens of the Commonwealth of Massachusetts.

My work on this paper began as part of my Master in Public Health degree, in a Health Care Practicum course under the leadership of former legislator Professor John McDonough. I appreciate his thoughtful teaching on how to make politics work from an academic and pragmatic perspective, as well as his critique and suggestions on the initial draft of this brief.

The writing of this brief has been an educational experience in itself, and its completion would not have been possible without the assistance of experts in the field who took the time to meet with me and explain their perspective on medical liability. I wish to thank Dr. Aaron Lazare (Chancellor Emeritus of the University of Massachusetts Medical School and author of *On Apology*); Dr. Timothy McDonald (Associate Chief Medical Officer for Safety, Risk Management and Quality) from the University of Illinois College of Medicine at Chicago; Dr. Lucian Leape (Professor at the Harvard School of Public Health); Dr. Michelle Mello (Professor at the Harvard School of Public Health); representatives from the Massachusetts Medical Society: Dr. Alan Woodward (Past President), Charles Alagero (Vice President and General Counsel), and Liz Rover Bailey (Associate Counsel); Doug Wojcieszak (Founder, SorryWorks!); State Senator Robert O'Leary and his legislative director Rebecca Davis; representatives from ProMutual: Maureen Mondor (Vice President, Risk Management), Almor Afonso (Vice President, Claims), and Anne Seggerman (Associate Counsel); Robert Hanscom (Vice President of Loss Prevention and Patient Safety, CRICO/RMF); Toni Golen (Chair, Committee on Quality Assurance, Department of Obstetrics and Gynecology, Beth Israel Deaconess Medical Center); and from Texas: Rick Callaway (law firm of Callaway and Brenning), Larry Thompson and Robert Smith (law firm of Lorange and Thompson).

With the assistance of each of these individuals, it is important to note that all errors, and most opinions, are exclusively the responsibility of the author.

1. INTRODUCTION

Massachusetts took a significant step forward in 2006 with the passage of its universal health care mandate. Though the design of this plan is certain to evolve over time, it is clear that any effort to mandate universal health care also carries a responsibility to tackle the issues of rising health care costs, and improving the value in a health care system that delivers inconsistent quality.

One area in which there are obvious opportunities to restrain costs and improve quality is that pertaining to medical liability. The legislature has been reluctant to take on malpractice reform for a variety of reasons. Such reluctance, and the opportunity to improve the system via innovative and practical reforms, is the driving force behind this brief. This brief will demonstrate that the current system of medical malpractice fails to serve patients or physicians, and does not achieve the goal of leading to systematic improvements in medical care. An innovative approach to medical malpractice, based on early disclosure, as well as apology and compensation for medical errors, has the potential to more equitably compensate patients injured by medical mistakes, restore the physician-patient relationship, improve our ability to prevent medical errors before they occur, and potentially reduce the cost of health care.

This innovative approach to medical malpractice, pioneered by the University of Michigan Health System, is being deliberated by individual hospitals and risk management systems within Massachusetts and throughout the United States. But insurers and hospitals are reticent to embark on real change on their own; hence there is a unique opportunity for the legislature to facilitate more rapid change by passing legislation and visibly promoting reform. This legislature has the prospect of treading an entirely new path towards liability reform, and in so doing, to improve on the value in a health care system that is open to all citizens of the Commonwealth.

2. BACKGROUND

2.1. The Inherent Failure of the Malpractice System

It may not be immediately apparent that our current medical malpractice system has failed. Popular conception is that the opportunity to file a lawsuit after a medical error is available to all and allows most patients to fairly recoup economic and non-economic damages, that the threat of a lawsuit distinctly deters health care providers from making future mistakes, and thus makes the overall system safer. But what is not apparent is a number of disturbing facts about why patients sue, how this system has fostered an adversarial relationship between physicians and patients, how few injured patients actually have the opportunity to seek compensation, and how little this system has actually done to improve the quality of care.

2.1.1. Why do patients sue?

Contrary to popular belief, patients do not sue their providers only to obtain financial compensation for an injury produced by a medical error. While financial remuneration for disability or lost wages is often part of a patient's intent in suing for damages, experts point out that most cases involve more complex reasons. Many patients sue their health care provider because they never receive an explanation, they feel abandoned by their physician or hospital after the event, and a lawsuit becomes the only way to find out any information about the circumstances of their injury. Essentially, patients often sue out of anger.¹⁰ This anger is a direct consequence of our nation's system of malpractice and risk management. When mistakes occur, it has been a traditional risk management strategy to encourage physicians to remain quiet and not to speak to the patient or anyone else about the event. It is assumed that if patients have full information about an adverse event, their rational response to the occurrence of an error would be to file a lawsuit. In contrast to this traditional view, it is in the absence of communication from the physician or health care institution that patients are angry and left without other recourse to find out information surrounding the details of their injury.

2.1.2. Inadequate patient compensation

There also appears to be tremendous discordance between medical injury and the actual filing of a malpractice claim. In a review of over 30,000 medical records and 3,500 malpractice claims, the Harvard Medical Practice Study revealed that only 2% of negligent injuries resulted in a malpractice claim, and that only 17% of claims appeared to involve a negligent injury.¹¹ That only 2% of negligent injuries result in a malpractice claim seems extreme, though it is supported by a similar rate of disconnect between negligent injury and the filing of claims in studies from California,¹² and Utah and Colorado.¹³

However, this seemingly endless reservoir of potential cases is not quite borne out in reality. Experience from places with early disclosure programs does not demonstrate a substantial increase in the number of claims identified involving patients who are told about a negligent injury of which they were previously unaware. The theoretically endless reservoir of cases is simply not reflected in the experience of functioning disclosure programs.¹⁴ But whatever the actual number of injuries that go without pursuing a claim, it is clear that there are too many patients injured as a consequence of a medical error who never have the opportunity to seek compensation.

¹⁰ Vincent C, Young M, Phillips A. Why do people sue doctors? A study of patients and relatives taking legal action. *Lancet* 1994;343(8913):1609-13.

¹¹ Studdert DM, Mello MM, Brennan TA. Medical malpractice. *N Engl J Med* 2004; 350(3):283-92.

¹² Danzon PM. Medical malpractice: theory, evidence, and public policy. Cambridge, MA: Harvard University Press 1985.

¹³ Thomas EJ, Studdert DM, Burstin HR, et al. Incidence and types of adverse events and negligent care in Utah and Colorado. *Med Care* 2000; 38:261-71.

¹⁴ Boothman R. The benefits of an open and honest dialogue: The University of Michigan Health System's medical malpractice claims experience. Beyond the Blame Game: A forum on professional liability in medicine. March 27, 2007. Waltham, MA.

Even when an injured patient does receive compensation, the delay from injury to payment is far too long. Delays from filing to resolution of cases average five years after injury, and often longer for cases with multiple defendants.¹⁵

2.1.3. Exorbitant costs being spent in the wrong place

The economic consequences of the current system are potentially disastrous. According to a study by Studdert of 1452 closed malpractice claims, 40% involved no identifiable medical injury, or involved an injury but no medical error. On the positive side, about 80% of these claims involving no injury or no error did not award a payment to the plaintiff. But the costs involved in pursuing and defending these cases involving neither injury nor medical error was substantial, about 60.2 million dollars for these claims.¹⁶

Perhaps more disconcerting, despite significant costs expended in pursuing or defending a lawsuit, patients keep only about 36 cents of every dollar spent on the system. Plaintiff attorneys' contingency fees account for 30% of any settlement or award, and the remainder goes to defense expenses and other administrative costs. So while the system wastes billions of dollars that could be spent on useful services, most of the money goes to those who deserve it least.

Finally, it is estimated that the cost paid by a family of four to support a dysfunctional tort system (including the indirect associated costs of defensive medicine and reduced access to health care) amounts to between \$1,000 and \$2,000 a year.¹⁷ This accounts for almost one-fourth of every family's health care premiums.

2.1.4. A Quality Improvement Hindrance

Most troubling, and what should be of the utmost importance to legislators, is that this system of medical malpractice hinders, rather than assists, efforts at quality improvement and error reduction in medicine. The ideal is a transparent system where mistakes can be used to make systemic improvements in health care quality. This is particularly because most adverse outcomes involve a series of mistakes or are related to systemic errors.¹⁸ The current tort system targets and assigns blame to individual physicians, even when it is obvious that medical errors are rarely the fault of an individual provider. So it is not surprising that medical malpractice has not had the intended effect of deterring medical errors or adding to safety improvements in the practice of medicine. Rather than creating an atmosphere that is conducive to openness about mistakes, the fear of litigation obstructs any willingness on the part of the medical community to be open about

¹⁵ Bovbjerg RR. Commentary: malpractice reform in policy perspective. *The Millbank Quarterly* 2007;85(2):297-305.

¹⁶ Studdert DM, Mello MM, Gawande AA, et al. Claims, errors, and compensation payments in medical malpractice litigation. *N Engl J Med* 2006; 354(19):2024-33.

¹⁷ McQuillan LJ, Abramyan H, Archie A. Jackpot justice: the true cost of America's tort system. Pacific Research Institute 2007.

¹⁸ Kohn L, Corrigan J, Donaldson M, eds. *To Err is Human: Building a Safer Health System*. Committee on Quality of Health Care in America, Institute of Medicine. National Academy Press, Washington, D.C. Available at http://www.nap.edu/catalog.php?record_id=9728#toc. Last accessed August 7, 2007.

mistakes, and has put “the patient safety reforms spurred by the IOM report on a collision course with the medical malpractice system.”¹⁹

It is apparent that many patients pursue litigation to find out the truth behind adverse outcomes in the care they or a family member received. In our current malpractice system, doctors and hospitals seeking to avoid lawsuits and personal humiliation associated with being charged with “negligence” face clear incentives to hide medical errors, rather than openly disclose errors and adverse events to patients. Ironically, it is when errors are hidden from patients and their families out of fear over a lawsuit, that the lawsuit becomes the only mechanism to discover the truth surrounding an adverse event.

Under the current malpractice system, the appropriate response to this troubling scenario is virtually impossible. Reducing systemic medical errors could begin with reporting, analysis, and dissemination of information about errors in the medical system. But providers are wary that such mandatory reporting in our current malpractice environment will open them up to further litigation. Such systems of reporting on medical errors, while vital for patient safety efforts, cannot begin without massive overhaul of the malpractice system. “Thus, the need to collect error data in an environment where medical injury compensation calls for scrutiny of provider fault constitutes a troubling deadlock for the patient safety movement.”²⁰

In Massachusetts, the antiquated and commonly called “Charitable Immunity Act” has been postulated as a further barrier to patient safety reform. Though somewhat nebulous in that it excludes activities deemed to be “commercial in character even though carried on to obtain revenue to be used for charitable purposes,” this act limits charitable institutions in the case of tort to a liability of \$20,000.²¹ This has the obvious effect of making physicians – not institutions – the prime target of lawsuits. If medical errors are a consequence of hospital-wide practices and system-wide faults, it is misplaced to focus the lawsuit on a single provider. On the other hand, it is likely that if malpractice reform only added a deeper pocket to the list of potential defendants, jury awards and overall malpractice costs might only rise. Furthermore, many hospitals are self-insured, so any malpractice award from within their system, even those directed against individual physicians, affects their fiscal bottom line. This fact, along with the fact that some hospitals are genuinely interested in improving patient safety and the practice of medicine, means that repeal of the Charitable Immunity Act is probably not a necessary precursor to the institution of early disclosure programs in the state.

2.1.5. Dismantling the Negligence Standard

Negligence has failed to serve as a standard for medical liability cases. To see why, first one only needs to examine the cause of most medical errors. The landmark 1999 IOM

¹⁹ Ibid

²⁰ Ibid

²¹ Chapter 231, Section 85K. Limitation of tort liability of certain charitable organizations; liability of directors, officers or trustees of educational institutions. General Laws of Massachusetts, 2006 Edition.

report *To Err is Human: Building a Safer Health System*, in 1999 draws one main conclusion:

The majority of medical errors do not result from individual recklessness or the actions of a particular group—this is not a “bad apple” problem. More commonly, errors are caused by faulty systems, processes, and conditions that lead people to make mistakes or fail to prevent them...Thus, mistakes can best be prevented by designing the health system at all levels to make it safer—to make it harder for people to do something wrong and easier for them to do it right...But when an error occurs, blaming an individual does little to make the system safer and prevent someone else from committing the same error.²²

Much like many other high risk industries – the airline and nuclear power industries for example – it is becoming more commonly accepted that errors in medicine are largely a consequence of system failures, not individual negligence. Furthermore, though negligence is the basis for the tort system, it has been demonstrated that negligent action is not the basis for a jury’s ruling. In a follow-up study of cases from the original Harvard Medical Practice Study, Brennan demonstrated that the severity of disability, even in the *absence* of negligence, predicted payment to the plaintiff.²³ If this is so, then why is the determination of negligence the foundation for the American medical liability system? Moreover, if most cases are settled prior to court, and only 1-2% of cases ever reach the courtroom, how can negligence be the standard upon which an equitable malpractice system is built?

It should be clear that dispensing with negligence as a standard for medical malpractice does not equate to a “no-fault” system equivalent to worker’s compensation. No-fault is a misnomer; most proposals to dismantle the standard of negligence promote the use of “avoidability.” This looks at whether an error occurred, not simply whether a patient was injured. This distinction is important, since a no-fault system is fiscally unsustainable and not necessary to achieve an improved medical malpractice system.

2.1.6. Section Summary

The current medical malpractice tort system is one that puts physicians at the mercy of an archaic risk management strategy and at odds with the very patients they are supposed to represent. It is a system that often makes it difficult for patients with real injuries to receive compensation. It is also a system where even when claims have merit, it is the severity of injury and not the presence of negligence that best predicts payment. Moreover, it is a system that incorrectly seeks to deter medical errors and improve medical practices by placing blame on individual physicians. Such practice simply cannot deter medical errors because the majority of errors are the result of system

²² Kohn L, Corrigan J, Donaldson M, eds. *To Err is Human: Building a Safer Health System*. Committee on Quality of Health Care in America, Institute of Medicine. National Academy Press, Washington, D.C. Available at http://www.nap.edu/catalog.php?record_id=9728#toc. Last accessed August 7, 2007.

²³ Brennan TA, Sox CM, Burstin HR. Relation between negligent adverse events and the outcomes of medical-malpractice litigation. *N Engl J Med* 1996;335:1963-7.

failures, not individual medical mistakes. In summary, we have a system that fails to meet its intended social goals of equitably compensating patients and deterring medical error. This malpractice system cannot be defended on the basis of achieving its stated aims, and it is time to implement a new way of compensating injured patients and deterring preventable injuries.

The following table provides a succinct summary of the failures of the medical liability system:

Failures of the Medical Liability System	
<i>Theoretical Goals</i>	<i>System Failures</i>
<input type="checkbox"/> Meeting the aims of patient safety/quality improvement	<input type="checkbox"/> Current system encourages hiding errors to avoid lawsuits. <input type="checkbox"/> There is no systems orientation in the liability system, despite the key role of systems in patient safety.
<input type="checkbox"/> Deterring bad medical practice	<input type="checkbox"/> Majority of mistakes are not due to single physician negligence; most are embedded in the system or require several mistakes. Filing a lawsuit against individual physicians does not change systems of bad practice. <input type="checkbox"/> There is no concrete evidence that the system deters medical negligence; rather it encourages rampant defensive medicine and soaring medical costs.
<input type="checkbox"/> Fairly compensating patients	<input type="checkbox"/> Only a very small percentage of injured patients ever receive any compensation from the system. Either they don't know a mistake occurred, or their injury was too minor to warrant a plaintiff attorney's time. <input type="checkbox"/> After administrative expenses, patients receive only about 36 cents of every dollar expended on the system.
<input type="checkbox"/> Consistency in jury awards	<input type="checkbox"/> Awards are notoriously unreliable and inconsistent, even in the same jurisdictions.

3. THE REAL MEDICAL MALPRACTICE CRISIS – PATIENT SAFETY

Much has been written about a cycle of “malpractice crises” in the 1970s, 1980s, and the current decade. Suffice it to say for this report that these crises are not a consequence of only “frivolous lawsuits,” disproportionate jury awards, unwise investing decisions made by malpractice insurers, or faulty insurer pricing decisions. All of these drivers have contributed to the malpractice crises. Malpractice crises have been for the most part state-specific phenomena of either availability (withdrawal of insurers) or affordability

(rising premiums along with lower incomes for physicians).²⁴ While currently there are issues of both availability and affordability in malpractice premiums, the most crucial aspect of the medical malpractice “crisis” is its under-appreciated role in preventing the medical community from addressing medical errors.²⁵

The fundamental malpractice “crisis” is that the system is a significant obstacle to improving patient safety and improving the value inherent in our medical system. As mentioned above, as a consequence of the standard of negligence and the system whereby mistakes are punished in a random fashion in a drawn out court battle, medical errors are often concealed. Yet, regulations that force the reporting of errors without reforming the malpractice system are a mistake, and can only worsen the already adversarial patient-physician relationship. An overhaul of the system, with *reform based on promoting the disclosure of medical errors, providing an apology when such errors occur, and supplying timely compensation to patients for injuries sustained as a consequence of these errors*, will on its own promote rapid advancement of patient safety initiatives.

This model system based on disclosure of medical errors is what the remainder of this report intends to address. Now that we understand why reform is drastically needed, the next section will focus on building a malpractice system that accomplishes the social goals of improving patient safety, adequately compensating patients injured by avoidable medical errors, reigning in the costs of medical malpractice, and restoring the bond between patients and physicians.

4. PREVIOUS APPROACHES TO MEDICAL LIABILITY REFORM

4.1. Traditional “Tort” Reform

Until recently, virtually all reform related to medical malpractice was modeled after California’s Medical Injury Compensation Reform Act of 1975 (MICRA). The major aspect of MICRA is its limit on non-economic damages to \$250,000, though there are other important reforms included in its provisions (see table below). Particularly note the reference to binding arbitration, which will become relevant later in this report under discussion of early disclosure and early compensation programs.

²⁴ Mello MM. Understanding medical malpractice insurance: a primer. The Robert Wood Johnson Foundation: Research Synthesis Report No. 8. January 2006.

²⁵ Ibid

MICRA Reform	Description	Massachusetts Law
<input type="checkbox"/> Cap on non-economic damages	<input type="checkbox"/> \$250,000 cap on non-economic damages (e.g. pain and suffering)	<input type="checkbox"/> \$500,000 cap <input type="checkbox"/> Jury may waive cap in severe cases
<input type="checkbox"/> Collateral Source Rule abrogated	<input type="checkbox"/> Allows for juries to be told how much of damages have been paid by another party, encouraging the jury to cut the award by that amount	<input type="checkbox"/> There exists a mandatory offset for collateral source payments
<input type="checkbox"/> Installment Payments	<input type="checkbox"/> Allows future damages over \$50,000 to be paid in installments instead of a lump sum, with the payments to stop if the plaintiff dies	<input type="checkbox"/> None existing
<input type="checkbox"/> 90 day notice before filing suit		<input type="checkbox"/> None existing
<input type="checkbox"/> Statute of Limitations	<input type="checkbox"/> Suit must be filed within one year from the discovery of an injury and within three years from injury	<input type="checkbox"/> 3 years from injury or discovery of injury
<input type="checkbox"/> Limits on lawyers contingency fees	<input type="checkbox"/> 1st \$50K: 40% <input type="checkbox"/> Next \$50K: 33.33 % <input type="checkbox"/> Next \$500K: 25% <input type="checkbox"/> Everything over \$600K: 15%	<input type="checkbox"/> 40% of first \$150,000 <input type="checkbox"/> 33% of next \$150,000 <input type="checkbox"/> 30% of next \$200,000 <input type="checkbox"/> 25% of any amount over \$500,000
<input type="checkbox"/> Binding arbitration (not a traditional "tort" reform)	<input type="checkbox"/> Patients and their health care providers may agree that any future dispute may be resolved through binding arbitration.	<input type="checkbox"/> None existing

Other Common Reforms Not in MICRA	Description	Massachusetts Law
<input type="checkbox"/> Joint and several liability reforms (to proportionate liability)	<input type="checkbox"/> Limits the financial liability of each defendant to the percentage fault that the jury allocates to each defendant. Otherwise, the plaintiff may collect the entire amount of the judgment from one plaintiff regardless of the plaintiff's degree of fault	<input type="checkbox"/> None existing
<input type="checkbox"/> Pre-trial screening panels	<input type="checkbox"/> Panel reviews the case at an early stage and provides opinion about whether the case has sufficient merit to proceed to trial	<input type="checkbox"/> Yes; though in practice virtually no cases are prevented from going forward and most are done with minimal review

Most approaches to medical liability reform have followed the example of MICRA. As of April 2006, there were 26 states with laws placing caps on non-economic or total damages. A synthesis report by Michelle Mello at the Harvard School of Public Health suggests that while caps on damages has the overall effect of reducing average award size by 20-30 percent, though there has been no good evidence to suggest that caps reduce the frequency of claims.²⁶ With respect to physician supply, caps on damages were associated with a 3% higher growth in physician supply over 3 years. Overall, Mello's report states that caps may be associated with a small increase in physician supply.²⁷ Research from the 1990s looking at the effect of caps on malpractice premiums demonstrates a 6-13 percent reduction in the rate of growth of premiums, though these studies do not control well for the role of state regulation of premiums. Perhaps more importantly, these studies show that while caps on damages can stabilize premiums in the short term, premiums even in states with caps will continue to rise in absolute terms.²⁸ In general, caps "address one of the worst symptoms (occasional awards at ridiculously high levels) but they do not cure the underlying tort syndrome of vague rules and inconsistent valuation of damage."²⁹

Despite Mello's report suggesting a minimal effect of such caps on lawsuit frequency, physician supply, and malpractice premium rates, recent experience in Texas tells another story. In 2003 the Texas legislature passed HB4, The Medical Malpractice and Tort Reform Act of 2003. The bill included a cap of \$250,000 (cumulative for all providers) on non-economic damages, though there was no limit on economic damages. The bill was accompanied by the passage of Proposition 12, a constitutional amendment giving the state legislature the authority to impose damage limits. Since 2003, the results have been staggering. Malpractice premiums overall have been reduced. "All major physician liability carriers in Texas have cut their rates since the passage of the reforms, most by double-digits. Texas physicians have seen their liability rates cut, on average, 24.3 percent. Two-thirds of Texas doctors have seen their rates slashed a quarter or more. Seventeen rate cuts have occurred in Texas since the passage of the 2003 landmark reforms."³⁰ The cumulative liability cost savings in terms of reductions in premiums and costs to the malpractice insurance carriers since January of 2004 is \$327.94 million.

Tort reform has also helped secure needed access to primary care as well as specialist physicians, and has bolstered access to care in medically underserved communities. During the first half of the 2006 fiscal year, there was an 88 percent increase in licensure applications from physicians seeking to practice in Texas (compared to the same period of fiscal year 2003).³¹ After a net loss of 14 obstetricians and 9 orthopedic surgeons from 2001 to 2003, in 2006 Texas experienced a net gain of 186 obstetricians, 156 orthopedic surgeons, and 26 neurosurgeons, including one neurosurgeon each in the medically underserved communities of Corpus Christi and Beaumont. Physicians in general are

²⁶ Mello MM. Medical malpractice: impact of the crisis and effect of state tort reforms. The Robert Wood Johnson Foundation: Research Synthesis Report No. 10. May 2006.

²⁷ Ibid

²⁸ Ibid

²⁹ Bovbjerg RR. Commentary: malpractice reform in policy perspective. The Millbank Quarterly 2007;85(2):297-305.

³⁰ Professional liability insurance reform. Available at <http://www.texmed.org/Template.aspx?id=780>.

³¹ Ibid

returning to critically underserved areas. “Since the passage of reforms, the Rio Grande Valley has added 189 physicians. Jefferson, Nueces and Victoria counties saw a net loss of physicians in the eighteen months prior to tort reform. Currently, all three counties are producing impressive gains.”³²

The evidence from Texas is convincing. If Massachusetts is going to improve access to care, particularly in underserved areas, tort reform including caps on non-economic damages will have to be considered as part of the answer.

As for the other litany of “tort” reforms, only two other reforms have demonstrated a positive effect. Joint-and-several liability has been shown to constrain the growth of insurance premiums, but has had no effect on claims payouts. Some studies on shorter statutes of limitations have found an effect on claims frequencies and premiums. Reforms involving contingency fee limits, collateral source offsets, pretrial screening panels, and periodic payments, have not demonstrated significant impact in the majority of studies.³³

In summary, medical liability reforms in the past have intended to make incremental changes to the tort system while leaving in place its basic framework. Though traditional tort reform methods have their place, this incremental approach to malpractice reform still fails to meet any of the fundamental goals we have set forth for a functional medical liability system. These reforms -and most of the other traditional “tort” reforms- are not meant to improve patient compensation for injury or to reduce the incidence of medical errors and adverse events.

5. A VIABLE ALTERNATIVE TO “TORT” REFORM?

5.1. *Disclosure and Success at the University of Michigan*

In August of 2001, Richard Boothman (Chief Risk Officer for the University of Michigan Health System) took a bold step. Prior to his arrival, the health system had- like most other health care organizations- no systematic way to approach adverse outcomes, medical errors, and pre-suit claims. It also had no organizational link between its claims experience and patient safety initiatives or staff education. Physicians took the liability for medical errors, and few lessons were learned in a systematic way from its physicians’ claims experience. Drawing on the success of a policy of open disclosure instituted in 1997 at the Veterans Affairs Medical Center in Lexington, Kentucky, in 2001 Mr. Boothman began a radical transformation in the way the University of Michigan Health System carried out its risk management. The changes included: an investment in “real” risk management to deal with errors before they lead to a lawsuit; the creation of an institutional infrastructure focused on patient safety and quality; achieving a commitment

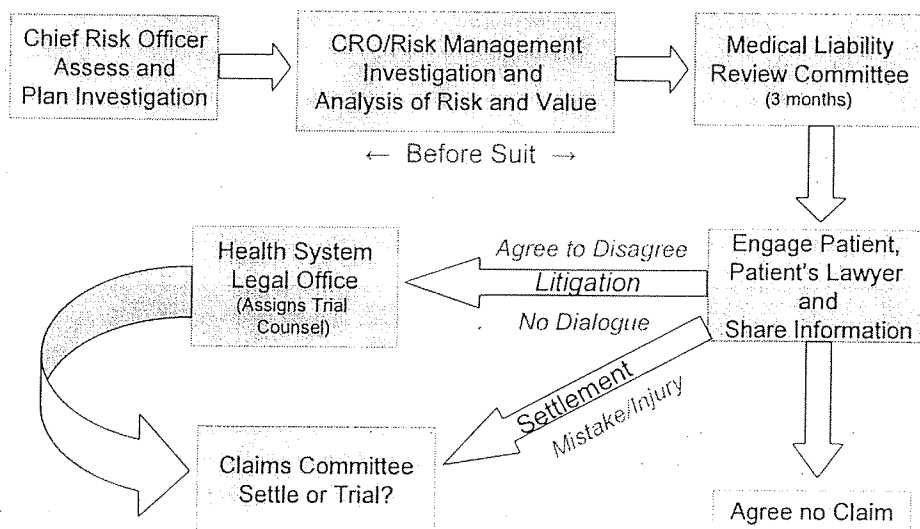
³² Ibid

³³ Mello MM. Medical malpractice: impact of the crisis and effect of state tort reforms. The Robert Wood Johnson Foundation: Research Synthesis Report No. 10. May 2006.

by the hospital's medical leadership; and the creation of the Chief Risk Officer position.³⁴ The chief aim was to take control of the health system's mistakes and create a positive experience for the physician, the patient, and the hospital.

The health system created a unique claims management model (simplified diagram illustrated below³⁵). When any mistake or adverse outcome was apparent, the risk management team would begin an intense review of the case. If an error occurred, the physician and risk management team would disclose the error to the patient, apologize for the error, share any information learned about the case, and offer to compensate the patient according to what it believed to be a reasonable amount. If the risk management team and hospital review of the case revealed that an adverse outcome occurred but in the absence of error, they would still initiate communication with the patient, but vigorously defend the case and not offer any compensation (hence this system is not akin to a no-fault system like that of workers' compensation). If the patient and his counsel disagreed with the findings, they could still bring the case as a formal lawsuit. Again, it is important to reiterate that this is not a no-fault approach, which would be fiscally unsustainable. Mr. Boothman states that the hospital will not pay for bad results, it will only settle if there is wrong doing.³⁶

Present UMHS Claims Management



³⁴ Boothman R. The benefits of an open and honest dialogue: The University of Michigan Health System's medical malpractice claims experience. Beyond the Blame Game: A forum on professional liability in medicine. March 27, 2007. Waltham, MA.

³⁵ Shapiro E. Disclosing medical errors: best practices from the "leading edge." IHI White Paper, In press.

³⁶ Boothman RC. Apologies and a strong defense at the University of Michigan Health System. The Physician Executive March-April 2006:7,10.

This model is in principle much different from COPIC's 3Rs (recognize, respond, resolve) program in Colorado. 3Rs is a "non-fault based program designed to prevent medical injuries from entering the ineffective, inefficient and adversarial legal system."³⁷ This early intervention program provides compensation up to \$25,000, with up to \$5,000 for loss of time expenses. Hence, this program centers around compensating minor or moderate cases, is restrictive about the types of injuries included, and has explicit exclusions for cases involving death or where the patient involves an attorney. From the outset, the two major goals of the 3Rs program have been to: 1) maintain the patient-physician relationship via constant communication and an appropriate apology; and 2) meet the patient's financial needs shortly after the injury occurs.³⁸

By all measures the 3Rs program has been successful in achieving both of these goals. However, in terms of patient safety, the COPIC model does not include a mechanism for tying the claims process and patient compensation into a timely root cause analysis of the adverse event. Nor does it include a mechanism for learning from the mistake to prevent similar cases in the future. The COPIC model appears to be mostly a mechanism for quickly compensating patients for relatively minor expenses. Critics have argued that the 3Rs program utilizes minor payments to avoid larger lawsuits in the future. While there may be an element of truth to the notion that compensating and communicating with patients will certainly impact the frequency of future lawsuits, patients in the 3Rs program do not have to sign a waiver and thus are entitled to file a lawsuit later if they are unsatisfied with the process. Hence the program appears fair and equitable to patients, but is lacking in its ability to impact the hospitals' systems processes.

The University of Michigan's approach is more comprehensive, and more in line with the American political atmosphere in that a patient is allowed to, or even encouraged, to have legal representation. In fact, one of the remarkable consequences of the program is that plaintiff's attorneys are now presenting cases to the Chief Risk Officer long before any lawsuit is filed. There is more open discussion between the risk management team and the plaintiff's attorneys because cases are being compensated fairly or being vigorously defended where there is no error. Patients no longer have to file a lawsuit just to serve as a fact-finding mission. Boothman summarizes that "the plaintiff's bar adjusted to our approach and began to come to us openly and directly. I believe the word is out that if they have a legitimate case, they share all the details with us, including their experts' reports and interviews with the family. I also believe that if they have a marginal or questionable case, they do not bother any more because they know we will fight those aggressively with the best of lawyers and the best of experts."³⁹

While the University of Michigan's program makes sense for all parties involved, it has also made a tremendous impact in the hospitals finances and claims experience. In 2001, the hospital had 262 open claims and suits. In under six years this was reduced to 88 total claims and suits. Average time from open to close of a case fell from 20.7 months

³⁷ Quinn R. COPIC's 3Rs Program. Recognize, respond to and resolve patient injury. Massachusetts Medical Society, November 20, 2006.

³⁸ Eichler M. Personal communication. January 29, 2008.

³⁹ Boothman RC. Apologies and a strong defense at the University of Michigan Health System. *The Physician Executive* March-April 2006:7,10.

to 9.5 months. The average transaction expense per case dropped from \$48,000 in 1997 to \$21,000 in 2003. The two most remarkable numbers are the following. First, the hospital's malpractice reserves have been cut from approximately \$72 million to \$15 million. Second, when the costs of defending cases is matched up with the year in which the care at issue occurred, costs decreased from \$3,083,792 in 1999 to \$1,123,636 in 2003.⁴⁰

With respect to physician retention, surveys of the medical staff show that 98% of the staff support this early disclosure and compensation program. 55% reported that the disclosure program was a significant factor in their decision to stay at the University of Michigan.

This approach also has aligned the incentives to disclose errors and learn from them to reduce medical error and improve patient safety. Each adverse outcome undergoes intense medical review; the findings are then utilized for clinical quality improvement initiatives, peer review, and educational opportunities. While there is no state organization that collects and reviews this information to assist quality improvement initiatives in other Michigan hospitals, this system could easily translate into wider reporting without any fear over it resulting in more lawsuits.

It seems clear that this approach further obviates the need for both legal exclusive remedy clauses (which limit the patient's option for pursuing compensation to the arbitration arena) and for a specialized health court. Since this approach is organized on an institutional level and patients reserve the right to a trial by jury if they disagree with the institution's decision, the state does not need to overcome many of the legal hurdles that would need to be faced to institute a specialized health court and bypass the trial by jury. Specifically with respect to the health court, most cases in the early disclosure model are managed by interacting with the patient and their attorney in an arbitration setting without even *filing* a lawsuit. This strategy reduces costs, improves the satisfaction of physicians and patients, and improves patient safety initiatives, whereas a health court model adds significant administrative costs to the state without achieving any of these goals.

The one major criticism of this disclosure approach is that it *theoretically* could increase costs due to the unrealized pool of patients who will be compensated after being informed their injury was a consequence of a medical error. In particular, David Studdert's group concluded, based on empirical modeling of a disclosure strategy, that there was a 94% chance that costs would increase after initiation of a disclosure program. This was largely as a consequence of increasing claim volume despite decreasing costs per claim.⁴¹ This potential for cost increases is one of the principal reasons why further health care institutions are wary of introducing a disclosure program. However, despite this

⁴⁰ Boothman R. The benefits of an open and honest dialogue: The University of Michigan Health System's medical malpractice claims experience. Beyond the Blame Game: A forum on professional liability in medicine. March 27, 2007. Waltham, MA.

⁴¹ Studdert DM, Mello MM, Gawande AA. Disclosure of medical injury to patients: an improbable risk management strategy. Health Affairs 2007;26(1):215-27.

theoretical model's conclusions, the successful experience of the University of Michigan system is a promising experience in the real world.

5.2. Experience with an Early Disclosure Program at the University of Illinois Medical Center

For the past two years, the University of Illinois Medical Center has also been operating a functional early disclosure program. The process of achieving acceptance of an early disclosure program took over 4 years, with the hospital's own defense lawyers presenting the biggest obstacle. Like most other health care institutions, traditional risk management and defense strategy insisted on "advising the hospital and its physicians to 'deny, deny, deny,' even in such cases as wrong-site surgery."⁴² But Tim McDonald and his colleagues continued the push for transparency based on the following concepts:

- "We are not just providing full disclosure and rapid settlement, we're taking each of these cases and learning from it.
- "The way we're going to successfully manage the medical malpractice crisis is through safer care, not tort reform.
- "The best risk management strategy is patient safety.
- "One important way to improve patient safety is to not make the same mistakes over and over again."⁴³

Like the program at the University of Michigan, the Illinois program seeks to identify adverse events, engage in an intensive review of all events to determine if an error was involved, disclose all adverse events and provide an apology when an error occurred, offer a financial remedy when appropriate, and utilize the lessons learned from the adverse event to institute process improvements to prevent future errors.⁴⁴ The architects of the program report the following steps as necessary in building an organizational response to adverse events from a patient safety perspective:⁴⁵

- **Reporting:** notifying the patient safety/risk management office personnel about the event.
- **Screening:** Initial investigation to determine whether event meets "unexpected adverse event" with some demonstrable harm.
- **Communication:** Creating a "Patient Communication Consult Service" for purposes of providing ongoing communication with patients and families following an unexpected adverse event without regard to cause of the event.
- **Investigation:** A rapid, more detailed investigation of the event to determine whether a "clear error" was made in the process.

⁴² Shapiro E. Disclosing medical errors: best practices from the "leading edge." Institute for Healthcare Improvement White Paper, In press.

⁴³ Ibid

⁴⁴ Ibid

⁴⁵ McDonald T, Chamberlin W. Full disclosure and rapid remedy: More than just saying sorry. Creating a comprehensive program for responding to adverse patient events. Journal of Management and Marketing in Health Care. In Press.

- **Apology and Remedy:** In the event of a “clear error” provision of an apology and an appropriate remedy.
- **Improve:** Linking process improvements with patient and family involvement and ongoing communication.
- **Analysis:** Establishing detailed databases for purposes of ongoing tracking and trending of patient safety activity related to adverse patient events, outcomes from disclosure sessions and reviewing the lessons learned.
- **Education and Assessment:** Once the process is defined, create an organizational plan for training and assessing competency of the appropriate health care providers in all of the disclosure steps.

The University of Illinois’ program is even more comprehensive than that in Michigan in a few key ways. First, training in disclosure is built into the educational curriculum for health care providers at all levels, from medical students and residents up to the most senior health care providers. This increases both the institutional competency and acceptance of early disclosure. Next, the institution utilizes a team called the Patient Communication Consult Service to provide on-the-spot training and support for providers whenever something goes wrong. This team is available 24 hours a day, and its members have expertise in all aspects of disclosure. Finally, the administration at Illinois has worked with an economist to develop an accounting algorithm to hold each department responsible for the economic impact of only their own errors. Hence, each department is responsible both in terms of safety metrics and for the financial repercussions of errors.⁴⁶

Given the success at the University of Michigan, it is not surprising that the program at the University of Illinois is already demonstrating remarkable success, in terms of physician and patient satisfaction, as well as in achieving an institutional culture change and acceptance of transparency, improving patient safety metrics, and reducing malpractice premiums for all providers. It appears too early for the institution to comment on any change in malpractice claims.

5.3. Distinguishing Disclosure Programs from a Health Court Model

In its most literal terms, a health court is simply a specialized trial court, where specially trained judges rather than juries make injury compensation decisions based on a standard of “avoidability” or “preventability.” Under this system, compensation is based on expert evidence reviewed by an experienced judge, and “compensation decisions are guided by *ex ante* determinations about the preventability of common medical adverse events...This knowledge, combined with precedent, is converted to decision aids that allow fast-track compensation decisions for certain types of injury...and also inform decisions about how much economic and noneconomic damages should be paid.”⁴⁷

The most recent model for a health court comes from Michelle Mello’s group at the Harvard School of Public Health and the nonprofit advocacy organization Common

⁴⁶ Personal communication, Timothy McDonald and David Mayer, October 12, 2007.

⁴⁷ Mello MM, Studdert DM, Kachalia AB, et al. “Health courts” and accountability for patient safety. *The Millbank Quarterly* 2006;84(3):459-92.

Good.⁴⁸ Their proposal recommends the institution of health courts starting with small scale demonstration projects at the level of a single liability insurer, with hospital captive insurers serving as ideal candidates for the initial pilots. For this system to function, patients must join the system after adequate advance notification and consent by their provider, and could then have the choice to opt out of the system (unless the state passed authorizing legislation to establish this health court system as the exclusive legal remedy for all covered patients and providers).

Under this system, an adverse event would trigger a review by the hospital to determine whether the event fell within the class of events covered by the system. Such events would be reported to the insurer, and the hospital would be required to notify the patient of the event and their right to seek compensation. The first offer of compensation would come from the insurer directly, after an intense review of the case and comparison to compensation previously offered for similar events. The claimant could either accept that offer, or proceed to review by the health court judge. At the health court, both parties are permitted to have legal representation, though Mello believes the claimant could easily proceed without the assistance of counsel in most cases. Then, the judge would make a decision in a few weeks, with the assistance of court-appointed medical experts.

The benefit of a health court system is that, at least in theory, it would bring more consistency and predictability to the medical liability system. Furthermore, hospital reporting of all adverse events to the health court would more easily facilitate a state-wide collection and review of all adverse events. However, it is not clear whether a health court system will have its intended impact. Again, most medical malpractice cases never even make it to trial, and are settled for a variety of reasons largely unrelated to the determination of error. Furthermore, aside from noteworthy cases resulting in extraordinarily large payments, when cases do make it to trial juries are generally favorable to health care providers, and generally do a decent job of compensating the plaintiff when an error has been made. The bigger problem is that a majority of patients who are injured by the medical system never find out an error has occurred and never have a chance to receive compensation.

In a closer review of this claims process proffered by Mello's group, the health court model is exactly that instituted by the University of Michigan and the University of Illinois except that under the health court model, if the patient is not satisfied by the initial offer of compensation by the hospital they are required to submit their claim to the health court. Under the early disclosure models, if the compensation is deemed unsatisfactory, the claimant reserves the right to a trial by jury. Both systems require the hospital to notify the insurer and the patient or family of any adverse events, and to submit the event to an intensive panel review. Both systems would require and be compatible with the reporting of adverse events and compensation to a state office responsible for maintaining a database of events and for coordinating analyses of the data towards the end of improving patient safety.

With such similarity between these two proposals, there are a few distinct advantages offered by the University of Michigan system over the health court model. First, unlike

⁴⁸ Ibid

the health court model, the early disclosure program could cover all patients at the health care organization, not just those patients who have been consented and enrolled by their provider. This allows for the inclusion of all patients treated in all settings where health care is delivered. Under the health court model, the requirement for enrollment and consent prior to the delivery of health court would all but exclude care rendered in unpredictable settings like the emergency department or in cases of emergent surgery. Since these are some of the highest risk settings, it makes no sense to institute a system whereby these settings are legally excluded. Second, the University of Michigan's system allows patients to reserve a trial by jury, a cornerstone of the American judicial system. In practice, only accepted offers of compensation would be accompanied by a release of further claims opportunity. Third, the health court model carries a substantial administrative cost not borne by the University of Michigan's system. A pilot health court project would cost the state approximately \$1.3 million over 5 years.⁴⁹ Under the University of Michigan's system, there is no cost to the state. Both systems would then have the additional (but worthwhile) cost of developing a comprehensive mechanism for reviewing all reported adverse events and coordinating patient safety improvements.

To conclude, the health court model and the early disclosure model both succeed where the current tort system has failed. Both models rid the system of a flawed standard of negligence and put in its place a system where the responsibility for adverse events falls on the entire health care organization. Both models achieve the aim of equitable and timely compensation for medical errors. Both models are compatible with efforts to improve patient safety via internal hospital improvements and a state-wide patient safety organization. Yet for the reasons discussed above, there are distinct advantages to the early disclosure model that make it the more logical model to institute in Massachusetts as a demonstration project.

5.4. Translating the Michigan and Illinois Experience into Success in Massachusetts

One of the remaining key questions is whether the successful experience with an early disclosure program in Michigan and Illinois can translate into a working model in Massachusetts. The simple answer appears to be yes. Furthermore, Massachusetts has the opportunity to once again become a role model for the rest of the United States.

From a legal perspective, since early disclosure programs are voluntary and reserve the right of the patient to a trial by jury, there are no obvious legal barriers to implementing such programs in Massachusetts. The most significant barrier to implementation of such programs in Massachusetts is that disclosure programs remain largely untested outside of the experience in Michigan and Illinois and on a federal level with the Veterans Affairs Medical Center in Kentucky. Similar to the data in Michigan, the data from Kentucky demonstrate a reduction of malpractice claim payments, though it is difficult to generalize this information because federal employees cannot be held liable for medical errors, and the federal government cannot be held legally responsible for punitive

⁴⁹ From the office of Senator Robert O'Leary. Budget for proposed project: Alternative medical liability demonstration. 2007.

damages.⁵⁰ But each of these cases has demonstrated that an early disclosure program can be successful and not result in a catastrophic increase in malpractice claims as predicted by some academicians. Nevertheless, with this limited experience with early disclosure programs, local risk managers, defense attorneys, as well as hospitals and physicians, are wary of the potential financial implications and effects on malpractice claims experience.

Another potential obstacle is that the University of Michigan, the University of Illinois, and VA programs involve “closed” systems, where the hospital and most affiliated physicians are backed by the same malpractice insurer. In Massachusetts, there are essentially three carriers of malpractice insurance. CRICO/RMF is the insurer for all of the hospitals and physicians within the Harvard system. ProMutual Group is the malpractice carrier for many individual hospitals and individual physician groups. Finally, several hospitals are now self-insured and have no external malpractice insurance carrier. There are occasional hospitals or physician groups that use other malpractice carriers.

This structure presents an obstacle because in a “traditional” malpractice insurance company, the determination of a course of action (for example settlement, continued defense of the case) is based on a complex calculation taking into account the type of injury and expected payout, the clinical scenario, certain characteristics of the health care provider involved, and a number of other factors. These pieces are certainly easier to control under a traditional liability model, as opposed to a system where the decision to communicate with the patient or offer compensation is being managed by several insurers with potential competing interests. The Michigan model requires communication and cooperation between the hospital and each malpractice insurer, and between the respective malpractice insurers. In some cases, each individual insurer will not have complete control over the handling of adverse events involving several health care providers. It is clear that the solution will not be easy; any solution to this major systems difference will require complex resolution of competing goals and cultures of the multiple parties involved.

While I consider this “open” structure an obstacle, it is not an insurmountable one. First, in most health care providers in the Commonwealth are insured either by CRICO, ProMutual, or a self-insurance model. Furthermore, the purpose of a “traditional” medical liability insurer is to reduce the exposure to liability, not advance patient safety. While CRICO and ProMutual have made definite strides in improving safety practices in our hospitals, we are still in need of a drastic change in the way we operate the system of medical liability, and the insurers will have to alter their operating strategies accordingly. It is understandable that a stable insurance company would not want to take a risk on a yet unproven program, but given the vast potential benefits of the Michigan model, the only way we will know if we can replicate Michigan’s success is by trying.

⁵⁰ Kachali A, Shojania KG, Hofer TP, et al. Does full disclosure of medical errors affect malpractice liability? Joint Commission Journal on Quality and Safety 2003;29:503-511.

Success of an early disclosure program will be dependent upon a strong Chief Risk Officer at each hospital, who carries the authority to work independently with each insurance company and to work with the hospital administrators and department chairs to translate lessons learned about adverse events into patient care practices. It will also be dependent upon a supportive hospital administration, one that genuinely is concerned with patient safety and improving the practice environment for its health care providers.

Interestingly, hospitals may be under more and more pressure to integrate their risk-management, patient-safety, and quality programs. These pressures include the prospective DPH requirement of hospital reporting of infection rates, as well as the changes to the Centers for Medicare and Medicaid Services' acute care hospital inpatient prospective payment system (IPPS) to ensure that Medicare no longer pays for the additional costs of certain preventable conditions (including certain infections) acquired in the hospital. Furthermore, in 2001 the Joint Commission (accreditation organization for hospitals) issued the first nationwide disclosure standard, requiring that patients be informed about all outcomes of care, including "unanticipated outcomes."⁵¹ And in 2006, the National Quality Forum endorsed a new safe-practice guideline on the disclosure of serious unanticipated outcomes to patients; these safe practices are used as standards in the pay-for-performance programs of the 29 large health care purchasing coalitions in the Leapfrog Group.⁵²

The other major obstacle is that there will undoubtedly be resistance to change from the trial bar, the malpractice industry, and some sectors of the hospital industry and health care profession. Trial attorneys will view this early disclosure program as a threat because it involves a change in the traditional tort system. However, this early disclosure model actually encourages attorney involvement, and allows more patients to access the system and receive compensation than does the current approach. Attorneys may argue that the ability to make an early offer may allow the hospital to "game" the system and to make only offers that they expect to cost less than continuing to litigate.⁵³ Certainly this possibility should be avoided, and can be done so by proper integration of the patient safety, quality, and risk management interests. A successful system must not be dominated by a traditional risk management philosophy.

There is also likely to be resistance to the implementation of an early disclosure program from within the malpractice industry. Traditional risk management practices still hold to the belief that remaining quiet after an adverse event is the best practice to reduce a lawsuit, and malpractice insurers are wary about cooperating in an open system where costs are apt to be less predictable. Finally, hospitals are already feeling overwhelmed by patient safety regulations, and some health care professionals will be wary of any system that puts errors out into the open and susceptible to inspection by their colleagues, administrators, malpractice insurers, and the public eye.

⁵¹ Gallagher TH; Studdert D; Levison W. Disclosing harmful medical errors to patients. *N Engl J Med* 2007;356(26):2713-9.

⁵² Ibid

⁵³ Bovbjerg RR. Commentary: malpractice reform in policy perspective. *The Millbank Quarterly* 2007;85(2):297-305.

Currently, all malpractice claims are reported directly to the Board of Registration in Medicine. Only actual payments are made public and reported to the National Practitioner Databank. Though the early disclosure and compensation program is likely – at least in the short term – to increase the overall number of instances where a patient is compensated for a preventable medical error, it does not necessarily follow that individual physicians will see more cases reported to the Board of Registration in Medicine and the National Practitioner Databank. Since the majority of errors are a consequence of systems failures, compensation payments often should be structured as institutional or administrative payments. This does not aim nor have the effect of protecting dangerous physicians. In fact, when the institution assumes ultimate responsibility for improving patient safety, it is in their best interest to intervene in the practice patterns of certain physicians or suspend their clinical privileges altogether. Nevertheless, there will need to be substantive changes made in the way cases are reported to the Board of Registration so that these programs do not become punitive to physicians. The point of these early disclosure and compensation programs is to bring physicians out of the shadows and reduce the fear of lawsuits.

Despite these obstacles, implementation of disclosure programs has actually begun on a limited scale in the Commonwealth. In 2006 the Harvard teaching hospitals and the Risk Management Foundation (Malpractice Captive for the Harvard Teaching Institutions) sponsored “When Things go Wrong: Responding to Adverse Events,” a consensus statement regarding the institutional approach to adverse events within the institution.⁵⁴ This consensus statement provides a rough model for implementation in the Commonwealth, and includes an institutional roadmap for dealing with each step of an adverse event. These steps include: initial communication with the family; continued support of the patient and family (addressing all patient or family concerns, maintaining continuity of care, coordinating follow-up, putting on hold all hospital bills, investigating short-term and long-term financial support); formal support of caregivers; sponsoring system-wide training and education programs for managing and communicating adverse events; and developing a hospital policy for responding to adverse events, performing root-cause analysis of adverse events, implementing system changes to prevent future errors, and reporting adverse events within the hospital and to wider regulatory agencies. This consensus statement, though considerably incomplete in its discussion of how to structure early offers of compensation, and not supported yet by the institutional adoption of its framework, is a model for its espousal of a moral and patient-centered approach to responding to adverse events. Please refer to the complete consensus statement, available at: <http://www.macoalition.org/publications.shtml>.

Within the Harvard system, one limited early disclosure and error reduction program has been successfully implemented in the Department of Obstetrics and Gynecology at Beth Israel Deaconess Medical Center. The program initially began in response to a sentinel case where a series of errors resulted in the death of an infant and a surgery to remove the mother’s uterus. Rather than waiting for the case to proceed to a court of law, the department chairman Dr. Ben Sachs reached out to the family, and a financial settlement

⁵⁴ When Things Go Wrong: Responding to Adverse Events. A Consensus Statement of the Harvard Hospitals. Massachusetts Coalition for the Prevention of Medical Errors 2006. Available from www.macoalition.org

was reached within four months, “which included an annual lectureship devoted to enhancing patient safety in the memory of the child.”⁵⁵ Commencing from that case, Dr. Sachs developed a program to identify adverse events (either by case review or from physician’s self-reporting), investigate them thoroughly, reach out to patients and families and communicate regarding the event, and then work in cooperation with the malpractice insurer to identify cases in which to offer compensation. This program is also tied to efforts at “team-building” in order to improve the quality and safety of health care delivered by the entire health care team. Being limited to one department, the claims experience is limited. But the overall belief is that the program has benefited patients, improved the quality of care, and reduced the number of cases ending up in court. Furthermore, the program has had positive effects on the morale all members of the health care team.⁵⁶

Brigham and Women’s hospital also took a step in the right direction, implementing a policy and a process for routinely disclosing adverse outcomes and medical errors to patients and families after the Joint Commission released its full disclosure policy in 2001. Though not comprehensive in scope or tied to education, process improvements, or compensation, Brigham and Women’s policy of disclosing adverse events or medical errors to patients has created a “sea change” in the way health care providers view communication with their patients.”⁵⁷

There is little doubt that momentum for early disclosure programs is building in Massachusetts and in other states. Though small-scale programs are an essential step towards broader implementation in Massachusetts, there is no question that more rapid advancement can proceed with the implementation of demonstration projects supported by the legislature.

⁵⁵ Sachs B. A 38-Year-Old woman with fetal loss and hysterectomy. JAMA August 2005;294(7):833-840.

⁵⁶ Personal communication. Toni Golen. Chair, Committee on Quality Assurance, Beth Israel Deaconess Medical Center, Department of Obstetrics and Gynecology.

⁵⁷ Shapiro E. Disclosing medical errors: best practices from the “leading edge.” Institute for Healthcare Improvement White Paper, In press.

6. RECOMMENDATIONS FOR MASSACHUSETTS

It is the experience from the University of Michigan and the University of Illinois, and the early promise in Massachusetts, which serves as the recommendations for this report. Most attractive for the legislature is that this approach actually requires little of the legislature itself, and though some funding would stimulate hospital interest, the program can theoretically be accomplished without additional state funding. However, the legislature is in the position to stimulate discussion on the issue and promote the adoption of early disclosure programs, mainly by encouraging a program on a pilot basis in hospitals or health care systems in Massachusetts. Listed here is a summary of legislative recommendations, including ones that can facilitate the adoption of early disclosure and compensation programs like that at the Universities of Michigan and Illinois.

1. The legislature should adopt legislation to institute demonstration projects of early disclosure/early compensation programs in the Commonwealth of Massachusetts, modeled after that in place at the University of Illinois Medical Center and the University of Michigan Health System. While each demonstration project should be catered to fit the unique characteristics of each participating hospital, the projects should adhere to certain guidelines as discussed in this brief's introduction, in section 5, and according to the basic implementation steps taken particularly at the University of Illinois. The chosen hospitals should have a strong risk management infrastructure and full support of the hospital administration. Within these demonstration projects, hospitals should be required to review all adverse events, and report such events to the insurer, patient, and the Department of Public Health (for analytic purposes, not yet for public domain). Pilot programs of this type should receive primary attention over the establishment of demonstration projects for health courts, which are recommended by S. 955 and S. 990.
2. The legislature should pass legislation requiring hospitals to adopt policies of "full disclosure" of adverse events and medical errors to patients and families. This would have the effect of stimulating the implementation of robust early disclosure programs in hospitals throughout the Commonwealth.
3. The legislature should pass S. 986, Senator Moore's "Act Relative to Timely Notice," which requires a person planning to take legal action against a health care provider to notify the provider 182 days before any legal action is commenced. This period of notification can serve to facilitate both communication and offers of compensation between the health care provider and risk management team on one side, and the patient on the other. As demonstrated by the experience in Michigan, this prior notification period has the potential to allow hospitals to utilize early compensation as a tool to prevent a malpractice claim.

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4. The legislature should adopt Senator O'Leary's S. 987, "An Act Relative to Health Care Providers' Statements of Regret." Currently 22 states have laws that make an apology involving a "benevolent gesture or expression of sympathy" inadmissible as admission of negligence. This legislation is not a necessary step to achieving the goals explained in this report. Furthermore, many plaintiff's attorneys believe that apologies actually help the health care provider from appearing malicious and may be beneficial to the health care provider. However, insofar as apology legislation may energize the conversation regarding the role of apologies and normalize their use following medical errors, it is a useful legislative tool.

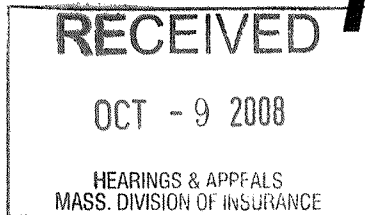
Furthermore, for physicians who do apologize and disclose medical errors to patients, they should be protected by placing limitations on their financial responsibility in the event of a lawsuit, and from having these errors reported or utilized for censure by the state medical board. Transparency and improved patient safety require a real culture change in medicine, which in turn can be fostered by reducing the negative consequences for individual practitioners potentially associated with full disclosure programs. On the other hand, there should be real consequences for providers, risk managers, administrators, or attorneys who deny or advise denial of adverse events or errors made while delivering care.

5. The legislature should adopt expert witness testimony such as that appearing in S. 953, which holds that expert witnesses are those who "(1) hold a non-restricted license from a state licensing board recognized by the Federation of State Medical Boards; (2) are currently board certified by a specialty board approved by the American Board of Medical Specialties or of the Advisory Board of Osteopathic Specialists from the major areas of clinical services as the defendant physician, and (3) actively practice in the same specialty as the defendant physician." The legislature must not allow physicians without experience in the defendant's specialty to serve as a plaintiff's expert witness.
6. The legislature should adopt reforms that institute proportionate liability in place of joint-several liability, such as that appearing in section 1 of S. 953. Proportionate liability would hold each defendant liable only for the amount of damages in direct proportion to that defendant's percentage of fault, and a separate judgment shall be rendered against that defendant for that amount. While this reform does not pertain directly to early disclosure programs, it is an essential tool for the few cases that end up in court and result in exorbitant and disproportionate awards to the plaintiffs.

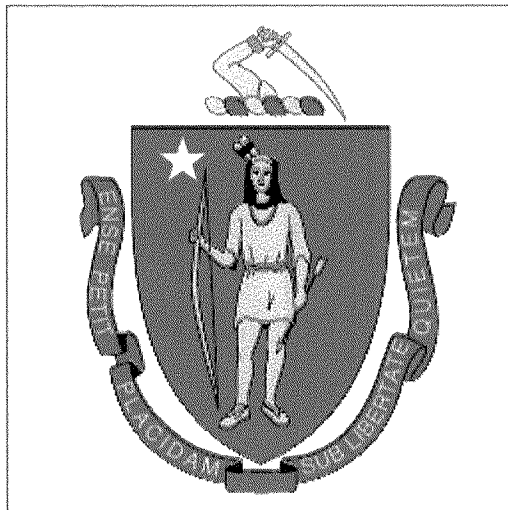
BIBLIOGRAPHY

1. Cohen T, Hughes K. Medical malpractice insurance claims in seven states, 2000-2004. Bureau of Justice Statistics Special Report, March 2007.
2. Massachusetts Medical Society Physician Workforce Study, Executive Summary 2007. Available at:
http://www.massmed.org/Content/NavigationMenu/NewsandPublications/ResearchReportsStudies/PhysicianWorkforceStudy/2007Workforce_ExecSummary.pdf
3. When Things Go Wrong: Responding to Adverse Events. A Consensus Statement of the Harvard Hospitals. Massachusetts Coalition for the Prevention of Medical Errors 2006. Available from www.macoalition.org
4. Boothman R. The benefits of an open and honest dialogue: The University of Michigan Health System's medical malpractice claims experience. Beyond the Blame Game: A forum on professional liability in medicine. March 27, 2007. Waltham, MA.
5. Lazare A. On Apology. Oxford. Oxford University Press, Inc. 2004.
6. Vincent C, Young M, Phillips A. Why do people sue doctors? A study of patients and relatives taking legal action. *Lancet* 1994;343(8913):1609-13.
7. McDonald T, Chamberlin W. Full disclosure and rapid remedy: More than just saying sorry. Creating a comprehensive program for responding to adverse patient events. *Journal of Management and Marketing in Health Care*. In Press.
8. Studdert DM, Mello MM, Brennan TA. Medical malpractice. *N Engl J Med* 2004; 350(3):283-92.
9. Danzon PM. Medical malpractice: theory, evidence, and public policy. Cambridge, MA: Harvard University Press 1985.
10. Thomas EJ, Studdert DM, Burstin HR, et al. Incidence and types of adverse events and negligent care in Utah and Colorado. *Med Care* 2000; 38:261-71.
11. Bovbjerg RR. Commentary: malpractice reform in policy perspective. *The Millbank Quarterly* 2007;85(2):297-305.
12. Studdert DM, Mello MM, Gawande AA, et al. Claims, errors, and compensation payments in medical malpractice litigation. *N Engl J Med* 2006; 354(19):2024-33.
13. Kohn L, Corrigan J, Donaldson M, eds. To Err is Human: Building a Safer Health System. Committee on Quality of Health Care in America, Institute of Medicine. National Academy Press, Washington, D.C. Available at http://www.nap.edu/catalog.php?record_id=9728#toc. Last accessed August 7, 2007.
14. Studdert DM, Brennan TA. No-fault compensation for medical injuries. The prospect for error prevention. *JAMA* 2001;286:217-23.
15. Brennan TA, Sox CM, Burstin HR. Relation between negligent adverse events and the outcomes of medical-malpractice litigation. *N Engl J Med* 1996;335:1963-7.
16. Mello MM. Understanding medical malpractice insurance: a primer. The Robert Wood Johnson Foundation: Research Synthesis Report No. 8. January 2006.
17. Professional liability insurance reform. Available at <http://www.texmed.org/Template.aspx?id=780>. Last accessed February 19, 2008.
18. Mello MM. Medical malpractice: impact of the crisis and effect of state tort reforms. The Robert Wood Johnson Foundation: Research Synthesis Report No. 10. May 2006.
19. Shapiro E. Disclosing medical errors: best practices from the "leading edge." Institute for Health Care Improvement White Paper, In press.
20. Boothman RC. Apologies and a strong defense at the University of Michigan Health System. The Physician Executive March-April 2006;7,10.
21. Mello MM, Studdert DM, Kachalia AB, et al. "Health courts" and accountability for patient safety. *The Millbank Quarterly* 2006;84(3):459-92.
22. Gallagher TH, Studdert D, Levison W. Disclosing harmful medical errors to patients. *N Engl J Med* 2007;356(26):2713-9.
23. Kachali A, Shojania KG, Hofer TP, et al. Does full disclosure of medical errors affect malpractice liability? *Joint Commission Journal on Quality and Safety* 2003;29:503-511.
24. Sachs B. A 38-Year-Old woman with fetal loss and hysterectomy. *JAMA* August 2005;294(7):833-840.

Massachusetts Fixed the “Malpractice Crisis” and Punishes the Victims



The Laws of the Commonwealth ENCOURAGE
Malpractice, and increases costs



Matt Rearwin
Father of Erik Rearwin
Sutton, Massachusetts
Division of Insurance Hearing
October 8, 2008

M2008-01
October 8, 2008

Good Morning!

- You are in a position to do something about medical malpractice costs.
- The course taken by the state for the past 4 decades has increased costs, and increased motivations and protections for malpractice.
- The state legislature, has in essence, decided to shift the cost burden to the victims
- This has been counterproductive to doctors, patients, and medical malpractice insurers
- Please buck the trend and recommend that some unjust laws be changed

Introduction to the Costs

- Social Costs
 - Every day, my family pays a price for medical malpractice
 - I know many families who do
 - Kids with crippled arms. Kids with intestines taken out. Kids deafened like my son. Kids with needless invasive procedures done. Kids blinded. Kids left in a vegetative state. Kids killed.
 - We have no legal recourse
 - This is Massachusetts
- Financial Costs
 - Instead of the malpractice insurer paying, the family pays (cash, home equity, retirement funds, bankruptcy)
 - The family medical insurance company pays
 - The state pays

A little history

- The Legislature in 1986 gave more of a shield to bad doctors via the statute of repose
- The Charitable Exemption law is rooted in an earlier time, when “charity” meant something different in 1876, and in 1971
- Children and families pay the price of this
- The SJC has ruled that the law stands, even in cases of “fraudulent concealment”
- The SJC has ruled many times that the Legislature should change the law if they want different outcomes
- The Legislature has ordered this hearing today

Statute of Repose

Chapter 231: Section 60D. Claim by minor against provider of health care; limitations

Section 60D. Notwithstanding the provisions of section seven of chapter two hundred and sixty, any claim by a minor against a health care provider stemming from professional services or health care rendered, whether in contract or tort, based on an alleged act, omission or neglect shall be commenced within three years from the date the cause of action accrues, except that a minor under the full age of six years shall have until his ninth birthday in which the action may be commenced, but in no event shall any such action be commenced more than seven years after occurrence of the act or omission which is the alleged cause of the injury upon which such action is based except where the action is based upon the leaving of a foreign object in the body.

Charitable Exemption

Chapter 231: Section 85K. Limitation of tort liability of certain charitable organizations; liability of directors, officers or trustees of educational institutions

Section 85K. It shall not constitute a defense to any cause of action based on tort brought against a corporation, trustees of a trust, or members of an association that said corporation, trust, or association is or at the time the cause of action arose was a charity; provided, that if the tort was committed in the course of any activity carried on to accomplish directly the charitable purposes of such corporation, trust, or association, liability in any such cause of action shall not exceed the sum of twenty thousand dollars exclusive of interest and costs. Notwithstanding any other provision of this section, the liability of charitable corporations, the trustees of charitable trusts, and the members of charitable associations shall not be subject to the limitations set forth in this section if the tort was committed in the course of activities primarily commercial in character even though carried on to obtain revenue to be used for charitable purposes.

No person who serves as a director, officer or trustee of an educational institution which is, or at the time the cause of action arose was, a charitable organization, qualified as a tax-exempt organization under 26 USC 501(c)(3) and who is not compensated for such services, except for reimbursement of out of pocket expenses, shall be liable solely by reason of such services as a director, officer or trustee for any act or omission resulting in damage or injury to another, if such person was acting in good faith and within the scope of his official functions and duties, unless such damage or injury was caused by willful or wanton misconduct. The limitations on liability provided by this section shall not apply to any cause of action arising out of said person's operation of a motor vehicle.

Summary of Those Laws

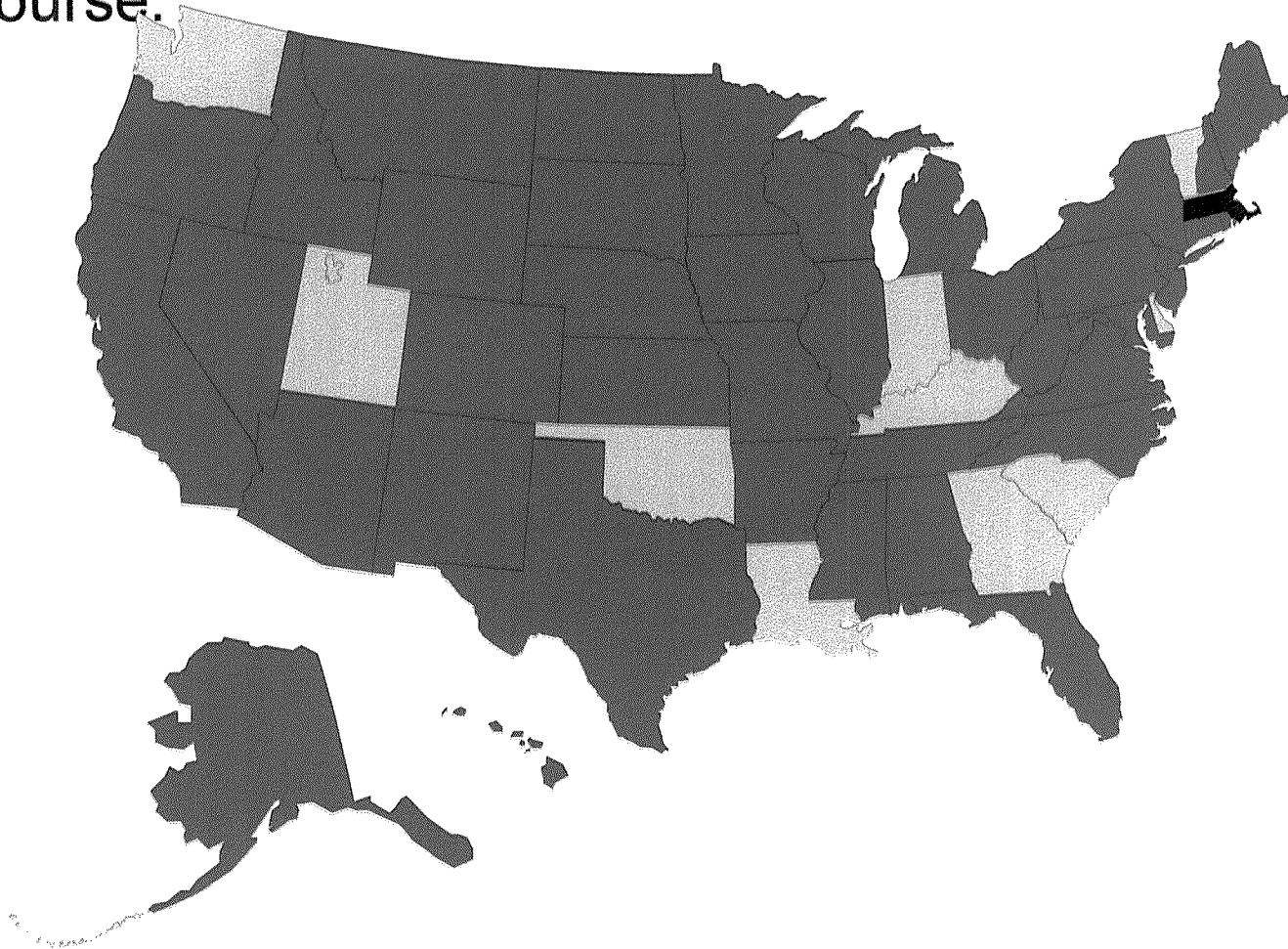
- If Doctors hide the facts for 7 years, they are in the clear
- Hospital CEOs, the people who would have the greatest ability to improve the quality of care, have no worries of legal liability. The \$20K award limit isn't enough to get a liability attorney going; it is 3 days pay for a CEO.
- Children like Sentree Joslyn, Andrew Chase, Lequasia Plummer, Matt Harlfinger, Aaron Nett, Dylan Keene, Kerrie Ann English, and Erik Rearwin pay the price for malpractice

Summary of the Impact of the Present Repose Law

- Withholding information and “fraudulent concealment” is rewarded
- Children and families are harmed
- The State picks up the tab with special ed and long term care, instead of those responsible
- Dangerous medical practices continue; hospitals don’t seem to adequately staff the doctor and nurse ranks.
- One means to improve the quality of care is the lawsuit, and that avenue is closed. When unethical behavior is found, it is beyond the time at which the Board of Registration in Medicine would do anything.
- Children in the future are harmed because the quality of medicine and medical ethics has not been driven to the full potential.
- ***YOUR CHILD OR GRANDCHILD COULD BE NEXT!!!!***

Time Limit in Other States?

- If Sentree, Andrew, Lequasia, Matt, Aaron or Erik was born in 40 other states, parents would have had legal recourse.



Charitable Immunity?

- Dylan Keene – left in a vegetative state; hospital records missing; the point is moot because the hospital is a charity
- Kerrie Ann English – blinded by surgical error, the \$20K limit was upheld
- Today, a hospital CEO like John O'Brien at UMMHC will earn \$20K in several days
- A charity (UMMHC) will hire the former state Medicaid administrator, Wendy Warring, for \$700K a year
- A charity (UMMHC) will have \$100 Million in the Grand Caymans
- Is this what the legislature had in mind in 1971 when thinking of a "charity"

Other States & Massachusetts

- Many other states are known for great doctors, as is Massachusetts
- Other states have statutes of limitations and repose which allow for a day in court
- The present Massachusetts law, if it is reducing malpractice insurance costs, is doing so in an unjust way, and children are being harmed
- These 40 states have 90% of the US population; this means that 90% of the people in the US have MORE RIGHTS than citizens of the Commonwealth.
- The Legislature certainly never intended this when the present law was passed in 1986

In Summary

- Massachusetts has codified a support for a doctors “Code of Silence”, this hurts kids and their families, and increases the malpractice done
- Massachusetts has codified protection for CEOs, at the expense of children. This is doubly bad, as the CEO is in the best position to create systemic improvements for all patients
- Even the SJC notes that these laws reward fraudulent concealment
- These laws are counterproductive: malpractice is encouraged and rewarded.

References

- www.erikslaws.com
- <http://www.statutes-of-limitations.com/>
- **Repose law** <http://www.mass.gov/legis/laws/mgl/231-60d.htm>
- **Exemption law** <http://www.mass.gov/legis/laws/mgl/231-85k.htm>
- **Joslyn case:** http://www.suffolk.edu/sjc/archive/opinions/SJC_09539.pdf
- **Chace case:** <http://www.socialaw.com/slip.htm?cid=15408&sid=121>
- **Plummer case:**
<http://caselaw.lp.findlaw.com/scripts/getcase.pl?court=ma&vol=appslip%5C/96p1550&invol=1>
- **Harlfinger case:** <http://caselaw.findlaw.com/scripts/getcase.pl?court=ma&vol=sjcslip/8356&invol=1>
- **Nett case:** <http://www.ca1.uscourts.gov/cgi-bin/getopn.pl?OPINION=00-1357.01A>
- **Keene case:** http://www.accessmylibrary.com/coms2/summary_0286-6095507_ITM
- **Other media coverage of Erik** <http://www.telegram.com/article/20070909/NEWS/709090463>
- <http://www.boston.com/partners/worldnow/necn/landingpage.html?clipid=1749282&topVideoCatNo=83467&c=83467&autoStart=true&activePane=info&LaunchPageAdTag=homepage>

Appendix

- The remaining pages will describe a few children and their situations in more detail

Sentree Joslyn: the Impact of the Present Law

- A case: Sentree died as a result of a mistake with a scalpel.
- This was kept from the parents, and when discovered, after the 7 year statute time, the case went to trial. The SJC noted the withholding of information was “fraudulent concealment”
- SJC affirmed the present law, and said, *“In the Franklin decision, we noted that any concern that the new rule would “fan the medical malpractice crisis by resulting in more claims that in turn contribute to higher insurance premiums and, finally, to curtailment of health care services,” was “better addressed to the Legislature, which of course, free to make a contrary reconciliation of the conflicting policies involved or to place an outside limit on the time for bringing a malpractice action” (emphasis added). In this regard, we referred to the laws of several other States that had done precisely that.”*
- What is the impact?
 - One child died, one family harmed, and a risky medical procedure is not identified, thus medical quality is not improved
 - The SJC notes the cost of malpractice insurance. The SJC also refers to what other states are doing.

Andrew Chace: the Impact of the Present Law

- Another case: Andrew was harmed at birth, his oxygen was restricted, and he is afflicted by severe mental and physical disabilities.
- After the statute duration, one of the medical staff brought forth information that the medical records were falsified. The case went to trial.
- SJC affirmed the present law, saying, *“The legislative purpose behind the two statutes of repose at issue in this case is the “reduction of the cost of malpractice insurance for health care professionals in order to insure affordable health care.” .”*
- The SJC quoted from an earlier ruling to remind us of the **inducement to fraudulent behavior** by the present law, *“Judge Hillman expressed concern over the potentially negative policy considerations for allowing a party who fraudulently concealed a cause of action to escape liability, stating that, to hold that a defendant can be relieved from liability for wrongful or tortious acts by concealing them during the period of repose would provide an incentive for fraud.” ”*
- The SJC noted, *“**our Legislature is willing to tolerate a certain degree of inequity** in order to realize the goals behind a statute of repose. Accordingly, this Court finds that fraudulent concealment cannot toll the statute of repose”*
- What is the impact?
 - The life Andrew should have had is not to be
 - Hiding the facts is shown to benefit those who may have caused harm
 - His mother is not afforded the financial benefits to optimally care for her son
 - It is unclear that the present law helps malpractice insurance costs.
 - It seems to be clear that the present law does not improve the quality of care or communications

Lequasia Plummer: the Impact of the Present Law

- Another case: Lequasia was harmed at birth [an arm injury]. After the mother became aware that the injury was avoidable, the case went to trial after the 7 year statute period.
- The SJC affirmed the present law, and said, *“In order to counter the effect of this decision on the cost of malpractice insurance and its resulting effect on the cost of health care, the Legislature amended the applicable statute of limitations for medical malpractice claims for both minors and adults by adding a statute of repose barring the bringing of an action against a health care provider more than seven years after the act or omission which gave rise to the cause of action.”*
- The Impact?
 - Lequasia is denied a day for justice in the courts
 - The SJC says it comes down to money
 - So who pays? The burden is upon the children and families of the Commonwealth, and....
 - this could cost the Commonwealth for a lifetime of disabilities, rather than the insurance company for the doctors and hospitals.

Matt Harlfinger: the Impact of the Present Law

- Another case: Matt was treated for an arm injury at age 4. A course of therapy was prescribed, but apparently the fracture had not healed. Another doctor found this out within the 7 year window, when treating the boy for continuing arm pain and problems.
- After the 7 year window, the case went to trial.
- SJC affirmed the present law, and said, *“The statute of repose at issue here was passed as part of a larger, long-term effort to curb the cost of medical malpractice insurance and keep such insurance available and affordable.”*
- The SJC also said, *“If, as the plaintiffs contend, the Legislature overreacted to the perceived danger, or if, as the plaintiffs argue, the costs of minors' claims brought after seven years are too minimal to have a real impact on insurers, the plaintiffs must address their arguments to the Legislature..”*.
- What is the Impact?
 - A boy who should have full use of his arm does not.
 - It is reinforced that a child who is unable to advocate for his own health care is left with poor care.
 - The SJC notes that it comes down to money, and the Legislature should be brought to bear on the matter.

Aaron Nett: the Impact of the Present Law

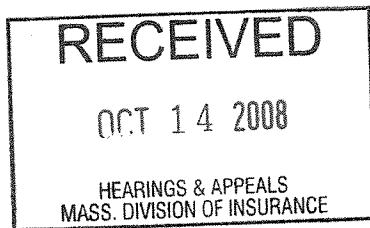
- Another case: Aaron was injured during birth 4/2/92. A suit was filed against the obstetrician at 4 years of age. During “discovery”, the hospital claimed records were destroyed. After 8 months, in response to a ‘subpoena duces tecum’, the hospital produced the records on 2/4/99, close to the 7 year point. With the records finally in hand, the parents realized that a radiologist may have misinterpreted an ultrasound prior to birth. The parents sought to change the suit to include the radiologist. The date was now 7 years and a few weeks beyond the date of the reading of the ultrasound.
- The case against the radiologist was rejected by the US District Court, based upon the present law.
- The Impact:
 - Keeping information from parents is shown to work to protect against lawsuit
 - Parents are unable to try to get justice for their son

Erik: the Impact of the Present Law

- Erik was given gentamicin at birth. Erik's parents weren't told of this; weren't told of the possible side effects or risks of deafness and balance disorders; weren't told that the dosages had to be monitored and were not.
- To diagnose and uncover the reasons for Erik's developmental problems, he has seen over 40 doctors at U-Mass Memorial, and he's endured spinal taps, sedations, and other needless treatments.
- When Erik was 8, parents were told by another mom of the drug, and began checking records, they found that Erik had been given the drug.
- The Impact?
 - This has cost the family dearly,
 - This costs the state over \$100K yearly for special ed.
 - Parents have no recourse.
 - Leaders at U-Mass Memorial have asserted that it is good ***NOT TO TELL*** parents of the use of gentamicin in published accounts
 - This does not benefit the quality of care.
- Erik has undergone \$50K of needless medical tests, invasive procedures, sedations, in order to understand his condition; no doctors ordering the tests mentioned anything about how his earlier treatments were at the root of it.



Florida
Department of Financial Services



**REVIEW OF FLORIDA
COMMITTEE SUBSTITUTE
FOR SENATE BILL 2-D**

**Calculation of Section 40
"Presumed Factor"**

Deloitte.

NOVEMBER 6, 2003

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November 6, 2003

Mr. J Steve Roddenberry
Deputy Director
Office of Insurance Regulation
J. Edwin Larson Building
200 East Gaines Street, Suite 121
Tallahassee, FL 32399-0326

Dear Mr. Roddenberry:

We are pleased to submit our actuarial review of Committee Substitute for Senate Bill 2-D and our calculation of Section 40's "Presumed Factor".

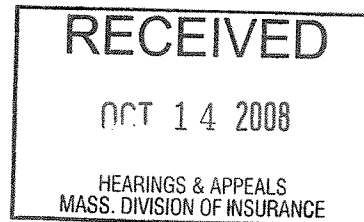
It was a pleasure working with you and we look forward to serving the Office of Insurance Regulation in the future. Please do not hesitate to call either Jan at (860) 543-7350, Kevin at (860) 543-7345 or Rich at (305) 789-9315 if we can be of any further assistance.

Sincerely,

Jan Lommele, FCAS, MAAA, FCA
Principal – Deloitte.

Kevin Bingham, ACAS, MAAA
Senior Manager – Deloitte.

Richard Simring, Attorney at Law
Partner – Stroock



0001484R

PRESUMED FACTOR

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PRESUMED FACTOR

I. EXECUTIVE SUMMARY

PURPOSE AND SCOPE

Deloitte & Touche LLP (Deloitte) has been retained by the Florida Department of Financial Services Office of Insurance Regulation (OIR) to evaluate the impact of recently passed Senate Bill 2-D (SB2D) on medical malpractice insurance rates in Florida.

Section 40 of the bill requires the OIR to calculate a presumed factor reflecting the impact that such reforms will have on rates for medical malpractice insurance and to publish such factor within 60 days of the effective date of the new law. The law further requires insurers to, within 60 days of publication of the presumed factor, make a rate filing reflecting the anticipated savings of the reforms.

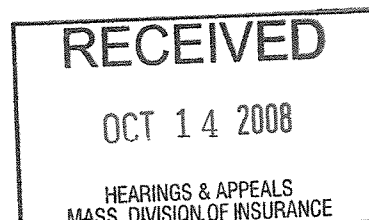
In accordance with the contract signed on September 19, 2003, Deloitte has been asked by the OIR to analyze each Section of SB2D and provide a presumed factor impact, by Section, expressed in the form of a one decimal place percentage adjustment to base rates. Where a Section has no rate impact, Deloitte will disclose it.

BACKGROUND

Medical Malpractice Synopsis¹

A claim for medical malpractice means a claim arising out of the rendering of, or the failure to render medical care services. An "action for medical malpractice" is a tort or breach of contract claim for damages due to the death, injury, or monetary loss to any person arising out of any medical, dental, or surgical diagnosis, treatment, or care by any provider of healthcare.

In any action for recovery of damages based upon medical malpractice, the claimant has the burden of proving the alleged actions of the healthcare provider represented a breach in the



PRESUMED FACTOR

prevailing standard of care for that type of healthcare provider. The prevailing professional standard of care for a given healthcare provider is that level of care, skill and treatment which, in light of all relevant surrounding circumstances, is recognized as acceptable and appropriate by reasonably prudent, similar healthcare providers.

DISTRIBUTION AND USE

Deloitte understands that all records or data produced by Deloitte in response to this engagement are subject to applicable public records law(s). OIR personnel are available to respond to any questions with respect to this report. Deloitte will direct all third party requests for such records to the OIR.

RELIANCE AND LIMITATIONS

Estimates of the presumed factor by Section are based on background information, publicly available information, exposure data and loss data provided by the OIR. A specific audit of the data and background information is beyond the scope of this project. We have conducted such reasonableness tests of the data as we felt appropriate. In all other respects, we have relied without audit or verification on the data and background information provided. Any assumptions, adjustments or modifications made by Deloitte to the data will be documented in detail throughout the remainder of this report.

In our opinion, the estimates presented herein for the OIR produce presumed factors by Section based on accepted actuarial standards and principles.

In estimating the presumed factor by Section, we have assumed that historical trends, adjusted for the impact of SB2D, can be used to predict the future. The estimates make no provision for extraordinary future emergence of new types of losses or new cures not sufficiently represented in the historical information we reviewed or which are not yet quantifiable such as a major

¹ 2003 University of Central Florida Governor's Select Task Force on Healthcare Professional Liability Insurance, Chapter 2

PRESUMED FACTOR

advancement in medical technology or a cure for a disease like cancer or Alzheimers. We have applied what we feel are reasonable procedures in our analysis. However, due to the volatility of the loss exposures reviewed, the historical tracking of data by claim and not by claimant, and the limited amount of historical jury verdict data quantifying economic verses noneconomic damages, no assurance can be offered that actual savings will emerge according to the estimates contained in this report.

In addition, Deloitte's Section by Section quantification of the presumed factor relies upon aggregate Florida data. Therefore, to the extent that an individual insurer's book of business mix varies significantly from Florida's aggregate data, the presumed factor may need to be adjusted to reflect an individual company's actual exposure.

For example, a medical malpractice insurance company that writes a heavy concentration of low risk specialties (e.g., chiropractors, allergists, dermatologists – no surgery) would likely see a much lower savings than estimated by the presumed factor since low risk specialties typically have minimal exposure to large jury awards and bad faith judgments.

OVERALL PRESUMED FACTOR

In accordance with Section 40 of the bill, Deloitte has estimated the following overall presumed factor reflecting the impact SB2D will have on rates for medical malpractice insurance companies in the state of Florida:

Presumed Factor: 7.8%

PRESUMED FACTOR

II. PRESUMED FACTOR BY SECTION

The documentation for each Section is laid out as follows:

- Section number and title;
- Noteworthy additions;
- Noteworthy deletions;
- Commentary; and
- Selected impact.

Our additions, deletions and commentary have been focused specifically on areas of SB2D that we feel are important in the determination of the presumed factor. There are a number of other additions and deletions that we have not commented on in each Section. The purpose of this section of our report is not to reiterate every change in SB2D, but to focus the reader's attention on additions and deletions that we consider relevant to the work we have been asked to perform.

A complete copy of SB2D including deletions, modifications and additions can be obtained from the web site www.myflorida.com under "find an agency" or by directly accessing the web site www.leg.state.fl.us.

The following Section by Section documentation assumes the reader has thoroughly read the 171 page SB2D Statutes with coding marking deletions and additions.

Section 1 – Findings

This Section documents the eighteen key findings identified by the Florida Legislature. The findings in this Section are consistent with findings identified in other states across the nation. Although the relative level of each crisis may vary by state, the following detail some of SB2D's findings:

PRESUMED FACTOR

- There is a medical malpractice insurance crisis in the State of Florida.
- The crisis impacts the quality and availability (e.g., physicians retiring early, not performing high-risk procedures) of health care.
- Florida is among the states with the highest medical malpractice insurance premiums in the nation.
- Premiums have increased dramatically during the past decade, above the national average.
- There are certain elements of damage presently recoverable that have no monetary value (i.e., noneconomic damages), except on a purely arbitrary basis, while other elements of damage (i.e., economic damages) are either easily measured on a monetary basis or reflect the ultimate monetary loss.
- The high cost of medical malpractice claims can be substantially alleviated by imposing a limitation on noneconomic damages in medical malpractice actions.

SELECTED IMPACT: 0.0%

Section 2 – Litigation Notice Requirements

NOTEWORTHY ADDITIONS: NONE

NOTEWORTHY DELETIONS: NONE

COMMENTARY: NONE

SELECTED IMPACT: 0.0%

PRESUMED FACTOR

Section 3 – Staff Membership and Clinical Privileges

NOTEWORTHY ADDITIONS: NONE

NOTEWORTHY DELETIONS: NONE

COMMENTARY: NONE

SELECTED IMPACT: 0.0%

Section 4 – Internal Risk Management Program

NOTEWORTHY ADDITIONS:

“A system for informing a patient or an individual identified pursuant to s. 765.401(1) that the patient was the subject of an adverse incident, as defined in subsection (5). Such notice shall be given by an appropriately trained person designated by the licensed facility as soon as practicable to allow the patient an opportunity to minimize damage or injury.”

“Each licensed facility shall annually report to the agency and the Department of Health the name and judgments entered against each health care practitioner for which it assumes liability. The agency and Department of Health, in their respective annual reports, shall include statistics that report the number of licensed care practitioners, by profession, for whom they assume liability.”

NOTEWORTHY DELETIONS:

Removal of old notification requirements.

COMMENTARY:

See our comments on patient notification below.

In addition, we note that most large providers of medical services have already created sophisticated risk management and loss prevention programs. Even private practices have generally retained consulting support for risk management practices and procedures that include loss prevention.

PRESUMED FACTOR

It is important to note that these practices also include measures to be taken to limit or avoid liability. One phenomenon that we have noted elsewhere in this report is that physicians are purchasing lower policy limits. This trend is not simply the result of shrinking insurance capacity and skyrocketing rates; it reflects a belief that plaintiffs' attorneys will gravitate toward practitioners carrying higher limits. Not wanting to be a primary target of a plaintiff attorney by carrying higher policy limits (while others physicians suffer smaller claims because of lower policy limits), physicians have acted rationally by reducing their liability limits to avoid being targeted as the first among several in any multiple defendant action.

SELECTED IMPACT: 0.0%

Section 5 – Repeals 395.0198

NOTEWORTHY ADDITIONS: NONE

NOTEWORTHY DELETIONS: Repeal of 395.0198

COMMENTARY: NONE

SELECTED IMPACT: 0.0%

Section 6 – Patient Safety

NOTEWORTHY ADDITIONS:

“(2) Each licensed facility shall appoint a patient safety officer and a patient safety committee, which shall include at least one person who is neither employed by nor practicing in the facility, for the purpose of promoting the health and safety of patients, reviewing and evaluating the quality of patient safety measures used by the facility, and assisting in the implementation of the facility patient safety plan.”

PRESUMED FACTOR

NOTEWORTHY DELETIONS: NONE

COMMENTARY:

The development of patient safety programs is a rapidly-emerging phenomenon among large healthcare provider systems. These are principally aimed at devising systems that examine past adverse events and even near-misses with a view toward avoiding preventable mistakes and engineering away the possibility of damage resulting from errors made by a single human being. Most large providers with whom we have worked have already implemented internal approaches to patient safety and are quite active in the field.

The Statute's provision (Section 10(2)) limiting the discoverability of patient safety data provides some incentive to continuing to develop these systems. The Statute will serve to build on progress that has been made thus far; few, if any, major healthcare providers will be only initiating patient safety programs strictly as a result of this Statute. Further, it is important to note that the law is drafted carefully to limit the discoverability of this data only insofar as it relates to the safety program. To the extent that the data becomes available in a way that is not strictly within the limits of the safety program, the data is discoverable. Also, there is little that prevents a person who has testified before a safety committee to essentially replicate that testimony in a different setting. The *testimony* cannot be used, but the witness *can* be recalled. The relevance of this passage will be limited for cases where it is hard to de-identify patient information as a result of specific case facts.

The larger impact of this aspect of the Statute will be its effect on smaller provider organizations. We expect that in order to comply with these provisions, most will be working with outside consultants to implement patient safety plans. At this time, we do not expect that these will represent a significant deviation from current risk management and patient safety practices, and are not likely to result either in significantly reduced malpractice events or consequent claims activity.

PRESUMED FACTOR

It is important to note that the intent of patient safety systems is to introduce a “no fault” aspect to the investigation of adverse incidents, with the goal of understanding the breakdown that led to the incident in order to design new patient care systems that engineer away potential errors. As medical errors are investigated in a “no fault” system, the patient safety system encourages practitioners to discuss errors in a safe environment without fear of retribution. Unfortunately, legislative changes with regard to practitioner discipline serve to undo the positive impact of this safe environment, simply reinforcing practitioners’ belief that acting to avoid liability remains the best course of action.

In sum, as medical errors are acted upon with moral outrage and a need to punish, practitioners cannot be realistically expected to maximize the benefit of safety systems that rely on an open discussion of past mistakes.

SELECTED IMPACT: De Minimis Savings

Section 7 – Duty to Notify Patients (Facility)

NOTEWORTHY ADDITIONS:

“An appropriately trained person designated by each licensed facility shall inform each patient, or an individual identified pursuant to s. 765.401(1), in person about adverse incidents that result in serious harm to the patient. Notification of outcomes of care that result in harm to the patient under this Section shall not constitute an acknowledgement or admission of liability, nor can it be introduced as evidence.”

NOTEWORTHY DELETIONS: NONE

COMMENTARY:

The Governor’s Select Task Force on Healthcare Report cited a study that conducted a survey in which the practitioner informed the patient that an error had been made only about 31% of the time, and had apologized in only about 33% of the cases. There appears to be a theory that

PRESUMED FACTOR

direct, improved communication with patients will reduce the likelihood of adversarial lawsuits. Healthcare risk management professionals with whom we have worked in prior engagements have nearly all reported that high-quality patient communication is an important influence in reducing the severity of malpractice claims.

Currently, because of a fear that any admission of error can lead directly to liability, most physicians are counseled to avoid admission of any error. This frequently leads to a significant reduction in patient contact and communication during a critical time – when the practitioner can assure the patient of his or her concern for the patient’s well-being.

The hope and expectation was that new notification requirements would stimulate behavior that has been observed in such other insurance lines as workers’ compensation. In that line of business, large corporate employers have implemented “Total Disability Management” programs that have featured early and intense intervention by the employer aimed at expressing concern for the well-being of the employee/claimant. It has been widely successful in reducing lost work time and returning employees to work more rapidly.

However, there are some critical differences between medical malpractice liability and workers’ compensation, the most important being that workers’ compensation is a “no fault” coverage. Employers are working to *minimize* the impact of employee workplace injuries, not deny responsibility for them. Therefore, their behavior towards the employee/claimant, while still carefully controlled, is not enveloped in concerns about liability.

The new requirement to notify patients directly and in person is public knowledge. Regardless of any good will that is intended by practitioners in timely notifying patients of adverse incidents, patients will know that they are being informed of “adverse incidents” because practitioners are *required* to do so.

PRESUMED FACTOR

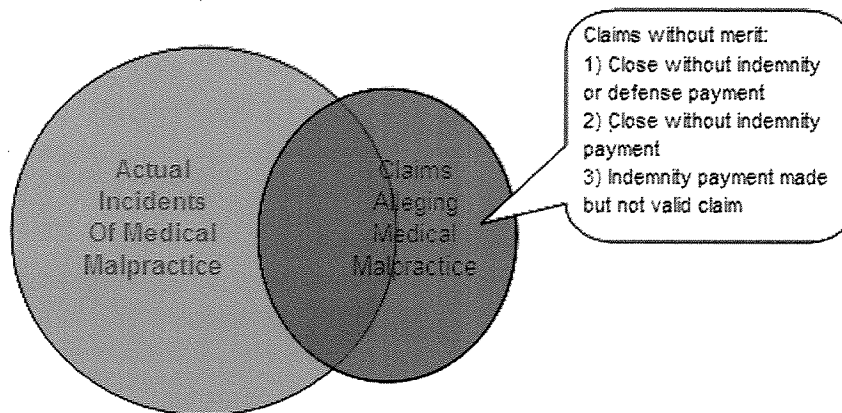
Furthermore, it is almost certain that the in-person notification will be a highly-scripted event; the practitioner or the facility representative delivering this notification will use language that is carefully crafted to emphasize non-admission of liability and strict compliance with the Statute. The improved patient communication that is hoped for in the Statute is likely to give way to pro forma “legalese” that may only serve to accelerate the claim process. In short, increased communication with patients is necessary, but not sufficient, in reducing the cost of claims; the quality and effectiveness of that communication at the human level is the critical factor.

Healthcare practitioners who are already very wary of the plaintiffs’ bar and its effects on their practices are not likely to change their communications style quickly, particularly when the new Statute is untested. This is particularly true given the Statute’s new provisions regarding reporting and disciplining of healthcare practitioners.

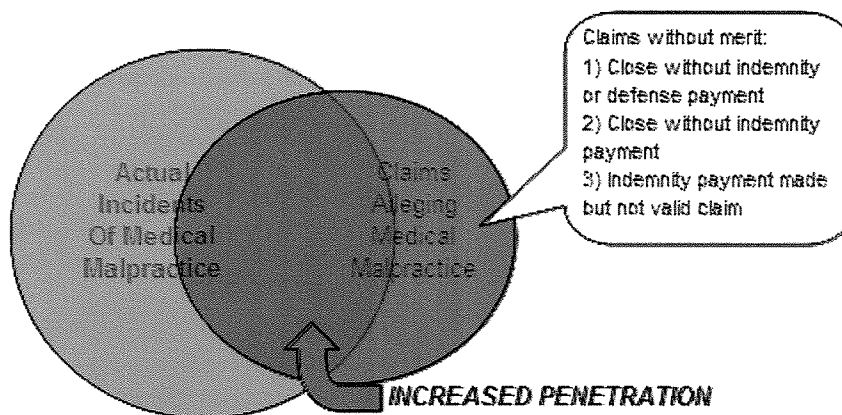
Practitioners are already required to notify the agency of numerous types of adverse incidents; the new legislation has added three new types of occurrences that would trigger required notification to the agency. And, “serious harm” may be an expression that requires further definition.

Among the total set of claims alleging medical malpractice, only a subset are valid; similarly, only a subset of actual malpractice events result in claims.

PRESUMED FACTOR



Under the new Statute, patients will be made aware of situations and conditions of which they would *not* have been made aware under the previous Statute, both because of the duty to notify the patient directly, and the expanded definition of “adverse incident.” Assuming that the notification requirement will not affect the number of actual malpractice events that occur, it is possible that notification will lead to higher claim frequency, and increased penetration of valid claims into the set of actual malpractice events.



Previously, adverse incidents reported only to the state could be investigated by the state, creating the likelihood that patients would first learn of the adverse incident from a third party. This set of

PRESUMED FACTOR

circumstances was likely to create an adversarial situation between patient/claimant and practitioner, leading to lengthy litigation. Now, due to the early direct patient communication necessitated by the Statute, it is possible that a higher proportion of these claims will be settled quickly.

It is worth noting that “adverse incident,” as defined in Section 4 of the legislation, does not match exactly with the definition that appears in Section 22. And it is troubling that “serious harm” is not defined anywhere in the legislation. It is certainly possible and even likely that this could be interpreted by patients and their attorneys as including psychological harm. In any case, the expansion of the definition of “adverse incident,” combined with the lack of definition of “serious harm,” creates a strong likelihood that overall claims frequency will increase.

In summary, while increasing patient communications is intended to protect the interests of patients and decrease the level of suspicion with which the healthcare practitioners are viewed, it is not clear that the notification requirement will lead to lower loss costs. We believe that claims frequency will likely increase; we also believe, however, that timely notification and communication can lead to faster and less expensive settlements. The net outcome is uncertain, and we would project a neutral impact.

SELECTED IMPACT: De Minimis Cost

Section 8 – Duty to Notify Patients (Health Care Practitioner)

NOTEWORTHY ADDITIONS:

“Every licensed health care practitioner shall inform each patient, or an individual identified pursuant to s. 765.401(1), in person about the adverse incidents that result in serious harm to the patient. Notification of outcomes of care that result in harm to the patient under this Section shall not constitute an acknowledgment (or) admission of liability, nor can such notifications be introduced as evidence.”

PRESUMED FACTOR

NOTEWORTHY DELETIONS: NONE

COMMENTARY: See above.

SELECTED IMPACT: De Minimis Cost

Section 9 – Civil Immunity for Members of or Consultants to Certain Boards, Committees, or Other Entities

NOTEWORTHY ADDITIONS: NONE

NOTEWORTHY DELETIONS: NONE

COMMENTARY: NONE

SELECTED IMPACT: 0.0%

Section 10 – Patient Safety Data Privilege

NOTEWORTHY ADDITIONS: NONE

NOTEWORTHY DELETIONS: NONE

COMMENTARY: NONE

SELECTED IMPACT: 0.0%

Section 11 – Department; General Licensing Provisions

NOTEWORTHY ADDITIONS: NONE

NOTEWORTHY DELETIONS: NONE

COMMENTARY: NONE

SELECTED IMPACT: 0.0%

PRESUMED FACTOR

Section 12 – Fees; Receipts; Disposition

NOTEWORTHY ADDITIONS: NONE

NOTEWORTHY DELETIONS: NONE

COMMENTARY: NONE

SELECTED IMPACT: 0.0%

Section 13 – Designated Health Care Professionals; Information

Required for Licensure

NOTEWORTHY ADDITIONS: NONE

NOTEWORTHY DELETIONS: NONE

COMMENTARY: NONE

SELECTED IMPACT: 0.0%

Section 14 – Practitioner Profile; Creation

NOTEWORTHY ADDITIONS: NONE

NOTEWORTHY DELETIONS: NONE

COMMENTARY: NONE

SELECTED IMPACT: 0.0%

Section 15 – Practitioner Profile; Update

NOTEWORTHY ADDITIONS: NONE

NOTEWORTHY DELETIONS: NONE

COMMENTARY: NONE

SELECTED IMPACT: 0.0%

PRESUMED FACTOR

Section 16 – Health Care Practitioners; Reports on Professional Liability Claims and Actions

NOTEWORTHY ADDITIONS: NONE
NOTEWORTHY DELETIONS: NONE
COMMENTARY: NONE
SELECTED IMPACT: 0.0%

Section 17 – Reports of Professional Liability Actions; Bankruptcies; Department of Health's Responsibility to Provide

NOTEWORTHY ADDITIONS: NONE
NOTEWORTHY DELETIONS: NONE
COMMENTARY: NONE
SELECTED IMPACT: 0.0%

Section 18 – Ownership and Control of Patient Records; Report or Copies of Records to be Furnished

NOTEWORTHY ADDITIONS: NONE
NOTEWORTHY DELETIONS: NONE
COMMENTARY: NONE
SELECTED IMPACT: 0.0%

PRESUMED FACTOR

Section 19 – Grounds for Discipline; Penalties; Enforcement

NOTEWORTHY ADDITIONS: NONE

NOTEWORTHY DELETIONS: NONE

COMMENTARY: NONE

SELECTED IMPACT: 0.0%

Section 20 – Disciplinary Proceedings.

NOTEWORTHY ADDITIONS: NONE

NOTEWORTHY DELETIONS: NONE

COMMENTARY: NONE

SELECTED IMPACT: 0.0%

Section 21 – Authority to Issue Citations

NOTEWORTHY ADDITIONS: NONE

NOTEWORTHY DELETIONS: NONE

COMMENTARY: NONE

SELECTED IMPACT: 0.0%

Section 22 – Mediation

NOTEWORTHY ADDITIONS: NONE

NOTEWORTHY DELETIONS: NONE

COMMENTARY: NONE

SELECTED IMPACT: 0.0%

PRESUMED FACTOR

Section 23 – Financial Responsibility (Physician)

NOTEWORTHY ADDITIONS: NONE

NOTEWORTHY DELETIONS: NONE

COMMENTARY: NONE

SELECTED IMPACT: 0.0%

Section 24 – Financial Responsibility (Osteopathic Physician)

NOTEWORTHY ADDITIONS: NONE

NOTEWORTHY DELETIONS: NONE

COMMENTARY: NONE

SELECTED IMPACT: 0.0%

Section 25 – Grounds for Disciplinary Action; Action by the Board and Department (Physician)

NOTEWORTHY ADDITIONS: NONE

NOTEWORTHY DELETIONS: NONE

COMMENTARY: NONE

SELECTED IMPACT: 0.0%

PRESUMED FACTOR

Section 26 – Emergency Procedures for Disciplinary Action

NOTEWORTHY ADDITIONS:

“Notwithstanding any other provision of law to the contrary, no later than 30 days after a third report of a professional liability claim against a licensed physician has been submitted, within a 60-month period, as required by ss. 456.049 and 627.912, the Department of Health shall initiate an emergency investigation and the Board of Medicine shall conduct an emergency probable cause hearing to determine whether the physician should be disciplined for a violation of s 458.331(1)(t) or any other relevant provision of the law.”

NOTEWORTHY DELETIONS: NONE

COMMENTARY: NONE

SELECTED IMPACT: 0.0%

Section 27 – Grounds for Disciplinary Action; Action by the Board and Department (Osteopathic)

NOTEWORTHY ADDITIONS: NONE

NOTEWORTHY DELETIONS: NONE

COMMENTARY: NONE

SELECTED IMPACT: 0.0%

Section 28 – Emergency Procedures for Disciplinary Action (Osteopathic)

NOTEWORTHY ADDITIONS: NONE

NOTEWORTHY DELETIONS: NONE

COMMENTARY: NONE

SELECTED IMPACT: 0.0%

PRESUMED FACTOR

Section 29 – Grounds for Disciplinary Action; Action by the Board; Investigations by Department (Podiatric)

NOTEWORTHY ADDITIONS: NONE
NOTEWORTHY DELETIONS: NONE
COMMENTARY: NONE
SELECTED IMPACT: 0.0%

Section 30 – Emergency Procedures for Disciplinary Action (Podiatric)

NOTEWORTHY ADDITIONS: NONE
NOTEWORTHY DELETIONS: NONE
COMMENTARY: NONE
SELECTED IMPACT: 0.0%

Section 31 – Grounds for Disciplinary Action; Action by the Board (Dental)

NOTEWORTHY ADDITIONS: NONE
NOTEWORTHY DELETIONS: NONE
COMMENTARY: NONE
SELECTED IMPACT: 0.0%

PRESUMED FACTOR

Section 32 – The Division of Administrative Hearings shall...

NOTEWORTHY ADDITIONS: NONE

NOTEWORTHY DELETIONS: NONE

COMMENTARY: NONE

SELECTED IMPACT: 0.0%

Section 33 – Patient Safety Instructional Requirements (Public School, College, and University)

NOTEWORTHY ADDITIONS:

“Each public school, college, and university that offers degrees in medicine, nursing, or allied health shall include in the curricula applicable to such degrees material on patient safety, including patient safety improvement. Materials shall include, but need not be limited to, effective communication and teamwork; epidemiology of patient injuries and medical errors; medical injuries; vigilance, attention, and fatigue; checklists and inspections; automation, technological, and computer support; psychological factors in human error; and reporting systems.”

NOTEWORTHY DELETIONS: NONE

COMMENTARY: NONE

SELECTED IMPACT: 0.0%

Section 34 – Patient Safety Instructional Requirements (Private School, College, and University)

NOTEWORTHY ADDITIONS:

“Each private school, college, and university that offers degrees in medicine, nursing, and allied health shall include in the curricula applicable to such degrees material on patient safety, including patient safety improvement. Materials shall include, but need not be limited to, effective

PRESUMED FACTOR

communication and teamwork; epidemiology of patient injuries and medical errors; medical injuries; vigilance, attention, and fatigue; checklists and inspections; automation, technological, and computer support; psychological factors in human error; and reporting systems.”

NOTEWORTHY DELETIONS: NONE

COMMENTARY: NONE

SELECTED IMPACT: 0.0%

Section 35 – The Agency for Health Care Administration Shall...

NOTEWORTHY ADDITIONS: NONE

NOTEWORTHY DELETIONS: NONE

COMMENTARY: NONE

SELECTED IMPACT: 0.0%

Section 36 – The Agency for Health Care Administration is directed...

NOTEWORTHY ADDITIONS: NONE

NOTEWORTHY DELETIONS: NONE

COMMENTARY: NONE

SELECTED IMPACT: 0.0%

PRESUMED FACTOR

Section 37 – Office of Program Policy Analysis and Government

Accountability must...

NOTEWORTHY ADDITIONS: NONE

NOTEWORTHY DELETIONS: NONE

COMMENTARY: NONE

SELECTED IMPACT: 0.0%

Section 38 – The Department of Health Shall...

NOTEWORTHY ADDITIONS: NONE

NOTEWORTHY DELETIONS: NONE

COMMENTARY: NONE

SELECTED IMPACT: 0.0%

Section 39 – Commercial Self-Insurance Funds

NOTEWORTHY ADDITIONS: NONE

NOTEWORTHY DELETIONS: NONE

COMMENTARY: NONE

SELECTED IMPACT: 0.0%

PRESUMED FACTOR

Section 40 – Rate Standards

NOTEWORTHY ADDITIONS:

Section 40 establishes the requirement for calculating a presumed factor by Section. Observations regarding Section 40 can be found in Section IV.

NOTEWORTHY DELETIONS: NONE

COMMENTARY: NONE

SELECTED IMPACT: 0.0%

Section 41 – Office of Program Policy Analysis and Government

Accountability Shall...

NOTEWORTHY ADDITIONS: NONE

NOTEWORTHY DELETIONS: NONE

COMMENTARY: NONE

SELECTED IMPACT: 0.0%

Section 42 – Medical Malpractice Self-Insurance

NOTEWORTHY ADDITIONS:

“remains solvent and”

NOTEWORTHY DELETIONS: NONE

COMMENTARY: NONE

SELECTED IMPACT: 0.0%

PRESUMED FACTOR

Section 43 – Medical Malpractice Insurance Contracts

NOTEWORTHY ADDITIONS: NONE

NOTEWORTHY DELETIONS: NONE

COMMENTARY: NONE

SELECTED IMPACT: 0.0%

Section 44 – Public Notice of Medical Malpractice Rate Filings

NOTEWORTHY ADDITIONS: NONE

NOTEWORTHY DELETIONS: NONE

COMMENTARY: NONE

SELECTED IMPACT: 0.0%

Section 45 – Professional Liability Claims and Actions; Reports by Insurers and Health Care Providers; Annual Report

NOTEWORTHY ADDITIONS: NONE

NOTEWORTHY DELETIONS: NONE

COMMENTARY: NONE

SELECTED IMPACT: 0.0%

Section 46 – Definitions (HMO)

NOTEWORTHY ADDITIONS: NONE

NOTEWORTHY DELETIONS: NONE

COMMENTARY: NONE

SELECTED IMPACT: 0.0%

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Section 47 – Quality Assurance Program; Second Medical Opinion Requirement

NOTEWORTHY ADDITIONS: NONE

NOTEWORTHY DELETIONS: NONE

COMMENTARY: NONE

SELECTED IMPACT: 0.0%

Section 48 – Medical Negligence; Standards of Recovery; Expert Witness

NOTEWORTHY ADDITIONS:

“(5) A person may not give expert testimony concerning the prevailing professional standard of care unless that person is a licensed health care provider and meets the following criteria:

(a) If the health care provider against whom or on whose behalf the testimony is offered is a specialist, the expert witness must:

1. Specialize in the same specialty as the health care provider against whom or on whose behalf the testimony is offered; or specialize in a similar specialty that includes the evaluation, diagnosis, or treatment of the medical condition that is the subject of the claim and have prior experience treating similar patients; and

2. Have devoted professional time during the 3 years immediately preceding the date of the occurrence that is the basis for the action to:

a. The active clinical practice of, or consulting with respect to, the same or similar specialty that includes the evaluation, diagnosis, or treatment of the medical condition that is the subject of the claim and have prior experience treating similar patients;

b. Instruction of students in an accredited health professional school or accredited residency or clinical research program in the same or similar specialty; or

c. A clinical research program that is affiliated with an accredited health professional school or accredited residency or clinical research program in the same or similar specialty.

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(b) If the health care provider against whom or on whose behalf the testimony is offered is a general practitioner, the ...”

“(10) In any action alleging medical negligence, an expert witness may not testify on a contingency fee basis.”

“(11) Any attorney who proffers a person as an expert witness pursuant to this Section must certify that such person has not been found guilty of fraud or perjury in any jurisdiction.”

NOTEWORTHY DELETIONS:

Removal of old expert witness criteria.

COMMENTARY:

Section 48 defines expert witness testimony and when a person may give expert testimony concerning the prevailing professional standard of care. Although the change in expert witness qualifications will likely increase costs for plaintiff attorneys and reduce the likelihood of the use of so called “general” experts, it is our belief that these savings will be offset by the increased costs associated with insurance companies having to use expert witnesses in defending cases and in other Sections of the bill.

SELECTED IMPACT:

De Minimis Cost

PRESUMED FACTOR

Section 49 – Notice Before Filing Action for Medical Negligence; Presuit Screening Period; Offers for Admission of Liability and for Arbitration; Informal Discovery; Review

NOTEWORTHY ADDITIONS:

“Notice to each prospective defendant must include, if available, a list of all known health care providers seen by the claimant for the injuries complained of subsequent to the alleged act of negligence, all known health care providers during the 2-year period prior to the alleged act of negligence who treated or evaluated the claimant, and copies of all of the medical records relied upon by the expert in signing the affidavit. The requirement of providing the list of known health care providers may not serve as grounds for imposing sanctions for failure to provide presuit discovery.”

“Upon receipt by a prospective defendant of a notice of claim, the parties shall make discoverable information available without formal discovery. Failure to do so is grounds for the dismissal of claims or defenses ultimately asserted.”

“Written questions”

“Medical information release”

“Sanctions”

NOTEWORTHY DELETIONS:

Removal of old arbitration wording.

COMMENTARY: NONE

SELECTED IMPACT: 0.0%

PRESUMED FACTOR

Section 50 – Mandatory Mediation and Mandatory Settlement Conference in Medical Negligence Actions

NOTEWORTHY ADDITIONS:

“Mandatory mediation and”

“(1) Within 120 days after the suit is filed, unless such period is extended by mutual agreement of all parties, all parties shall attend in-person mandatory mediation in accordance with s. 44.102 if binding arbitration under s. 766.207 has not been agreed to by the parties. The Florida Rules of Civil Procedure shall apply to mediation held pursuant to this Section.”

NOTEWORTHY DELETIONS: NONE

COMMENTARY: NONE

SELECTED IMPACT: 0.0%

Section 51 – Health Care Providers; Creation of Agency Relationship with Governmental Contractors

NOTEWORTHY ADDITIONS: NONE

NOTEWORTHY DELETIONS: NONE

COMMENTARY: NONE

SELECTED IMPACT: 0.0%

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Section 52 – Comparative Fault

NOTEWORTHY ADDITIONS: NONE

NOTEWORTHY DELETIONS: NONE

COMMENTARY: NONE

SELECTED IMPACT: 0.0%

Section 53 – Settlement Agreements; Prohibition on Restricting Disclosure to Division of Medical Quality Assurance

NOTEWORTHY ADDITIONS:

“(1) Each final settlement agreement relating to medical negligence shall include the following statement: “The decision to settle a case may reflect the economic practicalities pertaining to the cost of litigation and is not, alone, an admission that the insured failed to meet the required standard of care applicable to the patient’s treatment. The decision to settle a case may be made by the insurance company without consulting its client for input, unless otherwise provided by the insurance policy.”

NOTEWORTHY DELETIONS: NONE

COMMENTARY: NONE

SELECTED IMPACT: 0.0%

PRESUMED FACTOR

Section 54 – Determination of Noneconomic Damages

NOTEWORTHY ADDITIONS:

- “(1) Definitions.”
- “(2) Limitation on noneconomic damages for negligence of practitioners.”
- “(3) Limitation on noneconomic damages for negligence of nonpractitioner defendants.”
- “(4) Limitation on noneconomic damages for negligence of practitioners providing emergency services and care.”
- “(5) Limitation on noneconomic damages for negligence of nonpractitioner defendants providing emergency services and care.”
- “(6) Setoff.”
- “(7) Actions governed by Sovereign Immunity Law.”

NOTEWORTHY DELETIONS: NONE

COMMENTARY:

Section 54 describes the cap on noneconomic damages for practitioners, nonpractitioners, non emergency room, emergency room, and situations when the cap is pierced. In order to develop the foundation for calculating the presumed factor for Section 54, the following items need to be addressed:

- Simplified Cap Flow Chart;
- Constitutional Issues;
- Policy Limits;
- Claimants;
- Inclusion of Minor Severity Types;
- ALAE Adjustment Assumptions;
- SB2D Phase in Assumptions; and
- Calculation of Presumed Factor.

Simplified Cap Flow Chart

The following flow chart illustrates the impact of Section 54 in an easy-to-follow format.

PRESUMED FACTOR

SECTION 54

766.118 DETERMINATION OF NONECONOMIC DAMAGES

□ Practitioner

<div>■ Non emergency room</div> <div>\$500,000 per claimant (2)(a)</div> <div>\$500,000 per practitioner (2)(a)</div>	"Pierced Cap"	<i>Death or permanent vegetative state</i>
		\$1,000,000 aggregate practitioner cap (2)(b) regardless of the number of claimants
<div>■ Emergency room</div> <div>\$150,000 per claimant (4)(a)</div> <div>\$300,000 aggregate practitioner cap (4)(b)</div>		<i>Manifest injustice plus catastrophic injury</i>
		\$1,000,000 aggregate cap recoverable by injured patient

□ Nonpractitioner

<div>■ Non emergency room</div> <div>\$750,000 per claimant (3)(a)</div> <div>\$750,000 per nonpractitioner (3)(a)</div>	"Pierced Cap"	<i>Death or permanent vegetative state</i>
		\$1,500,000 aggregate nonpractitioner cap (3)(b) regardless of the number of claimants
<div>■ Emergency room</div> <div>\$750,000 per claimant (5)(a)</div> <div>\$1,500,000 aggregate non practitioner cap (5)(b)</div> <div>Nonpractitioner defendants may receive a full setoff for payments made by practitioner defendants (5)(c)</div>		<i>Manifest injustice plus catastrophic injury</i>
		\$1,500,000 aggregate cap recoverable by injured patient

Definitions

Claimant means any person who has a cause of action for damages based on personal injury or wrongful death arising from medical negligence.

Health care practitioner means any person licensed under chapter 457 (acupuncture); chapter 458 (medical practice); chapter 459 (osteopathic medicine); chapter 460 (chiropractic medicine); chapter 461 (podiatric medicine); chapter 462 (naturopathy); chapter 463 (optometry); chapter 464 (nursing); chapter 465 (pharmacy); chapter 466 (dentistry); chapter 467 (midwifery); part I (speech-language pathology and audiology), part II (nursing home administration), part III (occupational therapy), part V (respiratory therapy), part X (dietetics and nutrition practice), part XIII (athletic trainers), or part XIV (orthotics, prosthetics, and pedorthics) of chapter 468; chapter 478 (electrolysis); chapter 480 (massage practice); part III (clinical laboratory personnel) or part IV (medical physicists) of chapter 483; chapter 484 (dispensing of optical devices and hearing aids); chapter 486 (physical therapy practice); chapter 490 (psychological services); or chapter 491 (clinical, counseling and psychotherapy services).

Non practitioner means hospitals, health maintenance organizations (HMOs), hospice providers, and other non-physician entities.

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Constitutional Issues

Section 54 of the new legislation creates Section 766.118, Florida Statutes, which imposes caps on the amount of noneconomic damages recoverable in all medical malpractice actions, including those involving wrongful death.

The specific cap amounts are discussed earlier in this report.

Section 54 likely will be challenged by the plaintiffs' bar alleging that the caps are unconstitutional under the following provisions of the Florida Constitution:

1. Right of access to the courts;
2. Equal protection;
3. Due process; and
4. "Taking" without just compensation.

The principal challenge will likely be brought under the access to courts provisions. There is no corresponding provision in the federal Constitution.

Article I, Section 21 of the Florida Constitution provides: "The courts shall be open to every person for redress of any injury, and justice shall be administered without sale, denial, or delay."

The Florida Supreme Court has adopted a two-part alternative test for weighing whether particular legislation unconstitutionally infringes on the access to courts provision. The Legislature must show that it either has established a "reasonable alternative" to the right that is being abolished (also known as the "commensurate benefit" requirement) or the legislature must show (i) an "overpowering public necessity" for the legislation and (ii) that there is no alternative method for satisfying the public necessity. Kluger v. White, 281 So. 2d 1, 4 (Fla. 1973).

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The Florida Supreme Court previously addressed the constitutionality of damages caps in medical malpractice actions in University of Miami v. Echarte, 618 So. 2d 189 (Fla. 1993), which is the only Florida case directly on point.

Echarte addressed the \$250,000 noneconomic damages cap that was enacted by the 1988 Florida Legislature as part of the voluntary arbitration provision that was added to the medical malpractice Statute. The Court concluded that the cap was constitutional and did not violate the access to courts provision.

The decision was essentially a 4-3 vote, with the politically liberal members of the court dissenting. Although Justice Kogan was recused from the decision, most commentators familiar with his jurisprudence would agree that he likely would have voted with the dissent.

It is important to note that **none** of the current justices of the Florida Supreme Court were sitting when Echarte was decided in 1993. However, at least two current members of the Court (Justices Anstead and Quince) have expressed doubt about the “soundness” of the access to courts analysis in Echarte. See St. Mary’s Hospital, Inc. v. Phillipe, 769 So. 2d 961, 974 (Fla. 2000).

The legislation at issue in Echarte allowed either the plaintiff or the defendant voluntarily to demand binding arbitration. If the plaintiff demanded arbitration and the defendant refused, then the plaintiff could proceed to trial by jury without any damages cap plus the opportunity to recover reasonable attorneys’ fees up to 25% of the award. If a defendant demanded arbitration and the plaintiff refused, then the plaintiff’s noneconomic damages were capped at \$350,000 at trial. If the parties agreed to arbitrate, then the Statute capped the plaintiff’s recoverable noneconomic damages at \$250,000. In return for arbitrating, however, the plaintiff gained, among others, the following benefits: prompt payment upon issuance of an arbitration award, limited appeals by the defendants, and recovery of reasonable attorneys’ fees up to 15% of the award.

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The Florida Supreme Court held that the cap was constitutional because it satisfied the “commensurate benefit” test under Kluger v. White. Specifically, the Court found that the arbitration provision provided a reasonable alternative (i.e., commensurate benefit) to plaintiffs because of the various benefits that plaintiffs received from agreeing to arbitrate, including speedy resolution, prompt payment of claims, lower attorneys’ fees, and limited appellate review.

The Court also held, in what is typically referred to as an “even if” argument, that the cap was constitutional “even if” the Statute did not provide a commensurate benefit to plaintiffs because the Legislature had satisfied the second test under Kluger v. White: an “overpowering public necessity” without any available alternative.

It is important to distinguish the Statute at issue in Echarte from SB2D. In Echarte, the cap only applied if one of the parties demanded arbitration. The cap had no applicability in the event that the parties both agreed to proceed in court. Here, the caps enacted by the 2003 Florida Legislature apply to all court cases involving injury or death due to medical negligence.

The Court’s conclusion regarding the second prong of Kluger v. White is particularly relevant here because it is doubtful that the new “blanket” cap on noneconomic damages can satisfy the “commensurate benefit” test. Relevant to this conclusion is Smith v. Department of Insurance, 507 So. 2d 1080 (Fla. 1987), where the Florida Supreme Court struck down the \$450,000 cap on noneconomic damages that the Legislature enacted as part of the “Tort Reform and Insurance Act of 1986.” The cap enacted as part of that Statute applied to all tort actions, not just medical negligence actions.

The Legislature did not argue in Smith that there was an “overpowering public necessity” for the cap. Thus, the Court only analyzed whether the cap provided a “commensurate benefit” to plaintiffs under Kluger v. White. The Court held that it did not. The Court specifically addressed and rejected the argument that the damages cap has not completely abolished any particular cause of action and therefore had not denied “access” to the courts.

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This reasoning focuses on the title to Article I, Section 21, "Access to court," and overlooks the contents which must be read in conjunction with Section 22, "Trial by jury." Access to courts is granted for the purpose of redressing injuries. A plaintiff who receives a jury verdict for, e.g., \$1,000,000, has not received a constitutional redress of injuries if the legislature statutorily, and arbitrarily, caps the recovery at \$450,000. Nor, we add, because the jury verdict is being arbitrarily capped, is the plaintiff receiving the constitutional benefit of a jury trial as we have heretofore understood that right. **Further, if the legislature may constitutionally cap recovery at \$450,000, there is no discernible reason why it could not cap the recovery at some other figure, perhaps \$50,000, or \$1,000, or even \$1. None of these caps, under the reasoning of appellees, would "totally" abolish the right of access to the courts. At least one of the appellees candidly argues that there is no constitutional bar to completely abolishing noneconomic damages by requiring potential injured victims to buy insurance protecting themselves against economic loss due to injury as an alternative remedy. That particular issue is not before us but we note that if it were permissible to restrict the constitutional right by legislative action, without meeting the conditions set forth in Kluger, the constitutional right of access to the courts for redress of injuries would be subordinated to, and a creature of, legislative grace or, as Mr. Smith puts it, "majoritarian whim."** There are political systems where constitutional rights are subordinated to the power of the executive or legislative branches, but ours is not such a system.

Smith, 507 So. 2d 1088-89 (Emphasis added).

Thus, it would appear that, in order for the 2003 legislation to pass muster under the "access to courts" provision, the Legislature must meet the second Kluger test: "overpowering public necessity" plus no alternative method for meeting that necessity.

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This legal reasoning was not lost on the Governor's Task Force, which obviously was acutely aware of the holding in Echarte and its analysis of the "overpowering public necessity" test. Indeed, the January 29, 2003 letter enclosing the Task Force report to the Governor specially says, "The task force has taken great care to conform its recommendations to the requirements of the Florida Constitution and the case law[.]"

In finding that the cap on noneconomic damages in the arbitration Statute satisfied the second Kluger test, the Echarte Court relied very heavily (almost exclusively) on the report and recommendations issued by the "Academic Task Force for Review of the Insurance and Tort Systems." The report made the following significant findings, among others: (i) the dramatic increase in the size or amounts of paid claims was the major cause of the increase in total claims payments; the frequency of claims against physicians had increased only slightly; (ii) strengthening the discipline and oversight of doctors was a supplement but not an alternative to tort reform.

The report in Echarte was the result of an "extensive" study, including seven public meetings and hearings, eight research projects studying data from, among others, the Insurance Services Office, a survey of 1,500 doctors and 1,500 medical malpractice lawyers, an analysis of insurance company data, and an analysis of civil litigation rates in Florida.

The heavy reliance on the task force report in Echarte will likely result in a comparison of that report to the report of the Governor's Select Task Force on Healthcare Professional Liability Insurance that is cited by the Legislature in its findings related to the Statute at issue here.

We have reviewed the Task Force report here in detail. The report, and the investigations, meetings, and analyses that were conducted by the Task Force prior to writing the report, were clearly designed to satisfy the holding in Echarte. Simply put, the Task Force has "dotted every 'i' and crossed every 't'". In particular, like the report in Echarte, this report concludes that (i) the severity of claim payments significantly increased between 1998 and 2000 and (ii) a cap on noneconomic damages is the "only" way to accomplish the Legislature's goal of reducing

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healthcare costs. Task Force Report, page xi (“Without the inclusion of a cap on potential awards of noneconomic damages in a legislative package, no legislative reform plan can be successful in achieving the goal of controlling increases in healthcare costs.”)

Nobody can predict how the Florida Supreme Court will rule when (not if, but when) the constitutionality of the new law is brought before it. Accordingly, we will not attempt to do so here, other than to observe, as we have above, that at least Justices Anstead and Quince appear to question even the limited holding in Echarte and are likely to take a critical view of the new caps.

Additionally, we would observe that the Task Force relies on the success of caps in California to support its recommendation for caps in Florida, and notes that California upheld the constitutionality of the caps. It is worth noting that California, unlike Florida, does not have a specific “access to courts” provision in its constitution.

In terms of timing, the Florida Supreme Court likely will not rule on the constitutionality of the new law until, at the earliest, the Fall of 2006. This is because it will take approximately 18 to 24 months for a jury verdict to be rendered in excess of the cap, after which an appeal will have to be taken to the intermediate appellate court in Florida. That appeal likely will take approximately one year to complete, after which the parties will be able to seek review in the Florida Supreme Court. It will take approximately another full year for the Florida Supreme Court to issue a decision.

In the event that the Florida Supreme Court declares the law unconstitutional, and if the basis of the court’s decision falls under the Florida Constitution, then it would be necessary to pass an amendment to the Florida Constitution to validate the caps. (If the decision is based on the United States Constitution, either the due process clause, the equal protection clause, or the right to jury clause, then an amendment to the United States Constitution would be required.)

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There are three basic methods to propose amendments to the Florida constitution: a three-fifths vote of each house of the Legislature; a petition drive reflecting the appropriate number of required signatures (about 8% of the voters); or a constitutional convention. Article XI, Fla. Const. Regardless of the method chosen to propose an amendment, the amendment must be approved by the electorate “at the next general election held more than ninety days after the joint resolution, initiative petition or . . . constitutional convention.” Article XI, Section 5(a). “If the proposed amendment or revision is approved by vote of the electors, it shall be effective as an amendment to or revision of the constitution of the state on the first Tuesday after the first Monday in January following the election, or on such other date as may be specified in the amendment or revision.” Article XI, Section 5(c). Thus, any proposed amendment would be required to be voted upon at the next general election after the amendment is validly proposed, which likely would be the year 2008 if the amendment is not proposed until after a ruling by the Florida Supreme Court on the constitutionality of the current legislation.

Section 40 – Rate Standards notes: “(c) If any provision of medical malpractice legislation enacted during the 2003 Special Session D of the Florida Legislature is held invalid by a court of competent jurisdiction, the office shall permit an adjustment of all medical malpractice rates filed under this section to reflect the impact of such holding on such rates so as to ensure that the rates are not excessive, inadequate, or unfairly discriminatory.”

For purposes of our analysis, we will calculate the presumed factor as if Section 54 is not held invalid by a court of competent jurisdiction. If Section 54 is found invalid, the Office of Insurance Regulation will adjust the overall presumed factor calculated in this report by subtracting the Section 54 presumed factor from the overall presumed factor.

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Policy Limits

The Governor's Select Task Force on Healthcare Professional Liability (GSTF) report documents the drastic reduction in insurance companies providing coverage in Florida, rising medical malpractice premiums and the impact on the affordability of policy limits in excess of \$250,000 for insurance consumers.

In order to estimate the impact of the cap on noneconomic damages, it is important to understand the mix of policy limits offered by insurance companies. The GSTF report, newspaper articles and industry publications document the current trend in Florida: healthcare providers are purchasing lower and lower policy limits (e.g., \$250,000 per occurrence/ \$750,000 in the aggregate) or are choosing not to purchase coverage at all. The following table is from the GSTF report, prepared by the RCH Healthcare survey of South Florida physicians:

Changes in Coverage Limitations

Percentage Buying:	Last Year	This Year
\$1,000,000/\$3,000,000	35.0%	30.7%
\$500,000/\$1,500,000	12.5%	11.4%
\$250,000/\$750,000	47.1%	51.5%
No Malpractice Coverage	5.4%	16.4%
Total	100.0%	100.0%

This survey, completed in November of 2002, illustrates the dramatic shift towards lower limits (or no coverage at all). Given the size of rate increases filed in 2003, the continuing after-effects of major insurance companies that have exited the Florida market, and the reduction in capacity offered by Florida's remaining insurers, we expect this trend to continue.

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As a part of our presumed factor analysis, we reviewed a number of medical malpractice filings made by Florida's largest insurers based on 2002 direct written premium. The medical malpractice ratemaking files we reviewed represented approximately 72% of the \$829 million of 2002 direct premium written in the State of Florida (NAIC database provided in Appendix E). The following table illustrates the distribution of policies identified in one of the rate filings we reviewed:

DISTRIBUTION BY POLICY LIMIT

Limits of Liability	Company B Physicians	Company B Surgeons
\$100,000/\$300,000	0.5%	0.0%
\$250,000/\$750,000	32.0%	43.7%
\$500,000/\$500,000	0.1%	0.0%
\$500,000/\$1,500,000	17.7%	16.7%
\$1,000,000/\$1,000,000	1.8%	1.7%
\$1,000,000/\$3,000,000	42.1%	36.9%
\$1,500,000/\$3,000,000	1.8%	0.6%
\$2,000,000/\$4,000,000	4.1%	0.4%
	100.0%	100.0%

The following table illustrates our estimation of the distribution of policies using the Florida closed claim database for disposition years 1983 through 2003:

PRESUMED FACTOR

FLORIDA CLOSED CLAIM DATABASE DISTRIBUTION BY LIMIT

<u>Policy Limits¹</u>	<u>Practitioner</u>	<u>Nonpractitioner</u>
100,000	6%	7%
250,000	23%	10%
500,000	15%	4%
1,000,000	37%	18%
2,000,000	6%	12%
5,000,000	2%	3%
10,000,000	3%	4%
> 10,000,000 ²	1%	28%
< 10,000,000 ³	7%	14%
TOTAL	100%	100%

Note: 1) Records with policy limit documented

2) Policy limits over \$10,000,000

3) Policy limits under \$10,000,000 not shown separately above

A review of more recent years confirms the shift towards lower policy limits as medical malpractice premiums started to rise. Given that we are in the middle stages of Florida's hard market, it is likely that the current database does not reflect the actual shift towards lower policy limits because of the following:

1. The database only displays closed claims which will tend to reflect an older mix of policy limits; and
2. The database does not include more recent policy renewals that would reflect some of the more staggering rate increases that have forced healthcare providers to forgo higher limit protection for stability in medical malpractice premiums.

The next table displays the increased limit factors (ILFs) that are used to convert basic limit manual rates of \$250,000/\$750,000 to a higher policy limits.

PRESUMED FACTOR

INCREASED LIMIT FACTORS

Limits of Liability	Company A Physicians & Dentists	Company A ER Med, OB/GYN, Radiologists	Company B Physicians	Company B Surgeons	Company C Physicians & Surgeons
\$100,000/\$300,000	0.750	0.750	0.736	0.736	0.725
\$250,000/\$750,000	1.000	1.000	1.000	1.000	1.000
\$500,000/\$1,500,000	1.350	1.400	1.279	1.313	1.275
\$1,000,000/\$3,000,000	1.900	2.040	1.624	1.674	1.558

Limits of Liability	Company D Surgeons	Company E Physicians	Company F Physicians Excluding Chiropractors	Company F Chiropractors	Company I Surgeons
\$100,000/\$300,000	0.864	0.754			
\$250,000/\$750,000	1.000	1.000	1.000	1.000	1.000
\$500,000/\$1,500,000	1.455		1.404	1.142	1.161
\$1,000,000/\$3,000,000	2.091	1.639	1.733	1.357	1.671

As one can see from above table, physicians and surgeons who want to purchase policy limits of \$1,000,000/\$3,000,000 must pay approximately 60% to 100% more than it would cost to purchase policy limits of \$250,000/\$750,000.

When one considers the fact that rates have increased in excess of 100% over the last couple of years for some physicians and surgeons, it is easy to see why they would be tempted to purchase lower limits of coverage in order to help offset the cost of rising medical malpractice premiums.

As more physicians and surgeons shift to lower policy limits, the less impact the caps on noneconomic damages will have. For example, if a physician purchases an insurance policy with limits of \$250,000/\$750,000, a \$500,000 cap on noneconomic damages adds little (if any) value to the insurance company in terms of savings when bad faith is not an issue. In certain situations where bad faith is an issue and noneconomic damages are capped, insurance companies could achieve savings when payments in excess of policy limits are reduced because of the cap (see Section 56).

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In order to get a better understanding of the policy limits currently being written by medical malpractice insurers in the State of Florida, the OIR assisted us in gathering policy limit information from some of the top insurers. The following table displays the policy limit distribution provided by each insurer, a weighted average of the insurers and our selected policy limit assumptions for use in calculating the presumed factor:

POLICY LIMIT DISTRIBUTION

■ Practitioner

Policy Limit	Company 1	Company 2	Company 3	Company Volume Weighted	Closed Claim Database (All Years)	Selected Distribution
\$100,000	0.0%	0.0%	0.1%	0.0%	6.6%	2.0%
\$250,000	4.6%	40.6%	25.7%	25.1%	25.2%	25.0%
\$500,000	12.1%	18.6%	15.9%	15.8%	16.1%	16.0%
\$1,000,000	62.2%	40.8%	54.9%	51.6%	39.4%	47.5%
\$2,000,000	17.3%	0.0%	3.1%	6.3%	6.3%	7.5%
\$5,000,000	0.0%	0.0%	0.2%	0.0%	2.3%	0.5%
<u>OTHER</u>	<u>3.8%</u>	<u>0.0%</u>	<u>0.0%</u>	<u>1.2%</u>	<u>4.1%</u>	<u>1.5%</u>
TOTAL	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

■ Nonpractitioner

Policy Limit	Company 1	Company 2	Company Volume Weighted	Closed Claim Database (All Years)	Selected Distribution
\$100,000	0.0%	0.0%	0.0%	8.2%	2.5%
\$250,000	1.8%	31.2%	19.1%	11.4%	17.5%
\$500,000	10.4%	12.1%	11.4%	4.6%	10.0%
\$1,000,000	64.6%	56.7%	60.0%	20.3%	50.0%
\$2,000,000	15.8%	0.0%	6.5%	14.3%	7.5%
\$5,000,000	0.0%	0.0%	0.0%	3.9%	2.5%
<u>OTHER</u>	<u>7.4%</u>	<u>0.0%</u>	<u>3.1%</u>	<u>37.3%</u>	<u>10.0%</u>
TOTAL	100.0%	100.0%	100.0%	100.0%	100.0%

Claimants

The word “claimant” as used in the chapter of the Florida Statutes relating to medical malpractice was defined as “any person who has a cause of action arising from medical negligence.” § 766.202(1), Fla. Stat.

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Section 58 of the new law revised the definition to read as follows: “any person who has a cause of action for damages based on personal injury or wrongful death arising from medical negligence.”

This revision was likely intended to make clear that the definition of “claimant” (and thus the cap on noneconomic damages and other revisions to the medical malpractice law) applied to both regular actions based on medical negligence and actions involving wrongful death arising from medical negligence.

Neither this revision or any other revision in the new law appears to change or alter which categories of persons can assert claims for noneconomic damages based on medical negligence. Those categories are as follows:

A. Non-Death

Persons who can typically recover noneconomic damages for medical negligence that does not result in the death of the injured person are as follows:

1. Injured person.
2. Spouse of injured person.
3. Children of injured person, regardless of the age of the “child,” but only if the “child” is unmarried and financially dependent on the injured person and the injury resulted in a permanent total disability. (Note: Typically, minor children and non-dependent adult children do not have significant claims for noneconomic damages due to injury to a parent)
4. Parents, but only if the injured person is under 18 at the time of the injury.

PRESUMED FACTOR

B. Death

The Florida wrongful death act, Section 768.21, Florida Statutes, enumerates which “survivors” of a deceased person can recover noneconomic damages for medical malpractice as follows:

1. Spouse.
2. All children under 25 years of age.
3. Parents, but only if the injured person is a child under 25 years of age.

For purposes of analyzing the caps, we have assumed the following distribution for the number of claimants and/or defendants:

Number of Claimants and/or Defendants			
1/1	2/2	3/3	4/4
25%	50%	20%	5%

In selecting the above distribution of claimants and/or defendants, we were comfortable with the general assumption that, on average, the closed claim database would average approximately two claimants (e.g., husband and wife, wife and child, etc.) over the entire sample of records. In order to reflect the possible variation in savings as the number of claimants and/or defendants vary, we decided to allocate 50% to the other categories as displayed above. We believe these assumptions are reasonable given the limitations of the closed claim database discussed below and our expectations regarding the number of claimants and defendants.

A discussion of our assumptions regarding the comparative fault of each defendant has been provided in the Observation Section of the report.

PRESUMED FACTOR

Inclusion of Minor Severity Types

Based upon a review of the “current” closed claim database file, we found that the average severity for injuries types 1 through 3 (i.e., those expected to have the least impact on the presumed factor calculation) were almost 4 times smaller than the average severity for injury types 4 through 9.

To improve efficiency, we decided to eliminate entries associated with the lowest severity injury types. The excluded severity injury types were;

1. Emotional Only – Fright, no physical damage.
2. Temporary Slight – Lacerations, contusions, minor scars, rash. No delay.
3. Temporary Minor – Infections, misset fracture, fall in hospital. Recovery Delayed.

The following severity injury types were not excluded:

4. Temporary: Major - Burns, surgical material left, drug side effect, brain damage. Recovery delayed.
5. Permanent: Minor - Loss of fingers, loss or damage to organs. Includes non-disabling injuries.
6. Permanent: Significant - Deafness, loss of limb, loss of eye, loss of one kidney or lung.
7. Permanent: Major - Paraplegia, blindness, loss of two limbs, brain damage.
8. Permanent: Grave - Quadriplegia, severe brain damage, lifelong care or fatal prognosis
9. Permanent: Death.

PRESUMED FACTOR

A review of the “current” closed claim database indicated that the lowest severity injury types represent over 25% of the claim counts, but only 8% of the indemnity payments.

Therefore, at the end of the savings calculations, we have selected a savings factor of 2.5% for the 8% portion of the indemnity payments we excluded. This 2.5% factor was selected based upon the relative average severity of these claims to the more severe claims and the low probability of the cap on noneconomic damages impacting these smaller dollar claims.

ALAE Adjustment Assumptions

A review of A.M. Best’s Financial Databases for P&C Companies indicate the following countrywide ratios of allocated loss adjustment expense (ALAE) to indemnity payments:

Medical Malpractice – Occurrence	30%
Medical Malpractice – Claims Made	36%

A review of the Florida rate filings indicated a ratio of ALAE to indemnity payments in the 40% to 55% range by year. We believe the higher than countrywide ratio is driven by Florida’s heavy distribution of lower policy limits. A lower average policy limit magnifies the impact of dollars spent defending a claim since the indemnity payments will be capped at a lower dollar level than similar cases settled throughout the rest of the country.

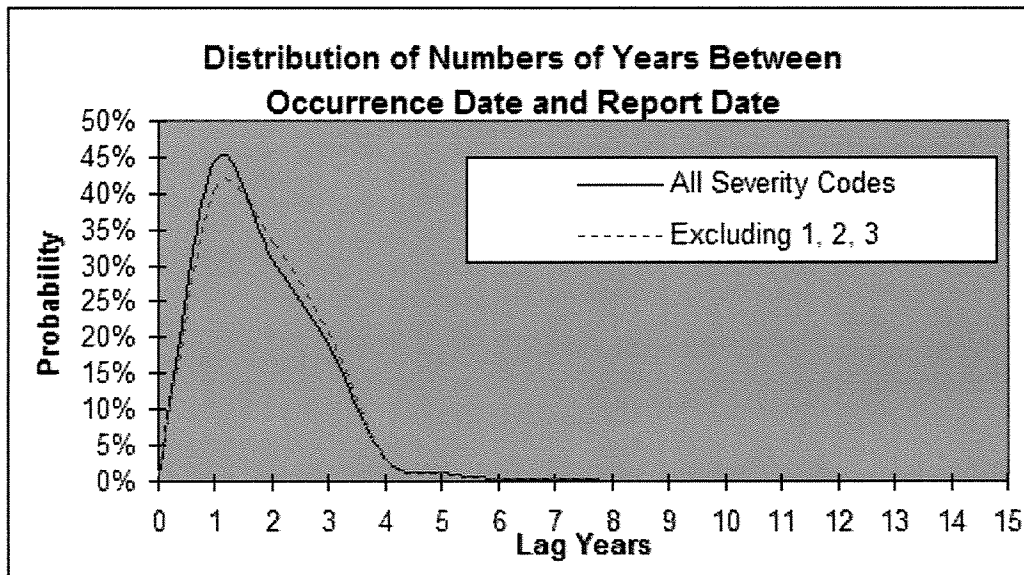
For purposes of calculating the presumed factor, we have assumed that ALAE costs equal roughly 45% of the indemnity payments made in Florida.

This assumption is important because the savings calculated in Section 54 only apply to indemnity payments. Medical malpractice policy limits do not apply to ALAE payments, only indemnity payments such as economic and noneconomic damages. Therefore, ALAE payments **should not** be adjusted to reflect the indemnity savings calculated in this Section using the closed claim database.

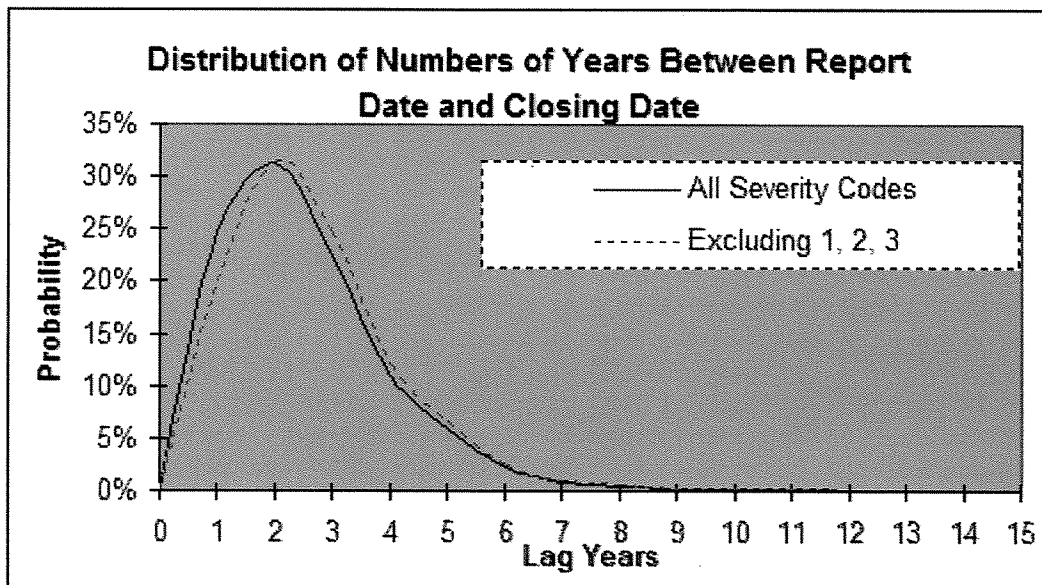
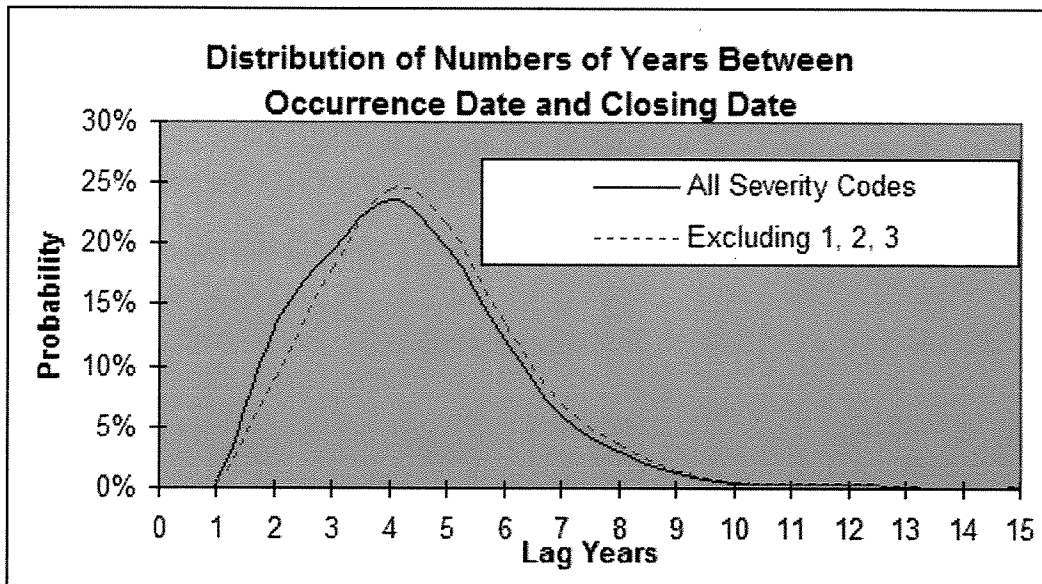
PRESUMED FACTOR

SB2D Phase in Assumptions

As is noted below in Section 86, the cap on noneconomic damages will likely not apply to injuries or misdiagnoses or other types of medical negligence that caused injury before September 15, 2003, even if presuit notice was initiated after September 15, 2003. Therefore, the impact of the law will take time to phase in. The following graphs illustrate our research on various lag times which we compiled from the closed claim database:



PRESUMED FACTOR



PRESUMED FACTOR

CLOSED CLAIM DATABASE LAG SUMMARY

Lag Years	Distribution of Numbers of Years Between		
	Occurrence Date and Report Date	Occurrence Date and Closing Date	Report Date and Closing Date
0	0.9%	0.0%	0.1%
1	40.5%	0.3%	20.2%
2	33.1%	9.0%	31.6%
3	20.7%	18.0%	24.6%
4	3.0%	24.6%	12.0%
5	1.2%	21.5%	6.7%
6	0.3%	13.4%	2.5%
7	0.2%	6.8%	1.0%
8	0.0%	3.5%	0.6%
9	0.0%	1.3%	0.3%
10	0.0%	0.5%	0.2%
11	0.0%	0.4%	0.2%
12	0.0%	0.3%	0.1%
13	0.0%	0.2%	0.1%
14	0.0%	0.1%	0.0%
15	0.0%	0.1%	0.1%
	100.0%	100.0%	100.0%

The mean lag is displayed below:

CLOSED CLAIM DATABASE LAG SUMMARY

Lag Years	Distribution of Numbers of Years Between		
	Occurrence Date and Report Date	Occurrence Date and Closing Date	Report Date and Closing Date
Mean	1.91	4.64	2.74

Based upon the above information, the average delay from the reporting of a claim to the closing of a claim will result in a phased in effect of the savings observed from the cap on noneconomic damages. Pre-SB2D claims with no savings will take time to be cleared out of the system. In addition, post-SB2D claims reflecting savings from the cap on noneconomic damages will take time to enter the system based upon the above lag distributions.

Therefore, we have selected a factor of 0.85 based upon a review of the lag factors above in order to reflect the fact that savings will be phased in over time. Using an analogy, the selected phase in

PRESUMED FACTOR

factor is similar to a present value factor that one would apply to a stream of future payments to convert them into today's current dollar value.

Calculation of Presumed Factor

For the interested reader, Appendix A, Summary Sheet B2 displays a flow chart of the presumed factor savings flow for Section 54. A visual may be helpful before reading on.

The following table displays the savings estimated by policy limit and the number of claimants and/or defendants:

PRESUMED FACTOR

Matrix of Indemnity Savings

■ Practitioner

Policy Limits	Selected Distribution	Number of Claimants and/or Defendants			
		1/1	2/2	3/3	4/4
\$100,000	2.0%	0.0%	0.0%	0.0%	0.7%
\$250,000	25.0%	1.5%	1.3%	2.4%	3.0%
\$500,000	16.0%	3.5%	3.0%	6.2%	8.6%
\$1,000,000	47.5%	16.9%	10.8%	12.6%	13.5%
\$2,000,000	7.5%	26.5%	16.0%	16.1%	16.1%
\$5,000,000	<u>2.0%</u>	<u>31.8%</u>	<u>19.0%</u>	<u>17.9%</u>	<u>17.5%</u>
	100.0%	13.9%	8.4%	9.8%	10.6%

■ Nonpractitioner

Policy Limits	Selected Distribution	Number of Claimants and/or Defendants			
		1/1	2/2	3/3	4/4
\$100,000	2.5%	0.0%	0.0%	0.0%	0.0%
\$250,000	17.5%	0.0%	0.0%	0.0%	0.0%
\$500,000	10.0%	0.0%	0.0%	0.0%	1.5%
\$1,000,000	50.0%	2.3%	1.8%	5.5%	8.6%
\$2,000,000	7.5%	11.8%	9.9%	14.2%	16.4%
\$5,000,000	2.5%	24.0%	19.4%	19.1%	18.6%
\$100,000,000	<u>10.0%</u>	<u>30.2%</u>	<u>19.9%</u>	<u>19.1%</u>	<u>18.6%</u>
	100.0%	8.3%	5.3%	7.2%	8.9%

■ Total

Policy Limits	Number of Claimants and/or Defendants			
	1/1	2/2	3/3	4/4
\$100,000	0.0%	0.0%	0.0%	0.6%
\$250,000	1.3%	1.2%	2.1%	2.6%
\$500,000	3.1%	2.6%	5.4%	7.7%
\$1,000,000	15.1%	9.7%	11.7%	12.8%
\$2,000,000	24.6%	15.2%	15.8%	16.1%
\$5,000,000	30.7%	19.1%	18.1%	17.6%
\$100,000,000	<u>30.2%</u>	<u>19.9%</u>	<u>19.1%</u>	<u>18.6%</u>
	13.1%	8.0%	9.4%	10.4%

*For a better understanding of the above matrix, Please refer to
Appendix B, Examples A, B, and C for detailed illustrations*

PRESUMED FACTOR

In order to calculate the presumed factor, we have to make the following adjustments:

1. Apply policy limit distribution assumptions (already completed above);
2. Apply claimant/defendant assumptions;
3. Adjust savings for severity injury types 1 through 3;
4. Apply ALAE assumption; and
5. Apply "phase in" assumption.

STEP 2:

	Number of Claimants and/or Defendants			
	1/1	2/2	3/3	4/4
Indemnity Savings:	13.1%	8.0%	9.4%	10.4%
Selected Allocation:	25%	50%	20%	5%

Indemnity Savings (2):

9.7%

STEP 3:

Severity Injury Code:	4 through 9	1 through 3
Indemnity Savings (2):	9.7%	2.5%
Selected Allocation:	92.0%	8.0%

Indemnity Savings (3):

9.1%

STEP 4:

Payment Type:	Indemnity	ALAE	
Indemnity Savings (3):	9.1%	0.0%	
Selected Allocation:	69.0%	31.0%	$= .45 / (1 + .45)$

Indemnity Savings (4):

6.3%

STEP 5:

Indemnity Savings (4):	6.3%
Phase in adjustment:	0.85

Presumed Factor:

5.3%

SELECTED IMPACT: 5.3%

PRESUMED FACTOR

Section 55 – The Legislature Finds and Declares ...

NOTEWORTHY ADDITIONS: NONE

NOTEWORTHY DELETIONS: NONE

COMMENTARY: NONE

SELECTED IMPACT: 0.0%

Section 56 – Bad Faith

NOTEWORTHY ADDITIONS:

“In all actions for bad faith against a medical malpractice insurer relating to professional liability insurance coverages for medical negligence, and in determining whether the insurer could and should have settled the claim within policy limits had it acted fairly and honestly towards its insureds with due regard for his or her interest, whether under **Statute or common law**:

(1)(a) An insurer shall not be held in bad faith for failure to pay its policy limits if it tenders its policy limits and meets other reasonable conditions of settlement by the earlier of either:

1. The 210th day after service of the complaint in the medical negligence action upon the insured. The time period specified in this subparagraph shall be extended by an additional 60 days if the court in the bad-faith action finds that, at any time during such period and after the 150th day after the service of the complaint, the claimant provided new information previously unavailable to the insurer relating to the identity or testimony of any material witness or the identity of any additional claimants or defendants, if such disclosure materially alters the risk to the insured of an excess judgment; or

2. The 60th day after the conclusion of all of the following:

- a. Deposition of all claimants named in the complaint or amended complaint.
- b. Deposition of all defendants named in the complaint or amended complaint, including, in the case of a corporate defendant, deposition of a designated representative.
- c. Deposition of all the claimants’ expert witnesses.
- d. The initial disclosure of witnesses and production of documents.

PRESUMED FACTOR

e. Mediation as provided in s. 766.108.”

“(1)(d) The fact that the insurer did not tender policy limits during the time periods specified in this paragraph is **not** presumptive evidence that the insurer acted in bad faith.”

NOTEWORTHY DELETIONS: NONE

COMMENTARY:

Section 56 describes the changes in the bad faith (a/k/a contractual obligations) law. In order to develop the foundation for calculating the presumed factor for Section 56, the following items need to be addressed:

- Bad Faith Example – Before SB2D
- Legal;
- Settlement Rate Statistics;
- Speed up in Loss Payout Example;
- Bad Faith and Medical Malpractice Rates;
- Calculation of Presumed Factor.

Bad Faith Example – Before SB2D

The following example walks through a sample claim resulting in bad faith using a \$5,250,000 jury verdict and a policy limit of \$250,000:

1. Insurer investigates and reviews the available claim information
2. Insurer decides not to tender policy limits because of its perception of the merits of the case
3. Case goes to trial and jury awards verdict
4. Insurer pays policy limit of \$250,000 and is then subject to a separate law suit in excess of the policy limits
5. Insurance company found liable for bad faith for refusing to tender the policy limits
6. Insurance company pays the excess verdict, or \$5,000,000

In summary, bad faith claims converts medical malpractice insurance contracts from limited to unlimited policies.

PRESUMED FACTOR

Legal

Section 56 creates an entirely new statutory provision that governs bad faith action in medical negligence situations.

A finding of “bad faith” renders an insurance company liable for the full amount of a judgment against its insured even if the amount of the judgment exceeds the policy limits.

Existing law allowed for two types of bad faith claims in Florida: first party bad faith claims (i.e., claims brought by the insured) and third-party bad faith claims (i.e., claims brought by the party injured by the insured).

First party bad faith claims are governed entirely by Section 624.155, Florida Statutes, which provides that an insurance company is liable for bad faith for failing to attempt “[i]n good faith to settle claims when, under all circumstances, it could and should have done so, had it acted fairly and honestly toward its insured and with due regards for his interest.” § 624.155(1)(b)(1), Fla. Stat. That Statute specifically provides that “[n]o action shall lie” if an insurance company pays the policy limits within 60 days of a written request.

Third-party bad faith claims are actionable under the same Statute as well as under common law. The common law standard is essentially the same as the statutory standard: the insurer is required to settle cases where a reasonably prudent person facing the prospect of paying the entire judgment would do so.

Thus, there are two separate actions that can be brought for third party bad faith in Florida. This is significant because, although the Statute provides for a 60-day period in which an insurer can pay the requested damages and avoid liability for bad faith, **there is no defined period under the common law.** Thus, depending on the circumstances, a plaintiff can give an insurance company only 10 or 20 days to respond to a demand for payment of damages (even if no underlying

PRESUMED FACTOR

complaint for damages against the tortfeasor has been filed) and, if the demand is not paid, a potential bad faith action may be asserted.

The new law makes a number of changes that affect bad faith claims in connection with medical negligence.

First, the new law indicates that it applies to both statutory and common law claims for bad faith.

Second, the new law provides that an insurer shall not be held in bad faith for failure to pay its policy limits if it tenders those limits (and meets other reasonable conditions of settlement) by the earlier of (i) the 210th day after service of the complaint or (ii) the 60th day after the conclusion of all party and expert depositions plus mediation. There are also provisions to extend these periods under certain circumstances.

Third, if the insurer does not tender its policy limits by the deadlines, then the Statute sets forth 10 criteria for a jury to follow in finding bad faith, such as the insurer's willingness to negotiate, whether the insurer timely notified the insured of an offer to settle, and whether the plaintiff provided relevant information to the insured on a timely basis.

The law did not eliminate third party bad faith actions as recommended by the Task Force. Nevertheless, the extended time period to investigate claims should allow insurers more time to make informed decisions about the strengths and weaknesses of a plaintiff's case and therefore arguably reduce instances of uninformed settlements that result in erroneous decisions to pay the full policy limits. In other words, the new extended time frames arguably will give insurers a better opportunity to avoid paying policy limits as a "knee jerk" reaction to a threat of bad faith, especially in cases that do not warrant payment of the full policy limits, such as where injuries are not as severe as they may first seem or where the injuries are the result of preexisting conditions that were not uncovered by the insurer's investigation given the short time frame for responding to a "bad faith" demand under common law.

PRESUMED FACTOR

We are cognizant of the view that the new time periods may not provide any added benefit because, as a practical matter, most insurers had between seven and nine months to investigate claims before being required to make a decision to tender the policy limits. Although this may have been true in some situations, there is strong anecdotal evidence of situations where plaintiffs serve a demand for payment of the policy limits in the first two or three months after an injury occurs, even before a lawsuit is commenced, and it is the problem of weighing the merits of paying the policy limits in those types of cases that is solved by the new time frames imposed by the new law.

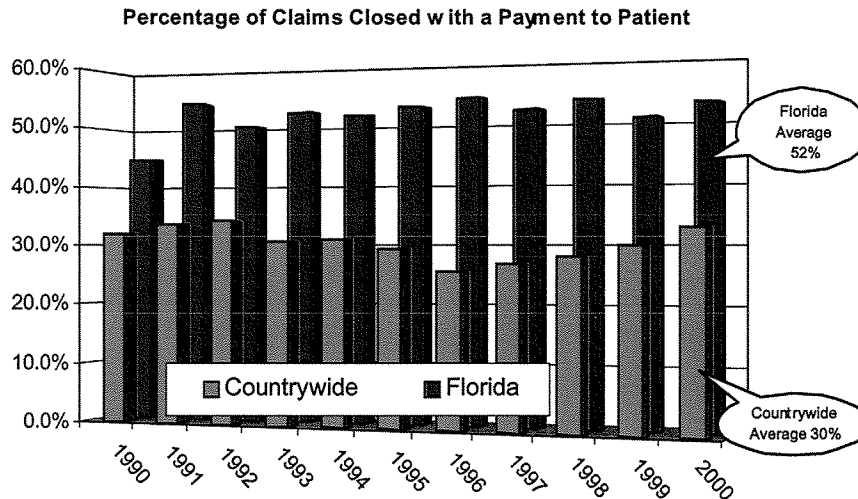
Settlement Rate Statistics

On August 14, 2003, A.M. BestWire published a story titled *Insurers Say Florida's New Med-Mal Legislation Falls Short on 'Bad Faith'*. In the article, Mr. Sam Miller of the Florida Insurance Council noted:

"In Florida, we are so concerned about being successfully sued for bad faith, even though we don't think we did anything wrong, that companies settle 50% of the cases that come in the door even when we know they are not meritorious, as opposed to 33% in the rest of the country..."

PRESUMED FACTOR

In order to analyze the impact of Section 56, we thought it was critical to obtain the detailed backup support for the settlement rates quoted by Mr. Miller. After receiving our written request, Mr. Miller provided the following support via email:



Mr. Miller noted:

"The graph above compares the percentage of cases closed for Florida to national data submitted to the Physicians Insurers Association of America from January 1, 1991 to December 31, 2000. The Florida data is derived from reports to the Office of Insurance Regulation through December 31, 1997 and First Professional Insurance Company's data using the universally accepted definition of a claim."

We have accepted the above support as a reasonable estimate of the current difference between Florida's settlement rate and the countrywide settlement rate.

PRESUMED FACTOR

Speed up in Loss Payout Example

The following table illustrates how a 25% and 50% shift in the payout pattern of losses can result in an increased rate indication as a result of lost investment income:

SPEED UP IN MEDICAL MALPRACTICE LOSS PAYOUT PATTERNS

Payout Year	Composite Rate Filing Incremental Payout	25% Shift In Loss Payout	50% Shift In Loss Payout	3.58% After Tax Discount Factor	Composite Discounted Incremental Payout	25% Discounted Incremental Payout	50% Discounted Incremental Payout
1	5.6%	9.5%	17.9%	0.983	5.5%	9.4%	17.6%
2	24.6%	25.5%	26.3%	0.949	23.3%	24.2%	24.9%
3	27.9%	26.7%	24.1%	0.916	25.6%	24.5%	22.1%
4	20.3%	18.4%	15.0%	0.884	17.9%	16.2%	13.2%
5	9.6%	9.0%	7.7%	0.854	8.2%	7.7%	6.6%
6	5.8%	5.3%	4.5%	0.824	4.8%	4.4%	3.7%
7	3.2%	2.9%	2.4%	0.796	2.5%	2.3%	1.9%
8	1.6%	1.4%	1.0%	0.768	1.2%	1.1%	0.8%
9	0.5%	0.5%	0.4%	0.742	0.4%	0.4%	0.3%
10	0.3%	0.3%	0.3%	0.716	0.2%	0.2%	0.2%
11	0.3%	0.2%	0.3%	0.692	0.2%	0.1%	0.2%
12	0.3%	0.2%	0.2%	0.668	0.2%	0.2%	0.1%
13	<u>0.0%</u>	<u>0.0%</u>	<u>0.0%</u>	0.645	<u>0.0%</u>	<u>0.0%</u>	<u>0.0%</u>
	100.0%	100.0%	100.0%		90.1%	90.6%	91.6%

IMPACT ON RATES:	0.6%	1.7%
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The speed up in loss payout increases costs for insurance companies. Dollars that were held as reserves earning investment income must now be paid out earlier, reducing the amount of investment income that can be used to reduce future medical malpractice rates.

Bad Faith and Medical Malpractice Rates

Based upon our review of Florida rate filings, medical malpractice insurers in the State of Florida have made bad faith payments for physicians and surgeons ranging from 3% to 17% of total losses payments limited to \$250,000 for the 1993 to 2002 years. For illustrative purposes, assuming annual loss payments of \$200 million dollars, this would equate to a range of \$6 million to \$34 million dollars of bad faith payments in a given year.

PRESUMED FACTOR

Although we believe SB2D tightens up the common law loophole as discussed above and will reduce the dollar amount of awards in excess of policy limits because of the caps on noneconomic damages (See Section 54), it is important to note that any benefit from savings on bad faith payments **will not** impact the presumed factor in Section 56, even if medical malpractice insurers saved the full 17% going forward. This is because medical malpractice insurance companies are not allowed to include bad faith payments in the development of their indicated manual rate changes. Stated another way, premiums that healthcare providers pay annually already exclude the impact of bad faith payments.

Our review of the rate filings also included research on the handling of reinsurance costs in the calculation of the insurer's indicated manual rate change. We wanted to make sure that bad faith payments, which are excluded from the ratemaking data, were not being included indirectly through the purchase of reinsurance coverage that covers extra contractual obligations. Essentially, we were checking to see if the variable expense calculations (used to derive the expected loss ratio) included a loading for bad faith payments. We observed the following handling by insurers:

1. Explicit loading for extra contractual obligations reinsurance costs; and
2. No reference to reinsurance costs in the variable expense calculations.

In situations where there was an explicit loading identified by the medical malpractice insurer, correspondence with the State Insurance Department and later modifications at the request of the Department illustrated that these costs had to be removed from the calculation of the final indicated manual rate. Therefore, explicit loadings for reinsurance premiums related to bad faith are not included in premiums healthcare providers pay and **will not** impact the presumed factor

In situations where no reference to reinsurance costs were made in the calculation of the variable expense factor, we believe some companies may be including extra contractual obligation reinsurance in their expense assumptions. In situations like these, one could argue that the

PRESUMED FACTOR

tightening up of the common law loophole discussed above could result in reduced reinsurance costs. Unfortunately, given the state of the medical malpractice market, reduced reinsurance capacity and the significant medical malpractice reserve strengthening reinsurers have taken over the past three years; it seems highly unlikely that reinsurers will lower their rates in reaction to SB2D. If anything, we would expect reinsurance rates to continue to rise over the next few years, regardless of the impact of SB2D. Furthermore, it seems unlikely that primary reinsurers will be able to leverage SB2D to negotiate lower reinsurance attachment appoints or better coverage terms. For the foreseeable future, we believe reinsurers will continue forcing primary insurers to retain more risk as reinsurers continue to move further away from the “working layer” loss level.

Calculation of Presumed Factor:

For the interested reader, Appendix A, Summary Sheet A displays a flow chart of the presumed factor savings flow for Section 56. A visual may be helpful before reading on.

We identified three potential areas of savings that would impact **insurance company** savings on Sheet A:

1. Savings and leverage gained from changes in bad faith strategies, driven by:
 - a. Settlement rates vs. countrywide rates
 - b. Change in settlement costs
 - c. Speed up in claim payments
 - d. Defense cost mitigation strategies.
2. Reduction in insurance company payments in excess of policy limits.
3. Reduction in reinsurance premium to reflect lower bad faith payments.

We identified one potential area of savings that would impact the **presumed factor** on Sheet A:

1. Savings and leverage gained from changes in bad faith strategies, driven by:
 - a. Settlement rates vs. countrywide rates
 - b. Change in settlement costs
 - c. Speed up in claim payments

PRESUMED FACTOR

d. Defense cost mitigation strategies.

As noted above, item 2 and item 3 have no real impact on the presumed factor. Therefore, the following discussion will focus mainly on the impact of item 1 on the presumed factor. Even though item 2 does not directly impact the presumed factor, we believe that a reduced threat from paying certain sizeable bad faith awards will indirectly affect the savings of medical malpractice insurers and their strategy for settling claims. By tightening up the common law loophole, providing time frames for tendering policy limits, and setting forth 10 criteria for the jury to follow in finding bad faith, we believe there will be a reduction in the number of “knee jerk” settlements and a reduction in the incentive for plaintiff attorneys to maximize the “hanging fruit” of possible large dollar bad faith awards.

With this said, Section 56 presents a formidable challenge in determining the presumed factor. We note the following:

- Florida’s settlement rate of 52% is significantly higher than the countrywide settlement rate of 30%. Although we think Section 56 will reduce the current percentage of claims closed with payment to a patient, we are skeptical that the ratio will move significantly closer to the countrywide average settlement rate. This is largely driven by the fact that Florida insurers write considerably lower policy limits than the rest of the country. This fact makes the consideration of defense cost mitigation strategies more important in Florida (see Section 54 for a Florida versus countrywide comparison of the ratio of ALAE payments to indemnity). When deciding to settle a claim, the insurer must consider the potential for bad faith payments **and** the cost/benefit of spending defense dollars on a claim that could be cheaper to settle. If an insurer can settle a claim for a percentage of the anticipated defense costs (e.g., 50%, 100%), or settle a claim for policy limits (e.g., \$250,000 in Florida versus \$1,000,000 or higher in the rest of the country), and avoid the risk of a catastrophic bad faith award, the choice to settle becomes a much easier decision in Florida.

PRESUMED FACTOR

We also noted above that most insurers already had between seven and nine months to investigate claims before being required to make a decision to tender the policy limits. In addition, some experts in the industry have even quoted time frames in excess of 12 months before being required to make a decision to tender the policy limits. For these claims, the new bad faith law does not really change the amount of time insurers have to investigate and avoid bad faith payments. Therefore, one would expect little or no change in the average settlement cost or timing of claim payments for these claims.

- We have noted above that any speed up in claim payment would reduce the investment income insurers can earn on reserves supporting the future payout of medical malpractice losses. This cost will partially offset some of the savings one would achieve by paying claims below policy limits earlier in the claim settlement process.
- By reducing the likelihood of bad faith awards in certain situations (e.g., when a plaintiff serves a demand for payment of the policy limits in the first two or three months after an injury occurs), we believe insurers will gain some leverage in avoiding some of the truly low value/high bad faith potential cases that shouldn't have been brought to trial in the first place. Although most of the savings here will not impact the presumed factor, the leverage created by the new law in certain situations will contribute to a decrease in the number of colorable claims for bad faith.

Given the above comments, we have selected a presumed factor of 2.5% for Section 56. This factor was determined by reviewing a number of different combinations of settlement rate reductions (e.g., 2.5%, 5%, 7.5% and 10%), allocation of claim count reductions to severity types, and average claim severities. The 2.5% factor was determined by reducing a 3.5% selected savings by 1% to reflect the cost impact on insurers for the speed up of claim payments.

SELECTED IMPACT: 2.5%

PRESUMED FACTOR

Section 57 – Legislative Findings and Intent

NOTEWORTHY ADDITIONS: NONE

NOTEWORTHY DELETIONS: NONE

COMMENTARY: NONE

SELECTED IMPACT: 0.0%

Section 58 – Definitions

NOTEWORTHY ADDITIONS:

Change of claimant definition to include “for damages based on personal injury or wrongful death”.

Change of economic damages to include “to the extent the claimant is entitled to recover such damages under general law, including the Wrongful Death Act.”

New definition of health care provider.

Change of noneconomic damages to include “to the extent the claimant is entitled to recover such damages under general law, including the Wrongful Death Act.”

NOTEWORTHY DELETIONS: NONE

COMMENTARY: NONE

SELECTED IMPACT: 0.0%

PRESUMED FACTOR

Section 59 – Limitations on Damages ...

NOTEWORTHY ADDITIONS: NONE

NOTEWORTHY DELETIONS: NONE

COMMENTARY: NONE

SELECTED IMPACT: 0.0%

Section 60 – Presuit Investigation

NOTEWORTHY ADDITIONS: NONE

NOTEWORTHY DELETIONS: NONE

COMMENTARY: NONE

SELECTED IMPACT: 0.0%

Section 61 – Presuit Investigation of Medical Negligence Claims and Defenses by Court

NOTEWORTHY ADDITIONS: NONE

Claimant investigation addition of “including a review of the claim and a verified written medical expert opinion by an expert witness as defined in s. 766.202”.

Defendant investigation addition of “including a review of the claim and a verified written medical expert opinion by an expert witness as defined in s. 766.202”.

NOTEWORTHY DELETIONS: NONE

COMMENTARY: NONE

SELECTED IMPACT: De Minimis Cost

PRESUMED FACTOR

Section 62 – Voluntary Binding Arbitration

NOTEWORTHY ADDITIONS: NONE

NOTEWORTHY DELETIONS: NONE

COMMENTARY: NONE

SELECTED IMPACT: 0.0%

Section 63 – Effects of Failure to Offer or Accept

NOTEWORTHY ADDITIONS:

Adds “damages subject to the limitations in s. 766.118”

NOTEWORTHY DELETIONS:

Removes “without limitation on damages”

COMMENTARY: NONE

SELECTED IMPACT: 0.0%

Section 64 – Limitation on Actions Against Insurers...

NOTEWORTHY ADDITIONS:

Section added.

NOTEWORTHY DELETIONS: NONE

COMMENTARY: NONE

SELECTED IMPACT: 0.0%

PRESUMED FACTOR

Section 65 – Good Samaritan Act; Immunity from Civil Liability

NOTEWORTHY ADDITIONS:

Clarification of “reckless disregard”. New wording “created an unreasonable risk of injury so as to affect the life or health of another, and such risk was substantially greater than that which is necessary to make the conduct negligent.”

NOTEWORTHY DELETIONS:

Clarification of “reckless disregard”. Removed wording “would be likely to result in injury so as to affect the life or health of another, taking into account the following to the extent they may be present;

- a. The extent or serious nature of the circumstances prevailing.
- b. The lack of time or ability to obtain appropriate consultation.
- c. The lack of prior patient physician relationship.
- d. The inability to obtain an appropriate medical history of the patient.
- e. The time constraints imposed by coexisting emergencies.”

COMMENTARY:

Section 65 amends the Good Samaritan Act, Section 763.13, Florida Statutes, to provide more stringent standards for finding doctors and hospitals liable for treatment provided in emergency situations.

The Good Samaritan Act, as amended by the new law, covers three distinct circumstances:

- (i) where a practitioner renders emergency medical care outside of a hospital or doctor’s office;
- (ii) where a hospital or health care provider is rendering emergency medical services inside an emergency room or trauma center; and (iii) where a practitioner is unexpectedly called upon to render emergency medical services in a hospital to a person who is not his or her patient.

- A. Services Provided Outside of a Hospital During An Emergency.

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The new law does not amend the rule for emergency services provided outside of a hospital.

B. Regular Emergency Room Care.

Under the old law, emergency room staff were given immunity unless treatment was provided (or not provided) under “circumstances demonstrating a reckless disregard for the consequences.”

The old law defined “reckless disregard” as conduct “which a health care provider knew or should have known, at the time such services were rendered, would be likely to result in injury so as to affect the life or health of another,” taking into account five factors: (i) the seriousness of the circumstances; (ii) lack of time to consult; (iii) lack of prior patient relationship; (iv) inability to obtain patient’s medical history; and (v) the time constraints imposed by other emergencies. § 768.13(2)(b)(3), Fla. Stat.

The old law also defined two circumstances that were excluded from the “reckless disregard” standard: (i) where the treatment at issue occurred after the patient was stabilized, unless follow-up surgery was required as a result of the emergency treatment; and (ii) where the treatment was unrelated to the original emergency. § 768.13(2)(b)(2), Fla. Stat. Thus, if either of these two exclusions were met, the standard reverted back to the regular negligence standard applicable in non-emergency medical care.

Section 65 amends the definition of “reckless disregard” and also amends the two excluded circumstances.

First, the definition of “reckless disregard” has been modified to create a higher threshold for finding emergency room practitioners liable for emergency room treatment. The new standard provides for immunity unless the services “**created an unreasonable risk of injury so as to affect the life or health of another, and such risk was substantially greater than that which is necessary to make the conduct negligent.**” The modification also deleted the five

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enumerated factors from consideration. It is worth nothing that this modification was enacted even though the Task Force found that the existing definition was sufficient. Only subsequent judicial interpretations and jury decisions will shed light on whether this new standard actually provides heightened immunity as compared to the old standard.

Second, the new law also modified the two existing exclusions but it is unclear whether the amendments will provide additional immunity.

With respect to the first exclusion, the old law excluded from heightened protection treatment that occurred after the patient was stabilized. According to the Governor's Task Force Report, this exclusion resulted in additional litigation over whether the patient was stabilized before treatment was rendered (and thus whether the regular negligence standard should apply). The Task Force recommended that the exclusion for stabilization be removed. In lieu of removing it, however, the legislature amended the exclusion. The new law now provides that the "reckless disregard" standard applies to treatment (including diagnosis, which is a change from the old law) that occurs "prior to the time" the patient is stabilized. By implication, the law still appears to allow the same argument by plaintiffs, namely, that treatment was provided after stabilization and therefore the immunity is inapplicable.

Similarly, the amendment to the second exclusion (treatment unrelated to the original emergency) seems to be "form over substance," now "including" treatment that is "related" to the original emergency. Again, by implication, the same exclusion seems applicable: treatment not related to the original medical emergency is not given immunity.

C. Non-Emergency Room Practitioners Treating Emergency Victims.

The new law carves out a special exception for practitioners who provide voluntary emergency care to a person who is not their patient while the practitioner is at the hospital making rounds or for reasons unrelated to patient care.

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In that circumstance, the practitioner is not liable unless the treatment amounted to conduct “that is willful and wanton and would likely result in injury so as to affect the life or health of another.” § 768(2)(c)(1), Fla. Stat.

This standard appears to provide an even greater degree of protection than the “reckless disregard” standard applicable to regular emergency room staff.

SELECTED IMPACT: De Minimis Savings

Section 66 – Damages

NOTEWORTHY ADDITIONS: NONE

NOTEWORTHY DELETIONS: NONE

COMMENTARY: NONE

SELECTED IMPACT: 0.0%

Section 67 – Sovereign Immunity

NOTEWORTHY ADDITIONS:

Healthcare practitioner language regarding acting as an agent of a state university board of trustees.

NOTEWORTHY DELETIONS: NONE

COMMENTARY: NONE

SELECTED IMPACT: 0.0%

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Section 68 – Itemized Verdict

NOTEWORTHY ADDITIONS: NONE
NOTEWORTHY DELETIONS: NONE
COMMENTARY: NONE
SELECTED IMPACT: 0.0%

Section 69 – Sovereign Immunity

NOTEWORTHY ADDITIONS: NONE
NOTEWORTHY DELETIONS: NONE
COMMENTARY: NONE
SELECTED IMPACT: 0.0%

Section 70 – Athletics in Public K-12 Schools

NOTEWORTHY ADDITIONS: NONE
NOTEWORTHY DELETIONS: NONE
COMMENTARY: NONE
SELECTED IMPACT: 0.0%

Section 71 through Section 87

NOTEWORTHY ADDITIONS: NONE
NOTEWORTHY DELETIONS: NONE
COMMENTARY:

Section 86 expresses the Legislature's intent that the law should apply retroactively, i.e., to incidents of medical negligence that occurred before the effective date of the law, with the provision that the changes to Chapter 766 should be applied only to cases of medical negligence for which a notice of intent to initiate litigation was mailed on or after the effective date of the new law (September 15, 2003).

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Thus, under this provision, the Legislature has indicated its intent that the amendments created by Sections 1 through 47 and 70 through 87 of the new law apply immediately, but the amendments created by Section 48 through 69 only apply to newly filed cases.

Section 86 recognizes, however, the retroactive application of new laws raises constitutional concerns (in particular, it raises due process concerns), and thus the Legislature indicated that its intent applies only if retroactive application “is not prohibited by the State Constitution or Federal Constitution.”

The primary issue that is raised by Section 86 is whether the amendments to Chapter 766 can be applied to cases in which the medical negligence (i.e., the injury or misdiagnosis) occurred before September 15, 2003.

The answer, as discussed below, is that the amendments affecting “substantive rights,” such as the cap on damages, likely **cannot** be applied to cases involving pre-September 15 incidents of medical negligence (even if the presuit notice is filed after September 15), but that amendments affecting “procedural rights,” such as the presuit notice requirements of informal discovery and providing a list of treating physicians, may be applied retroactively. Obvious gray areas, such as whether the amendments to the bad faith laws are procedural or substantive, will likely have to be resolved by the Florida Supreme Court.

The Florida Supreme Court has adopted a two-part test for determining whether it is permissible to apply an amended Statute retroactively. Metro. Dade County v. Chase Fed. Hous. Corp., 737 So. 2d 494, 499 (Fla.1999).

The first test is whether the Legislature intended the amendment to apply retroactively. In this case, the answer is obviously “yes.”

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The second test is whether retroactive application is constitutionally permissible. *Id.* (citing State Farm Mut. Auto. Ins. v. Laforet, 658 So. 2d 55, 61 (Fla.1995)).

Courts will not permit retroactive application of a Statute if the Statute "impairs vested rights," even when the Legislature expressly states that the Statute is to have retroactive application.

In short, procedural amendments may be applied retroactively; amendments affecting substantive rights may not.

"Substantive law prescribes duties and rights and procedural law concerns the means and methods to apply and enforce those duties and rights."

A substantive, vested right is "an immediate right of present enjoyment, or a present, fixed right of future enjoyment." Sanford v. McClelland, 163 So. 513, 514-15 (1935). A vested right is thus a "fixed" right that cannot be abrogated or taken away without violation of the possessor's right to due process. Chase Fed., 737 So. 2d at 503 ("Thus, retroactive abolition of substantive vested rights is prohibited by constitutional due process considerations.") .

Here, because previous reforms to the medical malpractice Statute have been compared to the limitations on rights set forth in the workers' compensation system, see, e.g., University of Miami v. Echarte, 618 So. 2d 189 (Fla. 1993), cases construing the workers' compensation Statutes are applicable by analogy for guidance.

The general rule in workers' compensation cases is that the substantive rights of the parties are fixed by the law in effect **on the date of the injury**, but that no party has a vested right in any particular procedure. See, e.g., McCarthy v. Bay Area Signs, 639 So. 2d 1114, 1115-16 (Fla. 1st DCA 1994).

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Accordingly, because the “date of the injury” has typically been viewed as the operative date for determining an injured party’s vested rights, it is likely that none of the substantive amendments to Chapter 766, such as the cap on damages, will apply to injuries or misdiagnoses or other types of medical negligence that caused injury before September 15, 2003 even if presuit notice was initiated after September 15, 2003. By contrast, changes to the presuit notice and discovery requirements are likely to be deemed procedural and therefore applicable to all cases in which presuit notice was initiated on or after September 15, 2003.

SELECTED IMPACT: 0.0%

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III. PRESUMED FACTOR SUMMARY MATRIX

COMMITTEE SUBSTITUTE FOR SENATE BILL 2-D

Presumed Factor Summary Matrix

Section	Title	Subject	Type of Reform	Selected Presumed Factor
1	Findings	18 Legislature findings	Other	0.0%
2	creates 395.0056	Litigation notice requirement	Hospital	0.0%
3	amends 395.0191	Staff membership and clinical privileges	Hospital	0.0%
4	amends 395.0197	Internal risk management program	Hospital	0.0%
5	repeals 395.0198	Repeal of section	Hospital	0.0%
6	creates 395.1012	Patient safety	Hospital	0.0%
7	creates 395.1051	Duty to notify patients - licensed facility	Hospital	0.0%
8	creates 456.0575	Duty to notify patients - health care practitioner	Physician	0.0%
9	Civil immunity for boards etc	Civil immunity	Tort	0.0%
10	Patient Safety Data Privilege	Patient safety and data privilege	Tort	0.0%
11	amends 456.013	Department; general licensing provisions	Physician	0.0%
12	amends 456.025	Fees; receipts; disposition	Physician	0.0%
13	amends 456.039	Designated HCP; information required for licensure	Physician	0.0%
14	amends 456.041	Practitioner profile; creation	Physician	0.0%
15	amends 456.042	Practitioner profile; update	Physician	0.0%
16	amends 456.049	HCP; reports on professional liability claims and actions	Physician	0.0%
17	amends 456.051	Reports on professional liability actions; bankruptcies; DOH responsibility to provide	Physician	0.0%
18	amends 456.057	Ownership and control of patient records; report or copies of records to be furnished	Physician	0.0%
19	amends 456.072	Grounds for discipline; penalties; enforcement	Physician	0.0%
20	amends 456.073	Disciplinary proceedings	Physician	0.0%
21	amends 456.077	Authority to issue citations	Physician	0.0%
22	amends 456.078	Mediation	Physician	0.0%
23	amends 456.320	Financial responsibility - physician	Physician	0.0%
24	amends 459.0085	Financial responsibility - osteopathic physician	Physician	0.0%
25	amends 458.331	Grounds for disciplinary action; action by the board and department	Physician	0.0%
26	creates 458.3311	Emergency procedures for disciplinary action	Physician	0.0%
27	amends 459.015	Grounds for disciplinary action; action by the board and department (osteopathic)	Physician	0.0%
28	creates 459.0151	Emergency procedures for disciplinary action (osteopathic)	Physician	0.0%
29	amends 461.013	Grounds for disciplinary action; action by the board; investigations by department (podiatric)	Physician	0.0%
30	creates 461.0131	Emergency procedures for disciplinary action (podiatric)	Physician	0.0%

COMMITTEE SUBSTITUTE FOR SENATE BILL 2-D

Presumed Factor Summary Matrix

Section	Title	Subject	Type of Reform	Selected Presumed Factor
31	amends 466.028	Grounds for disciplinary action; action by the board (dental)	Physician	0.0%
32	DoAH shall ...		Administrative	0.0%
33	creates 1004.08	Patient safety instructional requirements (public school, college, university)	Other	0.0%
34	creates 1005.07	Patient safety instructional requirements (private school, college, university)	Other	0.0%
35	AHCA shall ...	Quality of care study based on NY and TX hospital quality reports	Physician	0.0%
36	AHCA ... is directed ...	Comprehensive study and report on the establishment of a Patient Safety Authority	Physician	0.0%
37	OPPAGA and ... must	Audit of DOH's health care practitioner disciplinary process and closed claims	Physician	0.0%
38	DOH shall ...	Workgroup to study the healthcare practitioner disciplinary process	Physician	0.0%
39	amends 624.462	Commercial self-insured funds	Insurance	0.0%
40	amends 627.062	Rate standards - ratemaking and insurer's base rate, "Presumed Factor"	Insurance	0.0%
41	OPPAGA must ...	merits of Public Counsel to examine insurance company rate filings	Other	0.0%
42	amends 627.357	Medical malpractice self-insurance	Insurance	0.0%
43	amends 627.4147	Medical malpractice insurance contracts	Insurance	0.0%
44	creates 627.41495	Public notice of medical malpractice rate filings	Insurance	0.0%
45	amends 627.912	Professional liability claims and actions; reports by insurers and HCP; annual report by office	Insurance	0.0%
46	amends 641.19	Definitions (HMO)	Insurance	0.0%
47	amends 641.51	HMO quality assurance program; second medical option required	Insurance	0.0%
48	amends 766.102	Medical negligence; standards of recovery; expert witness	Tort	0.0%
49	amends 766.106	Notice before filing for medical negligence; pre-suit screening; offers for admission of liability and for	Tort	0.0%
50	amends 766.108	Mediation	Tort	0.0%
51	amends 766.1115	Health Care Providers; Creation of Agency Relationship with Governmental Contractors	Tort	0.0%
52	amends 766.112	Comparative fault	Tort	0.0%
53	amends 766.113	Settlement agreements	Tort	0.0%
54	creates 766.118	Noneconomic damages	Tort	5.3%
55	the legislature finds ... ems	Emergency medical services	Tort	0.0%
56	creates 766.1185	Bad faith	Tort	2.5%
57	amends 766.201	Legislative findings and intent	Tort	0.0%
58	amends 766.202	Definitions	Tort	0.0%
59	creates 766.2021	Limitations on damages...	Tort	0.0%
60	amends 766.203	Presuit investigation	Tort	0.0%

COMMITTEE SUBSTITUTE FOR SENATE BILL 2-D

Presumed Factor Summary Matrix

Section	Title	Subject	Type of Reform	Selected Presumed Factor
61	amends 766.206	Presuit medical expert opinion	Tort	0.0%
62	amends 766.207	Voluntary binding arbitration of medical negligence claims	Tort	0.0%
63	amends 766.209	Effects of failure to offer or accept voluntary binding arbitration	Tort	0.0%
64	creates 768.0981	limitations on actions against	Tort	0.0%
65	amends 768.13	Good Samaritan Act; immunity from civil liability - clarification of "reckless disregard"	Tort	0.0%
66	amends 768.21	damages	Tort	0.0%
67	amends 768.28	Sovereign immunity	Tort	0.0%
68	amends 768.77	itemized verdict	Tort	0.0%
69	Nothing in this act constitutes a waiver of	Sovereign immunity	Tort	0.0%
70	amends 1006.20	Athletics in public k-12 schools	Tort	0.0%
71	DOH shall study and report	Inclusion of medical review panels in pre-suit process	Other	0.0%
72	amends 391.025	Applicability and scope	Other	0.0%
73	amends 391.029	Program eligibility	Other	0.0%
74	amends 766.303	Florida Birth-Related Neurological Injury Compensation Plan; exclusiveness of remedy	Other	0.0%
75	amends 766.304	Administrative law judge to determine claims	Administrative	0.0%
76	amends 766.305	Filing of claims and responses; medical disciplinary review	Other	0.0%
77	adds to 766.309	Determination of claims; presumption; findings of administrative law judge binding on participants.	Administrative	0.0%
78	amends 766.310	Administrative law judge awards for birth-related neurological injuries; notice of award	Administrative	0.0%
79	amends 766.314	Assessments; plan of operations	Other	0.0%
80	OPPAGA shall complete a study	Florida birth-related neurological injury compensation association	Other	0.0%
81	DOH and AHCA staff funding	Appropriations of \$687,786 and \$1,629,994, respectively	Other	0.0%
82	OIR funding for implementing Act	Appropriations of \$1,450,000	Other	0.0%
83	Patient safety initiative funding	Appropriations of \$850,000	Other	0.0%
84	If any law that is amended by this act	Procedural	Other	0.0%
85	If any provisions of this act or its applications ...	Procedural	Other	0.0%
86	It is the intent of the legislature to apply ...		Other	0.0%
87	Effective date of act	September 15, 2003	Other	0.0%

COMMITTEE SUBSTITUTE FOR SENATE BILL 2-D Presumed Factor Summary Matrix

Section	Title	Subject	Type of Reform	Selected Presumed Factor
ALL	Total Presumed Factor		All	7.8%
NOTE:	AHCA - Agency for Health Care Administration DoAH - Division of Administrative Hearings DOH - Department of Health HCP - Health care professional OIR - Office of Insurance Regulation OPPAGA - Office of Program Policy Analysis and Government Accountability			
Chapter	Title (Name - not to be confused with an aggregation of Chapters)			
395	Hospital Licensing and Regulation			
456	Health Professions and Occupations: General Provisions			
458	Medical Practice			
459	Osteopathic Medicine			
461	Podiatric Medicine			
466	Dentistry, Dental Hygiene, and Dental Laboratories			
624	Insurance Code: Administration and General Provisions			
627	Insurance Rates and Contracts			
641	Health Care Service Programs			
766	Medical Malpractice and Related Matters			
768	Negligence			
1004	Support for Learning			

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IV. OBSERVATIONS

Observations

This section of the report addresses issues that may span multiple Sections of SB2D or require a more detailed discussion than presented above.

- **“Presumed Factor” (Section 40)**

Section 40 requires a rate freeze and mandatory medical malpractice rate filing to reflect the savings of SB2D. Rates approved on or before July 1, 2003 for medical malpractice insurance remain in effect until the effective date of the filing required by SB2D. Insurers must make that rate filing effective no later than January 1, 2004, to reflect the savings of SB2D, using the presumed factor established by the Office of Insurance Regulation.

If, however, the medical malpractice insurer contends that the presumed factor results in a rate that is excessive, inadequate, or unfairly discriminatory, the insurer may use a different factor subject to the prior approval of the Office of Insurance Regulation. Section 40 states:

“(b) Any insurer or rating organization that contends that the rate provided for in paragraph (a) is excessive, inadequate, or unfairly discriminatory shall separately state in its filing the rate it contends is appropriate and shall state with specificity the factors or data that it contends should be considered in order to produce such appropriate rate. The insurer or rating organization shall be permitted to use all of the generally accepted actuarial techniques provided in this Section in making any filing pursuant to this subsection. The office shall review each such exception and approve or disapprove it prior to use. It shall be the insurer’s burden to actuarially justify any deviations from the rates required to be filed under paragraph (a).”

Deloitte’s Section-by-Section quantification of the presumed factor relies upon aggregate Florida data. Therefore, to the extent that an individual insurer’s book of business mix varies

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significantly from Florida's aggregate data, the presumed factor may need to be adjusted to reflect an individual company's actual exposure.

For example, a medical malpractice insurance company that writes a heavy concentration of low risk specialties (e.g., chiropractors, allergists, dermatologists – no surgery) would likely see a much lower savings than estimated by the presumed factor since low risk specialties typically have minimal exposure to large jury awards and bad faith judgments.

On the other hand, a medical malpractice insurance company that writes a heavy concentration of high risk specialties (e.g., Neurologists, Gynecologists with significant annual deliveries, Obstetricians) might see a higher savings than estimated by the presumed factor when compared to aggregate Florida data which also includes lower risk specialties.

It is up to each medical malpractice insurer with direct written premium in the State of Florida to determine if the presumed factor presented in this report produces rates that are excessive, inadequate, or unfairly discriminatory to the company based upon their own independent analysis and review of their own book of business.

- **Modification to the “Presumed Factor” in Section 54**

In the calculation of the presumed factor for the cap on noneconomic damages, we have provided a matrix of indemnity savings shown by policy limit and for practitioner versus non-practitioner. It is conceivable that some medical malpractice insurers with a dramatically different distribution of policy limits or practitioner versus non-practitioner split may attempt to use the matrix to calculate their own presumed factor.

If a company were to calculate their own Section 54 presumed factor, we note the following considerations for the OIR's consideration:

1. The medical malpractice insurer must walk through the five steps in order to complete the calculation of the presumed factor.

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2. If the practitioner versus non-practitioner split assumption is changed from our current reliance on the closed claim database mix, the medical malpractice insurer must add an additional step. This step would illustrate their assumed split assumption. The five steps should then be followed.
3. It may be in the OIR's best interest to request additional information in future rate filings documenting the distribution of policy limits split out by practitioner versus non-practitioner. Although we don't like to burden insurers with additional data requests, the information would reduce the likelihood of someone making the argument to the OIR that some insurers may be gaming the system by accepting the presumed factor when they should actually be reflecting higher savings.
4. Even with the above adjustments, the claims in the closed claim database may not be representative of the claims (e.g., average severity, severity type, and split of damages) an individual medical malpractice carrier may observe. The low risk specialty insurer discussed above is a great example. Changing the assumptions may be of little value if the insurer's book of business focuses only on low risk exposures.

- **“Presumed Factor” and the Current Rate Indication**

It is important to note that the presumed factor determined in this analysis must be considered in combination with the medical malpractice insurance company's current indicated manual rate change adjusted for the benefits of SB2D. As is noted in the Contingencies article *The Million-Dollar Challenge: Measuring the Impact of Medical Liability Tort Reform*²:

“If an insurance company's indicated premium rate change is +40.0 percent, and the estimated premium savings from tort reform 37.5 percent, insurance consumers in the above example would NOT see a 37.5 percent premium savings but a net premium increase of 2.5 percent (e.g., 40.0 percent - 37.5 percent). This fact is often misunderstood and lost in the communication of tort reform's final impact.”

² September/October 2003 Contingencies Magazine [The Million-Dollar Challenge: Measuring the Impact of Medical Liability Tort Reform](#), Kevin Bingham.

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If a medical malpractice insurance company has rates that are excessive, inadequate, or unfairly discriminatory, Section 40 allows the company (see first bullet) to file alternative rates. Using the +40.0 percent manual rate indication quoted in the above article, the insurance company would file a +40.0 percent increase minus the presumed factor, not the presumed factor.

It is important to stress this fact when the public and most legislators are expecting to see rates drop by the impact of the presumed factor, not increase by the manual rate indication less the presumed factor. This was a challenging issue to communicate in our recent work in Texas and will likely present similar challenges in Florida when doctors are expecting a rate decrease, **not a reduced increase**.

- **Noneconomic Damages – Freeze of Rates**

Section 40 requires a freeze of all rates approved on or before July 1, 2003, with the freeze remaining in effect until the effective date of the filing required by SB2D. For those medical malpractice insurers whose proposed rates were not approved before July 1, 2003, they have to wait until SB2D allows new rates to be filed. These insurers will likely see their rate inadequacy build during the “freeze” period. This building rate inadequacy will likely increase the probability that insurers in this category will need to file a reduced increase, and not an overall decrease. Given the current state of Florida’s medical malpractice marketplace, we would expect the majority of insurers to fall into this category (i.e., we don’t believe there are many insurers that were waiting to file rate decreases before the freeze).

- **Noneconomic Damages – Phase In of Law**

As is noted above in Section 86, the cap on noneconomic damages will likely not apply to injuries or misdiagnoses or other types of medical negligence that caused injury before September 15, 2003, even if presuit notice was initiated after September 15, 2003. Therefore, the full impact of the savings from the cap on noneconomic damages will take time to phase in. Based upon our review of the rate filings, it is not uncommon for only 25% to 35% of

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claims to be reported in the first year of a claims made policy's effective date. Stated another way, 65% to 75% of claims are reported in the second and subsequent year after the policy is issued. We have adjusted our presumed factor in Section 54 using lag statistics from the closed claim database to reflect the impact of the phase in. We are comfortable that our presumed factor falls within a reasonable range of potential savings.

- **Noneconomic Damages – Spreading vs. Telescoping Comparative Fault**

Florida law does not allow a defendant to be jointly liable for a plaintiff's noneconomic damages. With the caps on noneconomic damages that have been created in Section 54, it is important to understand their impact on potential plaintiff attorney strategies when it comes to arguing the comparative fault of defendants. A simple example may help illustrate the issue now facing Florida plaintiff attorneys and their clients:

Jury verdict: \$2,400,000

	Scenario 1 - "Spread"			Scenario 2 - "Telescope"		
<u>Defendant</u>	<u>Comparative Fault</u>	<u>Award Before Cap</u>	<u>Capped Award</u>	<u>Comparative Fault</u>	<u>Award Before Cap</u>	<u>Capped Award</u>
Physician 1	25.0%	\$600,000	\$500,000	92.5%	\$2,220,000	\$500,000
Physician 2	25.0%	\$600,000	\$500,000	2.5%	\$60,000	\$60,000
Physician 3	25.0%	\$600,000	\$500,000	2.5%	\$60,000	\$60,000
Physician 4	25.0%	\$600,000	\$500,000	2.5%	\$60,000	\$60,000
		\$2,400,000	\$2,000,000		\$2,400,000	\$680,000
				Difference:		\$1,320,000

As you can see from the above example, it is in the plaintiff attorney's best interest to argue for the "spreading" of comparative fault between defendants when the ratio of noneconomic damages to economic damages is high. This strategy optimizes the benefit of the caps by spreading the maximum possible damages to each defendant. On the contrary, "telescoping" comparative fault to one defendant quickly forces damages above the statutory caps.

As the ratio of noneconomic damages to total damages decreases, the above strategy for optimizing the benefit of the cap becomes less important. In situations with big pocket

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defendants (e.g., hospital), the issues of “telescoping” vs. “spreading” becomes less important. Instead, it is more important to capitalize on the joint and several liability for economic damages (see s. 768.81(3)) if there is a belief that the other small pocket defendants will be unable to pay their fair share of the economic damages.

- **Noneconomic Damages – Claimant Assumptions**

The current closed claim database does not include information regarding the number of claimants. One could argue (and reasonably should) that a jury would react differently to a case with one claimant (e.g., wife) versus a case with multiple claimants (e.g., wife and five kids). For purposes of our analysis, we have assumed that the historical distribution of claims in the closed claim database represent a reasonable mix of potential multi-claimant law suits. Therefore, we believe our approach to estimating the presumed factor discussed in Section 54 and Appendix B is reasonable given the limitations on the historical data.

- **Cap on Noneconomic Damages – Clarification of Savings**

In order to understand the true savings medical malpractice insurance companies receive from the implementation of a cap on noneconomic damages, it is important to walk through a simplified example of how individuals might communicate the savings from SB2D:

JURY VERDICT EXAMPLE - \$500,000 POLICY LIMIT

	<u>Economic Damages</u>	<u>Noneconomic Damages</u>	<u>Total Damages</u>	<u>Policy Limits Payable</u>
Before Senate Bill 2-D	\$1,500,000	\$3,500,000	\$5,000,000	\$500,000
	<u>Economic Damages</u>	<u>Noneconomic Damages</u>	<u>Total Damages</u>	<u>Policy Limits Payable</u>
After Senate Bill 2-D	\$1,500,000	500,000	\$2,000,000	\$500,000
	<u>Economic Damages</u>	<u>Noneconomic Damages</u>	<u>Total Damages</u>	<u>Policy Limits Payable</u>
Change	\$0	\$3,000,000	\$3,000,000	\$0
% Change	0.0%	85.7%	60.0%	0.0%

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As one can see from the above example, the \$5,000,000 jury verdict against a single practitioner defendant can be communicated in three different ways:

1. Noneconomic damages are reduced by approximately 86%.
2. Total damages are reduced by 60%.
3. Insurance company payments are reduced by 0%.

The drastic difference in perceived effect of the cap is driven by the point of view of the individual receiving or paying the damages. In the first two communications, the percentage reduction is from the point of view of the plaintiff. In the third communication, the percentage savings is from the point of view of the insurance company.

In this example, even though the noneconomic damages are reduced by 86%, the insurance company doesn't lower its loss payments at all. This is an extremely important point given the significant reduction in policy limits being purchased by healthcare providers in the State of Florida over the past few years. As policy limits drop, the savings insurance companies can pass on to insurance consumers decreases. For policy limits purchased under \$500,000, there is little or no benefit to pass on to insurance consumers at all.

The only potential savings for the insurance company in the above example would be if the insurer would have been found in bad faith before the passage of SB2D and not in bad faith after the passage of SB2D. The insurance company's payment of \$2,000,000 (i.e., \$500,000 policy limit + \$1,500,000 bad faith payment) would drop by the \$1,500,000 bad faith payment or 75%. Although this reduction in payments is significant, medical malpractice insurance companies currently do not include bad faith payments in their ratemaking data. Therefore, there is no impact on the presumed factor (See Section 56 for full discussion).

- **High Policy Limits "Catch 22"**

Healthcare providers in the State of Florida who purchase higher policy limits (e.g., greater than \$1,000,000) are often put in an increasingly difficult situation as their healthcare provider

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peers continue to purchase lower limits (if any). In situations where multiple physicians are named as defendants, it is common knowledge that physicians with the higher policy limits represent the most attractive target for plaintiff attorneys. Therefore, it becomes easier to understand the counterintuitive argument that healthcare providers should purchase the lowest possible limits in order to reduce likelihood of being sued for bigger awards than other defendants.

- **ALAE**

During our analysis of SB2D, we have been careful to consider the impact of the bill on the insurer's cost of defending claims. It is our belief that what the law "gives with one hand, it takes away with the other." For example, Section 48 defines expert witness testimony and when a person may give expert testimony concerning the prevailing professional standard of care. Although the change in expert witness qualifications will likely increase costs for plaintiff attorneys and reduce the likelihood of the use of so called "general" experts, it is our belief that these savings will be offset by the increased costs associated with insurance companies having to use expert witnesses in defending cases and in other Sections of the bill.

- **SB2D Impact on Policy Limit Purchasing Trends**

After medical malpractice insurers incorporate the presumed factor into their rates, one could try and argue that the incentive to purchase lower policy limits would be alleviated by the savings resulting from SB2D. Unfortunately, the overall presumed factor calculated in this report will likely have little or no impact on the current trend of doctors purchasing lower policy limits. Therefore, we do not believe that there will be a rush of healthcare providers deciding to purchase higher policy limits which would alter our current assumptions regarding the distribution of policy limits that we used in our calculation of the presumed factor in Section 54.

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- **Bad Faith – Offset to Speed up of Payout Patterns**

We noted above that Section 56 would likely result in the speed up of claim payments in medical malpractice claims and a reduction in investment income achievable by insurers. We also believe that for a small number of claims of questionable merit, SB2D will increase the likelihood that insurers will see the case through to a jury trial. For these specific claims, switching from a settlement before SB2D to a jury verdict after SB2D would actually slow down the payout pattern. In the aggregate, we believe the current law will result in a speed up in the payout of losses as discussed in Section 56.

- **Bad Faith – Common Law Example**

One of the perceived practical benefits of the new law is demonstrated by the following real life example which has been modified for confidentiality. An insurance company received a pre-suit request to settle a potential medical malpractice matter for the policy limits of \$1 million. The plaintiff had been rendered a quadriplegic due to the alleged negligence of the doctor and his staff. The offer letter, which was sent approximately 60 days after the procedure that resulted in the injury, gave a 20-day deadline for the insurer to respond. The insurer missed the deadline due to simple inadvertence by one of its personnel. The plaintiff thereafter rejected the \$1 million tender and filed suit. Ultimately, to avoid a trial and to avoid a potential bad faith claim, the insurer settled for **6 times** the policy limits.

The new 210 day deadline will make it much less likely that such "administrative" inadvertence will result in potential bad faith claims because plaintiffs will no longer be able to impose artificially short response deadlines under common law. In addition, insurers will have more time to investigate claims and make more informed decisions about settlement.

- **Disciplinary Challenge**

Medical malpractice is often times communicated in the news as "bad doctors routinely doing bad things." Stories like that of a Doctor in Hawaii who was recently sued for at least the eighth time are not standard drivers of claims. Although stories like his often dominate the

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news headlines (i.e., he hack sawed and inserted a screwdriver into a patient's back instead of the titanium rod which he misplaced before the operation), one mustn't extrapolate this type of gross negligence onto the entire physician population.

The fact of the matter is that medical malpractice is essentially "good doctors doing unfortunate things" in the vast majority of the claims. Most clear cut malpractice claims (e.g., wrong blood type, amputation of the wrong leg) represent a small fraction (e.g., less than 4%) of the total medical malpractice claims that are reported every year. Of these claims, there is often no clear cut repeat offender that a regulatory body can identify and remove from practice. When there is an individual who appears to have more claims relative to other doctors, it may be because he or she practices in a high risk specialty (e.g., surgeons and OB/GYNs versus chiropractors and dermatologists) or a more difficult territory in the state (e.g., high risk Dade County or Broward County versus lower risk Saint Johns County or Martin County). Therefore, one could theoretically discipline 4% of the doctors every year and still not reduce the likelihood of future adverse events.

All people, especially healthcare practitioners feel horrible when a mistake is made and a patient is injured under their care. If a physician could reverse an adverse event; there isn't a doctor in the world that wouldn't turn back the clock. Unfortunately, medical malpractice events cannot be fixed or reversed as easy as other professionals such as the revising of an actuarial analysis or restatement of previously incorrect "audited" financial statements. When a doctor is sued, it is very traumatic event. In most cases, disciplinary proceedings add further salt to the wounds without creating a real solution. As the Institute of Medicine's³ study *To Err is Human* stated:

"The focus must shift from blaming individuals for past errors to a focus on preventing future errors by designing safety into the system. This does not mean that

³ 2000 Institute of Medicine study To Err Is Human – Building a Safer Health System

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individuals can be careless. People must still be vigilant and held responsible for their actions. But when an error occurs, blaming an individual does little to make the system safer and prevent someone else from committing the same error."

Without question, Doctors like the Hawaii doctor mentioned above should be disciplined. Excluding Florida's own Hawaii like examples, it is important to reiterate that the current Sections dealing with practitioner discipline will not help to dramatically reduce or eliminate medical malpractice costs in Florida.

- **Closed Claim Database – Publicly Documented Caveats**

Our analysis of the cap on noneconomic damages relies upon Florida's Closed Claim Database (CCD). A number of individuals and organizations have commented on the integrity of the data contained in the CCD. We believe the Select Committee on Medical Liability Insurance Report (SCMLI)⁴ and the GSTF Report clearly illustrate some of the issues. The SCMLI Report states:

"Questions have been raised concerning the integrity of the Closed Claim Database, and there are additional factors which should be considered when this data is used as a barometer of the current medical malpractice market. The database reflects claims that have been closed as of any one point in time. The injuries occurred many years prior to the claims' closures. So, when one looks for changes in severity or for frequency trends, looking at the number and size of claims that have recently been closed evidences an incomplete picture. Better data would be the inclusion of the number of claims, and the associated reserves established thereon, that are currently being realized by insurers. Rate filings include data that reflect claims paid in prior years and the reserves that have been set relative to claims filed in those years, but not yet paid or closed.

⁴ March 2003 Florida House of Representatives Select Committee on Medical Liability Insurance Report

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It is the number and severity of claims currently being incurred that seem to be the most concern to the insurance industry. The industry is seeing two things happen that are not reflected in the Closed Claim Database. They are seeing an increasing number of claims being filed. Likewise, some are finding the need to set higher reserves for those claims in response to recent experience in either litigating the claims or settling them prior to litigation. It may not matter whether or not this perception is ultimately deemed accurate. If such perception results in the legitimate establishment of increased reserves; reported losses (for income purposes) effectively rise; and rate increases naturally follow – or insurers reduce their willingness to provide the coverage – or the insurers even leave the State altogether.”

“The Closed Claim Database is being increasingly relied upon to draw conclusions about the current state of the medical malpractice market. The OIR has contended that while the information in the Database is not without value, the contents do not reflect a current, comprehensive picture of the medical malpractice market. They note that the data is not validated. Conclusions drawn from the Database should recognize this fact. Not all entities providing medical malpractice in Florida are required to report closed claims to the Office. Moreover, it cannot be assured that all of the insurance entities required to report to the Database have consistently done so. Finally, not all licensed physicians have insurance. The OIR argues that, accordingly, analyses that presume a comprehensive Database may be fundamentally flawed.

There are a couple of additional concerns raised by the OIR with the Database. For more than 20 years, the information was submitted to OIR by insurers on paper. The paper information was then key-punched into the database by P.R.I.D.E. The OIR was not able to supervise this data entry, nor was there any formal OIR-administered audit program in place during these years. For the years this data was entered into the system via the Florida’s prison system, the OIR can not attest that all of the submitted data was entered, or that it was entered correctly.”

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The GSTF Report states:

“The FLDOI database is available on CD and comes with the following disclaimer.

“Neither the Department of Insurance nor the State of Florida accepts legal liability or responsibility for the accuracy, completeness or usefulness of this information on closed claim reports filed by insurers. This information is unaudited.”

The FLDOI database consists of two databases. “Archive” contains years 1975 up to mid-July 1999 and “Current” contains data from mid-July 1999 to present. The Department of Insurance provides very specific information regarding duplicate records and steps that need to be taken to successfully work with the data.

Concerns have been raised by some stakeholders at Task Force meetings that this database is incomplete due to underreporting of claims. Steve Roddenberry, Deputy Director of the Division of Insurer Services at the Florida Department of Insurance, confirms that some insurers may not report to the FLDOI as required. In addition, self-insurers, off-shore captives, risk retention groups, and surplus line companies do not report to the closed claim database ”

The GSTF Report also has comments from consulting firms that had to modify the data when using it for analysis purposes.

Although we recognize the questions that have been raised concerning the integrity of the CCD, we have taken what we believe are reasonable and prudent steps to cleanse the data into a useable format. In addition, we believe the following items help to mitigate the concerns regarding the credibility of the closed claim data and adjustments we have made to clean up the database:

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1. Similar to other studies mentioned in the GSTF Report, we have eliminated duplicate claim records. (see Appendix B for details)
2. Noneconomic damages are capped in our study.
 - a. Adjustments that we have made to gross up the noneconomic portion of the settlements capped at policy limits are mitigated by the application of the cap. As is shown in Appendix B, a majority of the claims did not need to be adjusted.
 - b. Assumptions that we have applied to trend the historical settlements to current dollar levels are mitigated by the application of the cap.
3. Total damages are capped at policy limits in our study.
 - a. Healthcare practitioners have been purchasing significantly lower policy limits than the claims that are included in the CCD. While the higher limits in the current database help to make the data more credible (i.e., higher limits provide a better estimate of the economic versus noneconomic split since policy limits are less likely to cap settlements), the lower policy limits significantly mitigate the impact of settlement and trend assumptions.
 - b. Policy limits cap noneconomic damages and economic damages. By overlaying the policy limits on top of the noneconomic damage caps mentioned above, the impact of the settlement and trend assumptions are further mitigated (see Appendix B for three different claim example illustrations).

Given the mitigating impact of the caps and policy limits, we feel the presumed factor calculated in Section 54 falls within a reasonable range of results. Furthermore, the impact compares reasonably with findings of the GSTF Report which quantified savings of 21% for a \$250,000 hard cap, 9% for a \$500,000 hard cap, and 2% for a \$1,000,000 hard cap.

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- **Recoverable Damages in Medical Malpractice Actions**

One of the changes implemented by the new law concerns the categories of damages that are recoverable in medical negligence arbitrations.

In essence, the legislature “overturned” a portion of the Florida Supreme Court’s decision in St. Mary’s Hospital, Inc. v. Phillipe, 769 So. 2d 961, 972-73 (Fla. 2000), which held that, with respect to the voluntary arbitration mechanism in the medical malpractice Statute, the categories of damages recoverable in a medical negligence case involving wrongful death were governed by the medical malpractice Statute and not by the Wrongful Death Statute.

Thus, under St. Mary’s, the court allowed a claimant who had elected voluntary arbitration in a wrongful death case involving medical negligence to recover damages for the lost earning capacity of the decedent, even though that type of economic damages would not have been recoverable in a wrongful death action outside of arbitration (i.e., in court). The basis for the court’s ruling was that the Legislature had not specified which act controlled the applicable damages in the event of a voluntary arbitration.

In the new law, the Legislature has answered the call by amending the definitions of both “economic” and “noneconomic” damages in Section 766.202 to include the following language: “to the extent the claimant is entitled to recover such damages under general law, including the Wrongful Death Act.”

The Legislature also amended the arbitration Section of the medical malpractice Statute to reflect that “damages shall be awarded as provided by general law, including the Wrongful Death act.” See Section 62 of the new law.

These amendments clarify that, in the event of a medical negligence action involving wrongful death, the damages recoverable, in both court and in arbitrations, are proscribed by the Wrongful Death Statute. Thus, if this new amendment had been in effect at the time of the St.

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Mary's decision, the claimant in that case would not have been permitted to recover economic damages for loss of future earning capacity of the decedent.

- **Complexity of Report**

We have done our best to document our findings and observations using examples and terminology with the least amount of actuarial and legal terminology. Although we have attempted to do this, certain sections of this report will still require additional attention for those readers unfamiliar with the field of actuarial science or interpretation of Statutes. We have included a ratemaking primer section in the appendices as well as numerous illustrations throughout the report to provide additional color to our written comments.

Given the short time frame we had to deliver the final report, we are hopeful that readers will appreciate the thoroughness of the report. Our team enjoyed working on this engagement.

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V. APPENDIX

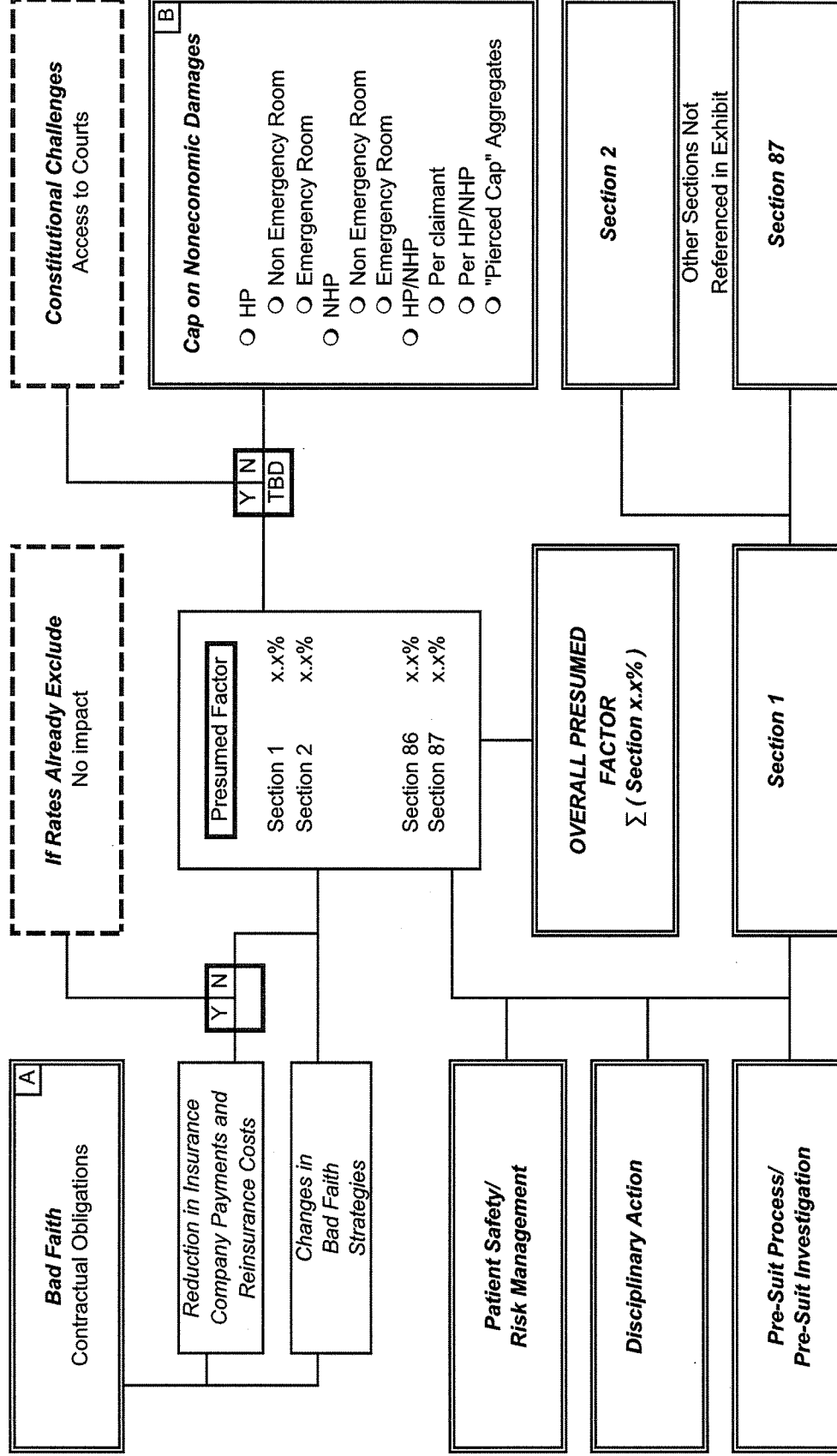
PRESUMED FACTOR

APPENDIX A

SB2D Savings Flow Chart

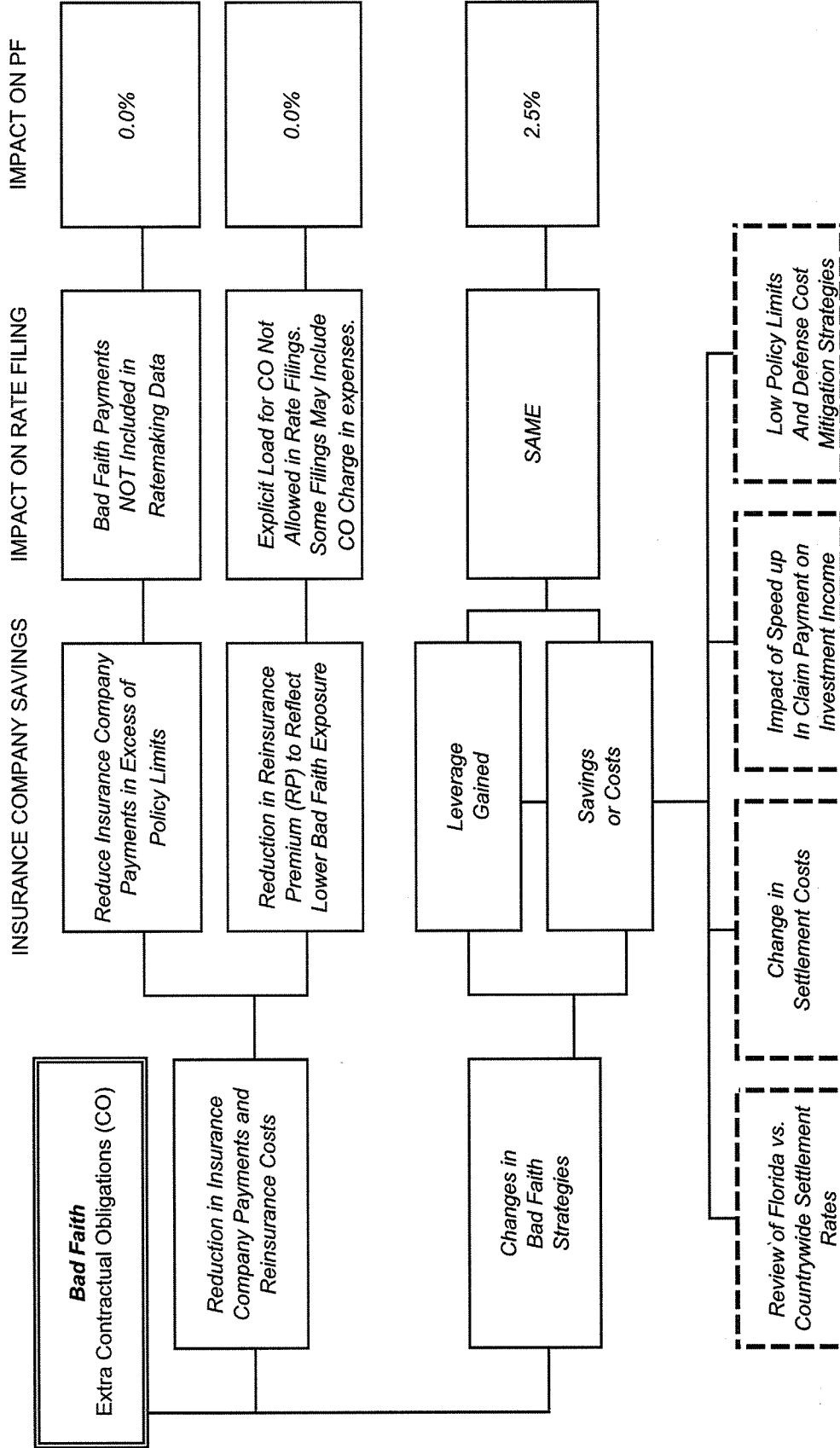
SECTION 40 "PRESUMED FACTOR (PF)" - SAVINGS FLOW

SUMMARY



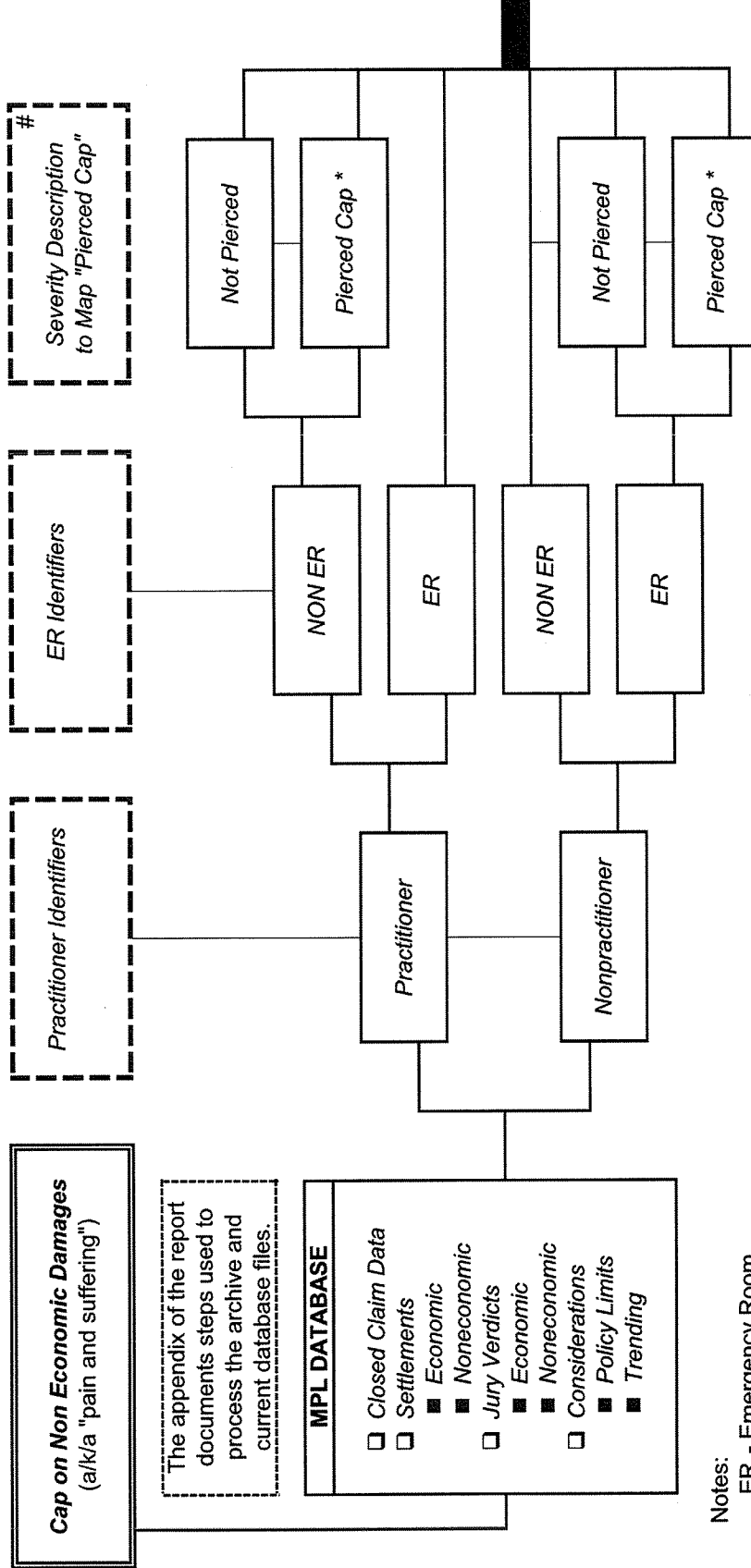
DELOITTE & TOUCHE

SECTION 40 "PRESUMED FACTOR (PF)" - SAVINGS FLOW BAD FAITH



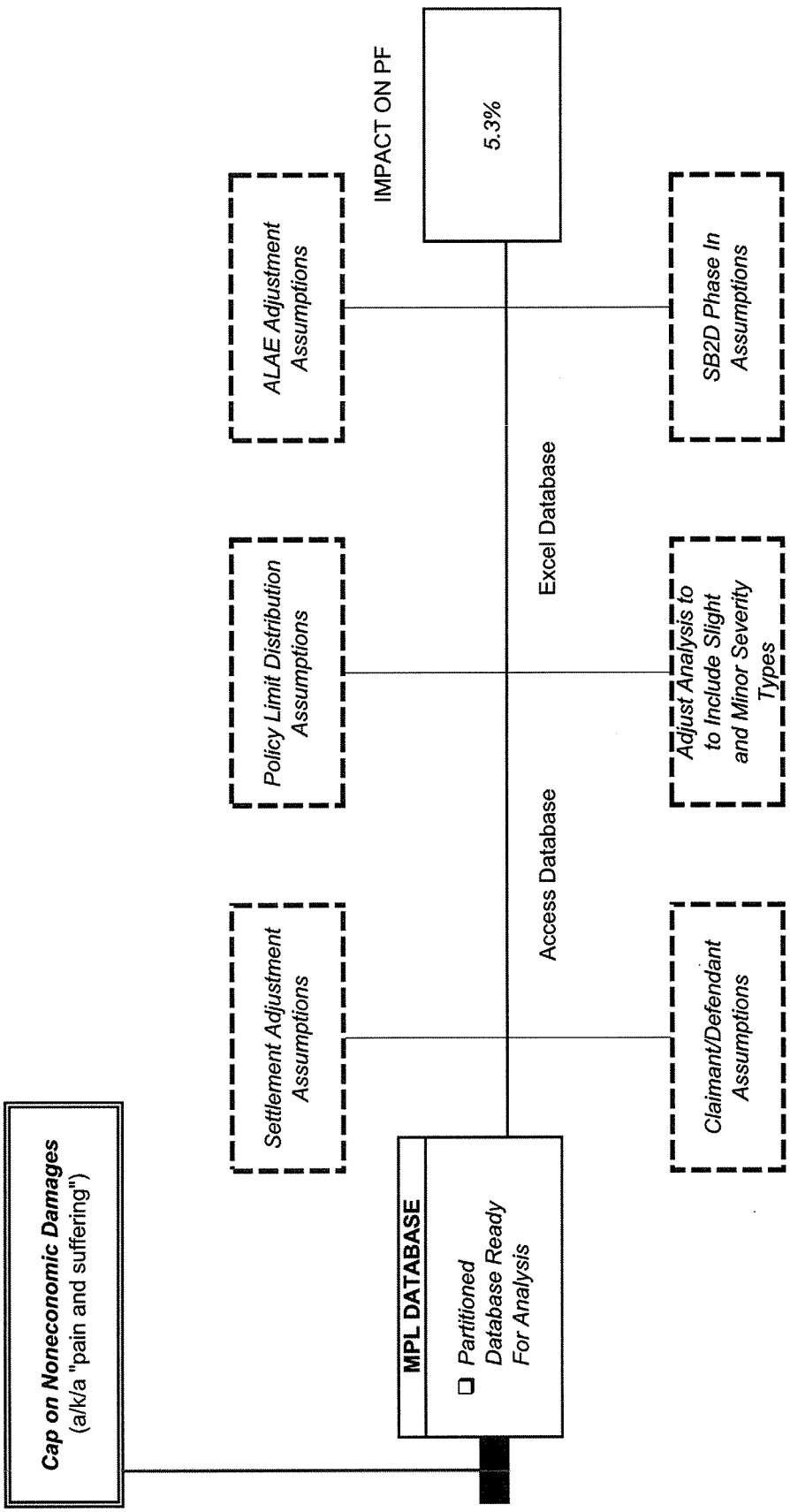
SECTION 40 "PRESUMED FACTOR (PF)" - SAVINGS FLOW CAP ON NONECONOMIC DAMAGES

SUMMARY
SHEET B.1



Notes:
ER - Emergency Room
* - Pierced Cap
1) Death or permanent vegetative state
2) Manifest injustice plus catastrophic injury
- Codes 1 (emotional only - fright, no physical damage) through 9 (death), Analysis excludes 1 through 3 (Slight and Minor).

SECTION 40
"PRESUMED FACTOR (PF)" - SAVINGS FLOW
CAP ON NONECONOMIC DAMAGES



SECTION 54

766.118 DETERMINATION OF NONECONOMIC DAMAGES

□ Practitioner

■ Non emergency room \$500,000 per claimant (2)(a) \$500,000 per practitioner (2)(a)	—	Death or permanent vegetative state \$1,000,000 aggregate practitioner cap (2)(b) regardless of the number of claimants
		Manifest injustice plus catastrophic injury \$1,000,000 aggregate cap recoverable by injured patient
■ Emergency room \$150,000 per claimant (4)(a) \$300,000 aggregate practitioner cap (4)(b)		

□ Nonpractitioner

■ Non emergency room \$750,000 per claimant (3)(a) \$750,000 per nonpractitioner (3)(a)	—	Death or permanent vegetative state \$1,500,000 aggregate nonpractitioner cap (3)(b) regardless of the number of claimants
		Manifest injustice plus catastrophic injury \$1,500,000 aggregate cap recoverable by injured patient
■ Emergency room \$750,000 per claimant (5)(a) \$1,500,000 aggregate non practitioner cap (5)(b) Nonpractitioner defendants may receive a full setoff for payments made by practitioner defendants (5)(c)		

Definitions

Claimant means any person who has a cause of action for damages based on personal injury or wrongful death arising from medical negligence.

Health care practitioner means any person licensed under chapter 457 (acupuncture); chapter 458 (medical practice); chapter 459 (osteopathic medicine); chapter 460 (chiropractic medicine); chapter 461 (podiatric medicine); chapter 462 (naturopathy); chapter 463 (optometry); chapter 464 (nursing); chapter 465 (pharmacy); chapter 466 (dentistry); chapter 467 (midwifery); part I (speech-language pathology and audiology), part II (nursing home administration), part III (occupational therapy), part V (respiratory therapy), part X (dietetics and nutrition practice), part XIII (athletic trainers), or part XIV (orthotics, prosthetics, and pedorthics) of chapter 468; chapter 478 (electrolysis); chapter 480 (massage practice); part III (clinical laboratory personnel) or part IV (medical physicists) of chapter 483; chapter 484 (dispensing of optical devices and hearing aids); chapter 486 (physical therapy practice); chapter 490 (psychological services); or chapter 491 (clinical, counseling and psychotherapy services).

Non practitioner means hospitals, health maintenance organizations (HMOs), hospice providers, and other non-physician entities.

Catastrophic Injury

1. Spinal cord injury involving severe paralysis of an arm, a leg, or the trunk
2. Amputation of an arm, a hand, a foot, or a leg involving the effective loss of use of that appendage
3. Severe brain or closed-head injury
4. Second-degree or third-degree burns of 25 percent or more of the total body surface or third-degree burns of 5 % or more to the face and hands
5. Blindness, as defined as a complete and total loss of vision
6. Loss of reproductive organs which results in an inability to procreate

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APPENDIX B

Section 54 Detailed Appendix

Florida Office of Insurance Regulation Medical Professional Liability Closed Claim Database

I. DATA BACKGROUND AND LIMITATIONS

For purposes of this engagement, the State of Florida Department of Financial Services, Office of Insurance Regulation (OIR) made available to Deloitte their historical Medical Professional Liability (MPL) closed claim database. We have made use of the closed claim database to assist us in deriving an estimate of the Senate Bill 2-D (SB2D) “presumed factor”. Specifically, the MPL database has been used extensively in the calculation of the presumed factor in Section 54.

The database has been maintained by the OIR and consists of thousands of claim entries submitted primarily by Florida MPL insurers. We initially discussed with OIR management their concerns regarding potential limitations on the use of the closed claim data. These limitations are suspected by the OIR to have arisen primarily from known inconsistencies in both the collection and the reporting of the closed claim data.

More specifically, original entries to the OIR database were collected and entered manually until mid-July 1999 when revised forms and instructions became available and electronic submission of data first began. Data has never been audited or checked for accuracy or completeness and OIR management suspects that errors and inconsistencies in the data submitted are likely.

Reliance upon the use of the OIR database is made with the above considerations in mind.

Additional details regarding the OIR closed claim database:

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- Until mid-July 1999 closed claim data was manually keyed in as received (the “Archive” file). After mid-July 1999, forms and the data collection system were re-designed to allow for electronic collection, mainly by diskette. An outside vendor helped to create a revised file layout. (The “Current” file resulted, containing all claims submitted for the first time after mid-July 1999).
- The MPL database does not provide historical information on the number of claimants associated with each claim (e.g., wife and five kids versus wife and no kids).
- The MPL database does not track the actual dollars paid (i.e., comparative fault) by each defendant. Instead, the database requires the input of the total dollar award for each claimant, regardless of their share of the damages. Therefore, when multiple defendants have inputted their claims into the MPL database, there will be duplicate dollars in the database.
- Only Florida authorized insurers are required to report closed claims to the OIR database. This excludes self-insurers and “unauthorized” insurers such as offshore and surplus lines insurers.
- The actual occurrence dates of individual MPL incidents are often several years prior to the date of closure. As a result, OIR closed claim data cannot be expected to be representative of current MPL trends and conditions without some adjustment or other consideration. We note that the database has claims closed as recently as summer 2003 and the instructions for the database mandate that claims be reported to the department within 30 days of closing.
- The version of the closed claim database provided to us contained claims closed through June of 2003.

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II. DATA PREPARATION

In light of the information and limitations outlined above, Deloitte took the following steps to prepare the OIR closed claim database for use in the presumed factor analysis.

PHASE I:

As outlined below, Phase I involved our initial data preparation efforts. Initial background information and guidance was first provided by OIR management. We began with a detailed review and testing of the raw data in order to become familiar with the nature and characteristics of the database. Claim entry forms and instructions were made available and were reviewed in order to become familiar with the intended content of several key data fields.

Several key tasks were performed during Phase I:

- We condensed multiple defendant record entries to a single record.
- To improve efficiency, we eliminated entries associated with the lowest severity injury types (i.e., those expected to have the least impact on the presumed factor calculation). The excluded severity injury types were;
 1. Emotional Only – Fright, no physical damage.
 2. Temporary Slight – Lacerations, contusions, minor scars, rash. No delay.
 3. Temporary Minor – Infections, misset fracture, fall in hospital. Recovery Delayed.
- We created a set of key captured loss fields which we populated from the entries made in the Archive and Current database segments. This allowed us to combine the Archive and Current database segments into one database with common key data fields.
- We subtotaled and cross checked loss dollar entries against posted totals and eliminated entries which could not be reconciled, subject to certain conditions.

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The following outlines the procedures involved in our Phase I data preparation efforts in greater detail:

Description of Phase I Procedure		Approximate Lines Beginning	
Step 1.	Original databases supplied by OIR. Closed claims only. "Archive" contained all claims with disposition dates prior to July 1999, also those initially logged prior to July 1999. "Current" contained claims newly logged on or after July 1999.	Archive	Current
		59,000	11,000

Description of Phase I Procedure		Approximate Lines Remaining	
Step 2.	"Current" entries only: Using the "MPL_DEPT_FILE_NUM" field, a unique file identifier in the "Current" database, lines with multiple defendants were collapsed to a single line per claim. Duplicates also eliminated in this process.	Archive	Current
		59,000	6,300

Description of Phase I Procedure		Approximate Lines Remaining	
Step 3.	Eliminated records with severity codes ("SEVERITY_CODE" (Archive) and "MPL_SEV_OF_INJURY_PI" (Current)), left blank and those with entries of either 1-"emotional only", 2-"temporary slight" or 3-"temporary minor". Remaining entries are for 4-"temporary major" up through 9-"permanent-death" claims.	Archive	Current
		27,400	4,700

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Description of Phase I Procedure		Approximate Lines Remaining	
Step 4.	"Archive" entries only. Attempted to remove claims with multiple defendants. A unique field identifier is not available in this file (the "DEPTNO_MPL_OTH" field does not appear to be unique). Sorted and searched on several fields, including occurrence date, severity code, (and injured party's age) and removed duplicates by inspecting for exact matches by hand.	Archive	Current
		26,900	4,700

Description of Phase I Procedure		Approximate Lines Remaining
Step 5.	"Archive" and "Current" databases combined. The following fields created. Refer to our <i>"Key Captured Loss Fields"</i> outline below: "Expense Paid", "Total Loss Cost", "Total Paid By Insurer", "Total Medical Cost", "Total Economic Loss", "Total Noneconomic Loss" and "Dollars Not Allocated".	Combined Data
		31,607

Description of Phase I Procedure		Approximate Lines Remaining	
Step 6.	A line by line comparison was made of two quantities: $B = [\text{"Total Loss Cost"}]$ versus $C+d = [\text{"Total Paid By Insurer"} \text{ plus deductible } (\text{"MPL_DEDUCT"} \text{ or } \text{"DEDUCT_PAID_DEFEND"})]$ Comparison resulted in 20,330 lines with (i) $C+d = B$ matching, (ii) 4,961 lines with $C+d > B$ and $B = \$0$, (iii) 1,589 lines with $C+d > B$ and $B > \$0$ and (iv) 4,727 lines with $C+d < B$. ("Dollars Not Allocated" now generated for (ii). Total usable files, items (i) and (ii).	Combined Data	
		(i) $C+d = B$	20,330
		(ii) $C+d > B$ ($B = \$0$)	4,961
		(iii) $C+d > B$ ($B > \$0$)	1,589
		(iv) $C+d < B$	4,727
		(v) Total used (i)+(ii)	25,291

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The following table displays the key captured loss fields used in connection with Steps 5 and 6 of our Phase I data preparation as described above:

TABLE OF KEY CAPTURED LOSS FIELDS			
		OIR Database Source	
		Current	Archive
Field Name	Description	Field Name	Description
(A) Expense Paid			
MPL_LOSS_ADJUST	Loss Adjustment expense paid to Defense Counsel	LOSS_ADJ_EXP	Loss adjustment expense paid to defense counsel
MPL_LOSS_ADJUST_OTHER	All other loss adjustment expense paid	OTHER_LOSS_ADJ_EXP	All other loss adjustment expense paid
(B) Total Loss Cost			
MPL_IP_MEDICAL_TO_DATE	Injured party's economic medical loss incurred to date	ECONO_MED_LOSS	Injured party's economic medical loss incurred to date
MPL_IP_WAGE_TO_DATE	Injured party's economic wage loss incurred to date	ECONO_WAGE_LOSS	Injured party's economic wage loss incurred to date
MPL_IP_OTHER_EXPENSE_TO_DATE	Injured party's economic other loss incurred to date	ECONO_OTH_EXP	Injured party's economic other loss incurred to date
MPL_IP_MEDICAL_FUTURE	Injured party's estimated future medical loss	FUTURE_MED_LOSS	Injured party's estimated future medical loss
MPL_IP_WAGE_FUTURE	Injured party's estimated future wage loss	FUTURE_WAGE_LOSS	Injured party's estimated future wage loss
MPL_IP_OTHER_EXPENSE_FUTURE	Injured party's estimated future other loss	FUTURE_OTH_EXP	Injured party's estimated future other loss
MPL_DEDUCT	Deductible	DEDUCT_PD_DEFEND	An amount of deductible paid by the defendant (insured)
MPL_NON_ECONOMIC_LOSS	Amount paid for injured party's non-economic loss	NON_ECONO_LOSS	Amount paid for injured party's non-economic loss
		TOT_EXPECT_PAY	Total expected payment to plaintiff if a structured settlement or periodic payments
(C) Total Paid By Insurer			
MPL_INDEMNITY_PAID	Amount paid to plaintiff by primary insurer	INDEM_PD_INS	An amount of money paid to the plaintiff by the primary insurer
		INDEM_PD_EXEC	An amount of money paid to the plaintiff by the excess insurer
		COST_OF_PAY	Cost to the insurer of the payments if a structured settlement or periodic payments
(D) Total Medical Cost			
MPL_IP_MEDICAL_TO_DATE	Injured party's economic medical loss incurred to date	ECONO_MED_LOSS	Injured party's economic medical loss incurred to date
MPL_IP_MEDICAL_FUTURE	Injured party's estimated future medical loss	FUTURE_MED_LOSS	Injured party's estimated future medical loss
(E) Total Other Economic Loss			
MPL_IP_WAGE_TO_DATE	Injured party's economic wage loss incurred to date	ECONO_WAGE_LOSS	Injured party's economic wage loss incurred to date
MPL_IP_OTHER_EXPENSE_TO_DATE	Injured party's economic other loss incurred to date	ECONO_OTH_EXP	Injured party's economic other loss incurred to date
MPL_IP_WAGE_FUTURE	Injured party's estimated future wage loss	FUTURE_WAGE_LOSS	Injured party's estimated future wage loss
MPL_IP_OTHER_EXPENSE_FUTURE	Injured party's estimated future other loss	FUTURE_OTH_EXP	Injured party's estimated future other loss
MPL_DEDUCT	Deductible	DEDUCT_PD_DEFEND	An amount of deductible paid by the defendant (insured)
(F) Total Noneconomic Loss			
MPL_NON_ECONOMIC_LOSS	Amount paid for injured party's non-economic loss	NON_ECONO_LOSS	Amount paid for injured party's non-economic loss
(G) Dollars Not Allocated			
If (C) + (Deductible) > (B), Difference is here.		If (C) + (Deductible) > (B), Difference is here.	

PHASE II:

The first step of Phase II involved the adjustment of the data selected from our Phase I efforts to their full unlimited values. In certain cases, this involved the “grossing up” of existing noneconomic loss components to levels reflecting an industry benchmark ratio of noneconomic losses to total losses of 70%. This benchmark ratio was selected based on a review of the closed claim database and publicly available information contained in the Government’s Select Task Force Report. In certain other cases, when individual loss components were absent from a claim, the 70% ratio was applied to the total loss amount to derive the noneconomic loss component of the claim. In the majority of cases, no adjustments were required.

PRESUMED FACTOR

The following table displays the specific conditions under which noneconomic loss adjustments have been made and the numbers of claims falling into each of our seven Phase II adjustment categories. We have designed these categories to reflect the relationships between each claim's policy limit and the total damage amount as well as the absence (or presence) of individual loss allocation data (i.e., components such as noneconomic loss, medical, wage loss, etc.). In some cases, the presence of noneconomic loss entries allowed us to examine an individual claim's ratio of noneconomic loss to total losses as an additional criterion for consideration. This consideration was called into play when an individual claim's total damages met the stated policy limit. In these cases, no adjustment to the noneconomic loss value was made when the ratio was greater than our industry benchmark assumption of 70% (i.e., code C below). When the ratio was less than 70% we kept the economic loss values unchanged while increasing the noneconomic loss to a level reflective of the 70% assumption (i.e., code B below). In addition, as shown below, we chose not to make adjustments to claims settled in court.:

Base Criteria For Adjustment of Noneconomic Vs. Economic Loss Components

Code	SITUATION	PHASE II ACTION	Claim Count	Claim Count Settled in Court
				(A)
A	Policy Limit > Total Damages, Losses Allocated	No change to noneconomic loss amounts.	18,783	2,287
B	Policy Limit = Total Damages, Ratio < Assumption	Grossed up total loss amount to keep economic loss the same and allow noneconomic loss to be the assumed percentage of total.	94	2
C	Policy Limit = Total Damages, Ratio > Assumption	No change to noneconomic loss amount.	802	13
D	Policy Limit > Total Damages, Not Allocated	Allocated economic and non economic loss based on assumed percentage.	3,766	100
E	Policy Limit = Total Damages, Not Allocated	Allocated economic and non economic loss based on assumed percentage.	340	10
F	Policy Limit < Total Damages, Allocated	No change to noneconomic loss amount.	651	143
G	Policy Limit < Total Damages, Not Allocated	Allocated economic and non economic loss based on assumed percentage.	855	38
	Total All Claims		25,291	2,593

Note: (A) If a claim was settled in court, the loss amounts were not adjusted, except for trend.

The next step in our Phase II data preparation efforts was to trend the claim values to current levels based on the disposition date of the claim. An annual trend of 6% was selected for the

PRESUMED FACTOR

economic component of loss. An annual trend of 6% was selected for the noneconomic loss component through 1993 with a 10% annual trend selected for the 1994 through 2003 years. The higher trend selection for noneconomic loss during the 1994 through 2003 years is intended to be reflective of the faster rate at which noneconomic loss has been increasing in recent years. As is often noted in the media, there has been an increase in the “lottery mentality” of jury awards in recent years. We believe the 4% adjustment helps to reflect this fact.

At this stage of Phase II all claims have been adjusted to an unlimited basis and also to a 2003 loss cost level.

The final step of Phase II was to enter the refined and adjusted data into the factor matrix model. The claims were first sorted and grouped by (i) emergency room versus non-emergency room, (ii) practitioner versus non-practitioner and (iii) non-pierced cap verses pierced cap. Further, pierced claim claims were separated between a) death or permanent vegetative state and b) manifest injustice plus catastrophic injury (see Appendix A, Summary Sheet B1).

In the factor matrix model, the loss from each claim was derived at numerous possible policy limits within each group, before and after the application of the appropriate cap on noneconomic damages and reflecting the impact of multiple claimants and/or defendants combinations.

PRESUMED FACTOR

Example A represents how a claim with \$700,000 of economic loss and \$1.4 million of noneconomic loss and limited by the non-pierced practitioner non-emergency room cap (i.e., \$500,000 for the first claimant/defendant, \$1,000,000 for the second claimants/defendants, \$1,500,000 for the third claimants/defendants, \$2,000,000 for the fourth claimants/defendants) would be entered into the practitioner non-emergency room group matrix. Note the column headings 1/1, 2/2, etc. which are intended to represent 1 claimant/defendant, 2 claimants/defendants, etc.:

EXAMPLE A

SHEET 1

PRE-SB2D

POST-SB2D

Damages	Value Without Policy Limits				Value Without Policy Limits			
	1/1	2/2	3/3	4/4	1/1	2/2	3/3	4/4
Economic	\$ 700,000	\$ 700,000	\$ 700,000	\$ 700,000	\$ 700,000	\$ 700,000	\$ 700,000	\$ 700,000
Noneconomic	\$ 1,400,000	\$ 1,400,000	\$ 1,400,000	\$ 1,400,000	\$ 500,000	\$ 1,000,000	\$ 1,400,000	\$ 1,400,000
Total	\$ 2,100,000	\$ 2,100,000	\$ 2,100,000	\$ 2,100,000	\$ 1,200,000	\$ 1,700,000	\$ 2,100,000	\$ 2,100,000

Representative Policy Limit	Maximum Policy Limits Available				Maximum Policy Limits Available			
	1/1	2/2	3/3	4/4	1/1	2/2	3/3	4/4
\$100,000	\$ 100,000	\$ 200,000	\$ 300,000	\$ 400,000	\$ 100,000	\$ 200,000	\$ 300,000	\$ 400,000
\$250,000	\$ 250,000	\$ 500,000	\$ 750,000	\$ 1,000,000	\$ 250,000	\$ 500,000	\$ 750,000	\$ 1,000,000
\$500,000	\$ 500,000	\$ 1,000,000	\$ 1,500,000	\$ 2,000,000	\$ 500,000	\$ 1,000,000	\$ 1,500,000	\$ 2,000,000
\$1,000,000	\$ 1,000,000	\$ 2,000,000	\$ 3,000,000	\$ 4,000,000	\$ 1,000,000	\$ 2,000,000	\$ 3,000,000	\$ 4,000,000
\$2,000,000	\$ 2,000,000	\$ 4,000,000	\$ 6,000,000	\$ 8,000,000	\$ 2,000,000	\$ 4,000,000	\$ 6,000,000	\$ 8,000,000
\$5,000,000	\$ 5,000,000	\$ 10,000,000	\$ 15,000,000	\$ 20,000,000	\$ 5,000,000	\$ 10,000,000	\$ 15,000,000	\$ 20,000,000

Representative Policy Limit	Value At Policy Limits				Value At Policy Limits			
	1/1	2/2	3/3	4/4	1/1	2/2	3/3	4/4
\$100,000	\$ 100,000	\$ 200,000	\$ 300,000	\$ 400,000	\$ 100,000	\$ 200,000	\$ 300,000	\$ 400,000
\$250,000	\$ 250,000	\$ 500,000	\$ 750,000	\$ 1,000,000	\$ 250,000	\$ 500,000	\$ 750,000	\$ 1,000,000
\$500,000	\$ 500,000	\$ 1,000,000	\$ 1,500,000	\$ 2,000,000	\$ 500,000	\$ 1,000,000	\$ 1,500,000	\$ 2,000,000
\$1,000,000	\$ 1,000,000	\$ 2,000,000	\$ 2,100,000	\$ 2,100,000	\$ 1,000,000	\$ 1,700,000	\$ 2,100,000	\$ 2,100,000
\$2,000,000	\$ 2,000,000	\$ 2,100,000	\$ 2,100,000	\$ 2,100,000	\$ 1,200,000	\$ 1,700,000	\$ 2,100,000	\$ 2,100,000
\$5,000,000	\$ 2,100,000	\$ 2,100,000	\$ 2,100,000	\$ 2,100,000	\$ 1,200,000	\$ 1,700,000	\$ 2,100,000	\$ 2,100,000

Representative Policy Limit	Savings			
	1/1	2/2	3/3	4/4
\$100,000	0.0%	0.0%	0.0%	0.0%
\$250,000	0.0%	0.0%	0.0%	0.0%
\$500,000	0.0%	0.0%	0.0%	0.0%
\$1,000,000	0.0%	15.0%	0.0%	0.0%
\$2,000,000	40.0%	19.0%	0.0%	0.0%
\$5,000,000	42.9%	19.0%	0.0%	0.0%

PRESUMED FACTOR

EXAMPLE A - CALCULATIONS

SHEET 2

PRE-SB2D

POST-SB2D

Damages	Value Without Policy Limits				Value Without Policy Limits			
	1/1	2/2	3/3	4/4	1/1	2/2	3/3	4/4
Economic		\$ 700,000				\$ 700,000		
Noneconomic		\$ 1,400,000			(A)	\$ 1,000,000		= \$1.4M capped at \$1.0M
Total		\$ 2,100,000	= Economic + Noneconomic			\$ 1,700,000	= \$0.7M + \$1.0M	

Representative Policy Limit	Maximum Policy Limits Available (B)				Maximum Policy Limits Available (B)			
	1/1	2/2	3/3	4/4	1/1	2/2	3/3	4/4
\$100,000		\$ 200,000				\$ 200,000		
\$250,000		\$ 500,000	= Policy Limit x # Def/Cmts			\$ 500,000	= \$250,000 x 2	
\$500,000		\$ 1,000,000				\$ 1,000,000		
\$1,000,000		\$ 2,000,000	= Policy Limit x # Def/Cmts			\$ 2,000,000	= \$1,000,000 x 2	
\$2,000,000		\$ 4,000,000				\$ 4,000,000		
\$5,000,000		\$ 10,000,000	= Policy Limit x # Def/Cmts			\$ 10,000,000	= \$5,000,000 x 2	

Representative Policy Limit	Value At Policy Limits (C)				Value At Policy Limits (C)			
	1/1	2/2	3/3	4/4	1/1	2/2	3/3	4/4
\$100,000		\$ 200,000				\$ 200,000		
\$250,000		\$ 500,000	= MIN [Economic + Noneconomic Max Policy Limits Available]			\$ 500,000	= MIN [\$1.7M, \$0.5M]	
\$500,000		\$ 1,000,000				\$ 1,000,000		
\$1,000,000		\$ 2,000,000				\$ 1,700,000	= MIN [\$1.7M, \$2.0M]	
\$2,000,000		\$ 2,100,000				\$ 1,700,000		
\$5,000,000		\$ 2,100,000				\$ 1,700,000	= MIN [\$1.7M, \$10.0M]	

Representative Policy Limit	Savings			
	1/1	2/2	3/3	4/4
\$100,000			0.0%	
\$250,000	1.0 - [\$0.5M / \$0.5M] =		0.0%	
\$500,000			0.0%	
\$1,000,000	1.0 - [\$1.7M / \$2.0M] =		15.0%	
\$2,000,000			19.0%	
\$5,000,000	1.0 - [\$1.7M / \$2.1M] =		19.0%	

NOTE: (A) Caps apply to noneconomic damages.

(B) Policy limits apply to noneconomic and economic damages.

(C) Maximum policy limits available assume "spreading" of comparative fault (see Observation Section).

PRESUMED FACTOR

To determine the presumed factor for this group, each Phase I adjusted claim is passed into the above matrix and the values are totaled for each claim to produce a single matrix of the same format that covers all claims for the group. The values “at policy limits after cap” are divided by the values “at policy limits before cap” to yield a matrix of presumed factor ratios for each possible policy limit and claimant/defendant combination. A single presumed factor is determined by averaging the matrix ratios using selected distributions of weighting current policy limit levels written by Florida insurers (down the columns) as well as the selected distribution of likely defendant/claimant numbers (across the rows). Our selections have been documented in Section 54.

As a final step, the overall presumed factor is adjusted to reflect several additional considerations including the “phase-in” effect of the law, the impact of including low severity injury types (i.e. 1-emotional only, 2-temporary: slight and 3-temporary: minor) and the impact of including allocated loss adjustment expenses.

We have provided two additional examples in order to demonstrate the importance of changing the magnitude of economic damages (and therefore the ratio of noneconomic damages to total damages):

- Example B displays a claim with \$10,000,000 of economic loss and \$10,000,000 of noneconomic loss, limited by the non-pierced practitioner non-emergency room cap.
- Example C displays a claim with \$100,000 of economic loss and \$10,000,000 of noneconomic loss, limited by the non-pierced practitioner non-emergency room cap.

For any of the other cap on noneconomic damage groups (e.g., practitioner emergency room, non-practitioner non-emergency room, etc.), the examples presented below would be similar. The only difference by group would be to reflect the appropriate cap.

PRESUMED FACTOR

EXAMPLE B

PRE-SB2D

POST-SB2D

Damages	Value Without Policy Limits				Value Without Policy Limits			
	1/1	2/2	3/3	4/4	1/1	2/2	3/3	4/4
Economic	\$ 10,000,000	\$ 10,000,000	\$ 10,000,000	\$ 10,000,000	\$ 10,000,000	\$ 10,000,000	\$ 10,000,000	\$ 10,000,000
Noneconomic	\$ 10,000,000	\$ 10,000,000	\$ 10,000,000	\$ 10,000,000	\$ 500,000	\$ 1,000,000	\$ 1,500,000	\$ 2,000,000
Total	\$ 20,000,000	\$ 20,000,000	\$ 20,000,000	\$ 20,000,000	\$ 10,500,000	\$ 11,000,000	\$ 11,500,000	\$ 12,000,000

Representative Policy Limit	Maximum Policy Limits Available				Maximum Policy Limits Available			
	1/1	2/2	3/3	4/4	1/1	2/2	3/3	4/4
\$100,000	\$ 100,000	\$ 200,000	\$ 300,000	\$ 400,000	\$ 100,000	\$ 200,000	\$ 300,000	\$ 400,000
\$250,000	\$ 250,000	\$ 500,000	\$ 750,000	\$ 1,000,000	\$ 250,000	\$ 500,000	\$ 750,000	\$ 1,000,000
\$500,000	\$ 500,000	\$ 1,000,000	\$ 1,500,000	\$ 2,000,000	\$ 500,000	\$ 1,000,000	\$ 1,500,000	\$ 2,000,000
\$1,000,000	\$ 1,000,000	\$ 2,000,000	\$ 3,000,000	\$ 4,000,000	\$ 1,000,000	\$ 2,000,000	\$ 3,000,000	\$ 4,000,000
\$2,000,000	\$ 2,000,000	\$ 4,000,000	\$ 6,000,000	\$ 8,000,000	\$ 2,000,000	\$ 4,000,000	\$ 6,000,000	\$ 8,000,000
\$5,000,000	\$ 5,000,000	\$ 10,000,000	\$ 15,000,000	\$ 20,000,000	\$ 5,000,000	\$ 10,000,000	\$ 15,000,000	\$ 20,000,000

Representative Policy Limit	Value At Policy Limits				Value At Policy Limits			
	1/1	2/2	3/3	4/4	1/1	2/2	3/3	4/4
\$100,000	\$ 100,000	\$ 200,000	\$ 300,000	\$ 400,000	\$ 100,000	\$ 200,000	\$ 300,000	\$ 400,000
\$250,000	\$ 250,000	\$ 500,000	\$ 750,000	\$ 1,000,000	\$ 250,000	\$ 500,000	\$ 750,000	\$ 1,000,000
\$500,000	\$ 500,000	\$ 1,000,000	\$ 1,500,000	\$ 2,000,000	\$ 500,000	\$ 1,000,000	\$ 1,500,000	\$ 2,000,000
\$1,000,000	\$ 1,000,000	\$ 2,000,000	\$ 3,000,000	\$ 4,000,000	\$ 1,000,000	\$ 2,000,000	\$ 3,000,000	\$ 4,000,000
\$2,000,000	\$ 2,000,000	\$ 4,000,000	\$ 6,000,000	\$ 8,000,000	\$ 2,000,000	\$ 4,000,000	\$ 6,000,000	\$ 8,000,000
\$5,000,000	\$ 5,000,000	\$ 10,000,000	\$ 15,000,000	\$ 20,000,000	\$ 5,000,000	\$ 10,000,000	\$ 11,500,000	\$ 12,000,000

Representative Policy Limit
\$100,000
\$250,000
\$500,000
\$1,000,000
\$2,000,000
\$5,000,000

Savings			
1/1	2/2	3/3	4/4
0.0%	0.0%	0.0%	0.0%
0.0%	0.0%	0.0%	0.0%
0.0%	0.0%	0.0%	0.0%
0.0%	0.0%	0.0%	0.0%
0.0%	0.0%	0.0%	0.0%
0.0%	0.0%	23.3%	40.0%

PRESUMED FACTOR

EXAMPLE C

PRE-SB2D

POST-SB2D

Damages	Value Without Policy Limits				Value Without Policy Limits			
	1/1	2/2	3/3	4/4	1/1	2/2	3/3	4/4
Economic	\$ 100,000	\$ 100,000	\$ 100,000	\$ 100,000	\$ 100,000	\$ 100,000	\$ 100,000	\$ 100,000
Noneconomic	\$ 10,000,000	\$ 10,000,000	\$ 10,000,000	\$ 10,000,000	\$ 500,000	\$ 1,000,000	\$ 1,500,000	\$ 2,000,000
Total	\$ 10,100,000	\$ 10,100,000	\$ 10,100,000	\$ 10,100,000	\$ 600,000	\$ 1,100,000	\$ 1,600,000	\$ 2,100,000

Representative Policy Limit	Maximum Policy Limits Available				Maximum Policy Limits Available			
	1/1	2/2	3/3	4/4	1/1	2/2	3/3	4/4
\$100,000	\$ 100,000	\$ 200,000	\$ 300,000	\$ 400,000	\$ 100,000	\$ 200,000	\$ 300,000	\$ 400,000
\$250,000	\$ 250,000	\$ 500,000	\$ 750,000	\$ 1,000,000	\$ 250,000	\$ 500,000	\$ 750,000	\$ 1,000,000
\$500,000	\$ 500,000	\$ 1,000,000	\$ 1,500,000	\$ 2,000,000	\$ 500,000	\$ 1,000,000	\$ 1,500,000	\$ 2,000,000
\$1,000,000	\$ 1,000,000	\$ 2,000,000	\$ 3,000,000	\$ 4,000,000	\$ 1,000,000	\$ 2,000,000	\$ 3,000,000	\$ 4,000,000
\$2,000,000	\$ 2,000,000	\$ 4,000,000	\$ 6,000,000	\$ 8,000,000	\$ 2,000,000	\$ 4,000,000	\$ 6,000,000	\$ 8,000,000
\$5,000,000	\$ 5,000,000	\$ 10,000,000	\$ 15,000,000	\$ 20,000,000	\$ 5,000,000	\$ 10,000,000	\$ 15,000,000	\$ 20,000,000

Representative Policy Limit	Value At Policy Limits				Value At Policy Limits			
	1/1	2/2	3/3	4/4	1/1	2/2	3/3	4/4
\$100,000	\$ 100,000	\$ 200,000	\$ 300,000	\$ 400,000	\$ 100,000	\$ 200,000	\$ 300,000	\$ 400,000
\$250,000	\$ 250,000	\$ 500,000	\$ 750,000	\$ 1,000,000	\$ 250,000	\$ 500,000	\$ 750,000	\$ 1,000,000
\$500,000	\$ 500,000	\$ 1,000,000	\$ 1,500,000	\$ 2,000,000	\$ 500,000	\$ 1,000,000	\$ 1,500,000	\$ 2,000,000
\$1,000,000	\$ 1,000,000	\$ 2,000,000	\$ 3,000,000	\$ 4,000,000	\$ 600,000	\$ 1,100,000	\$ 1,600,000	\$ 2,100,000
\$2,000,000	\$ 2,000,000	\$ 4,000,000	\$ 6,000,000	\$ 8,000,000	\$ 600,000	\$ 1,100,000	\$ 1,600,000	\$ 2,100,000
\$5,000,000	\$ 5,000,000	\$ 10,000,000	\$ 10,100,000	\$ 10,100,000	\$ 600,000	\$ 1,100,000	\$ 1,600,000	\$ 2,100,000

Representative Policy Limit
\$100,000
\$250,000
\$500,000
\$1,000,000
\$2,000,000
\$5,000,000

Savings			
1/1	2/2	3/3	4/4
0.0%	0.0%	0.0%	0.0%
0.0%	0.0%	0.0%	0.0%
0.0%	0.0%	0.0%	0.0%
40.0%	45.0%	46.7%	47.5%
70.0%	72.5%	73.3%	73.8%
88.0%	89.0%	84.2%	79.2%

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APPENDIX C

Ratemaking Primer

On March 13, 2003, Mr. James Hurley presented testimony to the United States Senate titled “Causes of the Medical Liability Insurance Crisis”⁵. We have included “The Ratemaking Process” section of the written testimony prepared by the Medical Malpractice Subcommittee of the American Academy of Actuaries (Mr. Bingham is a member of the subcommittee):

“Ratemaking is the term used to describe the process by which companies determine what premium is indicated for a coverage. In the insurance transaction, the company assumes the financial risk associated with a future, contingent event in exchange for a fixed premium before it knows what the true cost of the event is, if any. The company must estimate those costs, determine a price for it and be willing to assume the risk that the costs may differ, perhaps substantially, from those estimates. A general principle of ratemaking is that the rate charged reflects the costs resulting from the policy and the income resulting from the anticipated policy covered losses, not what is actually paid or is going to be paid on past policies. It does not reflect money lost on old investments. In short, a rate is a reflection of future costs.

In general, the actuarial process used in making these estimations for medical malpractice insurance starts with historical loss experience for the specific coverage and, usually, for a specific jurisdiction. Rates are determined for this coverage, jurisdiction, and a fixed time period. To the appropriately projected loss experience, a company must incorporate consideration of all expenses, the time value of money and an appropriate provision for risk and profit associated with the insurance transaction.

⁵ United States Senate Committee on Appropriations Subcommittee on Labor, Health and Human Services, Education, and Related Agencies - Hearing on “Causes of the Medical Liability Insurance Crisis”, Statement of James Hurley, ACAS, MAAA, Chairperson, Medical Malpractice Subcommittee, American Academy of Actuaries

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For a company already writing a credible volume of the coverage in a state, the indications of the adjusted ultimate loss experience can be compared to its current premiums to determine a change. For a company entering the line or state for the first time, obtaining credible data to determine a proper premium is often difficult and, sometimes, not possible. In the latter situation, the risk of being wrong is increased significantly.

Additionally, some lines of insurance coverage are more predictable than other lines. The unpredictability of coverage reflects its inherent risk characteristics. Most companies would agree that costs and, therefore, rates for automobile physical damage coverage, for example, are more predictable than for medical malpractice insurance because automobile insurance is relatively high frequency/low severity coverage compared to medical malpractice insurance. In the case of auto physical damage, one has a large number of similar claims for relatively small amounts that fall in a fairly narrow range. In medical malpractice insurance, one has a small number of unique claims that have a much higher average value and a significantly wider range of possible outcomes. There also is significantly longer delay for medical malpractice insurance between the occurrence of an event giving rise to a claim, the reporting of the claim, and the final disposition of the claim. This longer delay adds to the uncertainty inherent in projecting the ultimate value of losses, and consequently premiums.

The following guidelines explain the ratemaking process:

- 1. Historical loss experience is collected in coverage year detail for the last several years. This usually will include paid and outstanding losses and counts. The data is reviewed for reasonableness and consistency, and estimates of the ultimate value of the coverage-year loss are developed using actuarial techniques.*
- 2. Ultimate losses are adjusted to the prospective level (i.e., the period for which rates are being made). This involves an appropriate adjustment for changes in*

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average costs and claim frequencies (called trend). Adjustments also would be made for any changes in circumstances that may affect costs (e.g., if a coverage provision has been altered).

- 3. Adjusted ultimate losses are compared to premium (or doctor counts) to determine a loss ratio (or loss cost per doctor) for the prospective period.*
- 4. Expenses associated with the business must be included. These are underwriting and general expenses (review of application, policy issuance, accounting, agent commission, premium tax, etc.) Other items to consider are the profit and contingency provision, reinsurance impact, and federal income tax.*
- 5. A final major component of the ratemaking process is consideration of investment income. Typically for medical malpractice insurance, a payment pattern and anticipated prospective rate of return are used to estimate a credit against the otherwise indicated rate.*

These five steps, applied in a detailed manner and supplemented by experienced judgment, are the standard roadmap followed in developing indicated rates. There are a number of other issues to address in establishing the final rates to charge. These include recognizing differences among territories within a state, limits of coverage, physician specialty, and others. The final rates will reflect supplemental studies of these various other aspects of the rate structure.

Many states have laws and regulations that govern how premium rates can be set and what elements can or must be included. The state regulators usually have the authority to regulate that insurance premium rates are not excessive, inadequate, or unfairly discriminatory. It is not uncommon for state insurance regulators to review the justification for premium rates in great detail and, if deemed necessary, to hold public hearings with expert testimony to examine the basis for the premium rates. In many states, the insurance regulator has some authority to restrict the premium rates that insurance companies can charge.”

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The following glossary of terms may be a useful reference guide to the reader:

Accident Year	An annual time period used in the statistical collection of claims data. Data for an accident year consists of all claims arising from events occurring during the particular period (e.g., 1/1/XX through 12/31/XX+1), regardless of time lags in the reporting or payment of claims.
Report Year	An annual time period used in the statistical collection of claims data. Data for a report year consists of all claims arising from events reported during the particular period (e.g., 1/1/XX through 12/31/XX+1), regardless of the occurrence date of the claim.
Paid Losses	The cumulative loss amount paid for a claim as of a particular point in time.
Reserves	An estimate of the unpaid amount of a report/accident year's loss experience as of a particular point in time. It includes all individual claim estimates as provided by the claim adjuster. It also includes any expected future change in those estimates as estimated by an actuary, which is referred to as incurred but not reported or IBNR.
Incurred Losses	The cumulative loss amount paid for a claim as of a particular point in time, plus outstanding unpaid amounts as estimated by a claims adjuster.
Ultimate Losses	Total losses for a particular report year or accident year. This equals the sum of all payments, case reserves and IBNR.
Reported Counts	The cumulative number of claims reported as of a particular point in time.
Loss Components	
<i>Indemnity-</i>	The portion of a claim relating to compensation for a claimant's economic and noneconomic damages.
<i>ALAE-</i>	The portion of a claim relating to the cost of settlement. This includes defense costs, court costs, medical reports, investigative reports, etc.

PRESUMED FACTOR

Loss Ratio	Ratio of losses (paid, incurred, or ultimate) to net earned premium as a percentage.
Claims Frequency	Ultimate number of claims divided by an exposure base (e.g., occupied beds, net earned premium).
Claims Severity	Ultimate losses divided by ultimate number of claims.
Development Factor	A multiplicative factor applied to either paid losses, incurred losses, reported counts or average severities in order to estimate ultimate losses, ultimate claims or ultimate severities.
Manual Rate Indication	<p>Sample Calculation:</p> <ul style="list-style-type: none">(1) Ultimate Loss and ALAE Ratio(2) Death, Disability and Retirement Load (DDRL)(3) Expected Loss Ratio(4) Average Policy Discount <p>Indication = $[(1) \times (2)] / [(3) \times \{1.0 - (4)\}] - 1.0$</p> <p>Note:</p> <ul style="list-style-type: none">a) Format of the formula varies by rate filing.b) Changes to other assumptions (e.g., territorial and class relativities) would also need to be included in order to determine the final base rate change.

PRESUMED FACTOR

APPENDIX D

SB2D Definitions

Claimant means any person who has a cause of action for damages based on personal injury or wrongful death arising from medical negligence.

Health care practitioner means any person licensed under Chapter 457 (acupuncture); Chapter 458 (medical practice); Chapter 459 (osteopathic medicine); Chapter 460 (chiropractic medicine); Chapter 461 (podiatric medicine); Chapter 462 (naturopathy); Chapter 463 (optometry); Chapter 464 (nursing); Chapter 465 (pharmacy); Chapter 466 (dentistry); Chapter 467 (midwifery); part I (speech-language pathology and audiology), part II (nursing home administration), part III (occupational therapy), part V (respiratory therapy), part X (dietetics and nutrition practice), part XIII (athletic trainers), or part XIV (orthotics, prosthetics, and pedorthics) of Chapter 468; Chapter 478 (electrolysis); Chapter 480 (massage practice); part III (clinical laboratory personnel) or part IV (medical physicists) of Chapter 483; Chapter 484 (dispensing of optical devices and hearing aids); Chapter 486 (physical therapy practice); Chapter 490 (psychological services); or Chapter 491 (clinical, counseling and psychotherapy services).

Non practitioner means hospitals, health maintenance organizations (HMOs), hospice providers, and other non-physician entities

Health care provider means any hospital, ambulatory surgical center, or mobile surgical facility as defined and licensed under Chapter 395; a birth center licensed under Chapter 383; any person licensed under Chapter 458, Chapter 459, Chapter 460, Chapter 461, Chapter 462, Chapter 463, part I of Chapter 464, Chapter 466, Chapter 467 or Chapter 486; a clinical lab licensed under Chapter 483; a health maintenance organization certificated under part I of Chapter 641; a blood bank; a plasma center; an industrial clinic; a renal dialysis facility; or a professional association

PRESUMED FACTOR

partnership, corporation, joint venture, or other association for professional activity by health care providers.

Economic damages means financial losses that would not have occurred but for the injury giving rise to the cause of action, including, but not limited to, past and future medical expenses and 80 percent of wage loss and loss of earning capacity to the extent the claimant is entitled to recover such damages under general law, including the Wrongful Death Act.

Noneconomic damages (a/k/a “pain and suffering”) means non financial losses that would not have occurred but for the injury giving rise to the cause of action, including pain and suffering, inconvenience, physical impairment, mental anguish, disfigurement, loss of capacity for enjoyment of life, and other non financial losses to the extent the claimant is entitled to recover such damages under general law, including the Wrongful Death Act.

Contractual obligations (a/k/a “bad faith”) means any matter regarding an insurance claim by an insured that is wrongfully denied by the insurer (e.g., unreasonable delay of payment, unreasonable denial of benefits, failure to thoroughly investigate a claim, etc.).

Helpful abbreviations

AHCA or Agency	Agency for Health Care Administration
DoAH	Division of Administrative Hearings
DOH	Department of Health
HCP	Health Care Professional
OIR	Office of Insurance Regulation
OPPAGA	Office of Program Policy Analysis and Government Accountability

PRESUMED FACTOR

APPENDIX E

Medical Malpractice Statistics by Company

Florida
Line of Business: Medical Malpractice

Company Name	2002 Med Mal Dir Prem Written	2002 Med Mal Dir Pre Earned	2002 Med Mal Dir Losses Incurred	2002 Med Mal Loss Ratio	2001 Med Mal Dir Prem Written	2001 Med Mal Dir Pre Earned	2001 Med Mal Dir Losses Incurred	2001 Med Mal Loss Ratio
First Professionals Ins Co	169,558,079	152,449,954	94,069,722	61.7%	109,672,505	89,044,736	60,151,888	67.6%
Health Care Ind Inc	106,482,154	106,482,154	86,394,037	81.1%	88,970,154	88,970,154	95,305,166	107.1%
Pronational Ins Co	69,113,034	60,347,429	23,617,524	39.1%	55,259,931	57,149,827	51,412,895	90.0%
MAG Mut Ins Co	52,976,737	40,956,626	42,365,308	103.4%	26,525,321	19,808,077	22,262,490	112.4%
Truck Ins Exch	50,996,746	53,497,755	70,389,982	131.6%	35,245,611	28,668,519	15,102,796	52.7%
Lexington Ins Co	49,142,955	31,925,627	20,492,933	64.2%	5,823,049	2,144,367	2,264,126	105.6%
Medical Protective Co	44,917,670	39,591,739	36,076,008	91.1%	31,096,627	30,731,371	33,677,746	109.6%
Doctors Co An Interins Exchn	38,848,939	28,511,037	22,888,656	80.3%	23,223,681	20,422,981	10,707,616	52.4%
Evanston Ins Co	36,189,511	25,487,045	16,799,194	65.9%	11,353,089	10,808,815	8,493,880	78.6%
TIG Ins Co	25,457,473	20,856,846	44,323,115	212.5%	21,469,578	21,880,706	15,938,329	72.8%
American Physicians Assur Corp	23,636,756	28,912,506	24,599,692	85.1%	26,690,239	21,451,709	25,789,305	120.2%
Anesthesiologists Pro Assur Co	16,770,204	14,284,978	8,775,981	61.4%	11,835,465	10,699,479	3,539,170	33.1%
American Healthcare Ind Co	13,737,893	21,007,412	33,518,266	159.6%	20,235,101	16,151,733	25,445,948	157.5%
Continental Cas Co	13,226,566	11,082,742	5,975,794	53.9%	23,542,376	22,609,659	5,398,082	23.9%
Chicago Ins Co	11,071,903	13,739,888	17,218,267	125.3%	12,461,372	10,546,455	12,555,545	119.0%
Steadfast Ins Co	8,620,597	9,069,825	26,849,699	296.0%	9,652,435	6,883,427	29,555,580	429.4%
St Paul Fire & Marine Ins Co	8,356,995	19,905,115	85,550,588	429.8%	24,422,097	21,024,763	35,808,730	170.3%
Everest Ind Ins Co	7,632,064	3,044,230	1,691,239	55.6%	-	-	-	-
Clarendon Natl Ins Co	6,256,410	14,029,875	14,386,074	102.5%	21,456,110	24,438,787	39,960,548	163.5%
American Cas Co Of Reading PA	4,801,070	4,478,692	1,749,589	39.1%	4,828,738	5,460,507	15,265,523	279.6%
Podiatry Ins Co Of Amer RRG Mut Co	4,635,090	4,345,723	3,018,346	69.5%	-	-	-	-
TIG Specialty Ins Corp	4,278,706	2,370,710	2,756,901	116.3%	959,352	1,158,689	3,504,102	302.4%
Columbia Cas Co	4,072,818	3,837,090	(1,451,828)	-37.8%	3,303,851	704,450	503,552	71.5%
NCMIC Ins Co	3,785,004	3,582,036	919,862	25.7%	3,221,697	2,926,417	(108,985)	-3.7%
Ophthalmic Mut Ins Co RRG	3,783,880	3,110,442	871,198	28.0%	-	-	-	-
National Union Fire Ins Co Of Pitts	3,647,949	1,816,833	18,432,302	1014.5%	186,737	223,577	8,033,243	3593.1%
Firemans Fund Ins Co	3,630,948	4,279,217	6,114,734	142.9%	4,306,718	3,719,127	2,147,009	57.7%
Oms Natl Ins Co Rrg	3,427,473	3,178,252	1,738,511	54.7%	-	-	-	-
Interstate Fire & Cas Co	3,197,895	5,991,773	7,956,257	132.8%	8,104,787	6,424,907	5,832,255	90.8%
Professional Underwrters Liab Ins Co	2,543,404	2,510,358	940,481	37.5%	1,860,976	1,237,392	164,292	13.3%
Preferred Physicians Medical RRG	2,413,908	2,437,822	3,319,759	136.2%	-	-	-	-
Admiral Ins Co	2,275,775	1,269,574	3,230,162	254.4%	1,005,997	933,471	12,183,302	1305.2%
Medical Assur Co Inc	2,253,024	2,003,409	4,384,834	218.9%	4,748,067	6,923,930	2,917,199	42.1%
Physicians Professional Liability RRG	2,252,284	729,187	184,709	25.3%	-	-	-	-
Royal Surplus Lines Ins Co	2,234,001	1,275,886	5,649,364	442.8%	1,030,460	961,311	15,582,880	1621.0%
Zurich American Ins Co	2,068,583	2,491,708	18,285,728	733.9%	7,617,101	12,588,915	25,236,100	200.5%
General Star Ind Co	1,907,952	755,287	134,000	17.7%	23,480	21,620	4,000	18.5%
American Healthcare Specialty	1,647,573	1,887,631	870,450	46.1%	898,483	832,417	1,277,304	153.4%
Ace American Ins Co	1,585,945	1,667,509	1,076,271	64.5%	1,695,846	1,501,882	1,119,254	74.5%
Illinois Union Ins Co	1,209,000	421,562	274,741	65.2%	13,500	114,958	(2,664)	-2.3%
Arch Specialty Ins Co	1,160,997	278,232	145,145	52.2%	-	-	-	-
Western World Ins Co	1,093,224	842,395	4,094,652	486.1%	647,907	1,110,930	4,381,564	394.4%
Fortress Ins Co	981,225	366,838	(3,759)	-1.0%	-	-	-	-
Cincinnati Ins Co	946,531	885,766	738,880	83.4%	1,068,916	895,455	(198,771)	-22.2%
Campden Cas & Ind Co Inc MD	940,215	283,299	163,523	57.7%	-	-	-	-
Granite State Ins Co	922,729	558,393	1,160,220	207.8%	366,510	355,814	1,162,430	326.7%
Executive Risk Specialty Ins Co	850,531	980,954	(205,112)	-20.9%	417,580	432,624	1,854,285	428.6%
Preferred Professional Ins Co	800,874	559,689	232,813	41.6%	-	-	-	-
Traders & Pacific Ins Co	750,000	125,342	83,603	66.7%	-	-	-	-
Connecticut Ind Co	729,670	565,045	250,219	44.3%	368,422	342,100	76,530	22.4%
PACO Assur Co Inc	706,870	622,779	115,883	18.6%	493,747	189,124	-	0.0%
First Specialty Ins Corp	624,189	1,222,173	(215,039)	-17.6%	823,171	705,869	240,259	34.0%
Gulf Ins Co	518,797	970,358	(232,212)	-23.9%	1,536,909	1,659,953	2,243,578	135.2%
Westport Ins Corp	499,526	431,692	133,964	31.0%	464,552	420,165	555,596	132.2%
Essex Ins Co	403,678	380,082	638,785	168.1%	269,513	184,231	143,977	78.2%
American Assoc Of Othodontists RRG	298,791	286,344	162,310	56.7%	-	-	-	-
Executive Risk Ind Inc	282,865	254,077	3,106,645	1222.7%	843,225	1,109,823	2,863,729	258.0%
American Equity Ins Co	231,332	293,378	13,682,749	4663.9%	1,327,855	3,474,024	7,999,171	230.3%
Kemper Ind Ins Co	231,174	623,282	2,427,326	389.4%	906,833	358,093	742,384	207.3%
Community Blood Cntr Exch RRG	184,045	172,358	(5,467)	-3.2%	-	-	-	-
Clarendon Amer Ins Co	177,743	1,723,151	(5,080,154)	-294.8%	8,479,338	7,280,227	6,469,627	88.9%
St Paul Mercury Ins Co	168,624	272,316	(1,018,494)	-374.0%	445,701	947,995	(45,410)	-4.8%
Lumbermens Mut Cas Co	133,845	55,789	52,188	93.5%	-	-	-	-
Genesis Ind Ins Co	129,500	165,020	520,500	315.4%	141,543	132,916	228,000	171.5%
Church Mut Ins Co	115,412	54,291	40,537	74.7%	43,062	30,669	51,106	166.6%
General Ins Co Of Amer	110,349	127,297	153,667	120.7%	135,311	104,883	36,276	34.6%
American Ins Co	94,904	25,758	12,000	46.6%	-	-	-	-
Scottsdale Ins Co	76,232	87,972	1,115,451	1268.0%	73,114	1,378,133	6,503,906	471.9%
Athena Assur Co	71,818	173,797	3,058,024	1759.5%	350,252	440,000	908,750	206.5%
TIG Ind Co	56,190	77,933	(177,010)	-227.1%	152,070	220,934	624,110	282.5%
Lion Ins Co	50,619	60,925	366,618	601.8%	435,418	556,913	3,211,788	576.7%
Lawrenceville Prop & Cas Co	34,226	35,791	231,887	647.9%	34,226	32,493	25,011	77.0%
St Paul Guardian Ins Co	31,576	138,811	2,464,271	1775.3%	427,533	571,934	4,387,539	767.1%
Colony Ins Co	28,495	17,932	-	0.0%	-	-	-	-
Westchester Surplus Lines Ins Co	21,596	21,596	3,682	17.0%	-	-	-	-
National Surety Corp	11,374	11,412	-	0.0%	5,143	3,392	-	0.0%
Colony National Ins Co	3,463	4,753	(35,654)	-750.1%	1,875	2,454	(105,377)	-4294.1%
Nationwide Mut Fire Ins Co	1,338	1,532	(1,396)	-91.1%	1,787	1,787	(391)	-21.9%
Kemper Cas Ins Co	1,226	2,098	-	0.0%	1,443	544	-	0.0%
Nationwide Mut Ins Co	647	507	(5,347)	-1054.6%	512	918	100	10.9%
Insurance Co Of The State Of PA	586	772	2,648	343.0%	1,987	3,076	(7,543)	-245.2%
Travelers Ind Co Of IL	176	176	3,485,237	1980248.3%	-	-	-	-
Liberty Mut Ins Co	150	44	-	0.0%	-	-	-	-
Western Ind Ins Co	55	-	(575,131)	-1045692.7%	6,295	215,317	242,617	112.7%

TOTAL	829,122,375	763,385,688	787,527,502	103.2%	623,012,281	572,331,925	631,623,027	110.4%
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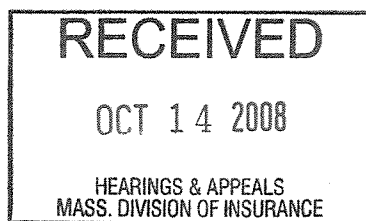
Florida
Line of Business: Medical Malpractice

Company Name	2000 Med Mal Dir Prem Written	2000 Med Mal Dir Pre Earned	2000 Med Mal Dir Losses Incurred	2000 Med Mal Loss Ratio	1999 Med Mal Dir Prem Written	1999 Med Mal Dir Pre Earned	1999 Med Mal Dir Losses Incurred	1999 Med Mal Loss Ratio
First Professionals Ins Co	69,981,763	65,649,122	36,456,829	55.5%	70,073,897	70,853,737	30,410,053	42.9%
Health Care Ind Inc	79,146,087	79,146,087	55,599,597	70.2%	74,707,458	74,707,458	61,986,675	83.0%
Promotional Ins Co	57,609,425	56,801,083	82,177,140	144.7%	57,114,420	56,442,471	10,419,812	18.5%
MAG Mut Ins Co	11,788,918	9,493,590	7,392,550	77.9%	6,612,025	8,121,409	10,123,100	124.6%
Truck Ins Exch	23,585,973	23,381,222	40,439,254	173.0%	12,885,174	15,432,591	31,141,555	201.8%
Lexington Ins Co	2,898,843	659,425	(1,179,232)	-178.8%	621,519	550,823	(4,803,736)	-872.1%
Medical Protective Co	25,368,190	21,618,073	39,506,544	182.7%	23,368,640	19,921,593	11,901,815	59.7%
Doctors Co An Interins Exchn	15,855,742	12,617,508	5,576,532	44.2%	8,450,127	5,158,899	3,545,474	68.7%
Evanson Ins Co	8,979,143	7,545,228	11,517,766	152.6%	6,915,784	7,589,328	6,004,911	79.1%
TIG Ins Co	18,604,025	16,545,926	11,658,616	70.5%	15,081,057	14,017,435	7,830,855	55.9%
American Physicians Assur Corp	20,181,528	17,094,630	15,834,126	92.6%	13,857,344	9,682,763	6,029,043	62.3%
Anesthesiologists Pro Assur Co	8,812,061	8,332,314	5,091,966	61.1%	7,465,806	7,122,492	3,628,839	50.9%
American Healthcare Ind Co	18,275,286	13,121,060	11,561,639	88.1%	12,743,355	11,824,723	8,940,951	75.6%
Continental Cas Co	7,661,250	6,689,494	(1,261,220)	-18.9%	4,970,235	6,933,732	5,719,685	82.5%
Chicago Ins Co	7,850,374	6,719,822	5,161,593	76.8%	5,052,089	4,586,244	3,402,503	74.2%
Steadfast Ins Co	5,114,016	3,660,416	14,575,503	398.2%	2,692,469	4,378,961	10,482,096	239.4%
St Paul Fire & Marine Ins Co	12,744,190	12,941,477	29,444,458	227.5%	21,372,913	25,902,809	32,443,850	125.3%
Everest Ind Ins Co	-	-	-	-	-	-	-	-
Clarendon Natl Ins Co	20,192,134	16,650,086	16,648,711	100.0%	17,981,931	16,871,289	11,309,121	67.0%
American Cas Co Of Reading PA	6,091,375	6,753,200	83,204	1.2%	6,561,361	6,814,985	14,179,758	208.1%
Podiatry Ins Co Of Amer RRG Mut Co	3,903,720	3,923,689	2,730,470	69.6%	803,156	737,438	1,936,144	262.6%
TIG Specialty Ins Corp	1,046,030	821,996	440,792	53.6%	1,236,721	1,418,410	1,626,573	114.7%
Columbia Cas Co	294,466	263,283	(894,338)	-339.7%	99,078	(854,735)	1,995,353	-233.4%
NCMIC Ins Co	2,739,235	2,745,040	900,126	32.8%	2,710,058	2,840,440	619,627	21.8%
Ophthalmic Mut Ins Co RRG	1,764,784	1,811,854	305,830	16.9%	1,914,576	1,883,545	(152,500)	-8.1%
National Union Fire Ins Co Of Pitts	374,626	1,269,119	8,556,785	672.7%	2,468,114	3,461,738	8,639,937	249.6%
Firemans Fund Ins Co	1,261,151	1,053,226	776,676	73.7%	1,501	1,501	167,281	11144.6%
Oms Natl Ins Co Rrg	2,748,089	2,677,961	(62,975)	-2.4%	2,768,817	2,748,045	1,204,791	43.8%
Interstate Fire & Cas Co	3,404,584	2,297,118	2,687,702	117.0%	1,194,324	1,115,686	528,303	47.4%
Professional Undrvtrs Liab Ins Co	734,979	380,479	224,450	59.0%	60,885	64,801	31,752	49.0%
Preferred Physicians Medical RRG	1,735,201	1,757,328	5,037,901	286.7%	2,389,745	2,383,368	2,541,252	106.6%
Admiral Ins Co	1,075,019	2,008,168	14,709,644	732.5%	3,126,313	3,024,685	5,980,200	197.7%
Medical Assur Co Inc	7,414,448	6,410,726	1,865,946	29.1%	3,993,603	5,022,572	2,783,222	55.4%
Physicians Professional Liability RRG	-	-	-	-	-	-	-	-
Royal Surplus Lines Ins Co	770,609	1,165,875	11,880,020	1019.0%	3,166,721	3,241,053	3,809,518	117.5%
Zurich American Ins Co	14,358,978	11,176,269	28,761,206	257.3%	13,125,285	12,149,144	16,125,585	132.7%
General Star Ind Co	16,194	7,607	-	0.0%	3,696	4,081	1,000	24.5%
American Healthcare Specialty	384,918	401,611	76,142	19.0%	221,380	30,695	15,371	50.1%
Ace American Ins Co	1,058,425	637,922	(37,321)	-5.9%	264,246	215,039	66,904	31.1%
Illinois Union Ins Co	313,984	210,199	56,594	26.9%	10,307	13,797	2,730	19.8%
Arch Specialty Ins Co	-	-	-	-	-	-	-	-
Western World Ins Co	1,476,766	879,643	2,626,141	298.5%	448,113	516,082	689,162	133.5%
Fortress Ins Co	-	-	-	-	-	-	-	-
Cincinnati Ins Co	741,307	746,353	298,481	40.0%	735,195	737,913	665,290	90.2%
Campmed Cas & Ind Co Inc MD	-	-	-	-	-	-	-	-
Granite State Ins Co	344,304	322,409	196,636	61.0%	280,273	132,617	1,278,693	964.2%
Executive Risk Specialty Ins Co	604,297	666,203	1,357,399	203.8%	593,122	683,791	364,324	53.3%
Preferred Professional Ins Co	-	-	-	-	-	-	-	-
Traders & Pacific Ins Co	-	-	-	-	-	-	-	-
Connecticut Ind Co	338,905	257,483	40,791	15.8%	108,731	33,133	-	0.0%
PACO Assur Co Inc	-	-	-	-	-	-	-	-
First Specialty Ins Corp	675,000	140,625	135,816	96.6%	-	-	-	-
Gulf Ins Co	1,783,470	1,750,743	600,716	34.3%	1,824,791	1,693,975	2,055,132	121.3%
Westport Ins Corp	183,838	175,049	24,939	14.2%	139,392	131,796	(401)	-0.3%
Essex Ins Co	19,659	7,345	401	5.5%	5,000	3,839	2,475	64.5%
American Assoc Of Othodontists RRG	249,526	247,973	58,493	23.6%	242,611	227,574	51,905	22.8%
Executive Risk Ind Inc	1,946,504	1,721,801	3,082,116	179.0%	1,243,690	1,091,131	581,355	53.3%
American Equity Ins Co	4,829,525	3,205,388	4,942,278	154.2%	1,674,479	1,246,039	759,183	60.9%
Kemper Ind Ins Co	19,104	9,631	4,007	41.6%	-	-	-	-
Community Blood Cntr Exch RRG	139,025	95,250	(18,584)	-19.5%	77,749	74,886	1,932	2.6%
Clarendon Amer Ins Co	612,100	109,187	81,890	75.0%	-	-	-	-
St Paul Mercury Ins Co	991,794	701,423	7,810,017	1115.5%	688,296	715,412	10,304,841	1440.4%
Lumbermens Mut Cas Co	-	-	-	-	-	-	-	-
Genesis Ind Ins Co	116,425	100,677	58,000	57.6%	50,039	38,607	18,000	46.6%
Church Mut Ins Co	23,950	23,880	152,658	639.3%	24,475	24,313	65,902	271.1%
General Ins Co Of Amer	47,605	32,478	(10,538)	-32.4%	7,246	5,120	13,332	260.4%
American Ins Co	-	-	-	-	-	-	-	-
Scottsdale Ins Co	4,328,873	4,544,468	7,552,126	166.2%	4,625,252	4,154,476	3,289,104	79.2%
Athens Assur Co	945,801	1,596,217	3,593,057	225.1%	2,163,918	2,297,639	1,825,485	79.5%
TIG Ind Co	261,085	245,785	308,179	125.4%	185,387	104,399	73,821	70.7%
Lion Ins Co	550,608	566,952	1,445,236	254.9%	884,975	303,292	215,000	70.9%
Lawrenceville Prop & Cas Co	26,182	24,801	16,232	65.4%	-	-	-	-
St Paul Guardian Ins Co	1,560,427	2,543,116	10,851,298	426.7%	1,498,684	3,437,219	4,531,489	131.8%
Colony Ins Co	-	-	-	-	-	-	-	-
Westchester Surplus Lines Ins Co	-	-	-	-	-	-	-	-
National Surety Corp	2,160	630	-	0.0%	-	-	-	-
Colony National Ins Co	2,042	75,148	98,400	130.9%	219,817	302,389	(30,952)	-10.2%
Nationwide Mut Fire Ins Co	1,774	2,048	207	10.1%	2,061	2,237	(169)	-7.6%
Kemper Cas Ins Co	-	-	-	-	-	-	-	-
Nationwide Mut Ins Co	918	1,443	(656)	-45.5%	2,295	2,283	267	11.7%
Insurance Co Of The State Of PA	4,385	5,117	(7,446)	-145.5%	9,457	15,177	(11,935)	-78.6%
Travelers Ind Co Of IL	231,102	231,102	1,565,948	677.6%	141,914	998,579	314,138	31.5%
Liberty Mut Ins Co	-	-	-	-	-	-	-	-
Western Ind Ins Co	832,613	1,779,175	2,491,429	140.0%	2,882,642	2,340,385	5,962,396	254.8%
TOTAL	490,030,839	449,248,776	513,636,893	114.3%	428,845,734	427,729,348	345,639,172	80.8%

Florida Office of Insurance Regulation



Medical Malpractice Financial Information, Closed Claim Database and Rate Filings



**Section 627.912(6), Florida
Statutes, as amended by
Senate Bill 2-D,
(Ch. 2003-416)**

Deloitte.

OCTOBER 1, 2004



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October 1, 2004

Ms. Lisa Miller
Deputy Director
Office of Insurance Regulation
J. Edwin Larson Building
200 East Gaines Street, Suite 121
Tallahassee, FL 32399-0326

Dear Ms. Miller:

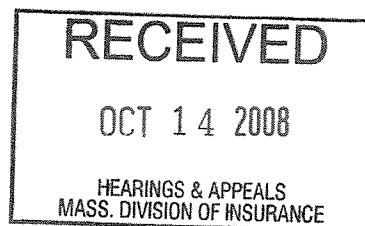
Deloitte Consulting is pleased to submit our report completing Section 45(6)(b) and (c) of CS for SB 2-D, 1st Engrossed.

It was a pleasure working with you and we look forward to serving the Office of Insurance Regulation in the future. Please do not hesitate to call either Jan at (860) 543-7350 or Kevin at (860) 543-7345 if we can be of any further assistance.

Sincerely,

Jan Lommele, FCAS, MAAA, FCA
Principal – Deloitte.

Kevin Bingham, ACAS, MAAA
Senior Manager – Deloitte.



Richard Simring, Attorney at Law
Partner – Stroock

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Member of
Deloitte Touche Tohmatsu

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I. EXECUTIVE SUMMARY

PURPOSE AND SCOPE

Deloitte Consulting LLP (Deloitte Consulting) has been retained by the Florida Department of Financial Services Office of Insurance Regulation (OIR) to complete the requirements of Section 627.912(6), Florida Statutes, as amended by Senate Bill 2-D, (Ch. 2003-416), which states:

“(b) OIR shall prepare an annual report by October 1 of each year, beginning in 2004, which shall be available on the Internet, which summarizes and analyzes the closed claim reports and the annual financial reports filed by insurers writing medical malpractice insurance in Florida. The report must include: (1) an analysis of closed claim reports of prior years in order to show trends in the frequency and amount of claims payments; (2) the itemization of economic and noneconomic damages; (3) the nature of the errant conduct; and (4) such other information that OIR determines is illustrative of the trends in closed claims. The report must also analyze the state of the medical malpractice insurance market in Florida including: (1) an analysis of the financial reports of those insurers with a combined market share of at least 80 percent of the net written premium in the state for medical malpractice for the prior calendar year; (2) loss ratio analysis for medical malpractice written in Florida; and (3) a profitability analysis of each such insurer. The report shall compare the ratios for medical malpractice in Florida compared to other states, based on financial reports filed with the National Association of Insurance Commissioners and such other information that OIR deems relevant.

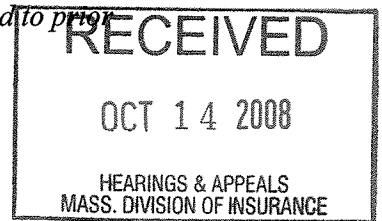
(c) The annual report shall also include a summary of the rate filings for medical malpractice which have been approved by the office for the prior calendar year, including an analysis of the trend of direct and incurred losses as compared to prior years.”

BACKGROUND

Medical Malpractice Synopsis¹

A claim for medical malpractice means a claim arising out of the rendering of, or the failure to render medical care services. An “action for medical malpractice” is a tort or breach of contract

¹ 2003 University of Central Florida Governor’s Select Task Force on Healthcare Professional Liability Insurance, Chapter 2



claim for damages due to the death, injury, or monetary loss to any person arising out of any medical, dental, or surgical diagnosis, treatment, or care by any provider of healthcare.

In any action for recovery of damages based upon medical malpractice, the claimant has the burden of proving the alleged actions of the healthcare provider represented a breach in the prevailing standard of care for that type of healthcare provider. The prevailing professional standard of care for a given healthcare provider is that level of care, skill and treatment which, in light of all relevant surrounding circumstances, is recognized as acceptable and appropriate by reasonably prudent, similar healthcare providers.

DISTRIBUTION AND USE

Deloitte Consulting understands that all records or data produced by Deloitte Consulting in response to this engagement are subject to applicable public records law(s). OIR personnel are available to respond to any questions with respect to this report. Deloitte Consulting will direct all third party requests for such records to the OIR.

RELIANCE AND LIMITATIONS

Deloitte Consulting's analysis of Section 45(6)(b) and (c) is based on background information, publicly available information, rate filings, responses to the market leader data request, and financial data provided by the OIR. A specific audit of the data and background information is beyond the scope of this project. Deloitte Consulting has conducted such reasonableness tests of the data as we felt appropriate. In all other respects, Deloitte Consulting has relied without audit or verification on the data and background information provided. Any assumptions, adjustments or modifications made by Deloitte Consulting to the data will be documented in detail throughout the remainder of this report.

A complete copy of Senate Bill 2-D (Ch. 2003-416) may be obtained from the Office of Secretary of State, website www.dos.state.fl.us (under Elections, Laws) or directly from the website of the Florida Senate at www.flsenate.gov.

The following report assumes the reader has thoroughly read all SB2D Statutes.

OVERALL CONCLUSIONS

- It is too early to evaluate and establish the ultimate impact of SB2D based upon our review of individual company financial reports, responses to our market leader data request, rate filing review, analysis of the Closed Claim Database and status of the Berges case.
- It is not possible at this time to estimate when the trial court in the Berges case will rule on the issue of whether the cap is constitutional. The defendants may argue that the issue is not "ripe" for determination unless and until a jury verdict is rendered in excess of the cap. The trial court therefore may postpone a decision on constitutionality until after the case goes to trial, which may take one or two years. Whenever the trial court does rule, however, there is a possibility that the parties will request a "fast track" appeal to the Florida Supreme Court, bypassing the intermediate appellate court. If that occurs (it is within the discretion of the intermediate appellate court to decide), then the appeal time in our original report could be expedited by approximately one year. Accordingly, a final decision on constitutionality from the Florida Supreme Court could occur within 12 to 18 months of a ruling by the trial court.
- We believe it is reasonable to focus on medical malpractice insurance company financial results over a time period roughly equal to the average historical medical malpractice cycle

when analyzing profitability. Analysis of profit and ratemaking decisions made based upon a few quarters' profits without considering the cumulative results over the average cycle would not portray the economic realities of the medical malpractice business.

- We believe that from a Florida perspective, the average return on surplus for the years reviewed in this study continue to be in the low single digits and well below levels which would indicate excessive profits.
- We believe the favorable first quarter 2004 operating ratios may indicate that Florida's companies will continue to be profitable through year-end 2004, helping to stabilize the need for future rate changes in the State of Florida.
- We believe rate increases should moderate over the next few years, driven by the favorable trend in report year/accident year loss ratios flowing into the ratemaking calculations.
- We believe that company leverage ratios and RBC ratios will likely improve as a result of rising surplus levels and a renewed focus on underwriting (i.e., targeting a combined ratio under 100%).
- Deloitte Consulting believes the OIR did a thorough job of reviewing the assumptions in the rate filings and asking for additional support.
- The trend towards lower policy limits and "going bare" will likely continue into the future.
- If the cap is declared unconstitutional, medical malpractice rates that reflected the PF will be inadequate by the amount of PF reflected in the rate filings (e.g., 5.3% PF for cap on non-economic damages), then Florida's insurers would need to file higher rates, re-visiting ratemaking assumptions and eliminating the effect of the presumed factor.

For a detailed listing of Deloitte Consulting's findings, please refer to **Section IV. Observations and Conclusions.**

II. SECTION 45(6)(b)

MEDICAL MALPRACTICE INDUSTRY OVERVIEW

The medical malpractice market is going through its third medical malpractice crisis or “hard” insurance market (i.e., period of rising rates) in thirty years. The first medical malpractice crisis occurred in the mid- to late- 1970s. The second medical malpractice crisis occurred in the mid- 1980s. The current medical malpractice crisis began in early 2001. As is noted in the Contingencies Magazine article *The Medical Malpractice Market: From National Dominance to Regional Focus*, the current hard insurance market has been driven by a number of factors:

- Rising loss trends;
- Higher and more volatile jury awards;
- Adverse reserve development on prior accident/report year loss reserves;
- Reduced carrier capacity;
- Rising cost of reinsurance;
- Varying success of tort reform packages in multiple states (e.g., constitutionality, ability to pass tort reform); and
- Declining investment returns².

Using insurance industry medical malpractice information from A.M. Best’s 2004 edition of *Best’s Aggregates & Averages - Property/Casualty Edition*³, we will walk the reader through a number of key metrics illustrating the performance of the medical malpractice industry through December 31, 2003. These statistics will help lay the groundwork for Deloitte Consulting’s detailed drill down into the performance of Florida’s medical malpractice writers with a combined market share of at least 80 percent of the net written premium in the state for the 2003 calendar year.

Our analysis of Florida’s top writers begins on page 30 of this report.

² July/August 2004 Contingencies Magazine (www.contingencies.org), *The Medical Malpractice Market: From National Dominance to Regional Focus*, Kevin Bingham.

³ A.M. Best Company (www.ambest.com), *Best’s Aggregates & Averages - Property/Casualty 2004 Edition*.

LEADING WRITERS AND INDUSTRY RESULTS

Table 1 displays the top ten medical malpractice insurance groups ranked by 2003 net written premium.

TABLE 1			
GROUP	NET WRITTEN PREMIUM (000s)		
	2001	2002	2003
MLMIC GROUP	671,866	921,924	843,474
AIG	235,272	486,587	785,346
GE GLOBAL INSURANCE	358,486	547,050	712,545
PROASSURANCE	265,418	367,911	476,523
HEALTH CARE IND	260,338	318,622	376,973
DOCTORS COMPANY	280,398	402,255	347,620
ISMIE MUTUAL	174,427	216,273	276,791
PHYSICIANS RECIP INS	125,403	150,757	273,010
NORCAL GROUP	227,543	223,631	257,347
CNA INSURANCE	116,700	181,930	243,761
INDUSTRY	6,074,675	7,080,968	8,279,450

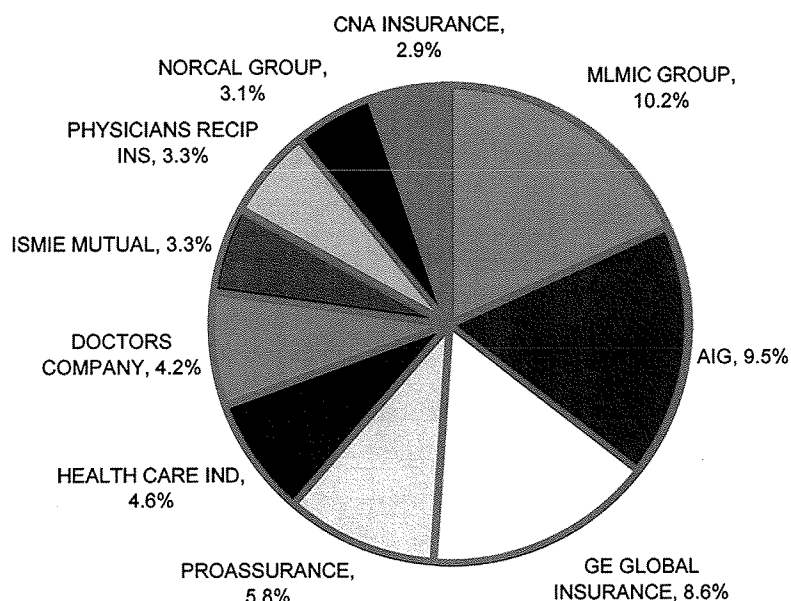
Table 2 displays the percentage change in net written premium for the insurance groups.

TABLE 2			
GROUP	% CHANGE IN NET WRITTEN PREMIUM		
	2001	2002	2003
MLMIC GROUP	-33.0%	37.2%	-8.5%
AIG	100.0%	106.8%	61.4%
GE GLOBAL INSURANCE	27.8%	52.6%	30.3%
PROASSURANCE	2.3%	38.6%	29.5%
HEALTH CARE IND	32.1%	22.4%	18.3%
DOCTORS COMPANY	33.5%	43.5%	-13.6%
ISMIE MUTUAL	25.8%	24.0%	28.0%
PHYSICIANS RECIP INS	173.5%	20.2%	81.1%
NORCAL GROUP	15.6%	-1.7%	15.1%
CNA INSURANCE	-31.0%	55.9%	34.0%
INDUSTRY	8.7%	16.6%	16.9%

For most of the groups⁴, the growth in net written premiums over the past few years can largely be explained by significant rate increases filed in their core states of business where medical malpractice trends indicated the need for large rate increases.

Table 3 displays the 2003 market share of the top ten insurance groups.

TABLE 3



GE Global Insurance includes the following major medical malpractice writing company:

- **Medical Protective Company – Top 80% Florida Writer (benchmark established by SB2D for this study)**

AIG includes the following major medical malpractice writing company:

- **Lexington Insurance Company – Top 80% Florida Writer (benchmark established by SB2D for this study)**

⁴ Insurance groups can own multiple insurance companies. Schedule Y – “Information Concerning Activities of Insurer Members of a Holding Company Group” of the NAIC Annual Statement displays the ownership structure of a typical insurance group. For example, FPIC Insurance Group, Inc. owns 100% of First Professionals Insurance Co., Inc. and 100% of Anesthesiologists Professional Assurance Co. The industry statistics displayed in this report are for insurance groups. The Florida company statistics shown in this report are for individual insurance companies.

Doctors Company includes the following major medical malpractice writing companies:

- **Doctors Co an Interinsurance Exchange – Top 80% Florida Writer (benchmark established by SB2D for this study)**
- Professional Underwriters Liability Insurance Company

Health Care Ind. includes the following major medical malpractice writing company:

- **Health Care Indemnity Inc. – Top 80% Florida Writer (benchmark established by SB2D for this study)**

ProAssurance includes the following major medical malpractice writing companies:

- Medical Assurance Company Inc.
- **Pronational Insurance Company – Top 80% Florida Writer (benchmark established by SB2D for this study)**

Table 4 displays the calendar year net⁵ incurred loss ratios (IL) for the top ten insurance groups.

Incurred losses, as used in the *Best Aggregates and Averages* report, means the cumulative amounts paid (e.g., economic damage, non-economic damage) for all claims as of a particular point in time, plus outstanding unpaid amounts as estimated by claim adjusters, plus an estimate for the actuarially determined incurred but not reported (IBNR)^{6,7}. The net incurred loss ratio equals the net incurred losses divided by net earned premium. The IL ratio measures how much of a premium dollar is dedicated to paying the insurance claims of the company in a calendar year, excluding loss adjustment expense (i.e., defense costs, court costs, medical reports, investigative reports, etc.). An IL ratio of 80% implies the company pays 80 cents for every dollar of premium earned to indemnify its insureds.

⁵ Net implies after the impact of reinsurance.

⁶ Actuarially determined IBNR can include the following items: 1) "Pure" incurred but not reported (IBNR) - claims not yet known and not recorded in the loss system; 2) "Pipeline" IBNR - claims known but not yet recorded in the loss system; 3) Case development - future development on known, recorded claims; and 4) Reopened claims - future reopened claims which are coded to the year in which the original claim occurred. All 4 items are considered for occurrence policies (i.e. accident year data). Item 1) is not included for claims-made policies (i.e., report year data).

⁷ The title "incurred losses" or "incurred losses and LAE" shown in Schedule P of the Annual Statement and used in the Best Aggregates and Averages includes a provision for IBNR. Using standard industry terminology, the inclusion of IBNR in the calculation of incurred losses or incurred loss and LAE is often referred to as "ultimate losses" or "ultimate losses and ALAE". Unless otherwise noted, each section will clarify the definition of incurred losses used by Deloitte Consulting.

TABLE 4			
GROUP	NET INCURRED LOSS (IL) RATIO		
	2001	2002	2003
MLMIC GROUP	104.8%	149.6%	102.7%
AIG	141.7%	112.0%	102.4%
GE GLOBAL INSURANCE	50.9%	80.7%	65.4%
PROASSURANCE	61.7%	52.4%	47.7%
HEALTH CARE IND	97.2%	88.1%	89.1%
DOCTORS COMPANY	65.1%	63.3%	68.1%
ISMIE MUTUAL	72.3%	99.5%	73.2%
PHYSICIANS RECIP INS	70.1%	14.9%	96.1%
NORCAL GROUP	71.5%	57.5%	52.3%
CNA INSURANCE	211.9%	74.3%	82.0%
INDUSTRY	98.6%	86.2%	82.7%

Table 5 displays the calendar year net incurred loss and loss adjustment expense (LAE) ratios for the top ten insurance groups. LAE means the cumulative payments made for defense and cost containment (i.e., defense costs, court costs, medical reports, investigative reports, etc.) and adjusting and other (i.e., fees/salaries for appraisers, expenses of adjusters and settling agents, etc.) for all claims as of a particular point in time, plus outstanding unpaid amounts as estimated by claim adjusters, plus an estimate for IBNR⁸. The net incurred loss and LAE ratio equals the net incurred losses and LAE divided by net earned premium. The IL and LAE ratio measures how much of a premium dollar is dedicated to paying the insurance claims and LAE costs of the company in a calendar year. An IL and LAE ratio of 120% implies the company pays 120 cents for every dollar of premium earned to defend and indemnify its insureds.

⁸ Loss adjustment expenses include defense and cost containment (DCC) and adjusting and other (AO). DCC represents expenses such as surveillance expenses, fixed amounts for medical cost containment, litigation management expenses, attorney fees incurred owing to a duty to defend, and fees/salaries for appraisers, investigators, rehab nurse, working on the defense of a claim. AO represent expenses such as fees and expenses of adjusters and settling agents, fees/salaries for appraisers, investigators, if working in the capacity of an adjuster, and attorney fees incurred in the determination of coverage, including litigation between an insurer and the policyholder. The insurance industry changed it's terminology in the late 90s from allocated loss adjustment expense (ALAE) to DCC and unallocated loss adjustment expense (ULAE) to AO, noting that the relationship was not one-to-one.

TABLE 5			
GROUP	2003 RATIOS TO NET EARNED PREMIUM		
	INCURRED LOSSES	LOSS ADJUSTMENT EXPENSE (LAE)	NET IL AND LAE RATIO
MLMIC GROUP	102.7%	47.3%	150.0%
AIG	102.4%	21.2%	123.6%
GE GLOBAL INSURANCE	65.4%	26.7%	92.1%
PROASSURANCE	47.7%	49.1%	96.8%
HEALTH CARE IND	89.1%	22.1%	111.2%
DOCTORS COMPANY	68.1%	40.7%	108.8%
ISMIE MUTUAL	73.2%	31.6%	104.8%
PHYSICIANS RECIP INS	96.1%	40.1%	136.2%
NORCAL GROUP	52.3%	48.3%	100.6%
CNA INSURANCE	82.0%	41.1%	123.1%
INDUSTRY	82.7%	37.1%	119.8%

Table 6 displays the combined ratios (CR) for the top ten insurance groups and industry.

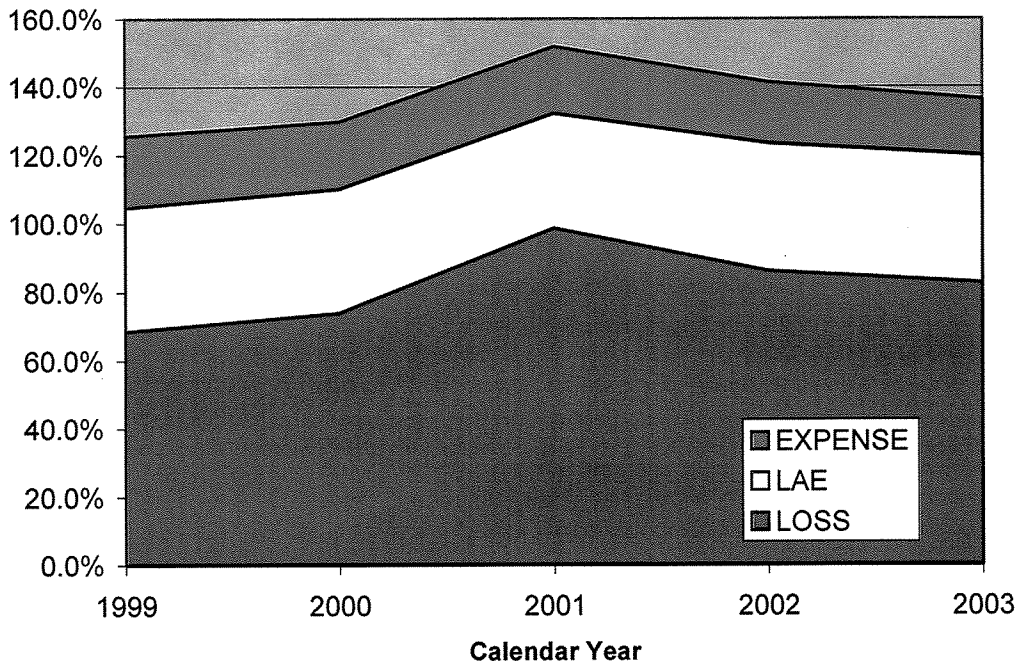
TABLE 6			
GROUP	2003 RATIOS		
	NET IL AND LAE RATIO	EXPENSE RATIO	COMBINED RATIO
MLMIC GROUP	150.0%	11.0%	161.0%
AIG	123.6%	12.5%	136.1%
GE GLOBAL INSURANCE	92.1%	15.5%	107.6%
PROASSURANCE	96.8%	13.3%	110.1%
HEALTH CARE IND	111.2%	1.4%	112.6%
DOCTORS COMPANY	108.8%	11.4%	120.2%
ISMIE MUTUAL	104.8%	13.7%	118.5%
PHYSICIANS RECIP INS	136.2%	16.8%	153.0%
NORCAL GROUP	100.6%	16.4%	117.0%
CNA INSURANCE	123.1%	19.9%	143.0%
INDUSTRY	119.8%	16.5%	136.3%
DIVIDEND RATIO:			0.5%
INCLUDING DIVIDEND RATIO:			136.8%

The CR equals the net IL and LAE ratio plus the expense ratio. The expense ratio equals the ratio of commission, brokerage, field supervision, collection expense, taxes, licenses, fees, and general expenses to net written premium. The CR measures how much of a premium dollar is dedicated to paying insurance costs of the company in a calendar year. A CR of 135% implies the company lost 35 cents for every dollar of premium earned before considering investment income.

Table 7 displays the combined ratio (CR) contribution by component excluding the impact of dividends for the industry.

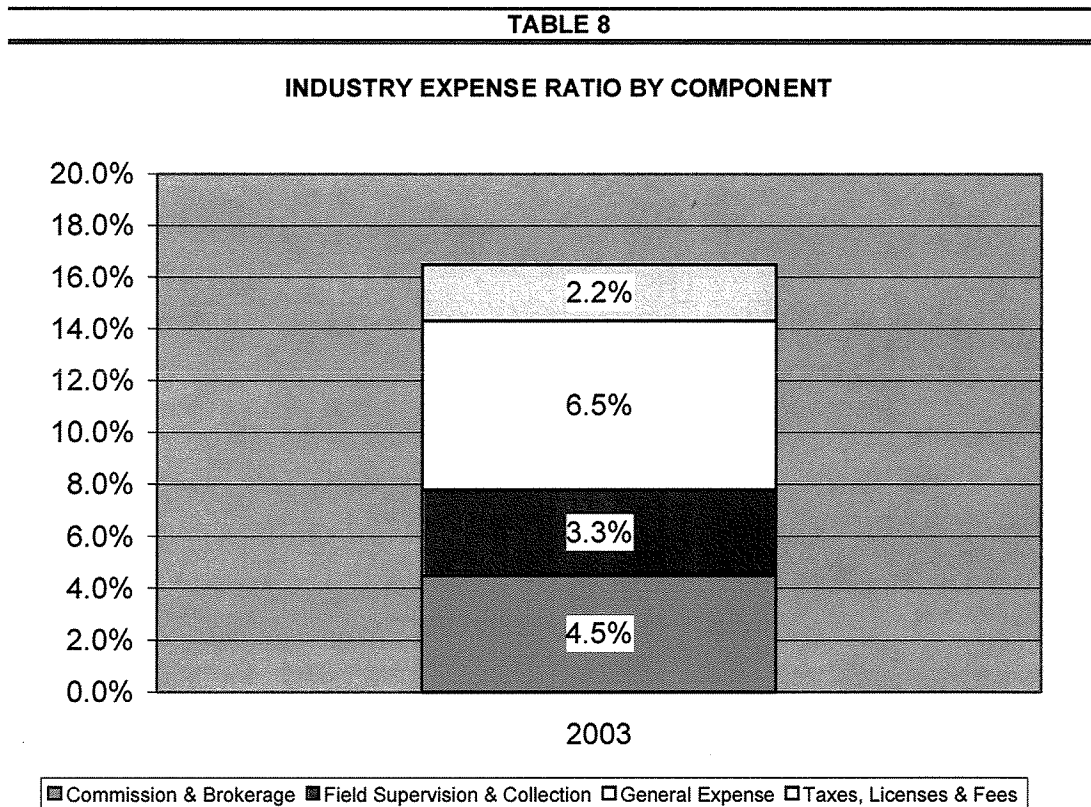
TABLE 7

INDUSTRY COMBINED RATIO CONTRIBUTION BY COMPONENT



The impact of the current hard market can be seen on the declining combined ratio since 2001.

Table 8 displays the components of the incurred expense ratio⁹ that underlie the industry combined ratio displayed above.



⁹ A.M. Best Company (www.ambest.com), *Best's Aggregates & Averages - Property/Casualty 2004 Edition*, "By Line Underwriting Experience" displays the above expense categories as a ratio to net written premium. For ratemaking purposes, general expenses and other acquisition, field supervision and collection expenses are often expressed as a percentage of earned premium.

Table 9 displays the before-tax operating ratios (OR) for the top ten insurance groups and industry. The OR equals the CR minus the net investment income and other income ratio to earned premium (NII). The OR measures how much of a premium dollar is left after considering the impact of investment income earned on the CR. An OR of 120% implies the industry lost 20 cents for every dollar of premium earned after the consideration of investment income.

TABLE 9			
GROUP	2003 RATIOS		
	COMBINED RATIO	NII AND OTHER INC. (TO NEP)	NET OPERATING RATIO
MLMIC GROUP	161.0%	19.6%	141.4%
AIG	136.1%	8.3%	127.8%
GE GLOBAL INSURANCE	107.6%	10.2%	97.4%
PROASSURANCE	110.1%	11.0%	99.1%
HEALTH CARE IND	112.6%	10.0%	102.6%
DOCTORS COMPANY	120.2%	6.0%	114.2%
ISMIE MUTUAL	118.5%	22.1%	96.4%
PHYSICIANS RECIP INS	153.0%	47.1%	105.9%
NORCAL GROUP	117.0%	13.3%	103.7%
CNA INSURANCE	143.0%	16.0%	127.0%
INDUSTRY	136.3%	15.6%	120.7%
DIVIDEND RATIO:			0.5%
INCLUDING DIVIDEND RATIO:			121.2%

Table 10 displays the net liability¹⁰ to surplus ratio (NLSR) and net written premium to surplus ratio (NPSR) for 54 organizations¹¹. The NLSR equals the net loss and LAE reserves divided by surplus. The NLSR provides a measure of underwriting leverage, and thus risk. Surplus serves as a financial buffer to guard against adverse events and changes in financial condition, such as

¹⁰ Net liability is defined as net loss and LAE reserves only (i.e., excludes other liabilities shown on Page 3 of the Annual Statement).

¹¹ A.M. Best Company (www.ambest.com), *Best's Aggregates & Averages - Property/Casualty 2004 Edition*. The 54 organizations (a/k/a, medical malpractice composite) represent groups and unaffiliated single companies for which more than 50% of their business is in medical malpractice. The medical malpractice net written premium of the 54 organizations represents over two thirds of the medical malpractice industry's total net written premium. The inclusion of organizations where medical malpractice is not a core focus of the company would reduce the informational value of the composite figures (e.g., company focuses mainly on personal lines, company with minimal medical malpractice business significantly increases asbestos or D&O reserves, etc.).

can result when reserve strengthening is required. A lower ratio signifies greater financial strength and a greater capacity to absorb adverse development in reserves. In lines of insurance such as medical malpractice that have significant potential for this to occur, it is important that the NLSR be relatively low, especially for companies that are not diversified insurance writers. The NPSR equals the net written premium divided by surplus. The NPSR measures the insurer's capacity to write additional business.

TABLE 10

LEVERAGE RATIOS - 54 ORGANIZATIONS

	2003	2002	2001	2000	1999
NLSR	2.867	2.951	2.213	1.941	1.826
NPSR	0.911	0.956	0.679	0.588	0.475
L&LAE RES (\$M)	17,437	16,323	14,847	14,019	13,682
% CHANGE	6.8%	9.9%	5.9%	2.5%	0.6%
NWP (\$M)	5,544	5,288	4,553	4,245	3,555
% CHANGE	4.8%	16.1%	7.3%	19.4%	2.0%
SURPLUS (\$M)	6,083	5,532	6,709	7,223	7,492
% CHANGE	10.0%	-17.5%	-7.1%	-3.6%	8.4%

As one can see from above, both the NLSR and NPSR have risen since their 1999 levels. The NLSR increase has been driven by the adverse development observed by companies over the past few years, in combination with declining surplus through 12/31/2002. The NPSR increase in recent years is driven by the cumulative impact of rate increases taken since early 2000, in combination with declining surplus through 12/31/2002.

Table 11 displays the after tax net income for the 2003 calendar year and the ratio to earned premium¹².

TABLE 11		
2003 PROFITABILITY - 54 ORGANIZATIONS		
INCOME STATEMENT ITEM	(000s)	% OF EP
PREMIUMS EARNED	5,413,857	100.0%
LOSSES INCURRED	4,017,374	74.2%
LAE INCURRED	2,085,632	38.5%
U/W EXPENSE INCURRED	835,264	15.4%
OTHER DEDUCTIONS	18,916	0.3%
DIVIDENDS TO POLICYHOLDERS	<u>20,426</u>	0.4%
NET U/W INCOME	(1,563,755)	-28.9%
NET INVESTMENT INCOME	924,221	17.1%
OTHER INCOME/(EXPENSE)	<u>98,517</u>	1.8%
PRETAX OPERATING INCOME	(541,017)	-10.0%
REALIZED CAPITAL GAINS (CG)	132,241	2.4%
INCOME TAXES INCURRED (TAX)	<u>30,240</u>	0.6%
NET INCOME	(439,016)	-8.1%
L&LAE RATIO		112.7%
EXPENSE RATIO		15.8%
<u>DIVIDEND RATIO</u>		<u>0.4%</u>
COMBINED RATIO		128.9%
<u>NET AN OTHER INCOME RATIO</u>		<u>18.9%</u>
OPERATING RATIO (BEFORE TAX & CG)		110.0%
<u>TAX & CG RATIO</u>		<u>-1.9%</u>
OPERATING RATIO (AFTER TAX & CG)		108.1%

The 54 organizations, representing over two-thirds of the 2003 industry net written premium, lost \$439 million in 2003, after reflecting the impact of items such as rate increases (impacts the premiums earned), reserve strengthening (impacts the losses and LAE incurred), changes in policyholder dividend strategies (impacts dividends to policyholders), and changes in investment strategy (impacts net investment income earned on bonds and realized capital gains on stocks sold throughout the year).

¹² Other areas of the report display the ratio of underwriting expenses to written premiums.

The above exhibit also displays the income statement items in the ratio format discussed earlier in the report. The net income ratio to earned premium of -8.1% equals 100% minus the 108.1% operating ratio. Stated another way, the industry lost 8.1 cents on every dollar of premium earned after considering investment income, realized capital gains and income taxes (i.e., after-tax earnings generated from operations and realized capital gains).

Table 12 displays the after tax net income and return on average surplus (ROS) for the past five years.

TABLE 12					
PROFITABILITY - 54 ORGANIZATIONS					
	2003	2002	2001	2000	1999
NET INCOME (\$M)	(439)	(903)	(328)	487	661
SURPLUS (\$M)	6,083	5,532	6,709	7,223	7,492
ROS	-7.6%	-14.8%	-4.7%	6.6%	9.2%

In the past three years, the 54 organizations have lost \$1.67 billion. In the past five years, the organizations have lost \$522 million. As the recently filed rate increases continue to flow into earned premiums, we would expect the net income of the 54 organizations and the industry to continue its favorable trend towards break-even in 2004. If development on prior accident/report year reserves continues to stabilize, net income could potentially result in a positive 2004 return on surplus (i.e., net income > 0) for the first time since 2000.

INDUSTRY SCHEDULE P CLAIMS-MADE RESULTS

Table 13 and Table 14 display total industry medical malpractice loss and premium information from Schedule P, Part 1F, Section 2 (claims-made).

TABLE 13				
CLAIMS-MADE				
REPORT YEAR	INCURRED LOSS AND LAE			% CHANGE IN NET
	DIRECT AND ASSUMED	CEDED	NET	
1994	3,714,696	833,724	2,880,972	
1995	4,493,594	1,226,495	3,267,099	13.4%
1996	4,830,076	1,428,749	3,401,327	4.1%
1997	5,362,052	1,506,247	3,855,805	13.4%
1998	5,908,567	1,602,015	4,306,552	11.7%
1999	6,070,505	1,734,468	4,336,037	0.7%
2000	6,557,360	1,935,740	4,621,620	6.6%
2001	6,794,741	1,759,923	5,034,818	8.9%
2002	6,883,076	1,779,995	5,103,081	1.4%
2003	7,237,393	2,141,333	5,096,060	-0.1%

TABLE 14				
CLAIMS-MADE				
REPORT YEAR	EARNED PREMIUM			% CHANGE IN NET
	DIRECT AND ASSUMED	CEDED	NET	
1994	4,108,461	1,081,378	3,027,083	
1995	4,296,211	1,239,623	3,056,588	1.0%
1996	4,222,431	1,083,902	3,138,529	2.7%
1997	4,493,025	1,188,259	3,304,766	5.3%
1998	4,427,296	1,051,196	3,376,100	2.2%
1999	4,458,248	1,009,761	3,448,487	2.1%
2000	4,565,525	1,217,578	3,347,947	-2.9%
2001	5,148,838	1,316,602	3,832,236	14.5%
2002	6,833,731	2,187,336	4,646,395	21.2%
2003	8,297,408	2,839,632	5,457,776	17.5%

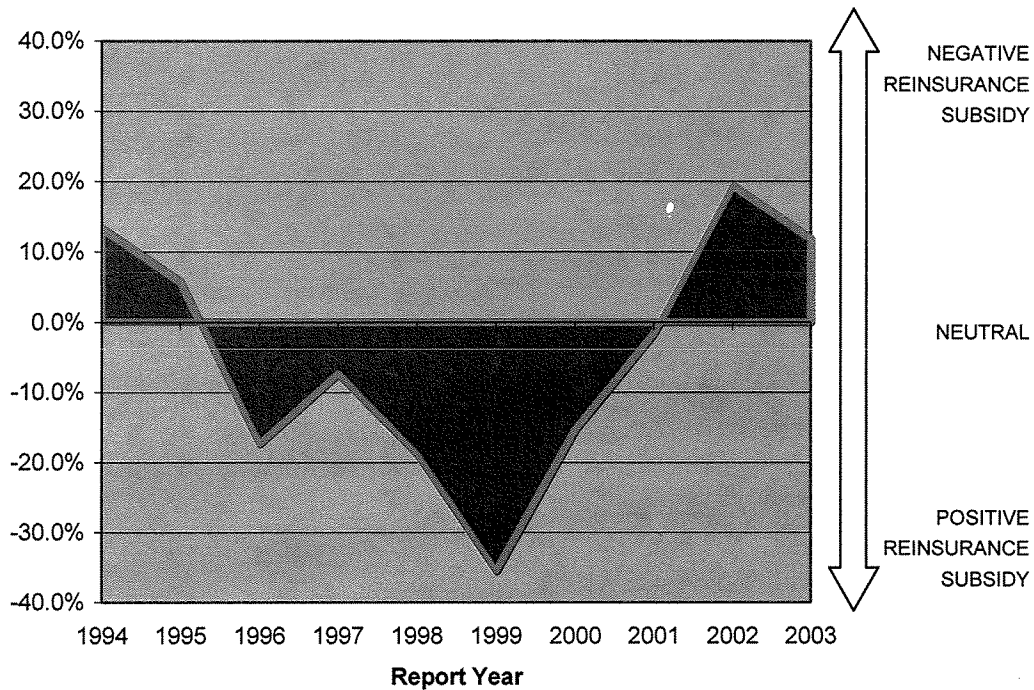
Table 15 and Table 16 display industry medical malpractice loss ratios and the amount of reinsurance subsidy.

TABLE 15				
CLAIMS-MADE				
REPORT YEAR	EARNED PREMIUM			D&A/ CEDED DIFF.
	DIRECT AND ASSUMED	CEDED	NET	
1994	90.4%	77.1%	95.2%	13.3%
1995	104.6%	98.9%	106.9%	5.7%
1996	114.4%	131.8%	108.4%	-17.4%
1997	119.3%	126.8%	116.7%	-7.4%
1998	133.5%	152.4%	127.6%	-18.9%
1999	136.2%	171.8%	125.7%	-35.6%
2000	143.6%	159.0%	138.0%	-15.4%
2001	132.0%	133.7%	131.4%	-1.7%
2002	100.7%	81.4%	109.8%	19.3%
2003	87.2%	75.4%	93.4%	11.8%

The reinsurance subsidy equals the direct and assumed loss ratio minus the ceded loss ratio. The subsidy level, combined with the level of reinsurance used by the industry, ultimately drives the final difference between direct and assumed loss ratios and net loss ratios that are recorded by the industry.

TABLE 16

CLAIMS-MADE REINSURER SUBSIDY LEVEL



As one can see from Table 16, the claims-made ceded incurred loss and expense ratios for report years 1996 through 2000 significantly exceeded the direct and assumed ratios, representing a positive reinsurance subsidy. Subsequent to 2001, the claims-made subsidy has switched from heavily positive to heavily negative. The change in subsidy level is driven by higher reinsurance rates (i.e., hard reinsurance market), stricter reinsurance terms & conditions, and the increase in primary company risk retention levels (e.g., doubling of most self-insured retention levels since year-end) forcing primary companies to retain more risk.

Table 17 displays industry medical malpractice incurred loss and defense cost containment (DCC) development on prior report years from Schedule P, Part 2F, Section 2 (claims-made).

TABLE 17

CLAIMS-MADE

DEVELOPMENT ON PRIOR YEARS - ADVERSE/(FAVORABLE)

REPORT YEAR	ONE YEAR	TWO YEAR	THREE YEAR	FOUR YEAR
PRIOR	(39,766)	(93,638)	(260,589)	(392,486)
1994	(9,981)	(38,945)	(50,581)	(108,583)
1995	858	(16,026)	(30,994)	(75,895)
1996	30,510	47,864	65,391	(37,552)
1997	9,473	44,607	113,664	111,786
1998	70,262	183,144	348,035	472,184
1999	96,684	155,644	445,157	1,660,222
2000	290,439	594,769	919,071	
2001	405,132	685,754		
2002	217,947			
	1,071,558	1,563,173	1,549,154	1,629,676

NOTE: LOSS & DCC

Report year 2002 and prior reserves developed adversely by \$1.07 billion in calendar year 2003. The majority of the adverse development was driven by report years 2000, 2001 and 2002. Over a four year period, one can see how report years 1998 and 1999 have increased significantly from their original report year estimates. This represents quite a change from report years 1996 and prior when reserves developed favorably over a four year period.

Table 18 displays a ten-year graph of the prior report year development in the current calendar year. Through calendar year 1999, medical malpractice insurers were able to use favorable development on prior report year reserves to help prop up the results of the current calendar year. Subsequent to 2000, development on prior report year reserves turned unfavorable (i.e., estimates were higher than originally thought), resulting in a negative impact on the current calendar year financials.

TABLE 18

CLAIMS-MADE

HISTORICAL PRIOR YEAR DEVELOPMENT - ADVERSE/(FAVORABLE)

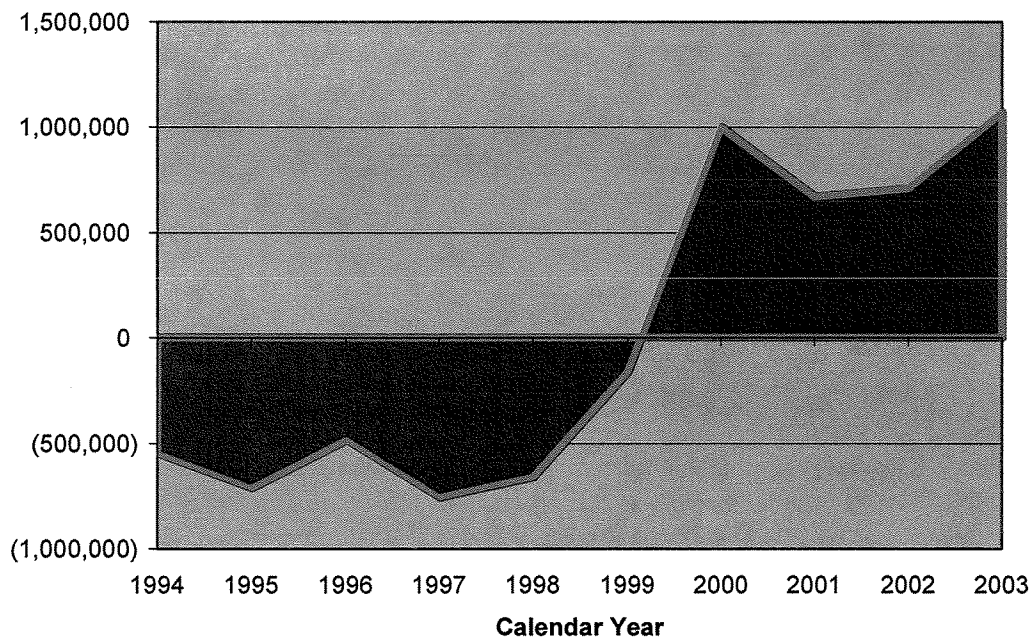


Table 19 displays the net calendar year contribution ratio (i.e., the ratio of the development on prior report year reserves to the net earned premium). Table 20 displays the difference between the report year and calendar year loss & DCC ratios. When the contribution ratio is favorable, the calendar year loss ratio is lower than the report year loss ratio. When the contribution ratio is unfavorable, the calendar year loss ratio is higher than the report year loss ratio.

TABLE 19

CLAIMS-MADE
NET CALENDAR YEAR CONTRIBUTION RATIO

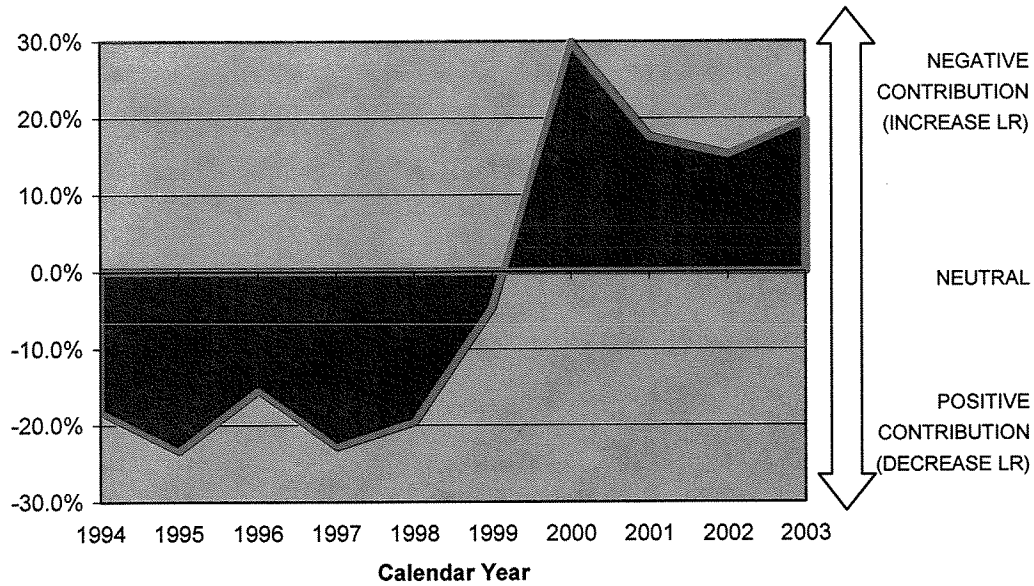
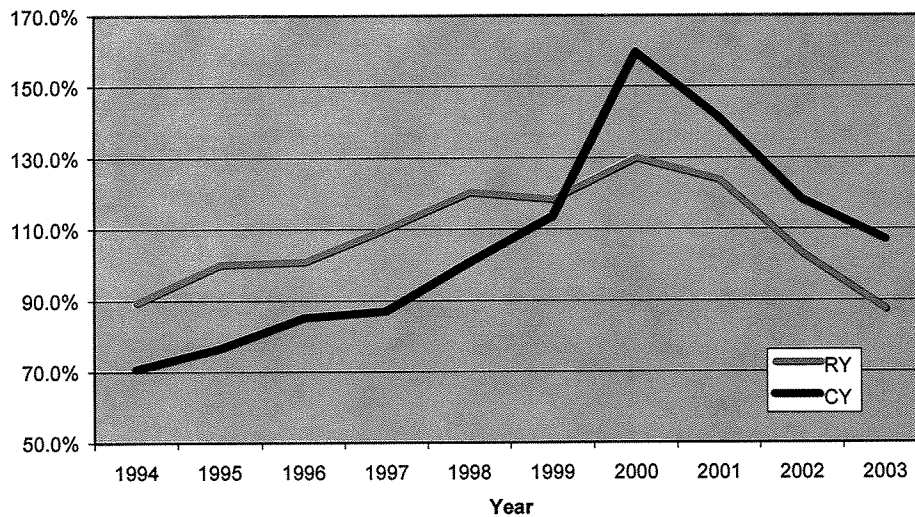


TABLE 20

CLAIMS-MADE
REPORT YEAR VERSUS CALENDAR YEAR LOSS & DCC RATIO



INDUSTRY SCHEDULE P OCCURRENCE RESULTS

Table 21 and Table 22 display total industry medical malpractice loss and premium information from Schedule P, Part 1F, Section 1 (occurrence).

TABLE 21				
OCCURRENCE				
ACCIDENT YEAR	INCURRED LOSS AND LAE			% CHANGE IN NET
	DIRECT AND ASSUMED	CEDED	NET	
1994	1,729,211	224,357	1,504,854	
1995	2,081,308	322,630	1,758,678	16.9%
1996	2,225,473	455,996	1,769,477	0.6%
1997	2,455,826	589,008	1,866,818	5.5%
1998	2,709,772	637,968	2,071,804	11.0%
1999	3,049,961	800,606	2,249,355	8.6%
2000	2,754,199	580,720	2,173,479	-3.4%
2001	2,760,488	528,561	2,231,927	2.7%
2002	2,778,507	409,228	2,369,279	6.2%
2003	3,009,995	503,205	2,506,790	5.8%

TABLE 22				
OCCURRENCE				
ACCIDENT YEAR	EARNED PREMIUM			% CHANGE IN NET
	DIRECT AND ASSUMED	CEDED	NET	
1994	1,619,845	286,573	1,333,272	
1995	1,770,961	350,076	1,420,885	6.6%
1996	1,756,672	381,255	1,375,417	-3.2%
1997	1,728,957	365,615	1,363,342	-0.9%
1998	1,748,676	350,219	1,398,457	2.6%
1999	1,862,050	417,062	1,444,988	3.3%
2000	2,254,380	422,354	1,832,026	26.8%
2001	2,259,943	553,742	1,706,201	-6.9%
2002	2,646,092	583,932	2,062,160	20.9%
2003	3,067,830	662,746	2,405,084	16.6%

Table 23 and Table 24 display total industry medical malpractice loss ratios and the amount of reinsurance subsidy.

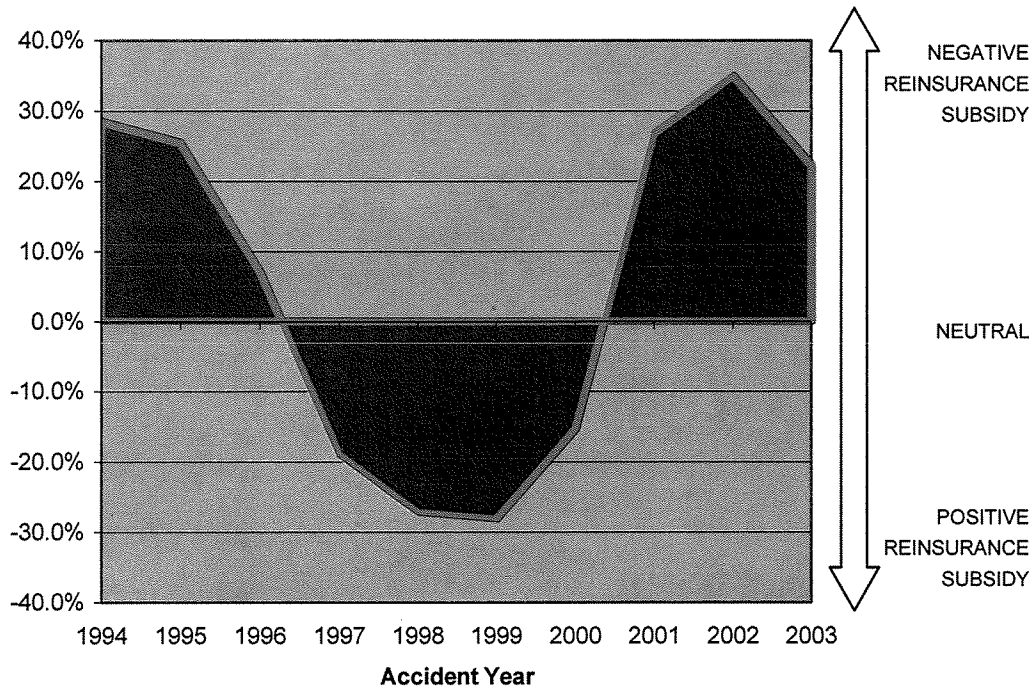
TABLE 23

ACCIDENT YEAR	OCCURRENCE			D&A/ CEDED DIFF.
	EARNED PREMIUM			
	DIRECT AND ASSUMED	CEDED	NET	
1994	106.8%	78.3%	112.9%	28.5%
1995	117.5%	92.2%	123.8%	25.4%
1996	126.7%	119.6%	128.7%	7.1%
1997	142.0%	161.1%	136.9%	-19.1%
1998	155.0%	182.2%	148.1%	-27.2%
1999	163.8%	192.0%	155.7%	-28.2%
2000	122.2%	137.5%	118.6%	-15.3%
2001	122.1%	95.5%	130.8%	26.7%
2002	105.0%	70.1%	114.9%	34.9%
2003	98.1%	75.9%	104.2%	22.2%

The reinsurance subsidy equals the direct and assumed loss ratio minus the ceded loss ratio. The subsidy level, combined with the level of reinsurance used by the industry, ultimately drives the final difference between direct and assumed loss ratios and net loss ratios that are recorded by the industry.

TABLE 24

OCCURRENCE REINSURER SUBSIDY LEVEL



As one can see from Table 24, the occurrence ceded incurred loss and expense ratios for accident years 1997 through 2000 significantly exceeded the direct and assumed ratios, representing a positive reinsurance subsidy. Subsequent to 2000, the occurrence subsidy has switched from heavily positive to heavily negative. The change in subsidy level is driven by higher reinsurance rates (i.e., hard reinsurance market), stricter reinsurance terms & conditions, and the increase in primary company risk retention levels (e.g., doubling of most self-insured retention levels since year-end) forcing primary companies to retain more risk.

Table 25 displays industry medical malpractice incurred loss and defense cost containment development on prior accident years from Schedule P, Part 2F, Section 1 (occurrence).

TABLE 25

OCCURRENCE

DEVELOPMENT ON PRIOR YEARS - ADVERSE/(FAVORABLE)

ACCIDENT YEAR	ONE YEAR	TWO YEAR	THREE YEAR	FOUR YEAR
PRIOR	3,562	(23,427)	11,510	(85,928)
1994	5,898	1,089	(15,494)	(49,368)
1995	13,688	7,653	(9,084)	(32,215)
1996	13,130	(24,257)	(45,975)	(4,085)
1997	(1,259)	(23,632)	(9,686)	89,710
1998	75,509	78,570	219,789	336,419
1999	157,697	239,099	416,636	467,417
2000	127,070	348,576	442,017	
2001	209,251	281,272		
2002	68,448			
	672,994	884,943	1,009,713	721,950

NOTE: LOSS & DCC

Accident year 2002 and prior reserves developed adversely by \$673 million in calendar year 2003. The majority of the adverse development was driven by accident years 1999, 2000 and 2001. Over a four year period, one can see how accident years 1998 and 1999 have increased significantly from their original accident year estimates. This represents quite a change from accident years 1996 and prior when reserves developed favorably over a four year period.

Table 26 displays a ten-year graph of the prior accident year development in the current calendar year. Through calendar year 1999, medical malpractice insurers were able to use favorable development on prior accident year reserves to help prop up the results of the current calendar year. Subsequent to 1999, development on prior accident year reserves turned unfavorable (i.e., estimates were higher than originally thought), resulting in a negative impact on the current calendar year financials.

TABLE 26

OCCURRENCE

HISTORICAL PRIOR YEAR DEVELOPMENT - ADVERSE/(FAVORABLE)

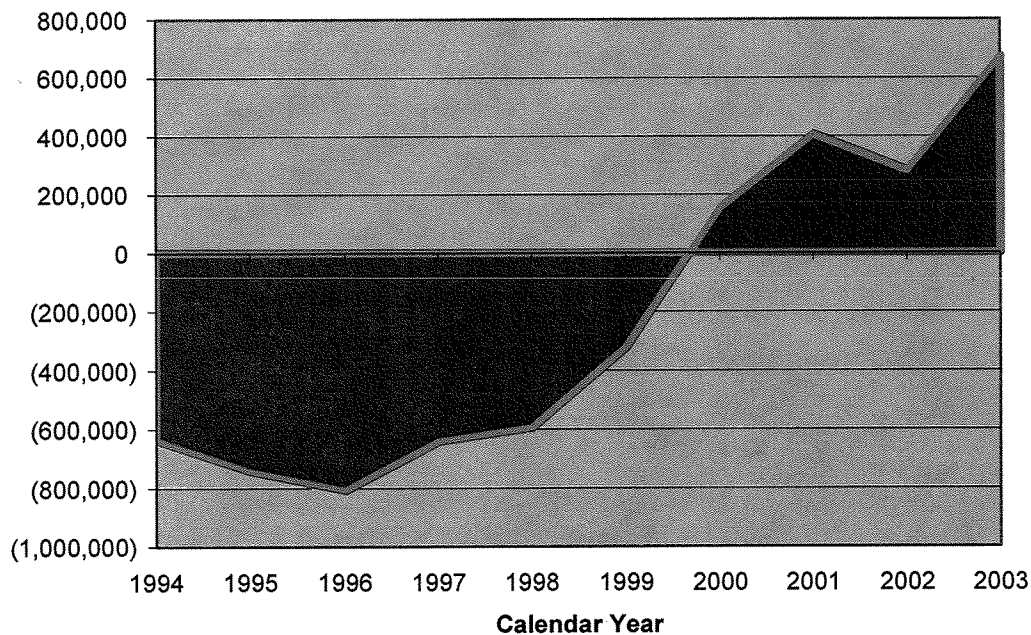


Table 27 displays the net calendar year contribution ratio (i.e., the ratio of the development on prior accident year reserves to the accident year net earned premium). Table 28 displays the difference between the accident year and calendar year loss & DCC ratios. When the contribution ratio is favorable, the calendar year loss ratio is lower than the accident year loss ratio. When the contribution ratio is unfavorable, the calendar year loss ratio is higher than the accident year loss ratio.

TABLE 27

OCCURRENCE
NET CALENDAR YEAR CONTRIBUTION RATIO

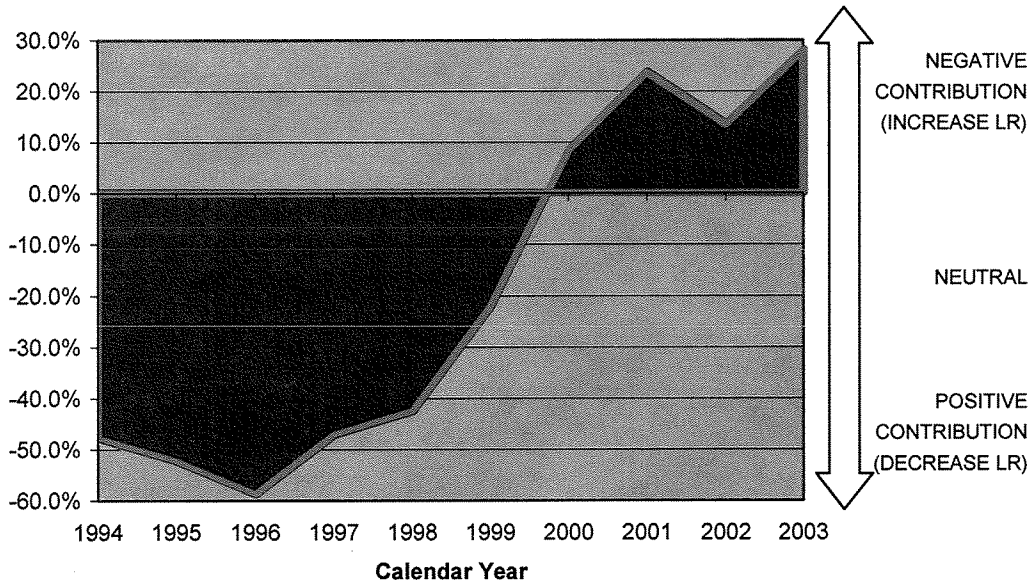
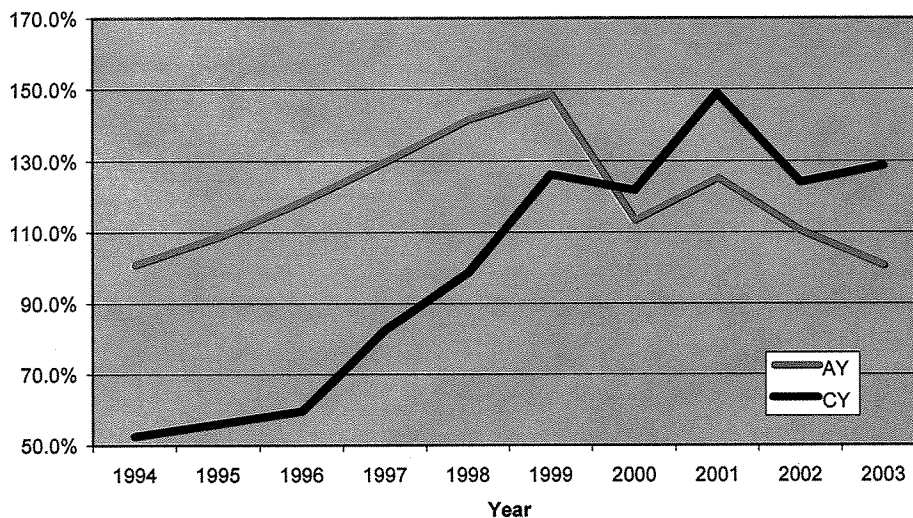


TABLE 28

OCCURRENCE
ACCIDENT YEAR VERSUS CALENDAR YEAR LOSS & DCC RATIO



STATE OF THE MEDICAL MALPRACTICE MARKET IN FLORIDA

For insurers representing over 80% of Florida's 2003 market share, using information from their December 31, 2003 Annual Statement filed with the Florida OIR, we will walk the reader through a number of key metrics illustrating the performance of these insurers through December 31, 2003. In addition, we will also discuss the performance of these insurers based upon their Statutory Accounting¹³ results through first quarter 2004.

Analysis of Financial Reports

Table F1 displays the market share of the eleven Florida writing companies we will analyze throughout the remainder of this report. The below companies represent over 80% of Florida's 2003 direct written premium and net written premium.

TABLE F1				
FLORIDA MEDICAL MALPRACTICE				
Writing Company Name	Deloitte Abbreviation	Direct Written Premium	% of Florida	Cumulative %
First Professionals Ins Co	FPIC	188,312,565	21.1%	21.1%
Health Care Ind Inc	HCII	115,509,472	13.0%	34.1%
Pronational Ins Co	PIC	77,102,502	8.7%	42.8%
Medical Protective Co	MPC	73,513,367	8.3%	51.0%
MAG Mut Ins Co	MMIC	70,481,160	7.9%	58.9%
Lexington Ins Co	LIC	63,560,018	7.1%	66.0%
Evanston Ins Co	EIC	37,956,032	4.3%	70.3%
Doctors Co An Interins Exchn	DCIE	29,992,132	3.4%	73.7%
Continental Cas Co	CCC	24,832,697	2.8%	76.5%
TIG Ins Co	TIC	20,134,711	2.3%	78.7%
Anesthesiologists Pro Assur Co	APAC	19,782,689	2.2%	80.9%
All Other Writing Companies		169,785,621	19.1%	100.0%
Total		890,962,966	100.0%	

¹³ Statutory accounting requirements are based on criteria established by the National Association of Insurance Commissioners in regard to the preparation of an insurer's financial statements required to be filed with a state insurance department. We note that our report does not include any discussion or metrics based on Generally Accepted Accounting Principles (GAAP), a widely accepted set of rules, standards, conventions and procedures for reporting financial information on public companies, as established by the Financial Accounting Standards Board.

Each company in Table F1 has its own unique strategy in writing medical malpractice business in the State of Florida. The following items illustrate the differences that may underlie the direct written premiums figures shown above:

Specialty Underwritten

Although the majority of written premium in the State of Florida covers physicians and surgeons, it is important to note that each company may target different types of specialties (e.g., chiropractors, emergency room, OB/GYN, neurosurgeon, etc.) or focus on the non-practitioner market (e.g., hospitals). For example, APAC focuses exclusively on insuring anesthesiologists. HCII¹⁴ focuses almost exclusively on insuring hospitals (i.e., does not target individual practitioners). Depending on each company's focus, the actual premium charged per policy will vary dramatically based upon the risk of the specialties targeted (e.g., chiropractor versus neurosurgeon), policy limits offered (e.g., \$250,000/\$750,000, \$1,000,000/\$3,000,000, etc.) and other discounts offered by the company (e.g., loss free credit, schedule credits/debits).

County Underwritten

The cost of insuring policyholders in some Florida counties is significantly higher than the cost in other counties. Depending on the area of the state where each company sells policies, the actual premium charged per policy will be directly impacted by the historical costs implied by the county (i.e., relative cost to other counties in the state).

¹⁴ HCII is a captive insurance company domiciled in the state of Colorado that provides professional liability insurance services for hospitals, ambulatory care centers and employed physicians that are affiliated with its ultimate parent, HCA Inc., and for hospitals affiliated with LifePoint Hospitals, Inc. and Triad Hospitals, Inc.

Policy Type Underwritten

Insurance policies may be issued on either an occurrence basis or a claims-made basis. A claims-made policy covers claims reported to the insurer during the contract period.¹⁵ An occurrence-basis policy provides coverage for insured events occurring during the contract period, regardless of the length of time that passes before the insurance company is notified of the claim. Physicians who purchase a first year, second year or even third year claims-made policy often pay significantly less premium than what it would cost to purchase an occurrence policy or a mature claims-made policy.

Although the majority of the written premium displayed in Table F1 is from claims made policies, we note that HCII writes primarily occurrence policies in the state of Florida.

Expenses

The cost of insuring policyholders varies by company depending upon its structure and how it approaches the insurance market (e.g., direct writer versus the use of agents). Commissions and brokerage, other acquisition expense and general expense can vary significantly by company. An illustration of the wide range of expense ratios underlying Florida rate filings will be discussed later in the **Rate Filing Trend Analysis** section of the report.

Admitted Company

An admitted company is an insurer granted permission (i.e., authorized) by Florida to sell specific lines of insurance within the state. While the procedure may vary from state to state, approval is usually granted when an insurer presents financial information demonstrating its financial stability. An admitted insurance company must make rate

¹⁵ Claims-made insurance policies contain "extended reporting" clauses or endorsements that provide for coverage, in specified circumstances (e.g., 5 years of coverage with the insurer before retirement), of claims occurring during the contract period but reported after the expiration of the policy. This coverage is often referred to as "free tail" or death, disability or retirement (DDR).

filings in accordance with Florida laws. All of the Table F1 companies are admitted insurers except for LIC and EIC.

Surplus Lines Company

According to Chapter 626, PART VIII (Surplus Lines Law) of the Florida Statutes, an "Eligible surplus lines insurer" means an unauthorized insurer which has been made eligible by the department to issue insurance coverage under the Surplus Lines Law. The Florida Surplus Lines Service Office defines Surplus Lines Insurance as:

"A risk or a part of a risk for which there is no market available through the original or producing agent in the standard or "admitted" market. Therefore, it is placed with non-admitted insurers, who are made eligible by the Florida Department of Financial Services to offer coverage in the State of Florida, in accordance with the surplus lines provisions of the state law¹⁶."

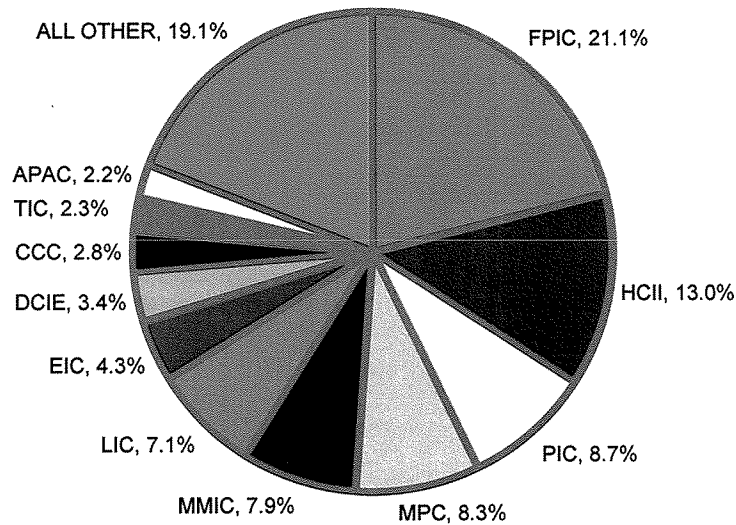
A surplus lines company is not required to make rate filings in the State of Florida. LIC and EIC are surplus lines insurers.

¹⁶ Please refer to the Florida Surplus Lines Service Office (www.fslso.com) for further information on Florida's surplus lines carriers and surplus lines Laws.

Table F2 graphically displays the 2003 market share of the top eleven writing companies¹⁷.

TABLE F2

2003 FLORIDA DIRECT WRITTEN PREMIUM



¹⁷ The Florida information comes from the Annual Statements and "Page 14" data provided by the insurance companies in response to our MLDR. In addition, when available, we pulled information from Sheshunoff Information Services (www.sheshunoff.com), Insurance Analyst: Property & Casualty Online Company Profiler Application.

Tables F3 and F4 display the 2003 direct written premium by line of business for all states.

TABLE F3

DIRECT WRITTEN PREMIUM (000's)
ALL LINES OF BUSINESS (LOB)

Companies	<i>Medical Malpractice (MM)</i>		<i>Workers</i>	
	Claims-Made	Occurrence	Compensation	All Other
FPIC	217,787	14,986	-	452
MPC	518,017	326,186	-	5,138
CCC	163,114	9,925	359,166	4,347,750
TIC	90,815	2,955	(3,292)	200,127
DCIE	325,046	49,672	-	3,937
HCII	2,332	377,439	-	27
APAC	32,589	1,599	30,852	-
PIC	151,416	25,388	-	8,605
MMIC	270,432	11,664	2,809	4,740
LIC	777,322	11,623	7,052	3,755,452
EIC	182,426	-	-	694,975

TABLE F4

DISTRIBUTION OF DIRECT WRITTEN PREMIUM (000's)
ALL LINES OF BUSINESS (LOB)

Companies	<i>Medical Malpractice (MM)</i>		<i>Workers</i>	
	Claims-Made	Occurrence	Compensation	All Other
FPIC	93%	6%	0%	0%
MPC	61%	38%	0%	1%
CCC	3%	0%	7%	89%
TIC	31%	1%	-1%	69%
DCIE	86%	13%	0%	1%
HCII	1%	99%	0%	0%
APAC	50%	2%	47%	0%
PIC	82%	14%	0%	5%
MMIC	93%	4%	1%	2%
LIC	17%	0%	0%	83%
EIC	21%	0%	0%	79%

Table F5 displays the direct written premium for the top five states including all lines of business.

TABLE F5

DIRECT WRITTEN PREMIUM - TOP 5 STATES (000's)
ALL LINES OF BUSINESS (LOB)

Companies	State 1	State 2	State 3	State 4	State 5	All Other
FPIC	188,580	17,685	10,888	7,632	5,003	3,437
MPC	143,052	107,248	74,856	73,513	35,126	415,546
CCC	477,192	386,089	337,352	287,015	210,403	3,181,905
TIC	55,228	32,753	32,401	22,130	16,874	131,218
DCIE	124,175	30,354	29,617	25,114	22,770	146,624
HCII	131,110	115,509	12,209	11,567	11,150	98,253
APAC	25,791	21,553	8,048	4,412	2,161	3,075
PIC	77,103	54,440	21,892	8,443	8,354	15,178
MMIC	150,627	72,823	45,079	8,991	8,968	3,158
LIC	715,637	439,090	381,189	334,334	230,861	2,450,339
EIC	208,469	79,594	78,625	48,636	41,318	420,761

Companies	Florida All LOBs	Florida MM	Florida MM %
FPIC	188,580	188,313	99.9%
MPC	73,513	73,513	100.0%
CCC	337,352	24,833	7.4%
TIC	32,401	20,135	62.1%
DCIE	30,354	29,992	98.8%
HCII	115,509	115,509	100.0%
APAC	21,553	19,783	91.8%
PIC	77,103	77,103	100.0%
MMIC	72,823	70,481	96.8%
LIC	381,189	63,560	16.7%
EIC	78,625	37,956	48.3%

As illustrated by the boxed figures, Florida falls in the top 4 market share for all eleven companies. At the bottom of the chart, one can see that the medical malpractice line of business represents a significant portion of the direct written premium for a majority of the companies except for Continental Casualty Company (i.e., CNA) and Lexington Insurance Company (i.e., AIG). These two companies are large national multiline carriers who do not focus exclusively on the medical malpractice line of business.

Table F6 displays the percentage of direct written premium for the top five states including all lines of business and the percentage of Florida medical malpractice premium to the company's total direct written premium.

TABLE F6						
DIRECT WRITTEN PREMIUM - TOP 5 STATES						
ALL LINES OF BUSINESS						
Companies	State 1	State 2	State 3	State 4	State 5	All Other
FPIC	81%	8%	5%	3%	2%	1%
MPC	17%	13%	9%	9%	4%	49%
CCC	10%	8%	7%	6%	4%	65%
TIC	19%	11%	11%	8%	6%	45%
DCIE	33%	8%	8%	7%	6%	39%
HCII	35%	30%	3%	3%	3%	26%
APAC	40%	33%	12%	7%	3%	5%
PIC	42%	29%	12%	5%	5%	8%
MMIC	52%	25%	16%	3%	3%	1%
LIC	16%	10%	8%	7%	5%	54%
EIC	24%	9%	9%	6%	5%	48%

Companies	Florida All LOBs	Florida MM %	MM % of DWP
FPIC	81%	81%	100%
MPC	9%	9%	100%
CCC	7%	1%	7%
TIC	11%	7%	62%
DCIE	8%	8%	99%
HCII	30%	30%	100%
APAC	33%	30%	92%
PIC	42%	42%	100%
MMIC	25%	24%	97%
LIC	8%	1%	17%
EIC	9%	4%	48%

As one can see from the bottom of the chart, FPIC is the most heavily focused Florida writer with 81% of its medical malpractice business being written in the state of Florida. Pronational Insurance Company is second with 42% of its medical malpractice business being written in the state of Florida.

Although we will provide financial information on CNA and AIG throughout the remainder of this report, we will focus most of our discussion on those insurers whose emphasis is more heavily weighted toward medical malpractice.

Table F7 displays the direct, assumed and ceded written premiums by insurance company. The following definitions apply in the table:

- Direct written premium (DWP) – The dollar amount charged when a policyholder contracts for insurance coverage before reinsurance has been ceded and/or assumed (e.g., OB/GYN purchases a claims made policy from a Florida insurance company).
- Assumed written premium (AWP) - Premiums accepted by an insurance company in exchange for accepting all or part of insurance on a risk or exposure (e.g., Florida insurance company insures another Florida insurance company)
- Gross written premium (GWP) = DWP + AWP
- Ceded written premium (CWP) - Premiums paid to an assuming company in exchange for that company accepting all or part of insurance on a risk or exposure (i.e., Florida insurance company purchases reinsurance).
- Net written premium (NWP) = GWP – CWP = DWP + AWP - CWP
- % Ceded = CWP / GWP

TABLE F7

2003 NET WRITTEN PREMIUM MEDICAL MALPRACTICE, ALL STATES						
Companies	Occurrence					
	Direct	Assumed	Gross	Ceded	Net	% Ceded
FPIC	14,986	12,728	27,713	15,343	12,370	55.4%
MPC	326,186	-	326,186	45,111	281,075	13.8%
CCC	9,925	95,444	105,369	46,213	59,156	43.9%
TIC	2,955	250	3,205	768	2,436	24.0%
DCIE	49,672	-	49,672	9,515	40,157	19.2%
HCII	377,439	442	377,880	9,497	368,384	2.5%
APAC	1,599	2,245	3,844	1,404	2,440	36.5%
PIC	25,388	77	25,465	353	25,112	1.4%
MMIC	11,664	-	11,664	1,677	9,987	14.4%
LIC	11,623	-	11,623	2,445	9,179	21.0%
EIC	-	-	-	-	-	-
TOTAL	831,437	111,185	942,622	132,327	810,295	14.0%

Companies	Claims-Made					
	Direct	Assumed	Gross	Ceded	Net	% Ceded
FPIC	217,787	41,086	258,873	168,108	90,765	64.9%
MPC	518,017	-	518,017	89,148	428,869	17.2%
CCC	163,114	159,729	322,843	136,880	185,964	42.4%
TIC	90,815	35,683	126,498	105,920	20,578	83.7%
DCIE	325,046	51,839	376,886	89,282	287,603	23.7%
HCII	2,332	6,257	8,589	-	8,589	0.0%
APAC	32,589	16,473	49,062	32,784	16,278	66.8%
PIC	151,416	18,086	169,502	7,332	162,170	4.3%
MMIC	270,432	-	270,432	126,258	144,174	46.7%
LIC	777,322	15,498	792,820	359,276	433,544	45.3%
EIC	182,426	21,790	204,216	66,927	137,289	32.8%
TOTAL	2,731,296	366,442	3,097,738	1,181,914	1,915,824	38.2%
TOTAL MM	3,562,732	477,627	4,040,359	1,314,241	2,726,119	32.5%

The percentage ceded by writing company varies dramatically, ranging from the low single digits to as high as almost 84%. The percentage ceded would vary by company depending upon the reinsurance attachment point selected, the type of protection purchased (e.g., per claimant excess of loss, catastrophic per incident excess of loss, quota share), company leverage ratios, risk based capital considerations, and the historical penetration of losses into the reinsurance layers.

We note that for many of Florida's insurers falling outside the top 80%, it is likely that the percentage ceded would be higher than the 32.5% average displayed above. This would be driven

by the lower surplus levels of smaller companies and their inability to absorb individual shock losses or heavier than expected attritional losses.

Table F8 displays the net liability to surplus ratio for each company.

TABLE F8					
BALANCE SHEET					
NET LIABILITY TO SURPLUS RATIO					
Companies	Q1 04	2003	2002	2001	2000
FPIC	1.56	1.78	1.71	1.90	1.89
MPC	2.71	2.77	2.35	1.82	1.96
CCC	2.52	2.69	2.38	2.14	1.78
TIC	1.38	1.60	1.38	1.36	1.22
DCIE	2.07	2.04	1.82	1.36	1.27
HCII	2.24	2.23	2.61	2.00	2.08
APAC	2.56	2.56	2.37	1.77	1.29
PIC	2.97	3.10	2.59	2.72	1.72
MMIC	1.68	1.69	2.04	1.59	1.55
LIC	1.41	1.37	0.91	0.59	0.55
EIC	1.83	1.88	2.02	2.06	2.32

The above statistics, which include all lines of business, compare to a medical malpractice composite industry NLSR of approximately 2.9 (see Table 10).

Based on the distribution of direct written premium displayed in Table 4, the companies that focus almost exclusively on medical malpractice (i.e., FPIC, MPC, DCIE, HCII, APAC, PIC and MMIC) appear to be well below the industry composite. Only PIC is slightly above the industry composite.

TABLE F9

**BALANCE SHEET
NWP TO SURPLUS RATIO**

Companies	2003	2002	2001	2000
FPIC	0.87	0.85	1.08	1.39
MPC	1.61	1.34	0.85	0.72
CCC	1.22	1.38	0.73	0.76
TIC	0.18	0.64	1.04	0.92
DCIE	0.96	1.16	0.74	0.57
HCII	0.60	0.66	0.45	0.36
APAC	1.25	1.37	1.30	1.43
PIC	1.03	0.76	0.75	0.44
MMIC	0.90	1.01	0.72	0.56
LIC	1.33	1.05	0.55	0.33
EIC	1.53	1.81	1.58	1.57

The above statistics, which include all lines of business, compare to a medical malpractice composite industry NPSR of approximately 0.9 (see Table 10).

Based on the distribution of direct written premium displayed in Table 4, the companies that focus almost exclusively on medical malpractice (i.e., FPIC, MPC, DCIE, HCII, APAC, PIC and MMIC) appear to be consistent with the industry composite. Only MPC's NPSR significantly exceeds the industry ratio. MPC's high ratio is largely driven by the size of the rate increases MPC has filed across the country over the past few years. APAC has a higher leverage ratio of 1.25, likely driven by the 47% share of direct written premium from workers compensation and primary focus on anesthesiologists.

CCC, TIC, LIC and EIC NLSR and NPSR ratios are impacted by the fact that 69% or more of their business is written in non-medical malpractice lines of business (e.g., workers compensation, personal lines, general liability, etc.).

Profitability Analysis

Table F10 displays each Company's after tax net income for the 2003 calendar year, first quarter 2004, and the ratio to earned premium¹⁸. Through first quarter 2004, the companies appear to be on track for operating ratios less than 100%¹⁹ after reflecting the impact of items such as rate increases (impacts the premiums earned), reserve strengthening (impacts the losses and LAE incurred), changes in policyholder dividend strategies (impacts dividends to policyholders), and changes in investment strategy (impacts net investment income earned on bonds and realized capital gains on stocks sold throughout the year).

Focusing on companies with a heavy percentage of Florida medical malpractice exposure (e.g., FPIC, PIC and HCII), the operating ratios are all under 100%. The favorable first quarter 2004 operating ratios may indicate that these Florida companies will continue to be profitable through year-end 2004, helping to stabilize the need for future rate changes in the State of Florida. In a perfect world (i.e., medical malpractice rates are currently set at adequate levels and prior year reserve estimates are perfect), companies would only have to keep up with loss severity trends, frequency trends, changing expenses associated with running the company, and changing investment returns²⁰ in future rate filings.

¹⁸ Other areas of the report display the ratio of underwriting expenses to written premiums.

¹⁹ Excluding CCC which was impacted by significant reserve strengthening not related to the medical malpractice line of business.

²⁰ For example, rising interest rates would produce higher investment income as the average portfolio yield increases over time. A rising portfolio yield would allow insurers to reflect higher investment income credit in the ratemaking process, resulting in lower rate indications.

Deloitte Consulting regularly attends the quarterly and year-end earnings calls of the major publicly traded medical malpractice insurers listed on the New York Stock and NASDAQ Exchanges. During recent earnings calls, the management of most companies publicly stated that their companies are actively targeting a combined ratio of 100% or less. Assuming net investment income and other income equal roughly 10% to 15% of earned premium, this would imply a target operating ratio ranging from 85% to 90% before taxes (assuming no adverse prior year reserve development). If a combined ratio of 95% is assumed, this would imply a target operating ratio ranging from 80 to 85%.

Section 627.912(6), Florida Statutes, as amended by Senate Bill 2-D, (Ch. 2003-416)

TABLE F10

INCOME STATEMENT
2003 PROFITABILITY (000s)

INCOME STATEMENT ITEM	FPIC	MPC	CCC	TIC	DCIE	HCII	APAC	PIC	MMIC	LIC	EIC
PREMIUMS EARNED	95,142	701,752	5,929,490	315,425	331,287	374,738	17,267	178,973	131,483	2,385,046	651,794
LOSSES INCURRED	53,115	441,910	4,965,060	211,183	229,974	334,028	10,538	90,979	81,324	1,661,428	325,752
LAE INCURRED	34,587	182,395	1,979,394	202,273	133,062	82,840	5,052	93,724	49,103	296,240	90,687
U/W EXPENSE INCURRED	15,797	110,221	2,132,375	124,359	56,088	4,948	3,201	28,725	26,760	266,800	192,052
OTHER DEDUCTIONS	0	0	128,411	0	0	0	0	0	0	0	0
DIVIDENDS TO POLICYHOLDERS	0	0	68,342	19	0	0	0	0	0	0	0
NET U/W INCOME	(8,357)	(32,774)	(3,344,091)	(222,409)	(87,836)	(47,078)	(1,525)	(34,455)	(25,705)	160,579	43,304
NET INVESTMENT INCOME	8,883	62,878	1,526,515	51,777	32,913	54,643	1,695	28,351	20,350	289,563	51,560
OTHER INCOME/(EXPENSE)	127	4,175	(415,508)	13,575	3	487	8	433	1,803	(817)	3
PRETAX OPERATING INCOME	652	34,279	(2,233,084)	(157,057)	(54,920)	8,052	179	(5,670)	(3,552)	449,324	94,866
REALIZED CAPITAL GAINS (CG)	4,693	29,555	(8,931)	143,810	(4,168)	(2,058)	1,234	828	4,575	61,179	20,358
INCOME TAXES INCURRED (TAX)	2,821	17,824	(678,863)	374	(9,022)	(5,549)	381	4,128	1,003	209,735	45,589
NET INCOME	2,524	46,010	(1,563,151)	(13,621)	(50,066)	11,543	1,032	(8,971)	21	300,768	69,635
L&LAE RATIO	92.2%	89.0%	117.1%	131.1%	109.6%	111.2%	90.3%	103.2%	99.2%	92.1%	63.9%
EXPENSE RATIO	16.6%	15.7%	38.1%	39.4%	16.9%	1.3%	18.5%	16.0%	20.4%	11.2%	29.5%
DIVIDEND RATIO	0.0%	0.0%	1.2%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
COMBINED RATIO	108.8%	104.7%	156.4%	170.5%	126.5%	112.6%	108.8%	119.3%	119.5%	93.3%	93.4%
NI/LAN OTHER INCOME RATIO	9.5%	9.6%	18.7%	20.7%	9.9%	14.7%	9.9%	16.1%	16.8%	12.1%	7.9%
OPERATING RATIO (BEFORE TAX & CG)	99.3%	95.1%	137.7%	149.8%	116.6%	97.9%	99.0%	103.2%	102.7%	81.2%	85.4%
TAX & CG RATIO	-2.0%	-1.7%	-11.3%	-45.5%	-1.5%	-0.9%	-4.9%	1.8%	-2.7%	6.2%	3.9%
OPERATING RATIO (AFTER TAX & CG)	97.3%	93.4%	126.4%	104.3%	115.1%	96.9%	94.0%	105.0%	100.0%	87.4%	89.3%

FIRST QUARTER 2004

PREMIUMS EARNED	27,024	147,396	1,682,056	31,602	109,953	92,512	4,395	44,724	35,539	750,381	174,928
NET INCOME	3,923	23,432	123,463	(146,989)	6,932	10,292	(231)	741	816	98,026	26,398
OPERATING RATIO (AFTER TAX & CG)	85.5%	84.1%	92.7%	565.2%	93.7%	88.9%	105.3%	98.3%	97.7%	86.9%	84.9%

Table F11 displays each Company's after tax net income and ROS for the past four years.

INCOME STATEMENT
PROFITABILITY (000s)

Restated Net Income (i.e., adding back 65% of ARD to NI)

Profitability can be extremely volatile from year to year as observed in Table 11. FPIC, which writes 81% of its medical malpractice book of business in Florida, had negative net income in 2000 and 2001. In 2002 and 2003, FPIC produced positive net income large enough to just offset the negative net income from the 2000 and 2001 years. Through first quarter 2004, FPIC continues to produce positive net income (see Table F10). HCII's negative net income in 2002 was driven by \$122 million of net investment losses partially offset by favorable development of \$22 million on prior accident years. DCIE's negative net income in 2003 was largely driven by adverse development on prior accident years of \$78 million.

The 2003 return on average surplus varies from a low of -14.0% to a high of 9.0%. The 2002 ROS varies from a low of -10.1% to a high of 17.0%. In all calendar years, the impact of items such as gains/(losses) on investment income and adverse development on prior accident years can significantly impact the ROS.

The ROS for the medical malpractice focused companies was 0.1% in 2003, -4.7% in 2002, 3.6% in 2001 and 6.1% in 2000 (see Table F11). These single digit returns hardly represent figures that would be indicative of excess profits in an industry where a target ROS of 15% is required to attract investor capital. Adjusting the net income and ROS figures to remove the impact of adverse/(favorable) reserve development on prior accident years²¹, the medical malpractice focused companies produced an adjusted ROS of 2.3% in 2003, -1.2% in 2002, 2.3% in 2001 and 2.5% in 2000. Even with the benefit of removing the adverse development in the 2003 and 2002 years, the ROS continues to be in the low single digits and well below the levels necessary to indicate excess profit levels.

²¹ In order to reduce the volatility in the actual net income and ROS figures, we have restated the ROS to remove the impact of the adverse/(favorable) prior year reserve development. Net income is restated by adding 65% of the adverse/(favorable) development back into net income. The 65% adjustment equals 100% minus an assumed 35% tax rate. We have not attempted to restate surplus in this simplistic example.

Table F12 displays the adverse/(favorable) development²² by year and by company:

TABLE F12					
ADVERSE/(FAVORABLE) RESERVE DEVELOPMENT (000's)					
ALL LINES OF BUSINESS					
	2003	2002	2001	2000	1999
FPIC	1,948	1,404	10,191	4,717	(16,387)
MPC	43,272	95,720	(45,978)	(77,899)	(41,636)
CCC	2,331,312	(167,170)	1,420,178	92,078	423,187
TIC	(345)	97,359	97,219	266,089	181,340
DCIE	78,109	105,014	1,762	(47,531)	(17,359)
HCII	(10,241)	(22,247)	(44,044)	(63,461)	(58,816)
APAC	68	605	243	(1,085)	(3,600)
PIC	65	(10,118)	25,318	(161)	(21,086)
MMIC	14,061	20,930	(19,132)	(9,292)	(1,627)
LIC	148,347	159,140	64,265	24,754	(6,208)
EIC	4,020	5,337	(10,042)	(31,840)	(18,450)
ALL COS	2,610,616	285,974	1,499,980	156,369	419,358
MM FOCUS	127,282	191,308	(71,640)	(194,712)	(160,511)

As one can see above, the medical malpractice focused companies (i.e., FPIC, MPC, DCIE, HCII, APAC, PIC and MMIC) all experienced favorable development through 2001, positively impacting the net income and ROS figures. The favorable development lasted one year longer than the industry results displayed in Table 18 and Table 26 which turned unfavorable in 2000. In 2002, development on prior accident years turned adverse, negatively impacting the calendar year net income and ROS figures.

In discussing profitability, it is important to remember that the medical malpractice line of business has a very long "tail". As will be discussed in the **Analysis of Closed Claim Database** section of this report, Florida medical malpractice claims take approximately three and a half years on average from the date of occurrence to the date of closing. In addition, approximately 1.4% of the claims in the Closed Claim Database take 9 or more years from the date of occurrence to the

²² Adverse development implies prior year estimates have increased. Favorable development implies prior year estimates have decreased.

date of closing. Given Florida's medical malpractice "tail" and the challenges associated with correctly determining premium rates companies must to charge today for claims where the ultimate cost may not be known for 9 or more years, it is important for readers of financial statements to focus on insurance company results over a multi-year period. Table F13 displays the composite profitability over the full four year period (i.e., 2000 through 2003).

TABLE F13					
COMPOSITE PROFITABILITY (000s)					
ALL LINES OF BUSINESS					
	NET INCOME	ROS	ADV/(FAV) DEV.	ADJ. NI	ADJ. ROS
FPIC	70	0.0%	18,260	11,939	2.9%
MPC	186,834	11.5%	15,115	196,659	12.1%
CCC	195,393	0.9%	3,676,398	2,585,052	11.6%
TIC	(425,980)	-10.3%	460,322	(126,771)	-3.1%
DCIE	(79,386)	-5.4%	137,354	9,894	0.7%
HCII	99,582	4.5%	(139,993)	8,587	0.4%
APAC	(618)	-1.0%	(169)	(728)	-1.2%
PIC	(27,560)	-3.4%	15,104	(17,742)	-2.2%
MMIC	3,628	0.6%	6,567	7,897	1.3%
LIC	674,326	9.3%	396,506	932,055	12.8%
EIC	130,766	11.2%	(32,525)	109,624	9.4%
ALL COS	757,056	1.8%	4,552,939	3,716,467	8.8%
MM FOCUS	182,551	2.5%	52,238	216,506	3.0%

Over the four year period, the medical malpractice focused companies produced an average ROS of 2.5%, or an adjusted ROS of 3.0% after removing the impact of the \$52.2 million in cumulative adverse development. From either perspective, the average ROS continues to be in the low single digits and well below levels which would indicate excessive profits.

As we noted in the beginning of this report, the medical malpractice market is going through its third crisis in the past three decades. It is also important to note that a number of Florida's current medical malpractice writers have been in business for only a relatively short time period and it is not possible to know how the companies would have performed during past historical cycles. Given the long "tail" nature of the medical malpractice market, the strong likelihood of future cycles, and the historically volatile results of the top Florida insurers, it is reasonable to focus on financial results over a time period roughly equal to the average historical medical malpractice cycle (e.g., cycle ranging from seven to nine years). Analysis of profit and ratemaking decisions made based upon a few quarters' profits without considering the cumulative results over the average cycle would not portray the economic realities of the medical malpractice business.

A long term focus by legislators, regulators, investors, actuaries, and healthcare providers is needed to help ensure that medical malpractice insurers will be able to build their surplus in a period of rising prices like Florida has been experiencing since 2001. The build up of surplus also allows Florida's insurers to withstand the pressures of a softer pricing environment and adverse reserve development which have an adverse impact on surplus. In situations where companies cannot replenish or build surplus, those who are weakly capitalized may find it more difficult to fulfill their obligations to policyholders. These companies may ultimately shift the burden of paying claims to the State Guaranty Fund (and other solvent insurers) or back to Florida healthcare providers when claim payments exceeded the \$300,000 Guaranty Fund maximum if companies were to become insolvent. For physicians and hospitals insured by risk retention groups, the inability to replenish or build up surplus is more severe since risk retention groups are not backed by the State Guaranty Fund, exposing healthcare providers to higher loss payments in the event of insolvency.

Adequate premium rates, solid leverage ratios and strong capitalization allows Florida's medical malpractice insurers to maintain their investment grade ratings from various rating agencies²³ and

²³ Examples include A.M. Best, Moody's, Standard & Poor's, Duff & Phelps

helps them to satisfy their Risk Based Capital requirements²⁴. Furthermore, the previous factors increase the probability that healthcare providers will be able to purchase sound and stable coverage with a much lower chance of having their insurer exit the market or potentially become insolvent.

Although net income and ROS is interesting from a profitability perspective, the trend in schedule P loss ratios and the trend in assumptions underlying each company's rate filing (see **Rate Filing Trend Analysis**) presents the most relevant picture of the direction that future rates will take for healthcare providers practicing in the State of Florida, since profit is primarily driven by the accident and report year loss ratio trends. These trends will be discussed below.

²⁴ Risk Based Capital (RBC) standards for the Property/Casualty insurance industry were developed by the National Association of Insurance Commissioners (NAIC). The NAIC RBC formula looks at five different risk charges; R_0 - investment in insurance affiliates, R_1 - fixed income securities, R_2 - equity investments, R_3 - credit risk, R_4 - reserving risk, and R_5 - written premium risk in order to derive the total capital requirements (TCR) and authorized control level (ACL) for a company. The $TCR = R_0 + (R_1^2 + R_2^2 + R_3^2 + R_4^2 + R_5^2)^{0.5}$ and the $ACL = 50\% \times TCR$. Depending upon the ratio of the insurers total adjusted capital to ACL, the following four levels of action are determined: Company Action Level at $2 \times ACL$ (i.e., RBC ratio of 200%), Regulatory Action Level at $1.5 \times ACL$, Authorized Control Level at $1.0 \times ACL$ and Mandatory Control Level at $0.7 \times ACL$.

Loss Ratio Analysis

Appendix A – Medical Malpractice Financial Metrics by Writing Company displays a five year recap of the calendar year loss ratios, loss adjustment expense ratios, expense ratios and combined ratios for all lines of business. In addition, **Appendix A** also displays the Schedule P one-year and two-year development on prior accident years for the 2003 and 2002 calendar years for all lines of business. The one-year development helps to explain any unusual movement in the calendar year loss ratios that result from changes in prior year reserve estimates (see Table F12 above).

For example, FPIC's 2002 and prior year reserve estimates developed unfavorably by \$1.9 million or 1.8% of the prior year-end surplus over the past year. Excluding other lines of business, FPIC's medical malpractice estimate developed unfavorably by just under \$1 million. APAC's and PIC's 2002 and prior year reserve estimates were essentially unchanged over the past year. MPC's 2002 and prior year reserve estimates developed unfavorably by \$43.3 million or 10.8% over the past year. Excluding other lines of business, MPC's medical malpractice estimate developed unfavorably by approximately \$42.1 million. HCII's 2002 and prior year reserve estimates developed favorably by \$10.2 million or 2.1% over the past year.

CCC, a large national multiline carrier, experienced significant prior year adverse development of \$2.3 billion or 45.6% of the prior year-end surplus over the past year. Of this \$2.3 billion, only \$16.2 million was from medical malpractice occurrence development. \$85.6 million was from claims-made development. Total medical malpractice development explained less than 4.5% of CCC's 2002 and prior year reserve development.

In order to review the trend in loss ratios without the impact of changes in prior year reserve estimates that can distort calendar year ratios, Deloitte Consulting has prepared Table F14 (claims-made) and Table F15 (occurrence) using report year and accident year data from Schedule P – Part 1.

Section 627.912(6), Florida Statutes, as amended by Senate Bill 2-D, (Ch. 2003-416)

Table F14 displays medical malpractice claims-made direct and assumed loss and LAE ratios and net loss and LAE ratios by company and year.

TABLE F14											
CLAIMS-MADE MEDICAL MALPRACTICE											
DIRECT + ASSUMED LOSS AND LAE RATIO'S											
REPORT YEAR	APAC	CCC	DCIE	EIC	FPIC	HCII	LIC	MMIC	MPC	PIC	TIC
1994	31.6	104.4	103.2	53.4	86.1		88.9	79.6	119.5	102.1	0.0
1995	101.0	129.9	88.3	78.5	109.3		132.9	67.9	116.1	97.9	7.0
1996	86.4	131.8	102.6	65.2	75.8		141.1	96.1	111.6	101.3	0.0
1997	131.4	141.1	88.7	63.4	122.9		180.0	107.4	120.6	118.1	85.4
1998	68.5	145.9	103.2	87.9	101.2		168.7	150.7	154.3	114.3	97.2
1999	102.4	152.9	74.6	110.1	103.4		362.8	162.3	157.8	130.0	144.9
2000	156.3	182.8	154.0	86.2	112.1		133.6	162.2	132.5	143.5	149.3
2001	133.3	165.3	114.6	67.8	89.3		85.2	172.5	113.9	117.6	168.1
2002	98.4	99.1	79.7	59.9	79.4	159.7	74.6	117.6	91.8	106.8	120.3
2003	106.9	74.5	82.3	60.8	80.0	103.5	75.3	94.6	83.4	94.8	82.9
NET LOSS AND LAE RATIOS											
REPORT YEAR	APAC	CCC	DCIE	EIC	FPIC	HCII	LIC	MMIC	MPC	PIC	TIC
1994	49.6	107.3	105.8	52.6	82.6		158.4	84.7	124.7	103.7	0.0
1995	102.2	129.9	90.6	79.7	102.3		206.6	82.3	129.5	99.3	20.2
1996	90.6	128.0	103.3	67.8	80.1		119.4	93.3	121.7	99.5	0.0
1997	81.0	137.7	91.2	64.9	120.0		279.9	96.0	130.1	118.3	121.8
1998	95.2	153.7	101.7	88.3	108.4		144.3	114.3	143.4	116.6	127.2
1999	101.4	141.7	75.4	107.9	96.6		452.3	114.6	153.0	123.3	137.3
2000	121.7	185.4	112.1	89.2	118.6		166.0	119.4	129.6	143.8	148.1
2001	96.8	267.3	120.0	72.6	95.0		97.8	144.4	118.4	114.8	164.0
2002	89.3	127.5	81.3	62.1	88.9	159.7	83.5	104.0	90.7	101.0	125.1
2003	93.0	74.5	89.8	61.8	93.2	103.5	86.0	86.1	86.9	96.0	86.1

On a direct + assumed and net basis, the numbers have been improving since the 2000 report year. This favorable trend is consistent with the rate increases filed by medical malpractice insurers over the past few years across the country. Focusing on the 2003 report year, all but one company has a net loss and LAE ratio under the 100% level. This is a significant improvement from the 2000 report year when only one company had a loss and LAE loss ratio under the 100% level.

Adjusting for each company's expense ratio (e.g., industry average of 16%), net investment income and other income ratio (e.g., industry average of 16%), and tax position; the current loss and LAE ratio trends and 2003 results should help to ensure that medical malpractice insurers continue to offer stable and financially sound protection to healthcare providers across the country.

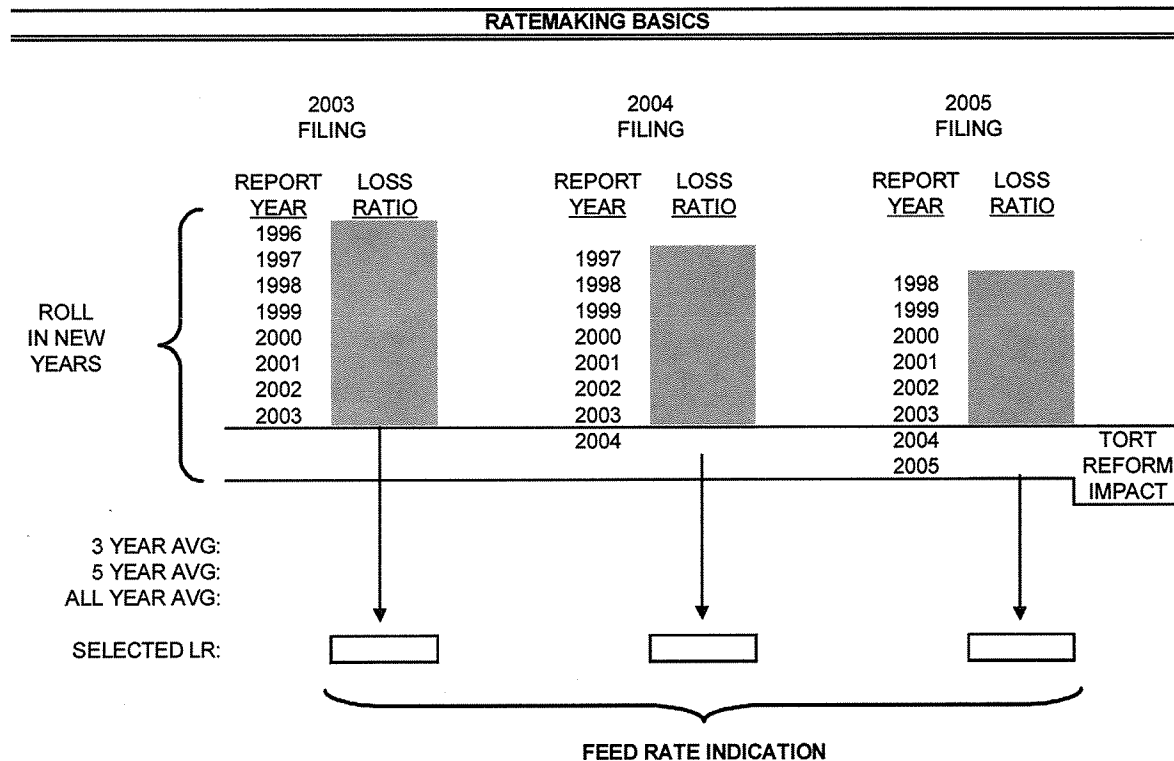
Section 627.912(6), Florida Statutes, as amended by Senate Bill 2-D, (Ch. 2003-416)

Table F15 displays medical malpractice occurrence direct and assumed loss and LAE ratios and net loss and LAE ratios by company and year.

TABLE F15											
OCCURRENCE MEDICAL MALPRACTICE											
DIRECT + ASSUMED LOSS AND LAE RATIO'S											
ACCIDENT YEAR	APAC	CCC	DCIE	EIC	FPIC	HCII	LIC	MMIC	MPC	PIC	TIC
1994		81.0	256.1			69.3		75.6	94.3	119.0	34.3
1995		56.7	214.9			90.7		70.9	93.9	105.0	42.2
1996		122.7	188.2			113.3		105.5	100.7	91.3	94.5
1997		77.7	216.3	0.0		124.3		82.5	102.9	107.3	97.9
1998	556.8	57.7	283.2	39.2	168.7	134.5		31.4	95.4	150.8	95.3
1999	104.2	59.4	62.8	0.0	79.1	148.0		61.9	103.9	221.7	171.2
2000	35.3	58.7	42.6		37.1	149.9		160.5	110.8	183.2	231.2
2001	69.9	44.1	119.6		93.7	122.0		129.9	92.9	149.2	138.9
2002	57.1	44.5	81.5		80.2	108.6		105.0	81.2	155.6	135.0
2003	57.5	48.0	60.2		89.0	111.6	98.4	64.1	81.0	128.0	116.0
NET LOSS AND LAE RATIOS											
ACCIDENT YEAR	APAC	CCC	DCIE	EIC	FPIC	HCII	LIC	MMIC	MPC	PIC	TIC
1994		130.7	359.8			71.0		60.2	95.7	106.4	55.4
1995		66.5	294.0			93.7		27.4	97.8	103.7	172.2
1996		145.7	238.0			110.0		121.4	102.3	90.8	116.6
1997		109.1	216.1	0.0		125.3		77.2	89.3	106.2	41.4
1998	676.5	82.6	282.0	39.2	156.7	136.8		23.9	78.1	147.1	92.8
1999	103.4	938.0	65.8	0.0	79.0	130.9		46.1	100.1	189.0	167.5
2000	32.1	41.5	300.4		34.2	147.3		112.8	109.1	171.6	292.1
2001	75.0	43.6	181.6		90.5	126.4		133.1	82.3	145.2	113.7
2002	57.7	52.8	182.2		58.0	112.8		124.7	79.5	145.1	108.9
2003	68.2	54.3	63.4		63.7	113.3	91.5	113.0	72.3	127.6	113.7

The occurrence numbers have also been improving. Given the heavy focus on claims-made business by a majority of Florida companies (except for HCII) and the countrywide shift away from writing occurrence policies (i.e., towards claims-made policies), Table F14 presents the more accurate picture of the overall loss and LAE ratio trends that would impact the majority of healthcare providers across the country and in Florida as will be discussed later.

Although ratemaking will be discussed in greater detail in the **Rate Filing Trend Analysis** section of this report, the exhibit below visually walks the reader through the importance of accident/report²⁵ year trends on medical malpractice insurance company rate filings.



Florida's admitted medical malpractice insurers submit rate filings to the OIR on an annual basis. In each filing, a new report year is added to the ratemaking analysis while an older year is rolled off. If, consistent with Tables F14 and F15, the trend in report year and accident year loss and LAE ratios is favorable for Florida insurers, the final selected loss and LAE ratio underlying each

²⁵ Ratemaking for claims-made policies uses data grouped by report year (i.e., the date the loss was reported to the insurer). Ratemaking for occurrence policies uses data grouped by accident year (i.e., the date the accident occurred). We have used report year in the above example for illustration purposes only. Either type of data could have been used to illustrate our point.

company's rate indication will improve²⁶. This is because the older years with higher loss ratios will be replaced over time with the lower loss ratios of the newer years.

In addition, as the benefits of SB2D roll into the data, the favorable impact of tort reform in Florida will also begin to impact the insurance company indications. Although not displayed in the above illustration, it is important to note that all Florida medical malpractice insurers were required to submit rate filings reflecting the "presumed factor" published by the OIR (or an adjusted "presumed factor" reflecting their own mix of business). These rate filings provided healthcare providers in the State of Florida with immediate relief, not a phased-in savings as would have happened if the savings had to phase-in over time with the reporting of claims impacted by SB2D.

Excluding tort reform adjustments like the "presumed factor", favorable report year and accident year loss ratio trends phase in over time. Depending upon how each insurer selects their ultimate loss and LAE ratio underlying their rate indication (e.g., 3 year average, 5 year average, etc.), the phase-in period can vary by company. If a company relies upon a 3 year average, their phase-in period would be shorter than a company relying upon an average in excess of 3 years. Given the long tail nature of the medical malpractice line of business, it would also be extremely risky to rely solely upon the current report year or accident year loss and LAE ratio. If companies relied solely upon the current year ultimate loss ratio as a basis for determining their indications, the annual rate changes would swing wildly in direct relationship to the immaturity and volatility associated with such a "green" estimate. By considering multiple years in the ratemaking formula, the annual rate indications become more stable and reduce the volatility in the annual premiums paid by Florida's healthcare providers.

²⁶ Some insurers develop their rate indications using pure premiums instead of loss and LAE ratios. We have used loss and LAE ratios for illustration purposes only. Either ratemaking approach could have been used to illustrate our point.

Section 627.912(6), Florida Statutes, as amended by Senate Bill 2-D, (Ch. 2003-416)

Table F16 displays the medical malpractice direct loss ratio derived from "Page 14" of the Annual Statement for Florida.

TABLE F16						
FLORIDA DIRECT LOSS RATIO						
Companies	DIRECT EARNED PREMIUM			INCURRED LOSS RATIO		
	2003	2002	2001	2003	2002	2001
FPIC	173,787,185	152,449,954	89,044,736	59.1%	61.7%	67.6%
HCII	115,509,472	106,482,154	88,970,154	71.3%	81.1%	107.1%
PIC	73,325,000	60,347,429	57,149,827	24.6%	39.1%	90.0%
MPC	63,205,523	39,591,739	30,731,371	129.3%	91.1%	109.6%
MMIC	65,767,026	40,956,626	19,808,077	65.0%	103.4%	112.4%
LIC	56,202,628	31,925,627	2,144,367	97.7%	64.2%	105.6%
EIC	35,536,453	25,487,045	10,808,815	53.4%	65.9%	78.6%
DCIE	35,812,399	28,511,037	20,422,981	53.2%	80.3%	52.4%
CCC	24,216,430	11,082,742	22,609,659	152.7%	53.9%	23.9%
TIC	23,529,680	20,856,846	21,880,706	104.3%	212.5%	72.8%
APAC	19,277,498	14,284,978	10,699,479	130.0%	61.4%	33.1%
ALL COS	686,169,294	531,976,177	374,270,172	73.9%	75.5%	82.6%
MM FOCUS	546,684,103	442,623,917	316,826,625	68.0%	71.0%	87.4%

Table F17 displays the medical malpractice direct DCC ratio and direct loss and DCC ratio derived from "Page 14" of the Annual Statement for Florida.

TABLE F17						
FLORIDA DIRECT LOSS AND DCC RATIOS						
Companies	DCC RATIO			LOSS AND DCC RATIO		
	2003	2002	2001	2003	2002	2001
FPIC	30.0%	21.8%	22.3%	89.1%	83.5%	89.9%
HCII	6.3%	11.5%	16.5%	77.6%	92.6%	123.7%
PIC	47.4%	43.5%	38.4%	72.0%	82.6%	128.4%
MPC	31.0%	30.9%	41.7%	160.4%	122.1%	151.3%
MMIC	23.1%	19.5%	52.1%	88.1%	123.0%	164.5%
LIC	11.7%	12.1%	-45.2%	109.4%	76.3%	60.4%
EIC	11.1%	12.3%	-0.7%	64.4%	78.2%	77.9%
DCIE	39.8%	19.8%	46.1%	93.1%	100.1%	98.5%
CCC	48.0%	7.3%	5.2%	200.6%	61.3%	29.0%
TIC	52.7%	39.1%	10.2%	157.0%	251.6%	83.0%
APAC	31.1%	22.2%	8.8%	161.1%	83.6%	41.9%
ALL COS	26.8%	21.9%	24.7%	100.7%	97.5%	107.3%
MM FOCUS	27.3%	22.8%	28.4%	95.3%	93.8%	115.9%

Over the three year period, the medical malpractice focused companies' direct loss and DCC ratio improved from 115.9% to 95.3%. The calendar year ratios improved significantly for HCII, PIC and MMIC. FPIC and DCIE remained fairly consistent. MPC and APAC both deteriorated in 2003.

The following seven tables display direct earned premium, direct loss and DCC ratios, the percentage distribution of premium, and the loss and DCC ratio relativity for calendar years 2001 through 2003 for the top five states.

Table F18 displays the medical malpractice direct DCC ratio and direct loss and DCC ratio derived from "Page 14" of the Annual Statement for the top 5 MPC states.

TABLE F18							
MPC TOP 5 DIRECT LOSS AND DCC RATIOS							
Company		DIRECT EARNED PREMIUM			LOSS AND DCC RATIO		
		2003	2002	2001	2003	2002	2001
MPC	FL	63,205,523	39,591,739	30,731,371	160.4%	122.1%	151.3%
	TX	129,780,889	85,158,862	58,161,998	119.7%	120.3%	32.9%
	OH	109,951,559	69,998,445	53,637,444	113.0%	91.0%	107.0%
	PA	70,150,840	44,128,288	26,598,907	87.9%	81.6%	91.2%
	KY	32,639,609	24,051,204	19,309,409	106.4%	88.9%	35.2%
		405,728,420	262,928,538	188,439,129	117.7%	103.4%	81.8%
MPC	FL	15.6%	15.1%	16.3%	1.36	1.18	1.85
	TX	32.0%	32.4%	30.9%	1.02	1.16	0.40
	OH	27.1%	26.6%	28.5%	0.96	0.88	1.31
	PA	17.3%	16.8%	14.1%	0.75	0.79	1.11
	KY	8.0%	9.1%	10.2%	0.90	0.86	0.43
		100.0%	100.0%	100.0%	1.00	1.00	1.00

Section 627.912(6), Florida Statutes, as amended by Senate Bill 2-D, (Ch. 2003-416)

Table F19 displays the medical malpractice direct DCC ratio and direct loss and DCC ratio derived from "Page 14" of the Annual Statement for the top 5 DCIE states.

TABLE F19							
DCIE TOP 5 DIRECT LOSS AND DCC RATIOS							
Company		DIRECT EARNED PREMIUM			LOSS AND DCC RATIO		
		2003	2002	2001	2003	2002	2001
DCIE	FL	35,812,399	28,511,037	20,422,981	93.1%	100.1%	98.5%
	CA	117,505,240	129,179,598	78,454,833	77.5%	85.4%	41.0%
	OH	27,935,354	15,449,785	13,282,953	80.2%	104.2%	135.4%
	VA	18,247,274	6,860,018	4,366,527	74.0%	104.1%	103.6%
	WA	21,770,431	15,104,688	9,419,321	108.9%	114.7%	113.8%
		221,270,698	195,105,126	125,946,615	83.2%	91.9%	67.9%
DCIE	FL	16.2%	14.6%	16.2%	1.12	1.09	1.45
	CA	53.1%	66.2%	62.3%	0.93	0.93	0.60
	OH	12.6%	7.9%	10.5%	0.96	1.13	2.00
	VA	8.2%	3.5%	3.5%	0.89	1.13	1.53
	WA	9.8%	7.7%	7.5%	1.31	1.25	1.68
		100.0%	100.0%	100.0%	1.00	1.00	1.00

Table F20 displays the medical malpractice direct DCC ratio and direct loss and DCC ratio derived from "Page 14" of the Annual Statement for the top 5 PIC states.

TABLE F20							
PIC TOP 5 DIRECT LOSS AND DCC RATIOS							
Company		DIRECT EARNED PREMIUM			LOSS AND DCC RATIO		
		2003	2002	2001	2003	2002	2001
PIC	FL	73,325,000	60,347,429	57,149,827	72.0%	82.6%	128.4%
	MI	54,576,947	49,123,077	43,145,692	62.9%	87.2%	84.8%
	IL	20,772,752	17,805,508	17,287,026	112.6%	145.1%	155.6%
	PA	7,795,724	8,454,338	4,484,973	212.0%	262.7%	320.5%
	KY	7,124,932	4,810,916	2,567,939	129.0%	184.4%	158.3%
		163,595,355	140,541,268	124,635,457	83.3%	106.4%	124.6%
PIC	FL	44.8%	42.9%	45.9%	0.86	0.78	1.03
	MI	33.4%	35.0%	34.6%	0.76	0.82	0.68
	IL	12.7%	12.7%	13.9%	1.35	1.36	1.25
	PA	4.8%	6.0%	3.6%	2.55	2.47	2.57
	KY	4.4%	3.4%	2.1%	1.55	1.73	1.27
		100.0%	100.0%	100.0%	1.00	1.00	1.00

Section 627.912(6), Florida Statutes, as amended by Senate Bill 2-D, (Ch. 2003-416)

Table F21 displays the medical malpractice direct DCC ratio and direct loss and DCC ratio derived from "Page 14" of the Annual Statement for the top 5 HCII states.

TABLE F21							
HCII TOP 5 DIRECT LOSS AND DCC RATIOS							
Company		DIRECT EARNED PREMIUM			LOSS AND DCC RATIO		
		2003	2002	2001	2003	2002	2001
HCII	FL	115,509,472	106,482,154	88,970,154	77.6%	92.6%	123.7%
	TX	134,208,307	109,117,631	93,958,833	75.9%	92.1%	125.2%
	CA	12,208,873	12,957,555	11,285,110	87.6%	85.6%	73.9%
	LA	11,567,046	10,291,536	9,890,103	87.6%	97.2%	106.8%
	NV	11,149,979	10,291,630	7,796,549	105.6%	97.2%	127.0%
		284,643,677	249,140,506	211,900,749	78.7%	92.4%	121.0%
HCII	FL	40.6%	42.7%	42.0%	0.99	1.00	1.02
	TX	47.1%	43.8%	44.3%	0.96	1.00	1.03
	CA	4.3%	5.2%	5.3%	1.11	0.93	0.61
	LA	4.1%	4.1%	4.7%	1.11	1.05	0.88
	NV	3.9%	4.1%	3.7%	1.34	1.05	1.05
		100.0%	100.0%	100.0%	1.00	1.00	1.00

Table F22 displays the medical malpractice direct DCC ratio and direct loss and DCC ratio derived from "Page 14" of the Annual Statement for the top 5 APAC states.

TABLE F22							
APAC TOP 5 DIRECT LOSS AND DCC RATIOS							
Company		DIRECT EARNED PREMIUM			LOSS AND DCC RATIO		
		2003	2002	2001	2003	2002	2001
APAC	FL	19,277,498	14,284,978	10,699,479	161.1%	83.6%	41.9%
	TN	15,900	12,325	11,299	161.1%	0.0%	-12.7%
	TX	7,396,216	4,039,004	706,134	161.1%	86.3%	128.6%
	AL	890,749	614,295	700,437	161.1%	219.8%	63.5%
	GA	1,770,770	1,093,457	524,251	161.1%	38.9%	136.1%
		29,351,133	20,044,059	12,641,600	161.1%	85.8%	51.8%
APAC	FL	65.7%	71.3%	84.6%	1.00	0.97	0.81
	TN	0.1%	0.1%	0.1%	1.00	0.00	-0.24
	TX	25.2%	20.2%	5.6%	1.00	1.01	2.48
	AL	3.0%	3.1%	5.5%	1.00	2.56	1.23
	GA	6.0%	5.5%	4.1%	1.00	0.45	2.63
		100.0%	100.0%	100.0%	1.00	1.00	1.00

Section 627.912(6), Florida Statutes, as amended by Senate Bill 2-D, (Ch. 2003-416)

Table F23 displays the medical malpractice direct DCC ratio and direct loss and DCC ratio derived from "Page 14" of the Annual Statement for the top 5 MMIC states.

TABLE F23							
MMIC TOP 5 DIRECT LOSS AND DCC RATIOS							
Company		DIRECT EARNED PREMIUM			LOSS AND DCC RATIO		
		2003	2002	2001	2003	2002	2001
MMIC	FL	65,767,026	40,956,626	19,808,077	88.1%	123.0%	164.5%
	GA	129,076,738	90,772,038	68,716,286	108.1%	146.7%	126.2%
	NC	39,072,818	23,568,356	12,383,603	90.9%	111.6%	93.5%
	VA	7,474,957	4,643,901	1,003,493	79.0%	59.8%	84.8%
	AL	7,404,082	4,777,952	3,033,640	47.7%	101.1%	72.1%
		248,795,621	164,718,873	104,945,099	97.5%	132.0%	127.6%
MMIC	FL	26.4%	24.9%	18.9%	0.90	0.93	1.29
	GA	51.9%	55.1%	65.5%	1.11	1.11	0.99
	NC	15.7%	14.3%	11.8%	0.93	0.85	0.73
	VA	3.0%	2.8%	1.0%	0.81	0.45	0.66
	AL	3.0%	2.9%	2.9%	0.49	0.77	0.56
		100.0%	100.0%	100.0%	1.00	1.00	1.00

Table F24 displays the medical malpractice direct DCC ratio and direct loss and DCC ratio derived from "Page 14" of the Annual Statement for the top 5 FPIC states.

TABLE F24							
FPIC TOP 5 DIRECT LOSS AND DCC RATIOS							
Company		DIRECT EARNED PREMIUM			LOSS AND DCC RATIO		
		2003	2002	2001	2003	2002	2001
FPIC	FL	173,787,185	152,449,954	89,044,736	89.1%	83.5%	89.9%
	PA	17,462,640	14,541,685	10,670,866	123.4%	78.0%	99.2%
	GA	10,878,048	8,651,331	3,110,340	71.9%	74.8%	112.0%
	AR	6,642,286	3,749,260	4,068	64.6%	64.6%	0.0%
	OH	7,588,744	8,800,168	1,414,895	45.2%	61.5%	61.2%
		216,358,903	188,192,398	104,244,905	88.7%	81.3%	91.1%
FPIC	FL	80.3%	81.0%	85.4%	1.00	1.03	0.99
	PA	8.1%	7.7%	10.2%	1.39	0.96	1.09
	GA	5.0%	4.6%	3.0%	0.81	0.92	1.23
	AR	3.1%	2.0%	0.0%	0.73	0.79	0.00
	OH	3.5%	4.7%	1.4%	0.51	0.76	0.67
		100.0%	100.0%	100.0%	1.00	1.00	1.00

ANALYSIS OF CLOSED CLAIM DATABASE

The Florida OIR Department of Financial Services collects closed claim reports filed by insurers. This information is stored in the closed claim database (CCD) and a copy of it, valued as of August 26, 2004, has been provided to Deloitte Consulting for the purposes of analyzing closed claim reports for those claims closed prior to August 26, 2004. It should be noted that the State of Florida takes no responsibility for the accuracy, completeness, or usefulness of the information filed by insurers and captured in the CCD. Deloitte Consulting has made every reasonable effort to scrutinize data entries and otherwise test the CCD in order to capture only those entries that may prove to be useful to the analysis. Appendix F of this report outlines the steps used to perform the data preparation process.

Trends in Frequency and Severity

Typically, the term “frequency” is used to define the ratio of numbers of claims to some base unit of exposure. The CCD however, does not lend itself to a meaningful comparison of claim counts to exposures in its present form. Therefore, when discussed in the Closed Claim Database section of this report, “frequency” will simply be defined as numbers of claims.

Given the long-tailed nature of medical malpractice claims and the “green” nature of the legislation, it is difficult to draw any conclusions on SB2D’s impact on claim frequency and severity. Deloitte Consulting has observed, however, an increase in the number of claims closing in recent years. Table C.1 demonstrates this upward trend over the past few years and continuing through the first 8 months of 2004 for all severity codes²⁷. Table C.1.1 displays the trend for

²⁷ Severity Code means the severity of injury scale found in the National Association of Insurance Commissioners (NAIC) medical professional liability insurance uniform claims report:

1. Emotional only – Fright, no physical damage Temporary
2. Insignificant – Lacerations, contusions, minor scars, rash. No delay.
3. Minor – Infections, misset fracture, fall in hospital. Recovery delayed.
4. Major – Burns, surgical material left, drug side effect, brain damage. Recovery Permanent
5. Minor – Loss of fingers, loss or damage to organs. Includes no disabling injuries.
6. Significant – Deafness, loss of limb, loss of eye, loss of one kidney or lung.
7. Major – Paraplegia, blindness, loss of two limbs, brain damage.
8. Grave – Quadriplegia, severe brain damage, lifelong care or fatal prognosis.

severity codes 1 to 3, Table C.1.2 displays the trend for severity codes 4 to 6, Table C.1.3 displays the trend for severity code 7, and Table C.1.4 displays the trend for severity codes 8 and 9.

TABLE C.1

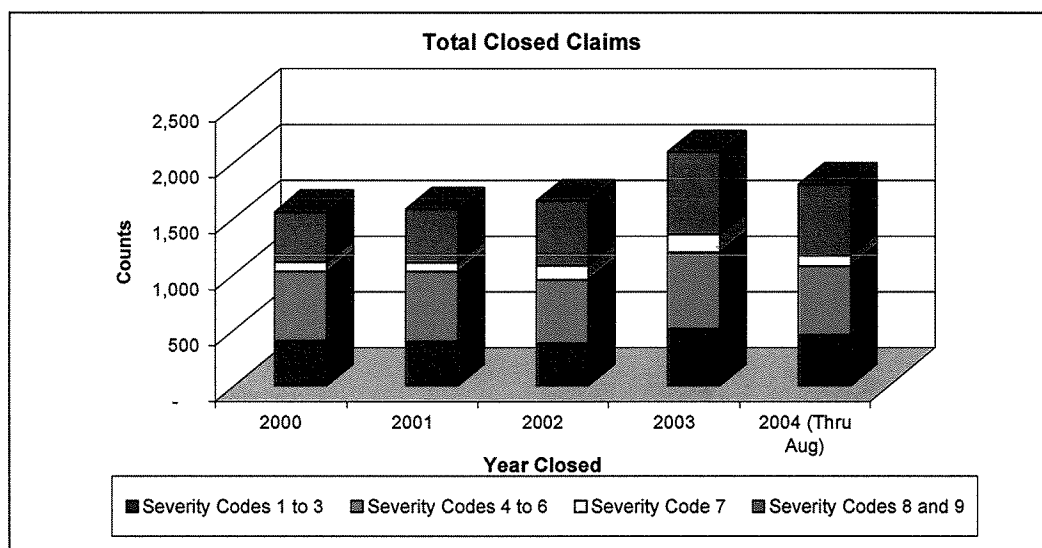


TABLE C.1.1

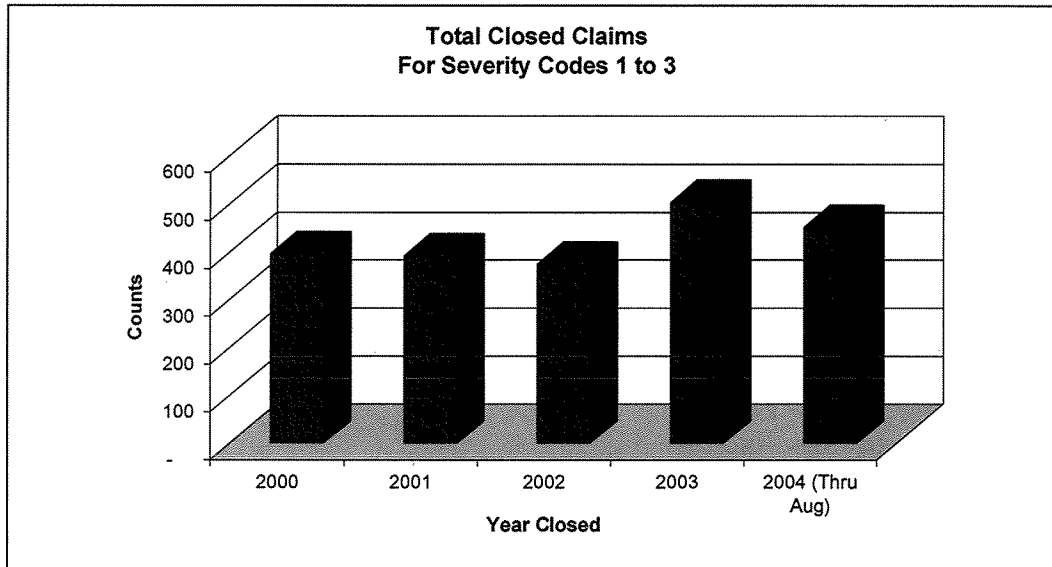


TABLE C.1.2

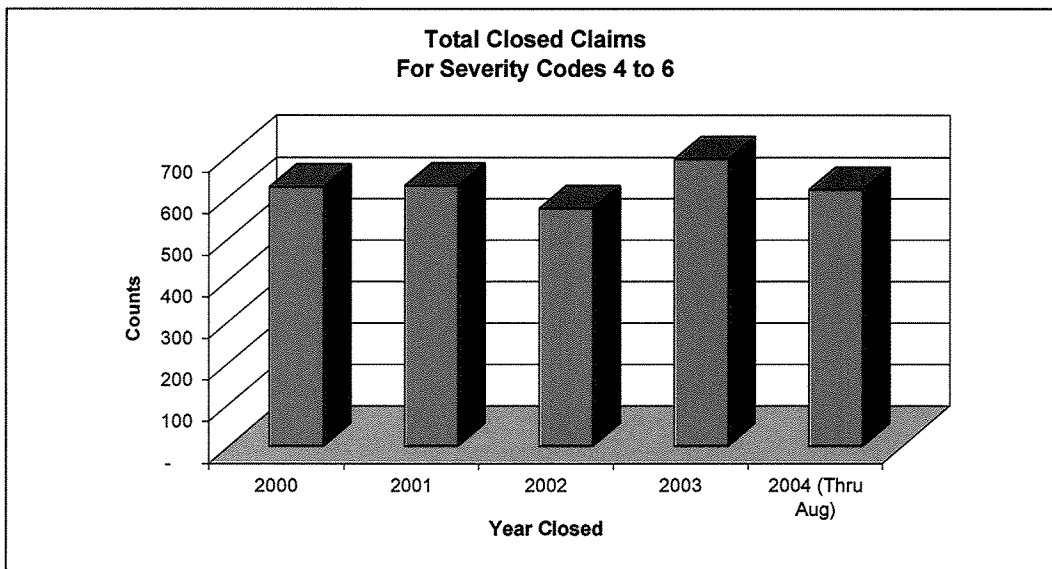


TABLE C.1.3

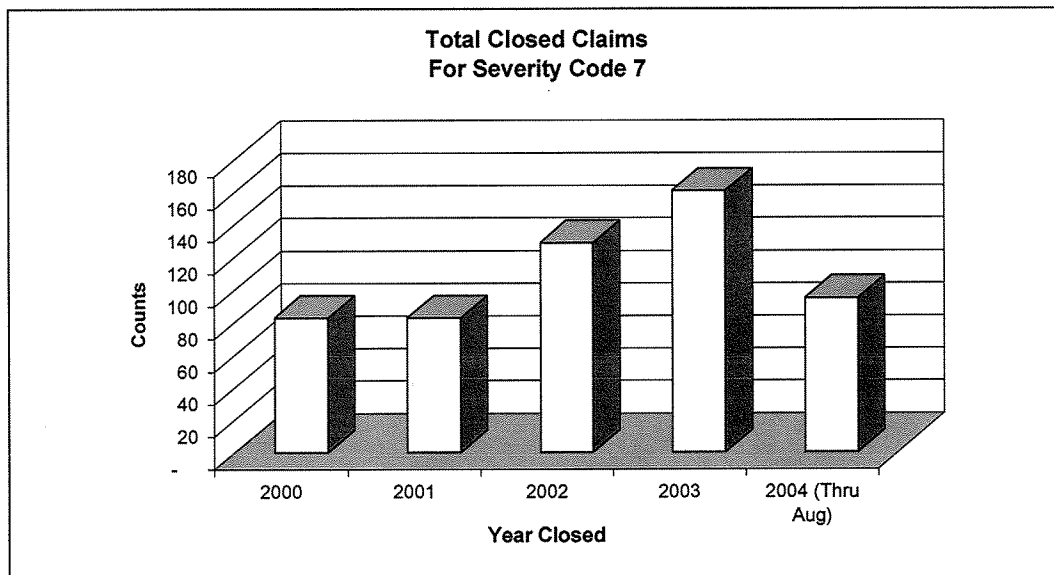
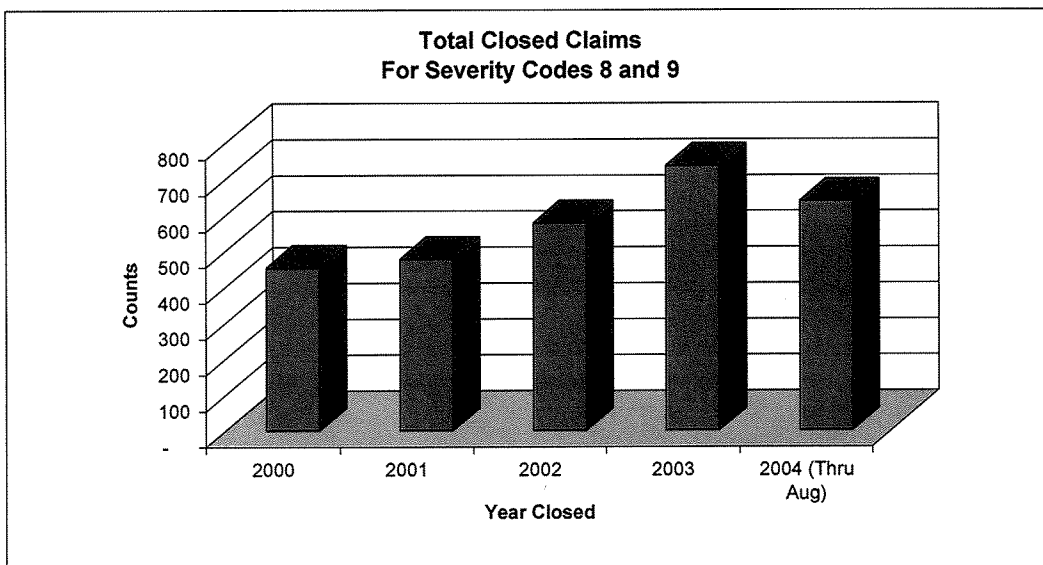


TABLE C.1.4



Tables C.2., C.3 and C.4 display the various lag times which have been compiled from the CCD. We have not noticed any material shift in the distributions from those published in our Presumed Factor Report, issued earlier this year.

TABLE C.2

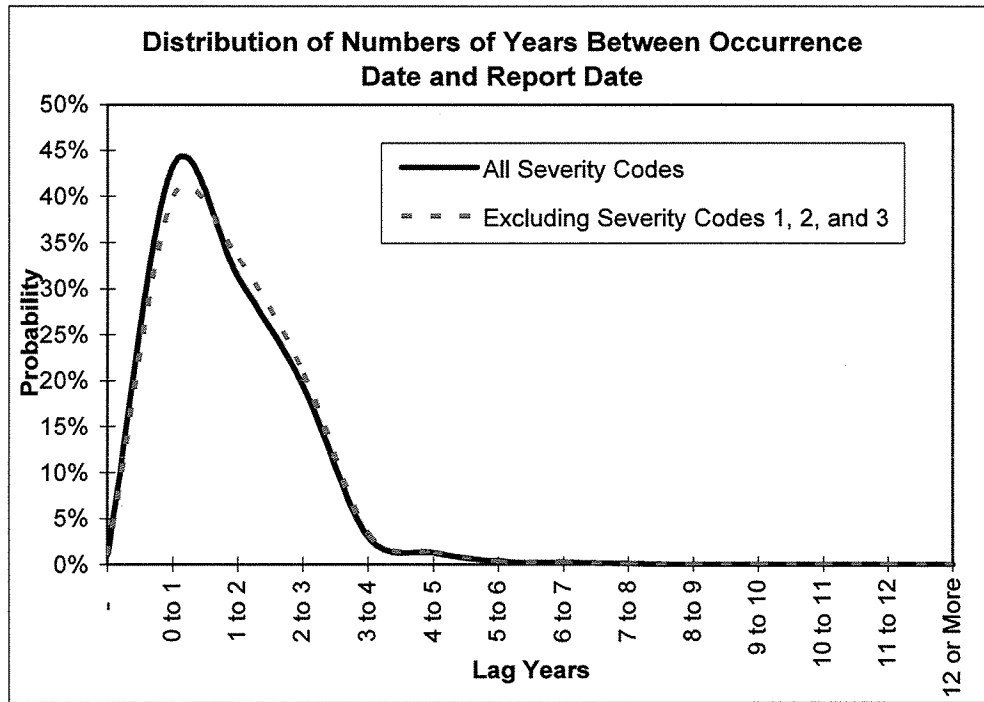


TABLE C.3

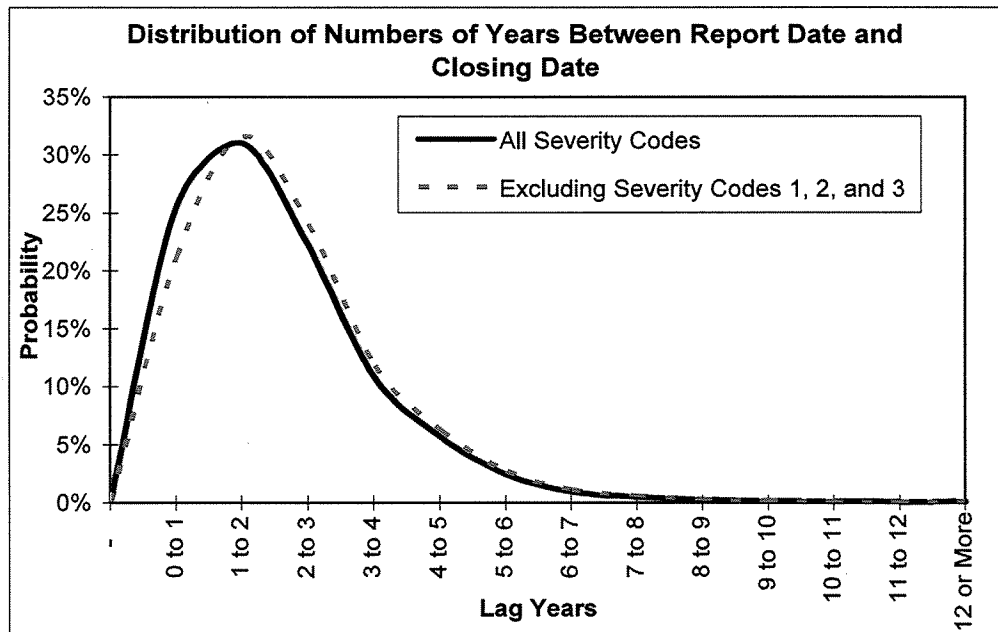


TABLE C.4

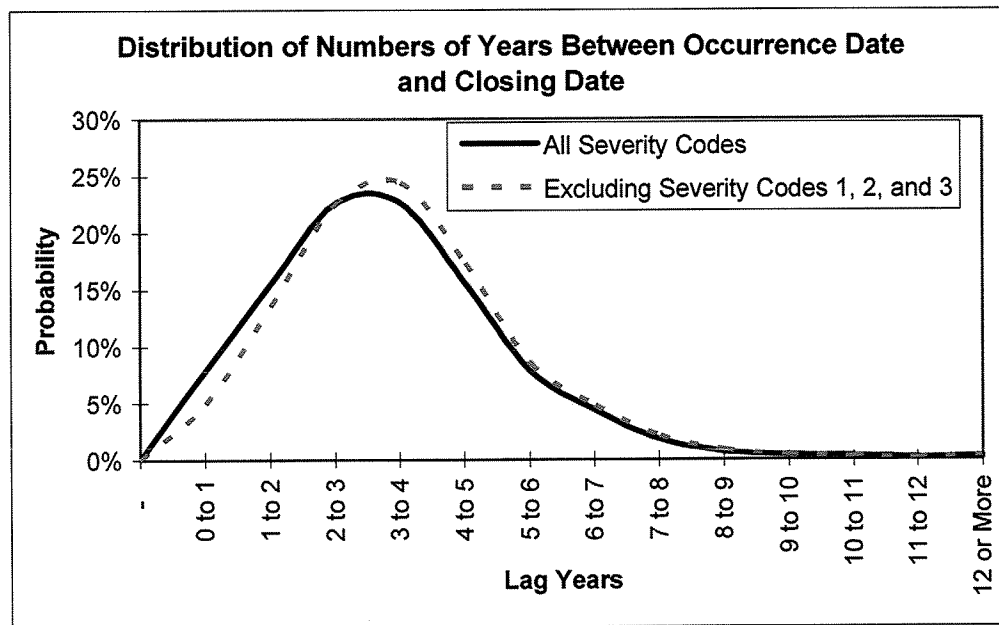


Table C.5 displays the lag distributions for claims with a severity code of 4 through 9.

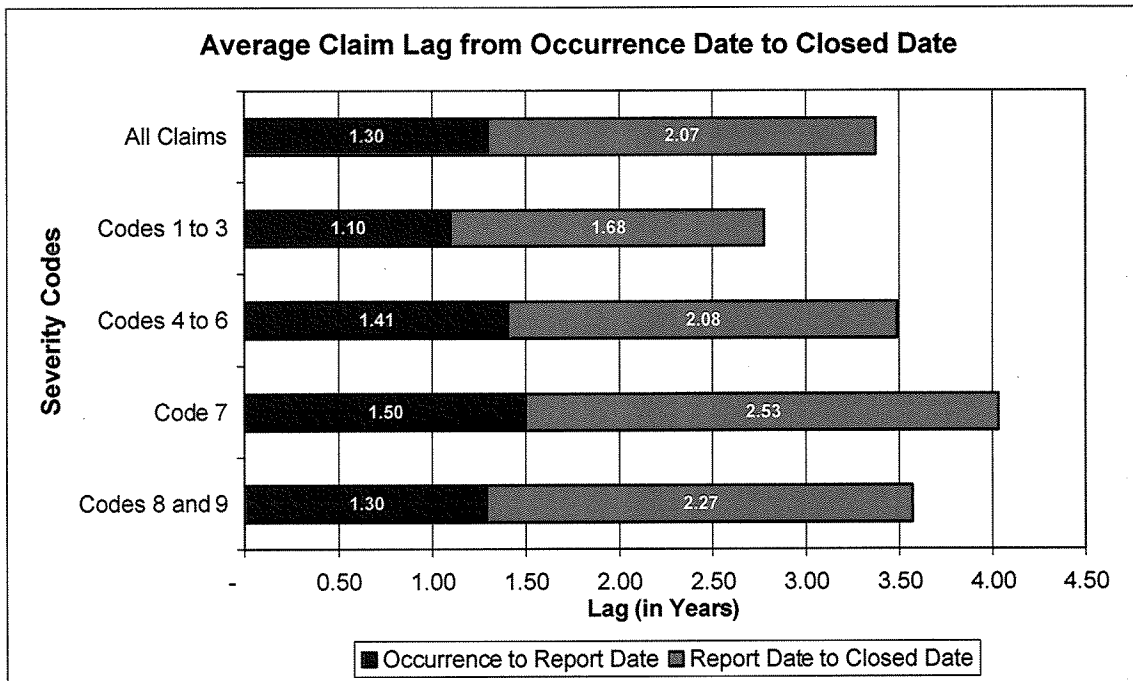
TABLE C.5

Lag Years	Distribution of Numbers of Years Between		
	Occurrence Date And Report Date	Report Date and Closing Date	Occurrence Date and Closing Date
-	0.9%	0.2%	0.0%
0 to 1	39.9%	21.2%	4.9%
1 to 2	33.2%	31.5%	13.5%
2 to 3	20.7%	24.0%	22.4%
3 to 4	3.2%	11.8%	24.4%
4 to 5	1.3%	6.2%	17.3%
5 to 6	0.3%	2.7%	8.5%
6 to 7	0.3%	1.1%	4.8%
7 to 8	0.1%	0.6%	2.1%
8 to 9	0.0%	0.3%	0.8%
9 to 10	0.0%	0.2%	0.4%
10 to 11	0.0%	0.1%	0.3%
11 to 12	0.0%	0.1%	0.2%
12 or More	0.0%	0.1%	0.3%
	100.0%	100.0%	100.0%
Mean*	1.36	2.19	3.56

*The Above Distributions Exclude Claims with Severity Codes 1, 2, and 3

As displayed in Table C.5, the mean or average time between occurrence date and the closing date for a claim with a severity code of 4 or greater is more than three and a half years. Table C.6 below displays the average lag times for different severity groups:

TABLE C.6



As stated earlier, distributions of the number of years between occurrence date and report date and the number of years between report date and closing date closely resemble those presented in our Presumed Factor Report. Although the third composite distribution, showing numbers of years between occurrence date and closing date, is also very similar to last year's distribution, Deloitte Consulting has chosen to display it above exclusive of the indexing adjustment used in the Presumed Factor Report to ensure that the three distribution means were additive when rounding up results to the nearest lag year in our calculations of distribution means (i.e. we chose to round each increment up to the next highest full year value). The distribution of numbers of lag years between occurrence date and closing date shown above now ensures that the distribution means are additive when mean calculations are indexed at or near lag period

midpoints (i.e., we do not round each lag period up to the next highest full year value). As a result of this refinement, the distribution means displayed differ from those presented in our Presumed Factor Report. It should be re-emphasized however, that these differences result only from our indexing adjustments and are not as a result of changes in the underlying data or distributions.

We observed a significant increase in the number of reported claims during the month of September 2003. This is consistent with the feedback shared with Deloitte Consulting during our analysis of SB2D and the determination of the Presumed Factor.

The increase in reported claims is displayed in table C.7, which shows the number of claims reported by month from September 2002 to December 2003. This increase in reported claims is likely the result of plaintiff attorney's "better safe than sorry" approach to filing the claims which could potentially be impacted by the cap on non-economic damages. It is also likely that this "rush" to report claims in September 2003 has already affected the number of claims reported in the months following. More specifically, we expect that many of the claims that would have otherwise been reported after September 2003 have now been filed in September 2003. As a result, we might expect to observe, fewer reported claims during the subsequent months (e.g., in Table C.7 we note a drop in claims reported during the months of October 2003, November 2003 and December 2003). We expect that additional data from future CCD analysis will help us to further support this expectation.

TABLE C.7

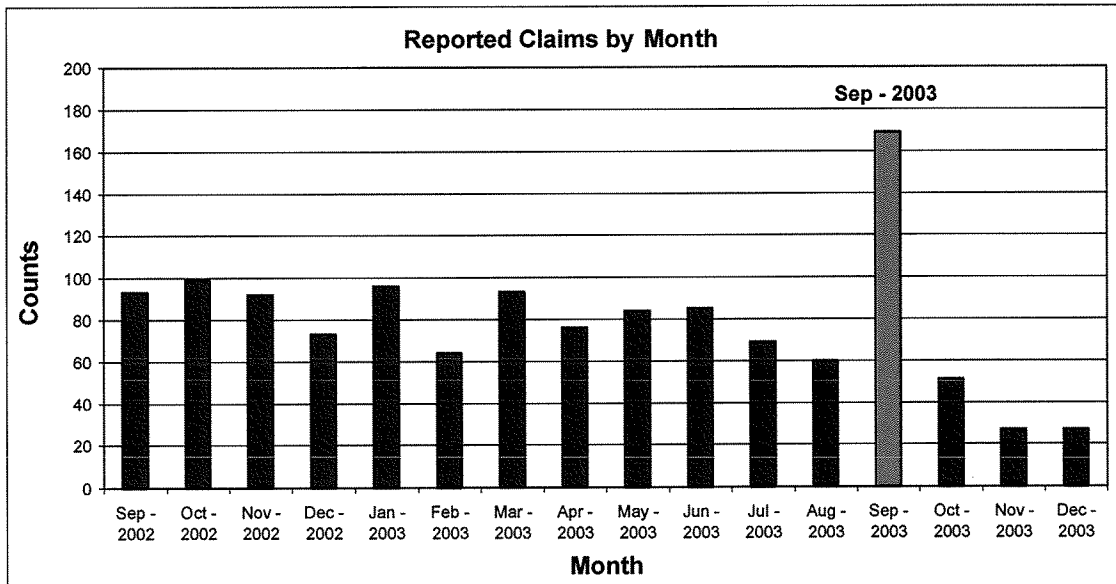
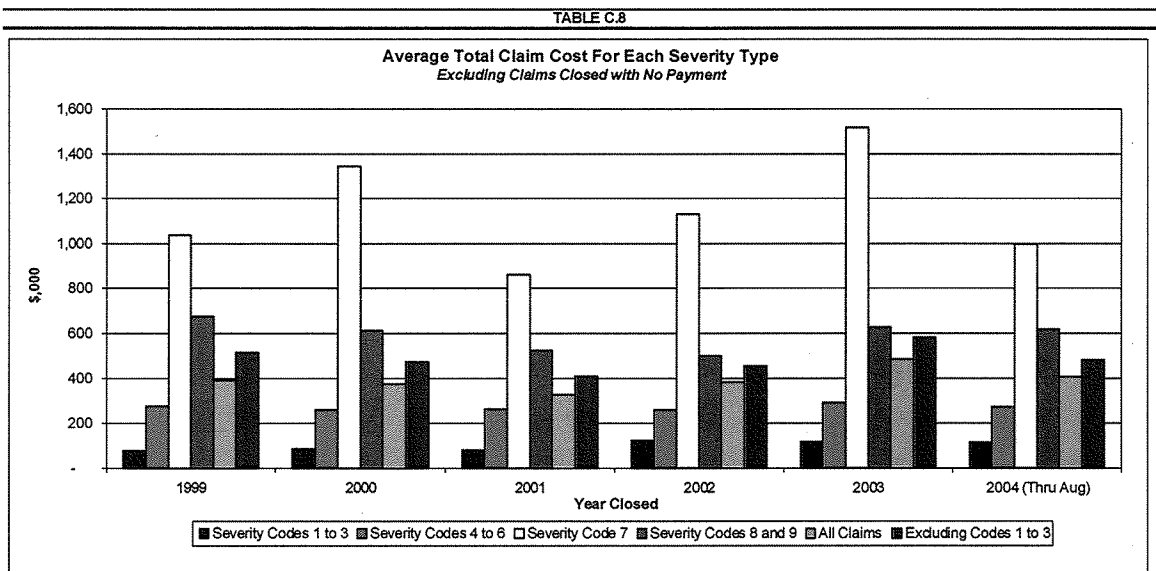


Table C.8 displays the severity of claims closed from 1999 through August of 2004. From the graph, note that for the latest full year of closed claims data, the average claims cost has risen above \$400,000 for all claims or just below \$600,000 for closed claims with a severity code of 4 or higher.



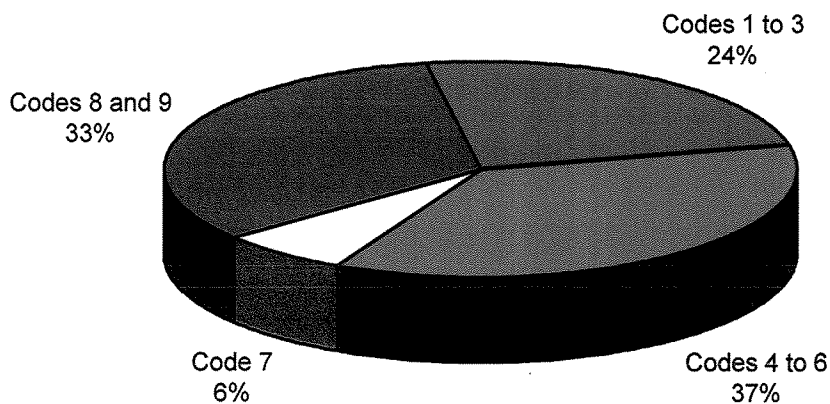
It is difficult to draw any significant conclusions on long term trends in the severity of claims which will be affected by the passage of SB2D, given the short time frame since the passage of SB2D and the limited amount of data in the closed claim database with the potential to have been impacted by SB2D.

Nature of Errant Conduct

Given the relatively short amount of time since SB2Ds passage and the fact that more severe claims typically have a longer claim lag, it is difficult to draw substantial conclusions regarding the impact of SB2D on the nature of errant conduct. The portion of claim counts in the lower severity codes for the closed claims reported after September 2003 is higher than typical historical levels. Table C.9 demonstrates this observation. As additional claims are closed from the post September 2003 reporting period and collected in the CCD, further assessments of this shift in severity type can be made with increased credibility.

TABLE C.9

**Portion of Closed Claim Counts by Severity Code, Reported
Prior to September 2003**



**Portion of Closed Claim Counts by Severity Code, Reported
September 2003 & Subsequent**

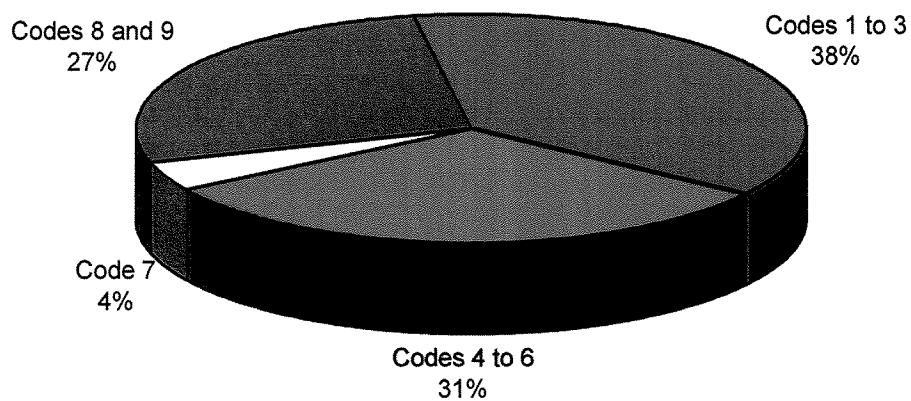
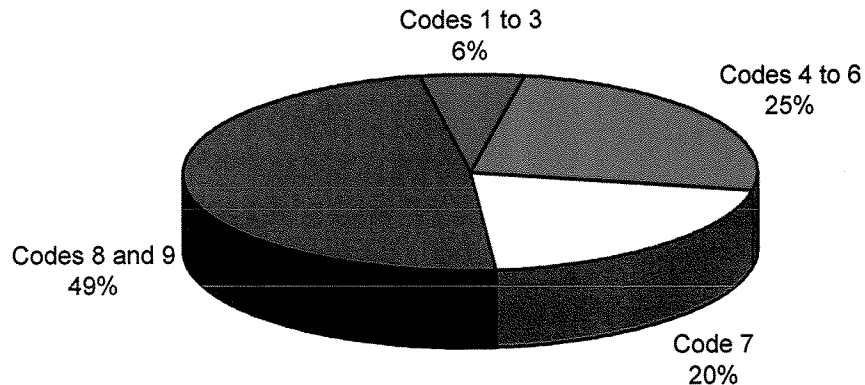


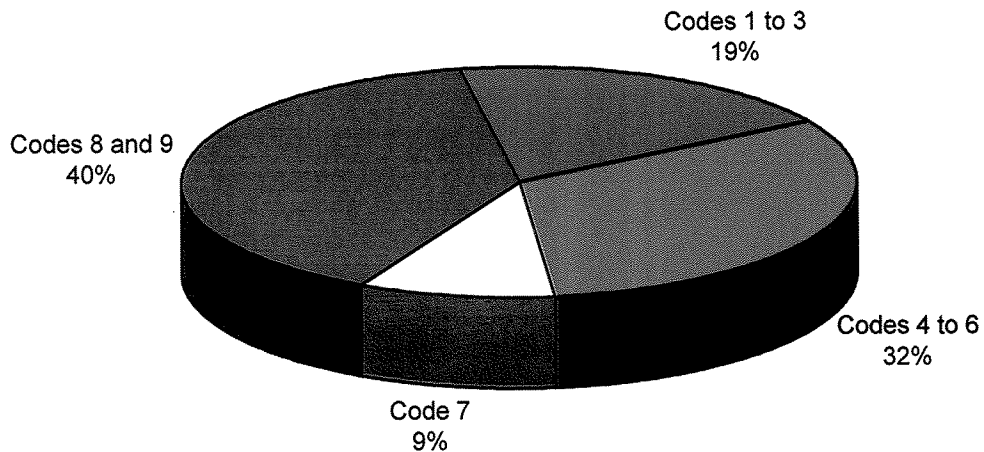
Table C.10 shows the breakdown of claims by severity code based on total dollars of cost.

TABLE C.10

**Total Loss Cost by Severity Code of Closed Claims Reported
Prior to September 2003**



**Total Loss Cost by Severity Code of Closed Claims Reported
September 2003 & Subsequent**



Itemization of Damages

Despite the limitations of the closed claim database with regard to certain claim entries which do not itemize loss costs between economic and non-economic components, Deloitte Consulting has been able to isolate only those CCD records that itemize these loss amounts for use in analyzing trends in economic and non-economic damages. Given the recent passage of SB2D and the observation that the average lag from occurrence to closing is more than 3 years for a typical claim (more than 3 ½ years for more severe injury types), it is difficult to use the CCD effectively to evaluate the impact of SB2D on non-economic damage awards. Tables C.11 and C.12 display the average total loss cost (C.11) and average cost of non-economic damages (C.12) for those closed claims with non-economic damages paid and with loss amounts itemized in the CCD. We note that there does not appear to be any significant decreases in either the average total loss cost or the average non-economic loss costs of claims closed through 2003.

TABLE C.11

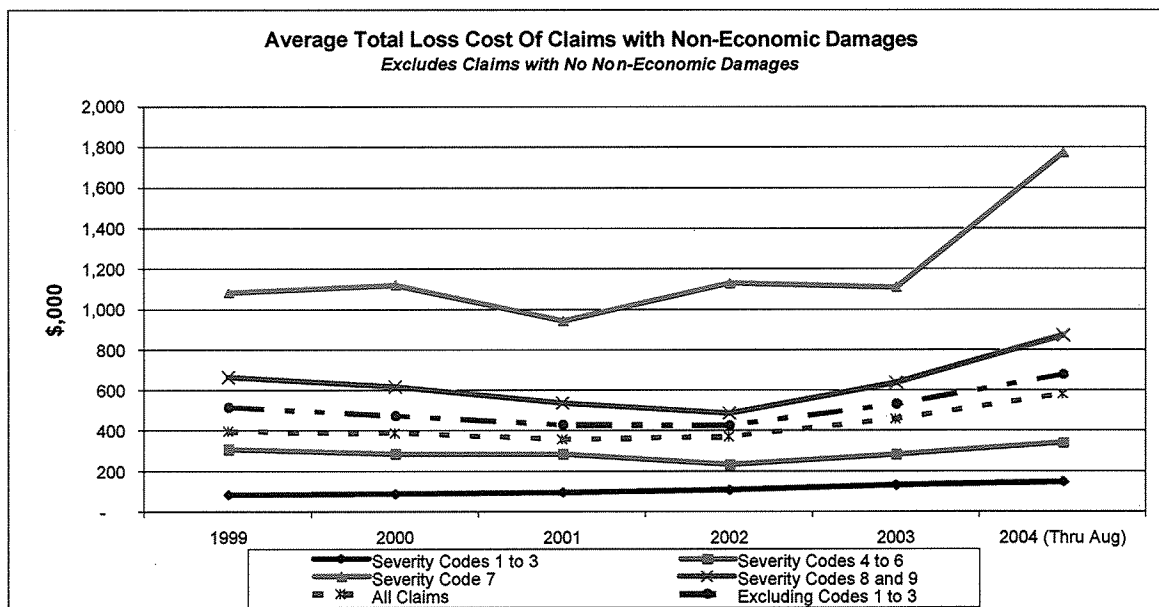
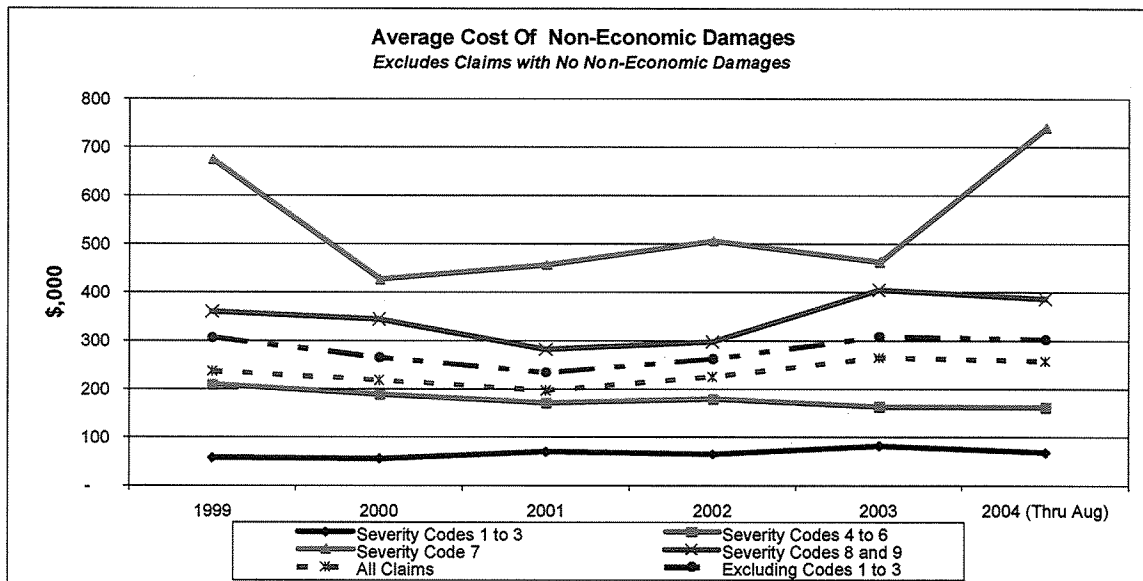
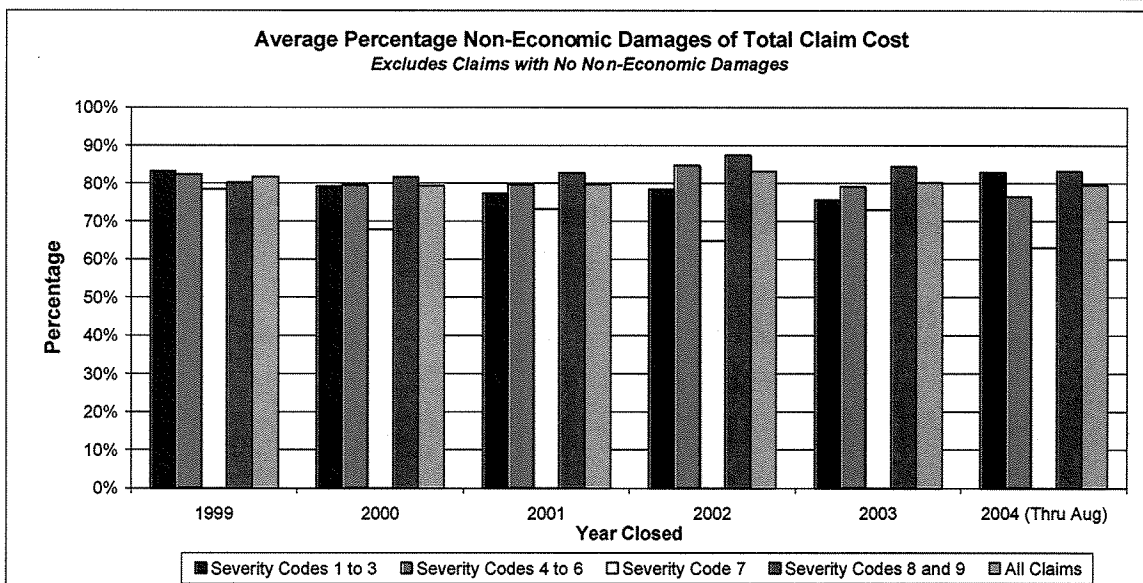


TABLE C.12



We also note that there does not appear to be any significant change in the average percentage of total loss costs resulting from non-economic damages for those claims with non-economic damages. Table C.13 displays this information by severity code group and by year of claim closing.

TABLE C.13



CASES ADDRESSING CONSTITUTIONALITY OF SB2D

COMPLETED CASES

As will be noted in the **Market Leader Data Request** section of this report, there has been little case activity addressing the constitutionality of SB2D. As of October 1, 2004, we are aware of only a single case that has found a portion of SB2D unconstitutional. As published on the eMediaWire web site:

"A Circuit Court Judge in Seminole County, Florida, has found a portion of Florida's 2003 medical malpractice reform legislation unconstitutional. It is believed this is the first case to address the constitutionality of the new law."

The article noted the following details of the case:

"On April 22, 2004, Circuit Court Judge Marlene Alva issued a short written order stating that the application of the new law was unconstitutional because it retroactively took away vested rights of patients who were already injured by malpractice before the date the new legislation was enacted. The case before Judge Alva concerned the liability of CIGNA HMO for the alleged negligence of one of its member physicians leading to the death of a 16 year-old patient in October 2002. Although the medical incident occurred before the new law was passed, Cigna HMO claimed the new law granted it retroactive immunity from suit. Scott R. McMillen, the attorney for the teenager's family, stated "The court's ruling is limited solely to the retroactivity issue, and what it means is that there is no immunity for any negligence occurring before September 15, 2003. But the case has broader importance because the same legal reasoning should also apply to the retroactive application of the damage caps on doctors and hospitals."

The court's ruling was based on an earlier Florida Supreme Court case and on a provision in the Florida Constitution granting all Florida's citizens the right of access to Florida's courts for redress of injury."

On page 73 of our November 6, 2003 report titled **Review of Florida Committee Substitute for Senate Bill 2-D, Calculation of Section 40 "Presumed Factor" (Presumed Factor Report)**, Deloitte Consulting stated the following:

Section 86 expresses the Legislature's intent that the law should apply retroactively, i.e., to incidents of medical negligence that occurred before the effective date of the law, with the provision that the changes to Chapter 766 should be applied only to cases of medical

negligence for which a notice of intent to initiate litigation was mailed on or after the effective date of the new law (September 15, 2003).

Thus, under this provision, the Legislature has indicated its intent that the amendments created by Sections 1 through 47 and 70 through 87 of the new law apply immediately, but the amendments created by Section 48 through 69 only apply to newly filed cases.

Section 86 recognizes, however, the retroactive application of new laws raises constitutional concerns (in particular, it raises due process concerns), and thus the Legislature indicated that its intent applies only if retroactive application "is not prohibited by the State Constitution or Federal Constitution."

The primary issue that is raised by Section 86 is whether the amendments to Chapter 766 can be applied to cases in which the medical negligence (i.e., the injury or misdiagnosis) occurred before September 15, 2003.

*The answer, as discussed below, is that the amendments affecting "substantive rights," such as the cap on damages, likely **cannot** be applied to cases involving pre-September 15 incidents of medical negligence (even if the pre-suit notice is filed after September 15), but that amendments affecting "procedural rights," such as the pre-suit notice requirements of informal discovery and providing a list of treating physicians, may be applied retroactively. Obvious gray areas, such as whether the amendments to the bad faith laws are procedural or substantive, will likely have to be resolved by the Florida Supreme Court.*

The Florida Supreme Court has adopted a two-part test for determining whether it is permissible to apply an amended Statute retroactively. Metro. Dade County v. Chase Fed. Hous. Corp., 737 So. 2d 494, 499 (Fla.1999).

The first test is whether the Legislature intended the amendment to apply retroactively. In this case, the answer is obviously "yes."

The second test is whether retroactive application is constitutionally permissible. Id. (citing State Farm Mut. Auto. Ins. v. Laforet, 658 So. 2d 55, 61 (Fla.1995)).

Courts will not permit retroactive application of a Statute if the Statute "impairs vested rights," even when the Legislature expressly states that the Statute is to have retroactive application.

In short, procedural amendments may be applied retroactively; amendments affecting substantive rights may not.

"Substantive law prescribes duties and rights and procedural law concerns the means and methods to apply and enforce those duties and rights."

A substantive, vested right is "an immediate right of present enjoyment, or a present, fixed right of future enjoyment." Sanford v. McClelland, 163 So. 513, 514-15 (1935). A vested right is thus a "fixed" right that cannot be abrogated or taken away without violation of the possessor's right to due process. Chase Fed., 737 So. 2d at 503 ("Thus, retroactive abolition of substantive vested rights is prohibited by constitutional due process considerations.").

Here, because previous reforms to the medical malpractice Statute have been compared to the limitations on rights set forth in the workers' compensation system, see, e.g., University of Miami v. Echarte, 618 So. 2d 189 (Fla. 1993), cases construing the workers' compensation Statutes are applicable by analogy for guidance.

The general rule in workers' compensation cases is that the substantive rights of the parties are fixed by the law in effect on the date of the injury, but that no party has a vested right in any particular procedure. See, e.g., McCarthy v. Bay Area Signs, 639 So. 2d 1114, 1115-16 (Fla. 1st DCA 1994).

Accordingly, because the "date of the injury" has typically been viewed as the operative date for determining an injured party's vested rights, it is likely that none of the substantive amendments to Chapter 766, such as the cap on damages, will apply to injuries or misdiagnoses or other types of medical negligence that caused injury before September 15, 2003 even if pre-suit notice was initiated after September 15, 2003. By contrast, changes to the pre-suit notice and discovery requirements are likely to be deemed procedural and therefore applicable to all cases in which pre-suit notice was initiated on or after September 15, 2003.

Judge Marlene Alva's written order is consistent with the findings discussed in Section 86 of our November 6, 2003 report.

ACTIVE CASES

As of October 1, 2004, the Office is aware of the first case in Miami actively seeking to have the limit on non-economic damages declared unconstitutional. As published on August 31, 2004 by the Tampa Tribune, the case involved the following allegations:

"The Bergesses had filed a lawsuit over the case of their daughter Mariaelena.

The doctors had treated Mariaelena for a cough and cold, but her symptoms got worse, the suit alleges.

Her mother later took her to the hospital. The girl eventually was seen by several specialists who diagnosed Stevens Johnson Syndrome, an adverse reaction to medication that can cause severe rashes, fever and swelling around the eyes. If left untreated, it can be fatal.

Marielena also suffered respiratory complications and severe skin problems that have left her disfigured, the complaint alleged."

Based on the August 30, 2004 Berges v. Lambkin-Alexander, M.D. et al. (case number 04-18664-CA-01) complaint filed in Miami-Dade County, we note the following issues identified in the complaint as "Primary Constitutional Claims", which question the constitutionality of SB2D:

"18. Prior to September 15, 2003, the recoverable damages in a medical malpractice case were not limited. Consequently, a plaintiff could seek the full measure of damages that a jury might award for any injuries that a jury might find were proximately caused by the negligence of the defendant doctors. The right to recover such unlimited damages as found by the jury reflect that persons who are innocent victims of wrongful conduct have the right and opportunity to obtain recourse and recompense from the tortfeasors.

19. Moreover, Article I, Section 21, of the Florida Constitution provides that the courts shall open for every person for redress of any injury, and justice shall be administered without sale, denial or delay.

20. It is uncontroverted, therefore, that there existed prior to September 15, 2003 a right to sue on and recover non-economic damages of any amount and that this right existed from the time the current Florida Constitution was adopted. The right to redress injury does not draw any distinction between economic and non-economic damages. Article I, Section 21, does not contain any language which would support the proposition that the right is limited, or may be limited, to suits above or below any given figure. It has, therefore, always been recognized under Florida law that great harm may befall victims of medical malpractice and the corresponding necessity for requiring those that are responsible to compensate such harms.

21. Chapter 2003-416, Laws of Florida, however, made far-reaching changes which affect compensable damages to such injured persons. Section 86 of that chapter provides for, among other things, caps on damages, changes to bad faith claims against insurers, and various procedural changes which would take effect September 15, 2003. The legislation purports to state that to the extent allowed by the Florida Constitution, such changes would apply to any prior medical incident for which a notice of intent to initiate litigation has not been mailed before September 15, 2003.

22. *The Bergeses sent out their notice of intent on February 19, 2004. Consequently, the Act purports to affect the monetary recovery that Mr. and Mrs. Berges may make on behalf of their severely injured minor child, Mariaelena Berges.*

23. *In particular, Fla. Stat. §766.118 provides the following limitation on non-economic damages for the negligence of the Defendant treating physicians:*

(a) With respect to a cause of action for personal injury or wrongful death arising from medical negligence of practitioners, regardless of the number of such practitioner defendants, non-economic damages shall not exceed \$500,000 per claimant. No practitioner shall be liable for more than \$500,000 in non-economic damages, regardless of the number of claimants.

(b) Notwithstanding paragraph (a), if the negligence resulted in a permanent vegetative state or death, the total non-economic damages recoverable from all practitioners, regardless of the number of claimants, under this paragraph shall not exceed \$1 million. In cases that do not involve death or permanent vegetative state, the patient injured by medical negligence may recover non-economic damages not to exceed \$1 million if:

1. The trial court determines that a manifest injustice would occur unless increased non-economic damages are awarded, based on a finding that because of the special circumstance of the case, the non-economic harm sustained by the injured patient was particularly severe; and

2. The trier of fact determines that the defendant's negligence caused a catastrophic injury to the patient.

(c) The total non-economic damages recoverable by all claimants from all practitioner defendants under this subsection shall not exceed \$1 million in the aggregate.

3. Limitation on non-economic damages for negligence of non-practitioner defendants --

(a) With respect to a cause of action for personal injury or wrongful death arising from medical negligence of non-practitioners, regardless of the number of such non-practitioner defendants, non-economic damages shall not exceed \$750,000 per claimant.

(b) Notwithstanding paragraph (a), if the negligence resulted in a permanent vegetative state or death, the total non-economic damages recoverable by such

claimant from all non-practitioner defendants under this paragraph shall not exceed \$1.5 million. The patient injured by medical negligence of a non-practitioner defendant may recover non-economic damages not to exceed \$1.5 million if:

(1) The trial court determine that a manifest injustice would occur unless increased non-economic damages are awarded, based on a finding that because of the special circumstances of the case, the non-economic harm sustained by the injured patient was particularly severe, and

(2) The trier of fact determines that the defendant's negligence caused a catastrophic injury to the patient.

(c) Non-practitioner defendants are subject to the cap on non-economic damages provided in this subsection regardless of the theory of liability, including vicarious liability.

(d) The total non-economic damages recoverable by all claimants from all non-practitioner defendants under this subsection shall not exceed \$1.5 million in the aggregate.

Pursuant to Fla. Stat. §766.118, catastrophic injury is defined to include second-degree or third-degree burns of 25% or more of the total body surface or third-degree burns of 5% or more to the face and hands. Fla. Stat. §766.118(1)(a)4. Mariaelena Bergees sustained Stephen Johnson Syndrome. This is the equivalent of second degree or third degree burns because her entire skin was sloughed off and blistered; and, her gastrointestinal tract was also burned and blistered.

24. The statute defines practitioner as licensed physicians as well as any entity vicariously liable for such physicians. There are four practitioner defendants: Dr. Bellietha Lambkin-Alexander; Dr. Rozalyn Paschal; Rozalyn H. Paschal, M.D., Inc.; and Rozalyn Hestor Paschal, M.D., P.A. The theories against the latter two defendants are vicarious liability.

25. The Plaintiffs contend that absent the application of Fla. Stat. §766.118, which they maintain is unconstitutional, Mariaelena would be entitled to the full measure of damages from the four practitioners.

26. On the other hand, the defendants will contend that non-economic damage recovery is capped by Fla. Stat. §766.118 in the amount of \$500,000 total from the four practitioners.

27. *The Plaintiffs contend that the limitation on non-economic damages is unconstitutional as will be more particularly set forth below. The Plaintiffs also contend that if this court finds that Fla. Stat. §766.118 is a constitutional limitation on non-economic damages, then the plaintiffs are subject to the limits pertaining to catastrophic injury. Therefore, the Plaintiffs are entitled to total non-economic damages from all four practitioner defendants in the amount of \$1 million in the aggregate.*

28. *Fla. Stat. §766.118 is unconstitutional inter alia for the following reasons: The statute caps the damages available to injured persons seeking redress through the courts. It has impermissibly burdened a plaintiff's ability to obtain access to the courts for full redress of all injuries. It has impaired a plaintiff's rights to all common law remedies without either providing an adequate alternative remedy or reflecting an overwhelming public necessity in the absence of less-restrictive alternatives, therefore denying access to courts in violation of Article I, Section 21, of the Florida Constitution, as well as access to courts under the Federal Constitution and the 14th Amendment.*

29. *The statute also denies equal protection by treating similarly situated natural person unequally and making invidious and irrational distinctions in violation of Article I, Section 2, and Article III of the Florida Constitution, and the Equal Protection Clause afforded under the 14th Amendment of the Federal Constitution. Among other things, it discriminates against the most seriously injured claimants by providing arbitrary compensation below a certain level of damages and partial compensation above a certain level against those injured persons who are less well off economically than plaintiffs who are able to financially bear the damages for which they are not compensated. The statute also discriminates by virtue of physical disability.*

30. *Moreover, the statute creates arbitrary classifications to benefit a particular industry, medical practitioners, and their insurers, in violation of Article III, Section 10 and 11 of the Florida Constitution and the 14th Amendment of the Federal Constitution. It impairs the right to trial by jury in violation of Article I, Section 22, of the Florida Constitution by turning the jury's determination of damages into an advisory opinion and by assigning to a judge the common-law authority of the jury. It denies due process because there is no compelling state interest effectuated by least restrictive means, as well as no reasonable relation to a legitimate or compelling governmental objective in violation of Article I, Section 9 of the Florida Constitution and the Fourteenth Amendment of the Federal Constitution. It does so in particular by creating arbitrary damage caps; by irrationally and arbitrarily defining various categories of injury; by irrationally and arbitrarily limiting damages recoverable from so-called non-practitioners; by protecting the medical practitioner rather than the medical practitioner's victim thereby irrationally extending its provisions to protect one class; and by serving no legislative objective related to the reduction of lawsuits against the protected class, medical practitioners, and their insurers.*

31. *In addition, Chapter 2003-416, Laws of Florida, which encompasses Fla. Stat. §766.118 violates the single subject requirement contained in Article III, Section 6 of the Florida Constitution. This is obvious from the description of the Act which is so lengthy that we will not repeat it here. Instead, we will attach it as Exhibit A. Suffice it to say that the Act purports to relate to medical incidents; involves the Agency for Healthcare Administration with respect to reviewing complaints against hospitals; deletes the requirement that persons act in good faith to avoid liability for disciplinary actions; relates to internal risk management programs; requires licensed facilities to annually report certain health care practitioners; provides for use of patient safety data; eliminates restrictions on licensure renewal fees for health care practitioners; deletes provisions with respect to criminal history checks; revises financial responsibility requirement of physicians; amends Fla. Stat. §624.462; provides guidelines for the formation and regulation of certain self-insurance funds; proscribes a health maintenance organization's right to control the professional judgment of a physician; amends Fla. Stat. §766.1115, .1112, .1113, .201, .303, and .21; creates Fla. Stat. §766.118 limiting non-economic damages; provides legislative findings and intent regarding emergency medical services; creates Fla. Stat. §766.1185; revises guidelines for immunity under the Good Samaritan Act; and many, many other revisions which will be seen in Exhibit A.*

32. *The statute is also unconstitutional under both the State and Federal Constitutions based on a violation of both substantive and procedural due process and equal protection because there is no rational basis for the caps on non-economic damages.*

33. *Fla. Stat. §766.118 also violates the separation of powers provision of Article II, Section 3, of the Florida Constitution.*

34. *The legislative enactment is a hodgepodge logrolling form of omnibus legislation that is obviously unconstitutional and embraces in the same bill incongruous matters having no rational relationship to each other or to the subjects specified in the titles. Distinct subjects affecting diverse interests have been combined in order to unite members who favored them. The Act is effectively the most gargantuan logroll in the history of Florida legislation.*

35. *The Plaintiffs are in doubt as to their legal rights and duties under the Act; and most specifically under Fla. Stat. §766.118 with respect to the applicability, or non-applicability of the caps on non-economic damages and the category into which this case fits, and specifically, whether the minor claimant has suffered a catastrophic injury. The Plaintiffs are equally uncertain as to the propriety of making a demand for policy limits from the Defendants or their insurers given the statutory changes to bad faith claims contained within this Act. These provisions are likewise subject to constitutional challenge, including but not limited to the following constitutional violations: (1) Article I, Section 21, Florida Constitution (access to courts); (2) 14th Amendment to the United*

States Constitution (due process and access to courts); (3) Article I, Section 2 and Article III of the Florida Constitution; and the 14th Amendment of the United States Constitution (equal protection); (4) Article I, Section 22, Florida Constitution (right to jury trial); (5) Article I, Section 9, and the 14th Amendment to the United States Constitution (due process); (6) Article III, Section 6 of the Florida Constitution (single subject); (7) substantive and procedural due process of both the Florida and United States Constitutions; and (8) Article II, Section 3 of the Florida Constitution (separation of powers).

36. If this court enters a judgment declaring that the statute is unconstitutional and the Plaintiffs are entitled to their common law remedies uncapped, then there may be no need to pursue the case incurring costs of discovery and of trial, because the case may be able to be mediated or settled to conclusion.

37. On the other hand, at this point the Plaintiffs cannot make an intelligent determination as to whether they are entitled to demand \$500,000 for practitioners; or a total of \$1 million from practitioners, assuming a catastrophic injury, or the full value of the case.

38. Accordingly, this is an appropriate case for declaratory relief. It will produce an adjudication of the constitutionality of the caps on non-economic damages and the bad faith legislation; or alternatively, will produce an adjudication of the category in which the injured Plaintiff falls, and which is critical to the decisions which the Plaintiffs must make including but not limited to claims for bad faith."

On page 33 of our Presumed Factor Report, Deloitte Consulting stated the following:

Section 54 of the new legislation creates Section 766.118, Florida Statutes, which imposes caps on the amount of non-economic damages recoverable in all medical malpractice actions, including those involving wrongful death.

The specific cap amounts are discussed earlier in this report.

Section 54 likely will be challenged by the plaintiffs' bar alleging that the caps are unconstitutional under the following provisions of the Florida Constitution:

- 1. Right of access to the courts;*
- 2. Equal protection;*
- 3. Due process; and*
- 4. "Taking" without just compensation.*

The principal challenge will likely be brought under the access to courts provisions. There is no corresponding provision in the federal Constitution.

Article I, Section 21 of the Florida Constitution provides: "The courts shall be open to every person for redress of any injury, and justice shall be administered without sale, denial, or delay."

The arguments in the *Berges v. Lambkin-Alexander, M.D. et al.* complaint are consistent with the legal observations discussed in Section 54 of our November 6, 2003 report. Essentially, our legal analysis was right on point.

It is not possible at this time to estimate when the trial court in *Berges* will rule on the issue of whether the cap is constitutional. The defendants may argue that the issue is not "ripe" for determination unless and until a jury verdict is rendered in excess of the cap. The trial court therefore may postpone a decision on constitutionality until after the case goes to trial, which may take one or two years. Whenever the trial court does rule, however, there is a possibility that the parties will request a "fast track" appeal to the Florida Supreme Court, bypassing the intermediate appellate court. If that occurs (it is within the discretion of the intermediate appellate court to decide), then the appeal time in our original report could be expedited by approximately one year. Accordingly, a final decision on constitutionality from the Florida Supreme Court could occur within 12 to 18 months of a ruling by the trial court.

A detailed discussion of the impact on rates and trend assumptions of the cap on non-economic damages being declared unconstitutional can be found in the **Observations and Conclusions** section of the report.

MARKET LEADER DATA REQUEST

As part of Deloitte Consulting's work plan, Deloitte Consulting was asked by the OIR to prepare a market leader data request (MLDR) in order to survey the top medical malpractice writers in the state of Florida. Based upon the market share information provided by the OIR, we selected the top insurers necessary to satisfy the 80 percent benchmark established by SB2D.

The purpose of the MLDR was to request financial information and written responses aimed at helping Deloitte Consulting analyze the current state of the medical malpractice market post SB2D.

Given the long tail nature of the medical malpractice line of business and the "green" nature of SB2D, Deloitte Consulting recognized before sending the MLDR that it might be too early for companies to quantify certain sections of SB2D in terms of benefits, savings and court activity. Even with this fact in mind, Deloitte Consulting still asked for as much information as possible with the foreknowledge that many of the questions may not be answerable at this time.

Deloitte Consulting did request that each company do its best to describe their experiences with and concerns regarding SB2D. Deloitte Consulting also recognizes that certain information requested in the MLDR may be confidential and potentially impact the outcome of current litigation. In those situations, Deloitte Consulting let the companies know that it should do their best to provide general comments instead of specific references to specific events.

Based upon the quality discussions Deloitte Consulting had throughout the MLDR request period with company representatives, the "green" nature of the law, and the short time period for responding to our MLDR, Deloitte Consulting believes the top insurers made a good faith attempt to answer our questions to the best of their ability.

General Comments

In the written responses and verbal discussions with company representatives, the companies made it clear that they felt it was too early to tell what the impact of the law would be. Essentially, companies stated that given the nature of medical malpractice and the fact that it is a long tail line of business, the timeframes involved in the legal system are much longer than the 10 month evaluation period since the passage of SB2D.

On page 38 of the Presumed Factor Report, Deloitte Consulting states the following in regards to time frames:

Nobody can predict how the Florida Supreme Court will rule when (not if, but when) the constitutionality of the new law is brought before it. Accordingly, we will not attempt to do so here, other than to observe, as we have above, that at least Justices Anstead and Quince appear to question even the limited holding in Echarte and are likely to take a critical view of the new caps.

Additionally, we would observe that the Task Force relies on the success of caps in California to support its recommendation for caps in Florida, and notes that California upheld the constitutionality of the caps. It is worth noting that California, unlike Florida, does not have a specific "access to courts" provision in its constitution.

In terms of timing, the Florida Supreme Court likely will not rule on the constitutionality of the new law until, at the earliest, the Fall of 2006. This is because it will take approximately 18 to 24 months for a jury verdict to be rendered in excess of the cap, after which an appeal will have to be taken to the intermediate appellate court in Florida. That appeal likely will take approximately one year to complete, after which the parties will be able to seek review in the Florida Supreme Court. It will take approximately another full year for the Florida Supreme Court to issue a decision.

In the event that the Florida Supreme Court declares the law unconstitutional, and if the basis of the court's decision falls under the Florida Constitution, then it would be necessary to pass an amendment to the Florida Constitution to validate the caps. (If the decision is based on the United States Constitution, either the due process clause, the equal protection clause, or the right to jury clause, then an amendment to the United States Constitution would be required.)

There are three basic methods to propose amendments to the Florida constitution: a three-fifths vote of each house of the Legislature; a petition drive reflecting the appropriate number of required signatures (about 8% of the voters); or a constitutional

convention. Article XI, Fla. Const. Regardless of the method chosen to propose an amendment, the amendment must be approved by the electorate "at the next general election held more than ninety days after the joint resolution, initiative petition or . . . constitutional convention." Article XI, Section 5(a). "If the proposed amendment or revision is approved by vote of the electors, it shall be effective as an amendment to or revision of the constitution of the state on the first Tuesday after the first Monday in January following the election, or on such other date as may be specified in the amendment or revision." Article XI, Section 5(c). Thus, any proposed amendment would be required to be voted upon at the next general election after the amendment is validly proposed, which likely would be the year 2008 if the amendment is not proposed until after a ruling by the Florida Supreme Court on the constitutionality of the current legislation.

There is a procedure in Florida for the trial court to rule that the statute is "unconstitutional" and then to "fast track" the appeal to the Supreme Court of Florida, bypassing the intermediate appellate court step discussed above (i.e., saving approximately one year).

For some of the questions, insurers also noted that their responses would be general in nature or not applicable at this point in time, for other questions the information requested by Deloitte Consulting was not available (e.g., not tracked in their systems), and depending on the business written by the insurer, some of the questions were not applicable (e.g., insurer does not write physicians).

Future Handling of "Presumed Factor"

As part of our MLDR, we asked medical malpractice insurers to discuss how it would handle the impact of the "Presumed Factor" (PF) in their next rate filing.

The responses varied significantly, ranging from companies who said it had not determined how the impact will be handled in their next rate filing; companies who discussed reflecting the November 6, 2003 PF of 7.8% as a reduction to their indicated loss and LAE pure premium with the intention of continuing to include the 7.8% PF in 2005 filings; and companies that noted for 2004 and subsequent coverage years, it is expected that the impact of the tort reforms will be reflected in the loss experience (i.e., no PF will be required), essentially treating the PF as a one time event.

Subsequent to receiving the MLDR responses, the OIR provided the following guidance to medical malpractice insurers:

"Senate Bill 2-D (enacted in August, 2003) required the Office of Insurance Regulation to publish the Presumed Factor described in the Bill. The Presumed Factor was to reflect a prospective adjustment of rates in anticipation of the savings provided by all the sections of the Bill. The Bill then required insurers to recognize the Presumed Factor as published by the Office in their rates within 60 days after its publication or to provide an appropriate alternative.

The Office suggests that a medical malpractice rate filing made subsequent to the required Presumed Factor Filing should not recognize only the Presumed factor as was published in 2003, but the effects of each section of the Bill on an insurer's particular book of business. Since some of the experience in a medical malpractice rate filing may have taken place after the Bill became effective, it is important that an insurer's analysis recognize how the prospective estimates of the effects of the Bill will be replaced with actual experience as that experience becomes available.

The Office will return as incomplete any medical malpractice rate filing which does not include an analysis of the actual effects of the Bill on rates as well as the prospective analysis included in the Presumed Factor."

Deloitte Consulting believes the above guidance by the OIR will help medical malpractice insurers better understand how to consider tort reform in their upcoming filings, removing the uncertainty observed in the wide range of responses we received.

One insurer noted the following:

"It is our intent that future rate filing will reflect an adjustment to loss experience pertaining to the period prior to the enactment of SB2D to account for the impact of the medical liability reform legislation. The adjustment will be made based upon the "presumed factor" or other more recent analysis as prescribed or deemed appropriate by the Florida Office of Insurance Regulation"

This response appeared to be the most consistent with the recent OIR guidance.

Patient Safety (Section 6)

As part of our MLDR, we asked medical malpractice insurers to discuss how the appointment of a patient safety officer and patient safety committee at each licensed facility has impacted patient safety in Florida.

The responses varied significantly, ranging from a number of companies who said it did not insure any facilities and therefore had no information or data; to an insurer who noted that **all** of its insured facilities in the State of Florida have a patient safety officer and a patient safety committee.

An exhibit provided by one of the insurers displayed its claim frequency by loss year (i.e., 1999 through 2003) for two territories. The reported frequency per 1,000 of exposure and claims with indemnity per 1,000 of exposure by territory provided little insight into trends. The reported frequency per 1,000 of exposure is shown below:

Loss Year	Territory 1	Territory 2
1999	46.5	35.0
2000	39.7	41.9
2001	43.1	38.3
2002	45.2	39.2
2003	44.7	34.7

The reported indemnity per 1,000 of exposure is shown below:

Loss Year	Territory 1	Territory 2
1999	25.6	16.1
2000	20.0	17.3
2001	25.1	14.0
2002	21.1	16.1
2003	21.5	10.3

As noted by the insurer:

“Since the statute was effective in 2003, it is premature to draw conclusions from this data about the effect of having a patient safety officer and committee in place.”

On page 8 of our November 6, 2003 report titled **Review of Florida Committee Substitute for Senate Bill 2-D, Calculation of Section 40 “Presumed Factor”**, Deloitte Consulting stated the following:

The development of patient safety programs is a rapidly-emerging phenomenon among large healthcare provider systems. These are principally aimed at devising systems that examine past adverse events and even near-misses with a view toward avoiding preventable mistakes and engineering away the possibility of damage resulting from errors made by a single human being. Most large providers with whom we have worked have already implemented internal approaches to patient safety and are quite active in the field.

Deloitte Consulting also stated:

The larger impact of this aspect of the Statute will be its effect on smaller provider organizations. We expect that in order to comply with these provisions, most will be working with outside consultants to implement patient safety plans. At this time, we do not expect that these will represent a significant deviation from current risk management and patient safety practices, and are not likely to result either in significantly reduced malpractice events or consequent claims activity.

It is still premature to draw conclusions regarding the impact of patient safety on Florida's licensed facilities.

Notifying Patients of "Adverse Incidents" (Section 7/Section 8)

As part of our MLDR, we asked medical malpractice insurers to discuss how successful its insured practitioners and non-practitioners (i.e., licensed facilities) have been at notifying patients of "adverse incidents" under SB2D.

Practitioner

All but one of the insurers focused on covering practitioners responded that it did not track the success of their practitioner insureds in notifying patients of "adverse incidents". As noted by one insurer:

"The primary duty for complying with this provision lies with the healthcare provider."

One insurer noted:

"Our insureds have always been instructed to call us when an adverse incident occurs. We encourage, instruct, direct and help with directly informing patients of adverse outcomes when appropriate."

Non-Practitioner

A number of insurers noted that it did not insure licensed facilities and are not privy to data pertaining to the extent to which non-practitioners are reporting adverse incidents.

One insurer noted:

"Our insured facilities have developed and implemented facility-specific guidelines that address patient notification of medical errors. The guidelines are derived from a model template. Hospital CEOs are accountable for making sure the process is successfully implemented and this implementation is validated as part of internal quality review. While individual hospitals keep detailed records of patient notification, that information is not aggregated or tracked by us. Anecdotally, as a percent of all inpatient and outpatient visits, that figure would be minuscule – considerably less than 1%."

Five Most Frequently Misdiagnosed Conditions (Section 10)

As part of our MLDR, we asked medical malpractice insurers to list the five most frequently misdiagnosed conditions of its insured practitioners.

Some insurers noted that it did not compile this information (e.g., computer system does not track allegations), while one insurer noted that because of who it insures, misdiagnosed medical conditions are not an issue.

A sample of the lists provided:

One insurer reported:

1. Breast cancer
2. Acute Myocardial Infarction (MI) (a/k/a heart attack)
3. Cancer of the mouth and gums
4. Cancer of the male genital organs
5. Cancer of the lung & Larynx

Note: Last three tied for third

Previous studies included fractures and appendicitis

Another insurer reported:

1. Breast cancer
2. Lung cancer
3. Appendicitis
4. Heart disease and related illnesses
5. Pulmonary embolism (i.e., a blockage of an artery in the lungs by fat, air, tumor tissue, or blood clot)

Another insurer reported:

1. Radiology – mammography – breast cancer
2. Emergency room – pulmonary embolism
3. Emergency room - aneurysm
4. OB/GYN – cesarean section vs. vaginal delivery
5. Primary care physicians - appendicitis

Another insurer focused on dentists reported:

1. Periodontal disease
2. Decay
3. Infection
4. Tooth fracture
5. Cancer

Practitioner Profiles (Section 14/Section 15)

As part of our MLDR, we asked medical malpractice insurers to comment on the usefulness of the practitioner profiles shown on the Florida Department of Health (DOH) website

<http://www.doh.state.fl.us/MQA/profiling>.

The responses varied from one insurer who noted it did not use the website as part of their underwriting process, to a number of insurers who said it uses the practitioner profiles in the underwriting process and find the profiles useful in this regard (e.g., researching of education, confirmation of board certification, licensing, practice location, etc.). One insurer noted:

“The Company utilizes this data base on all new applicants during the underwriting process. The data base is used to verify information contained on the application completed by the doctor and also is used to verify insurance history which is helpful to the Company. We have found that the information is not always up to date as some doctors have not updated their profile after the initial profile. In these instances, we will have to call the doctor to verify information or pursue another source. Overall the database is a useful tool used by the Underwriting Department.”

However, none of the insurers have surveyed its insured practitioners or are aware of any data regarding practitioner satisfaction with the profiles on the DOH website.

Suspension for Non-Payment (Section 23)

As part of our MLDR, we asked medical malpractice insurers to list and describe any instances where physicians have been suspended for non-payment of awards.

All of the insurers responded that the companies were not aware of any instances where physicians have been suspended. One insurer stated:

"To the best of our information and knowledge, we are unaware of any instances where physicians have been suspended for non-payment of awards under Section 23 of SB2D."

Another insurer stated:

"Since we provide our physicians with financial protection against liability awards, we have not been directly involved in any instance where a physician has been suspended for non-payment of an award."

Another insurer stated:

"As Section 23 pertains to physicians who maintain an escrow account or obtain a letter of credit as proof of financial responsibility, with failure to timely pay an award or judgment relative to the maintenance of either form of financial responsibility, our Company does not have any information regarding this issue."

Expert Witness Testimony (Section 48)

As part of our MLDR, we asked medical malpractice insurers to discuss the impact of SB2D on expert witness testimony.

All the responses from the insurers noted that it is too early to evaluate the impact of Section 48.

One insurer noted:

"While it is too soon relative to the effective date of SB2D to assess the impact of Section 48 of SB2D on the availability of expert witnesses, thus far our Company has not seen a shortage of defense experts and is without knowledge as to any limitation of plaintiff's

experts. Medical malpractice lawsuits in Florida lacking in merit should not be characterized as frivolous because the adoption of the pre-suit requirement to file a verified expert opinion generally eliminates "frivolous" claims."

Another insurer noted:

"To date, we have not observed any discernible impact on the qualifications of expert witnesses in medical malpractice files submitted after September 15, 2003. Because the statutory changes are less than one year old and because the typical medical malpractice claim takes much longer than one year to fully litigate, we do not have a statistically significant pool of cases to draw from in order to adequately respond to this request. To date, there has been no limitation on either the plaintiff's side or the defense side with regard to the introduction of expert witnesses. Likewise, we have not seen any reduction or elimination of frivolous claims that can no longer be supported as a result of the new parameters for expert witnesses under SB2D. We do not anticipate much, if any, favorable impact on our Florida cases."

Another insurer noted:

"Because these lawsuits are in the early stages of discovery and the courts have not addressed the issue yet, Our Company has not observed any limitations on plaintiff or defense experts. From a defense standpoint, the Company is not experiencing any difficulty locating qualified experts to review cases in the pre-suit period. The Company has no knowledge as to whether the plaintiff attorneys are having difficulty locating experts to sign affidavits in order to file a Notice of Intent. The Company has not experienced any reduction in the number of frivolous claims."

Another insurer noted:

"Too early to evaluate. We believe the impact of SB2D will require several years to evaluate."

Another insurer noted:

"While the definition of "limitation" in the query requires further clarification, our Company has not observed any express limitations on plaintiff or defense experts. From our perspective, the provisions pertaining to expert witnesses have not deterred the filing of frivolous lawsuits or constrained expert witness testimony."

Another insurer noted:

"Yes, plaintiff's attorneys are reluctant to proceed with a lawsuit unless they have a bona fide expert. There has been very little impact on the elimination of frivolous claims that can no longer be supported by experts defined under SB2D."

Another insurer noted:

"It is too early to assess the impact of Section 48 of SB2D dealing with expert witness testimony. We have not yet observed any limitation of defense of plaintiff experts. We are not able to determine if claims have not been brought against our insureds because they can no longer be supported by experts as defined under SB2D."

On page 85 of our November 6, 2003 report titled **Review of Florida Committee Substitute for Senate Bill 2-D, Calculation of Section 40 "Presumed Factor"**, Deloitte Consulting stated the following:

During our analysis of SB2D, we have been careful to consider the impact of the bill on the insurer's cost of defending claims. It is our belief that what the law "gives with one hand, it takes away with the other." For example, Section 48 defines expert witness testimony and when a person may give expert testimony concerning the prevailing professional standard of care. Although the change in expert witness qualifications will likely increase costs for plaintiff attorneys and reduce the likelihood of the use of so called "general" experts, it is our belief that these savings will be offset by the increased costs associated with insurance companies having to use expert witnesses in defending cases and in other Sections of the bill.

Based upon the responses from the MLDR, it is too early to establish the impact of SB2D on expert witness testimony.

Notice (Section 49)

As part of our MLDR, we asked medical malpractice insurers to discuss the impact of SB2D dealing with issues such as notice before filing of a claim and pre-suit screening.

One insurer noted:

"It is too early to determine if there is any impact of Section 49 of SB2D. Our company would not have any knowledge of the percentage of plaintiffs sending copies of complaints to the DOH or the percentage of plaintiffs providing pre-suit information regarding all known doctors who have seen the claimant."

Another insurer noted:

"However, as there has only been 14 incidents reported where the new law is applicable, we lack sufficient information to comment. Regarding the reports to DOH, we are not recipients of that information, as it does not apply to insurance carriers."

Another insurer noted:

"Most plaintiff attorneys copy the DOH on the Notice of Intent that we receive. A significant number of plaintiff attorneys do not provide the names of potential co-defendants."

Another insurer noted:

"We can note that the Company has seen a small percentage of plaintiff attorneys actually comply with the requirement of sending copies of complaints to the DOH. As for the requirement that a list of all treating physicians be included with the Notice of Intent, it is our experience that most plaintiff attorneys simply send a copy of the medical records along with the NOI. In more cases than not, the medical records are incomplete. This information would be best gathered from the plaintiff attorneys for an accurate assessment of compliance with the requirement noted."

Another insurer noted:

"Our company does not have information regarding the percentage of plaintiffs who are sending copies of complaints to the DOH and of those who are providing pre-suit information regarding all known physicians who have seen the claimant for the relevant injuries. Unless there is an inquiry from a state professional licensing board, we do not receive such notices on a consistent basis. Mechanisms to track this information should reside with the state."

Another insurer noted:

"The impact on new filings is difficult to assess since the number of insureds has declined during the same period. Almost all plaintiffs are sending copies of complaints to the DOH and providing pre-suit information."

Another insurer noted:

"Our company does not track this data."

Arbitrations and Mediations (Section 50)

As part of our MLDR, we asked medical malpractice insurers to provide information on the ratio of settlements under binding arbitrations to all claims closed both before and after SB2D. We also asked for a similar ratio for mediations.

One insurer noted:

"Our Company has not and does not participate into binding arbitration agreements either before or after September 15, 2003. Our Company occasionally participates in pre-suit mediation, however, we have seen in many instances, the plaintiff will waive early mediation because 120 days of discovery is not adequate time to evaluate a case and enter into meaningful settlement discussions. Although the Company occasionally participates in pre-suit mediations, we do not believe these occur frequently enough to develop a meaningful ratio."

Another insurer noted:

"Our Company has never participated in a binding arbitration."

Another insurer noted:

"Prior to SB2D, the rate of matters closed via binding arbitration would be less than 1%; subsequent to SB2D we have no cases "settled" via binding arbitration. We have not noticed any change in the ratio of settlements either through binding arbitration or through mediation based upon the introduction of the new medical malpractice provisions that went into effect on September 15, 2003. First, as a practical matter, given the duration of the typical medical malpractice lawsuit, we do not have enough settlements of post-September 15, 2003 claims in order to provide a statistically significant analysis. We are not aware of anyone who has arbitrated any post-September 15, 2003 claim. Further, we do not have statistics reflecting the ratios of binding arbitrations to overall claims, or mediations to overall claims, to be able to answer this question."

Another insurer noted:

"In our several year history in Florida, we have only offered to arbitrate 6 cases and all of the cases have been settled before the formal arbitration panel. We have only offered to arbitrate one case since 9/15/03."

Another insurer noted:

"Due to a Florida Supreme Court ruling concerning statutory binding arbitration, this method of resolving medical malpractice claims has not been used by the Company for, at least, the past five years. As to Section 50 of SB2D, our Company has not had any cases that have been settled in accordance with this new law."

Another insurer noted:

"There are no known claims closed under binding arbitration before or after SB2D."

Another insurer noted:

"Our company does not track this data."

Another insurer noted:

"There is no means by which to track the ratio of settlements under binding arbitration or mediation to claims closing both before and after SB2D. This information could probably be obtained through the National Practitioner Database (NPDB). Medical liability insurers supply information to the NPDB regarding the means by which a claim was closed, e.g., verdict, mediation, settlement, or other. However, our Company does not compile data regarding the ratios."

Cap on Non-Economic Damages (Section 54)

As part of our MLDR, we asked medical malpractice insurers to answer seven questions related to the cap on non-economic damages.

Question 1: Please list any court cases in the state of Florida that have imposed a cap on non-economic damages.

None of the companies were aware of any court cases in Florida that have imposed a cap on non-economic damages.

One insurer noted:

"One Seminole County judge recently entered an order enforcing the non-economic cap provisions of the Medical Malpractice Act. However, it is not a case being handled by

our company and therefore we do not have any details on statistics arising out of that claim."

Question 2: Please list any claims your company is currently litigating that have a high probability of resulting in non-economic damages that exceed the SB2D caps.

A number of the companies responded that it didn't have the information available, didn't track it in an organized fashion, or felt that if it provided the information, it could potentially jeopardize the defense of the company's current cases and possibly increase the exposure of the Company and their insureds.

One insurer in this category did note:

"We are currently handling lawsuits that could invoke the non-economic damages caps. Many of these claims are still in pre-suit, or it is premature to precisely evaluate the potential non-economic portion of the claims. Non-economic damages in such cases would ordinarily be well in excess of the economic damages. Application of the caps in these cases would significantly reduce the non-economic damages value of the claims. We do not think it would be appropriate to comment on specific pending litigation."

Another insurer in this category noted:

"Given the nature of medical malpractice claims, a majority of our Company's claims have situations that, if determined adversely to the Company, have a high probability of resulting in non-economic damage that exceed the caps. Many of our cases involve wrongful death and people with permanent injuries that require long-term care or involve significant loss of income. It is not possible to provide non-economic and economic dollar estimates given the high volume of active cases and the very subjective nature of this analysis. For post September 15, 2003 cases, it is still too early to predict since most of the cases are still in the initial discovery stages."

Two of the companies did provide economic and non-economic damage estimates regarding cases that could potentially exceed the cap on non-economic damages²⁸.

²⁸ The information provided by the two companies displayed economic and non-economic damage estimates only. No other confidential suit specific information was provided to Deloitte Consulting.

One insurer listed 10 suits all filed before September 19, 2004 with potential non-economic damages in excess of \$1,000,000 that could be subject to the cap.

Another insurer listed 23 suits with non-economic damages ranging from \$210,000 to \$1,000,000 that could be subject to the cap.

Question 3: Please discuss your perception of the constitutionality of the non-emergency room caps on non-economic damages for practitioners and non-practitioners?

One insurer noted:

"We have not analyzed the constitutionality of the non-emergency room caps on non-economic damages as there has been insufficient experience to offer a comment on this issue."

Another insurer noted:

"No comment."

Another insurer noted:

"Our company does not have an official opinion as to whether the damage caps imposed by the passage of SB2D will ultimately be held to be valid under Florida's constitution."

Another insurer noted:

"The language regarding both the cap on non-economic damages in emergency and non-emergency cases was drafted in a manner to withstand constitutional challenge based on prior Florida Supreme Court decisions. We anticipate there will be cases in which the constitutionality of these caps is challenged, and it is unknown what the courts will rule"

Another insurer noted:

"Florida courts have historically been reluctant to uphold limits on damages in lawsuits. As a result, our claims personnel are reluctant to give great credibility to the caps until such time as they are tested. Having said that, we have adopted the presumed factors in our two most recent rate filings. These factors assume that the caps will in fact be held constitutional. However, if the caps are found to be unconstitutional, our rates may be inadequate."

Another insurer noted:

"We estimate that there is a 50% chance that the cap will be declared constitutional. We have no legal opinion."

Another insurer noted:

"The constitutionality of the non-emergency room caps will have to be tested by a court of law. The Company has no way to gauge what the courts in Florida will decide and it would be fruitless to speculate on the outcome."

Another insurer noted:

"Our company believes the various caps enacted by the State of Florida as part of SB2D to be constitutional. Our company does, however, recognize that the Florida courts have struck prior limitations on damages, while others have been upheld. However, based on the findings of the Legislature in enacting the medical practice damage limitations, and the actual crisis impacting the medical malpractice insurance market at the time SB2D was enacted, our Company is cautiously optimistic that the courts will uphold the limitations on non-economic damages contained in SB2D. However, if the example of other states is followed in the case of Florida, it will be a period of years before all challenges to the constitutionality of the various provisions statute are brought and fully resolved. During that period, it is unlikely that the State will realize the full benefit of the caps enacted as part of SB2D."

Question 4: Please discuss your perception of the constitutionality of the non-emergency room caps on non-economic damages for practitioners and non-practitioners?

Most of the insurers repeated their answers from question 3. The following companies provided unique answers to question 4.

One insurer noted:

"The constitutionality of the cap on non-economic damages in emergency cases stands a good chance of being upheld on public policy grounds, i.e., shortage of physicians who provide emergency room services."

Another insurer noted:

"We estimate that there is a more than 50% chance that the emergency room caps will be declared constitutional."

Question 5: Please discuss and provide any available data showing whether the cap on non-economic damages has helped your negotiating position in any of the cases you have settled in 2004 (e.g., speed up in claim settlement, elimination of frivolous claims, etc.)?

A number of the companies responded that it is too early to comment on this question since the caps have not been tested and most of the cases filed after September 15, 2003 are still in the very early stages of discovery (i.e., not close to settlement). However, a few companies added the following commentary.

One insurer noted:

"The plaintiff counsel that we encounter in the defense of claims refuse to recognize any value in the cap on non-economic damages imposed by SB2D and, therefore, it is our current perception that it is having no effect in the settlement of claims. Medical malpractice lawsuits in Florida lacking merit should not be characterized as frivolous because the adoption of the pre-suit requirement to file a verified expert opinion generally eliminates "frivolous" claims."

The company also provided a summary of the average cost of closed claims before 9/15/2003 and after 9/15/2003:

Category	Before 9/15	After 9/15
Average Total Cost	\$32,140	\$38,809
Average Indemnity Payment	\$200,740	\$229,885

Note: Indemnity limited to \$500,000, Claims reported after January 1, 1999

Another insure provided the following summary of the average cost of closed claims before 9/15/2003 and after 9/15/2003:

Category	Before 9/15	After 9/15
Average Total Cost	\$40,987	\$75,713
Average Indemnity Payment	\$222,167	\$253,909

Note: Indemnity limited to \$500,000, Claims reported after January 1, 1999

Another insurer noted:

"As noted above, because the statutory changes are less than one year old and because the typical medical malpractice claim takes much longer than one year to fully litigate, we do not have a statistically significant pool of cases to draw from in order to adequately respond to this request. To date, we can say that we have yet to see any discernable change in any of the three areas identified in the July 8, 2004 memorandum. However, this is subject to change once we do have a statistically significant pool of cases to analyze."

Another insurer noted:

"The average indemnity payment for claims in Florida for the fourth quarter of 2003 was approximately 60% higher than the average indemnity payment for claims in the first three quarters of 2003 and the average ALAE for the fourth quarter 2003 was approximately 23% higher than it was for the first three quarters of 2003. While this increase is significant, it cannot be totally attributable to the effects of SB2D as the data does not include any post September 15, 2003, SB2D judgments as it is still too premature for those cases to enter the court system."

Another insurer noted:

"To date, the cap on non-economic damages has not helped our negotiating position with respect to any claims settled in 2004."

Question 6: How is your perception of the constitutionality of the cap on damages being reflected in your post SB2D rate filings?

A number of the companies referred to its previous responses discussing the constitutionality of the caps and how it would handle the PF in future rate filings.

One insurer noted:

"Rate filings submitting following the enactment of SB2D reflected the "presumed factor" as directed by the Florida Office of Insurance Regulation."

Another insurer noted:

"Our Company provided full credit for the presumed factor as required by law."

Another insurer noted:

"The Company's most recent filing submission employed the presumed factor calculated by Deloitte & Touche LLP in their November 6, 2003 review of SB2D (7.8%) as a reduction to the Company's indicated loss and loss adjustment expense pure premium, without any adjustment to reflect the possibility of the damage caps being ruled unconstitutional. Thus, the assumption implicit in the Company's filing is that the damage caps will be upheld as constitutional. If they are instead found invalid, then the presumed factor employed by the Company will need to be reduced to reflect this development."

Another insurer noted:

"The Company has not made a rate filing as of today's date. The Company has not changed the way it computes its rates based on the constitutionality of the cap on damages. It will continue to develop rates based on current and past data. The Company will, however, modify the assumptions made during the ratemaking process given the ramifications of the caps on damages."

Another insurer noted:

"At this time, we do not anticipate our perception of the constitutionality of the cap on damages to have an impact on our post SB2D PF rate filings."

Question 7: How did you reflect the \$150,000/\$300,000 emergency room caps in your recent PF filing required under SB2D?

One insurer noted:

"The impact of the emergency room caps on non-economic damages was presumed to have been included in the scope of the "presumed factor". No separate adjustment was expressly incorporated for this element."

Another insurer noted:

"Our Company provided full credit for the presumed factor as it applied to emergency room physicians as the calculated presumed factor reflected in the last rate filing included the impact of this cap."

Another insurer noted:

"On September 15, 2003, we had a pending rate filing with the Florida Office of Insurance Regulation requesting, among other items, an increase in the class relativity for emergency medicine. This filing was withdrawn. We did not request the class relativity increase in our later approved filing."

Another insurer noted:

"The Company's most recent filing submission reflected the lower emergency room caps under SB2D by reducing the class factors applicable to those specialties."

Another insurer noted:

"The Company followed the requirements of the legislation and the insurance department in regard to the implementation of the presumed factor for its January 1, 2004 rate filing. There was no specific adjustment for emergency medicine."

Another insurer noted:

"In our prior filing, we did not make an explicit adjustment to the emergency room rates beyond that contemplated by the overall PF."

Deloitte Consulting regularly attends the quarterly and year-end earnings calls of the major publicly traded medical malpractice insurers listed on the New York Stock and NASDAQ Exchanges. During a second quarter earnings call, the management of one company noted that it had not seen any tort reform benefit from the effects of SB2D. The Company also noted that plaintiff attorneys generally view the law as unconstitutional. To date, the Company has only recognized the Presumed Factor.

Bad Faith (Section 56)

As part of our MLDR, we asked medical malpractice insurers to answer five questions related to the bad faith. For some of the questions, companies noted that it did not capture the information or it was unavailable. We have not included those responses below.

Question 1: Please discuss how many times your company has tendered policy limits since September 15, 2003.

One insurer noted:

"None for claims opened after 9/15/2003."

Another insurer noted:

"The meaning of the word "tender" under Florida law is "offered" and we do not track or record this specific category of data in any organized format whatsoever that would permit access or analysis."

Another insurer noted:

"None."

Another insurer noted:

"2 times."

Another insurer noted:

"None of the cases filed where the act applies. It is our belief that Section 56 does not apply to cases pending or for incidents occurring prior to September 15, 2003. Otherwise we have tendered policy limits on 25 cases since September 15, 2003 but most if not all were for incidents occurring prior to September 15, 2003."

Another insurer noted:

"We have not tendered policy limits in any case since September 15."

Another insurer noted:

"Please be advised, the tendering of policy limits does not constitute "bad faith" payments. Bad faith payments imply that for whatever reason, the insurer breached its duty to the insured and damages resulted. The Company has tendered policy limits 26 times since September 15, 2003 in the state of Florida.

Occasionally, the Company will pay in excess of policy limits to protect its insured from personal exposure. However, the Company has only received 5 NOIs since September 15, 2003 where the incident date is after September 15, 2003 and none of these cases have been resolved."

Question 2: Please provide the approximate number of plaintiff attorney demand letters received before and after SB2D.

Most insurers noted that it did not track this information.

One insurer noted:

"It can be generally stated that our Company almost always receives a demand letter at some point in all lawsuits both before and after SB2D."

Another insurer noted:

"As a general rule, we receive demand letters on all litigation cases sometime prior to trial."

Another insurer noted:

"We were unable to determine at this time, as we did not previously capture this information. For the cases filed where SB2D applies: none."

Another insurer noted:

"The phrase "plaintiff attorney demand letters" is not defined and could have different meanings in various cases. The Company would require further explanation of what constitutes a demand letter. In addition, the Company does not separately code whether it receives correspondence of this type and determination of a number would require a manual review of all claim files."

Question 3: Please provide the number of claim settlements per policy both before and after SB2D.

One insurer noted:

"Given the short period of time that has passed since the effective date of SB2D, and the fact that it takes an average of approximately 2 – 2.5 years to settle claims, there is no meaningful data on the number of claim settlements before and after SB2D."

Another insurer noted:

"151 claims were closed with loss payment before September 15, 2003 and 20 claims were closed with loss payment on or after September 15, 2003."

Another insurer noted:

"This question is not clear. Our policies are written on a per individual insured basis. If a settlement is made it is done per insured defendant and allocated accordingly."

Another insurer noted:

"We write an occurrence policy and therefore this question does not apply to our Company."

Another insurer noted:

"The Company has not settled any claims that have been reported after September 15, 2003 with an incident date that occurred after September 15, 2003. The timing is premature for any meaningful data comparison. In addition, we note that the Company historically has not determined claims settlement on a per policy basis."

Question 4: Please provide the average severity of settled claims both before and after SB2D.

One insurer noted:

"The following average severities (which include both incurred loss and ALAE) were determined for closed Florida professional liability insurance claims for our Company's medical malpractice and specified medical product lines, as of 7/31/2004."

Claims closed with >0\$ incurred loss+ALAE, which were opened on or after 1/1/2000, but before 9/15/2003 (172 claims):\$141,559.

Claims closed with >0\$ incurred loss+ALAE, which were opened on or after 9/15/2003 (only 6 claims, very green!): \$43,402.

Claims closed with >0\$ incurred loss (not including ALAE), which were opened on or after 1/1/2000, but before 9/15/2003 (115 claims): \$207,664.

Claims closed with >0\$ incurred loss (not including ALAE), which were opened on or after 9/15/2003 (only 2 claims, very green!): \$125,207."

Another insurer provided the following summary of the average cost of closed claims before 9/15/2003 and after 9/15/2003:

Category	Before 9/15	After 9/15
Average Total Cost	\$32,140	\$38,809
Average Indemnity Payment	\$200,740	\$229,885

Note: Indemnity limited to \$500,000, Claims reported after January 1, 1999

Another insurer provided the following summary of the average cost of closed claims before 9/15/2003 and after 9/15/2003:

Category	Before 9/15	After 9/15
Average Total Cost	\$40,987	\$75,713
Average Indemnity Payment	\$222,167	\$253,909

Note: Indemnity limited to \$500,000, Claims reported after January 1, 1999

Another insurer noted:

"The average severity for the 151 claims closed with loss payment before September 15, 2003 was \$206,168. The average severity for the 20 claims closed with loss payment after September 15, 2003 is \$319,301."

Another insurer noted:

"The average severity of all claims closed with payment prior to September 15, 2003 is \$248,463. The average severity of all claims closed with payment on or after September 15, 2003 is \$231,444. The credibility of this number is difficult to evaluate provided that the severity average prior to September 15, 2003 is based on a larger population of closed claims than those after September 15, 2003 (only 10 months of data)."

Another insurer noted:

"If the intent is to measure the impact of SB2D on claim severity then, given the duration of the typical medical malpractice lawsuit, we do not have enough settlements of post-September 15, 2003 claims in order to provide a statistically significant analysis."

Another insurer noted:

"The Company has not settled any claims that have been reported after September 15, 2003 with an incident date that occurred after September 15, 2004. The timing is premature for any meaningful data comparison."

Question 5: Have your defense mitigation strategies changed since the passage of SB2D?

One insurer noted:

"No."

Another insurer noted:

"Yes. We have modified our defense strategies to ensure compliance with the new "bad faith" provisions."

Another insurer noted:

"We are still evaluating the effect, if any, SB2D will have on claim negotiation strategies."

Another insurer noted:

"Our defense strategies have always been to act in utmost good faith to our policyholders. At this point, it is premature to comment on how the passage of SB2D may affect our defense mitigation strategies."

Another insurer noted:

"No. We have not and do not expect that bad faith will be an issue."

Another insurer noted:

"Our defense mitigation strategies have not changed since the enactment of SB2D. The Company will most likely not modify its strategies until the constitutionality of the caps is upheld in the courts."

Good SAM (Section 56)

As part of our MLDR, we asked medical malpractice insurers to comment on the impact of “good SAM” under Section 56 of SB2D.

One insurer noted:

“None.”

Another insurer noted:

“To the best of our knowledge, we are not aware of any information that would provide insight on the impact of the “good SAM” section 56 of SB2D, nor are we aware of any claims where good SAM has had a favorable impact.”

Another insurer noted:

“We have no claims impacted by the good Samaritan statute.”

Another insurer noted:

“No data available.”

Another insurer noted:

“We have not seen an impact of Section 56.”

Another insurer noted:

“The Good SAM provision has not been tested in the courts and has not impacted any of our cases. It has been our early experience that the lower courts seem hesitant to apply the provision except under extreme circumstance.”

Another insurer noted:

“We have not experienced good SAM claims.”

Policy Limit Trends

As part of our MLDR, we asked medical malpractice insurers to comment on the breakdown of policy limits sold by policy count both before and after SB2D.

Section 627.912(6), Florida Statutes, as amended by Senate Bill 2-D, (Ch. 2003-416)

One insurer noted:

"The minimum limits purchased by Florida dentists are \$1,000,000/\$3,000,000. Therefore, the limit profile of our company has not changed as we have not experienced the purchase of lower policy limits by these Insureds since enactment of SB2D."

Another insurer noted:

"Between 2002 and 2003 we observed:

- 1. fewer purchases of insurance at any limit*
- 2. on an absolute number as a percentage of total policies, fewer were purchased at a limit of \$1MM/\$3MM.*

We believe that the trend toward fewer applicants buying coverage and those that do purchase coverage purchasing lower limits is due to the cost of insurance."

Another insurer provided the following data:

PER OCCURRENCE LIMIT	1999	2000	2001	2002	2003 - Pre 9/15	2003 - Post 9/15	2004 Through June 30
\$100,000	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
\$250,000	25.0%	24.0%	32.0%	41.0%	54.0%	52.0%	61.0%
\$500,000	22.0%	22.0%	18.0%	20.0%	20.0%	21.0%	18.0%
\$1,000,000	44.0%	42.0%	41.0%	32.0%	21.0%	24.0%	18.0%
\$1,500,000	5.0%	5.0%	3.0%	2.0%	1.0%	1.0%	1.0%
\$2,000,000	3.0%	4.0%	3.0%	3.0%	3.0%	1.0%	2.0%
\$3,000,000	0.0%	0.0%	1.0%	1.0%	0.0%	0.0%	0.0%
\$4,000,000	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
\$5,000,000	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
UNKNOWN	2.0%	3.0%	1.0%	1.0%	1.0%	1.0%	0.0%
TOTAL	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

Section 627.912(6), Florida Statutes, as amended by Senate Bill 2-D, (Ch. 2003-416)

Another insurer provided the following data:

PER OCCURRENCE LIMIT	1999	2000	2001	2002	2003 - Pre 9/15	2003 - Post 9/15	2004 Through June 30
\$100,000	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
\$250,000	16.0%	13.0%	13.0%	21.0%	50.0%	60.0%	59.0%
\$500,000	15.0%	9.0%	6.0%	11.0%	6.0%	3.0%	11.0%
\$1,000,000	68.0%	78.0%	81.0%	68.0%	44.0%	36.0%	30.0%
\$1,500,000	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
\$2,000,000	0.0%	0.0%	0.0%	0.0%	1.0%	0.0%	0.0%
\$3,000,000	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
\$4,000,000	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
\$5,000,000	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
UNKNOWN	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
TOTAL	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

Another insurer noted:

“Over the past two years we have seen a trend toward physicians purchasing lower policy limits. We believe this trend is in response to increased price and not a specific reaction to the non-economic caps or other aspects of SB2D.”

LIMITS PURCHASED	DISTRIBUTION AS OF 8/31/2003	CURRENT DISTRIBUTION
\$100K/\$300K	0.03%	0.03%
\$250K/\$750K	16.54%	20.78%
\$500K/\$1.5M	19.05%	21.30%
\$1M/\$1M	0.07%	0.06%
\$1M/\$3M	61.41%	57.83%
\$2M/\$4M	1.10%	0.00%
\$3M/\$5M	1.80%	0.00%
TOTAL	100.0%	100.0%

Another insurer noted:

“The table below provides distributions of policies sold by limits for the six-month periods before and after enactment of SB2D. As these are not annual periods, there may be some difference due to the different cohort of policies reflected in the two periods.”

PER OCCURRENCE LIMIT	04/01/03 THROUGH 09/30/03	04/01/03 THROUGH 09/30/03
\$100,000	0.3%	0.3%
\$200,000	0.1%	0.0%
\$250,000	47.7%	46.4%
\$500,000	19.8%	16.9%
\$1,000,000	30.7%	34.9%
\$1,500,000	0.6%	0.9%
\$2,000,000	0.6%	0.3%
\$3,000,000	0.1%	0.1%
\$4,000,000	0.1%	0.0%
\$5,000,000	0.0%	0.0%
TOTAL	100.0%	100.0%

Another insurer noted:

"It is premature to draw conclusions about the effect on the purchase of limits."

Another insurer noted:

"We see a continuing trend toward the purchase of lower limits of liability. Additionally, we have lost a number of policyholders who have indicated that they are leaving the insurance market and will practice without insurance."

Distribution Policy Limits	12/31/2002	12/31/2003	03/31/2004
\$250,000	49.6%	60.4%	62.0%
\$500,000	15.5%	15.4%	14.5%
\$1,000,000	34.8%	24.2%	23.6%

Targeting Lower Policy Limits

In reviewing the above results, one has to ask the following question:

"Who is driving the shift towards lower policy limits; physicians or insurers?"

Although we think the primary driving force behind the purchase of lower policy limits is physicians looking to offset large premium increases with lower cost reduced policy limits, we note the comments made by one of Florida's newest medical malpractice reciprocal insurers in a May A.M. Best Bestwire news article:

"Our Company's focus will be on making insurance products available and affordable for doctors, he said. One way to do that is to offer across-the-board low-limit coverage that meets the statutory limits of \$100,000 per claim or \$300,000 annual aggregate for physicians not admitting patients to a hospital and \$250,000 per claim or \$750,000 annual aggregate for physicians who do admit patients into a hospital setting."

The article also noted:

"Physicians can save thousands of dollars a year with lower limits, but the industry has hurt doctors by offering high-limit insurance. That made doctors a very attractive financial target."

Going Bare

In response to questions raised by a stock analyst during a second quarter earnings call, the management of one company responded that the number of doctors going bare in the state of Florida is a huge problem. Company management noted that plaintiff attorneys, who target insured doctors for their insurance company backed policy limits, are essentially compounding the rate problem by letting "bare" doctors off the hook.

During the same Company's first quarter earnings call, management similarly noted that it was worried about Florida cases where its insured physicians have been sued along with "bare" doctors as co-defendants. In these situations, the Company stated that it had been viewed as the "deep pocket". In addition, the Company noted that it was worried that plaintiffs who truly deserve compensation won't be able to recover what they should be able to recover.

On page 7 of our November 6, 2003 titled **Review of Florida Committee Substitute for Senate Bill 2-D, Calculation of Section 40 "Presumed Factor"**, Deloitte Consulting stated the following:

It is important to note that these practices also include measures to be taken to limit or avoid liability. One phenomenon that we have noted elsewhere in this report is that physicians are purchasing lower policy limits. This trend is not simply the result of shrinking insurance capacity and skyrocketing rates; it reflects a belief that plaintiffs' attorneys will gravitate toward practitioners carrying higher limits. Not wanting to be a

primary target of a plaintiff attorney by carrying higher policy limits (while others physicians suffer smaller claims because of lower policy limits), physicians have acted rationally by reducing their liability limits to avoid being targeted as the first among several in any multiple defendant action.

Deloitte Consulting also stated on page 40:

Given the size of rate increases filed in 2003, the continuing after-effects of major insurance companies that have exited the Florida market, and the reduction in capacity offered by Florida's remaining insurers, we expect this trend to continue.

Based upon the MLDR responses, medical malpractice studies²⁹, recent news stories and statements made by insurers during public company earnings calls, the trend towards lower policy limits and doctors going bare will likely continue in the near future. Although some new insurers have entered the market, we don't anticipate any drastic differences in the cost of coverage that would create a sudden interest in purchasing higher policy limits in the state of Florida.

Other Impacts

As part of our MLDR, we asked medical malpractice insurers to discuss any other impacts of SB2D that should be noted from a financial perspective that we did not address in our MLDR.

Some of the insurers had no additional comments.

One insurer noted:

"Our Company appreciates the opportunity to provide feedback on this survey and cannot cite any other impact of SB2D from a financial perspective."

²⁹ For example, in the NAIC's May 2004 study "Medical Malpractice Insurance Report – A Study of Market Conditions and Possible Solutions to the Recent Crisis", the executive summary noted that "there are many reports of providers establishing plans of self-insurance or doing without vital liability coverage entirely."

Another insurer noted:

"At this time we have seen no financial impact from SB2D. SB2D applies to claims that both occurred and were reported after 9/15/03. It will take time for us to measure any differences as these claims work their way through the system."

Another insurer noted:

"We believe it is too early to tell of any financial impact resulting from SB2D."

Another insurer noted:

"From a financial standpoint, it should be noted that in the event the constitutionality of the caps is not upheld in court, the effect of the presumed factor rate adjustment and any other consideration of tort reform will most likely render inadequate the rates charged during 2004 and thereafter. Under present law, there will be no way to recoup these shortfalls. However, because the damage caps alter the assumptions that underlie the Company's rate filing, an adverse decision would necessitate an immediate rate filing with appropriate changes in assumptions. It should be noted that the longer it takes for the caps to be tried in the courts, the greater the impact on rates becomes due to annual compounding of the deficiency."

III. SECTION 45(6)(c)

SUMMARY OF PRIOR YEAR RATE FILINGS

As requested by SB2D, we have provided a summary of the 2003 calendar year medical malpractice rate filings which have been approved by the OIR.

INSURER NAME	PROGRAM TYPE	INSURER INDICATED RATE NEED*	APPROVED STATEWIDE RATE CHANGE	EFFECTIVE DATE NEW	EFFECTIVE DATE RENEWAL
ISO	(P&S)	7.4%	7.4%	6/1/2003	6/1/2003
MEDICAL PROTECTIVE CO.	(P&S)	42.9%	39.7%	1/1/2003	1/1/2003
MEDICAL PROTECTIVE CO.	Dental	7.9%	5.7%	3/1/2003	3/1/2003
FIRST PROFESSIONALS INS. CO.	(P&S)	24.0%	21.1%	12/1/2002	12/1/2002
PRONATIONAL INS. CO.	(P&S)	31.4%	27.9%	1/1/2003	1/1/2003
MEDICAL ASSURANCE CO.	(P&S)	57.6%	57.6%	1/1/2003	1/1/2003
GULF INS. CO.	(Chiro.)	Rule filing			
ISO	(P&S)	6.0%	6.0%	6/1/2003	6/1/2003
MEDICAL PROTECTIVE COMPANY	(P&S)	Rule filing			
MEDICAL PROTECTIVE COMPANY	(P&S)	Rule filing			
NATIONAL UNION FIRE INS. CO.	(P&S)	Rule filing			
HEALTH CARE INDEMNITY, INC	(Hospitals)	39.9%	39.9%	1/1/2003	1/1/2003
PICA GROUP	(Chiro.)	12.4%	12.4%	1/1/2003	1/1/2003
MAG MUTUAL INS. CO.	(P&S)	Rule filing			
HEALTH CARE INDEMNITY	(P&S)	New Program		1/1/2003	1/1/2003
CONNECTICUT INDEMNITY COMPANY	(Dentist)	30.0%	20.0%	1/1/2003	1/1/2003
TRUCK INSURANCE EXCHANGE	(P&S)	37.1%	22.9%	3/1/2003	3/1/2003
MEDICAL PROTECTIVE COMPANY (THE)	(Dentist)	Rule filing		3/1/2003	3/1/2003
DOCTOR'S COMPANY, AN INTERINSURANCE EXCHANGE	(P&S)	0.0%	-4.0%	3/1/2003	4/1/2003
AMERICAN PHYSICIANS ASSURANCE CORPORATION	(P&S)	47.6%	19.0%	12/1/2002	12/1/2002
MEDICAL ASSURANCE COMPANY, INC (THE)	(P&S)	8.0%	8.0%	2/1/2003	2/1/2003
NATIONAL FIRE INSURANCE COMPANY OF HARTFORD	(P&S)	New Program		2/5/2003	2/5/2003
AMERICAN CASUALTY COMPANY OF READING, PA	(P&S)	New Program		2/5/2003	2/5/2003
PHYSICIANS INSURANCE COMPANY	(P&S)	New Program		3/1/2003	3/1/2003
FIREMAN'S FUND INSURANCE COMPANY	(Dentist)	16.7%	15.0%	4/15/2003	4/15/2003
FLORIDA MEDICAL MALPRACTICE JUA	(P&S)	9.8%	9.8%	7/1/2003	7/1/2003
MEDICAL PROTECTIVE COMPANY (THE)	(Dentist)	Rule filing		3/1/2003	3/1/2003
CONTINENTAL CASUALTY COMPANY	(Hospitals)	Withdrawn from Market		5/9/2003	5/9/2003
FIRST PROFESSIONAL'S INSURANCE COMPANY, INC	(P&S)	Rule filing	0.0%	5/1/2003	5/1/2003
HEALTHCARE UNDERWRITERS GROUP OF FLORIDA	(Dentist)	New Program		7/1/2003	7/1/2003
ANESTHESIOLOGISTS PROFESSIONAL ASSURANCE	(Aneth.)	34.1%	28.0%	7/1/2003	7/1/2003
STATE FARM FIRE AND CASUALTY COMPANY	(Dentist)	New Program		8/15/2003	8/15/2003
CONTINENTAL CASUALTY COMPANY	(P&S)	New Program		8/1/2003	8/1/2003
AMERICAN CASUALTY COMPANY OF READING, PE	(P&S)	Rule filing		9/15/2003	9/15/2003
CONNECTICUT INDEMNITY COMPANY	(Dentist)	Rule filing		11/15/2003	11/15/2003
FLORIDA HEALTHCARE PROVIDERS INSURANCE EXCHANGE	(P&S)	New Program			

NOTE: (P&S) – Physicians and Surgeons

SUMMARY OF "PRESUMED FACTOR" FILINGS

In addition to the summary of the 2003 calendar year medical malpractice rate filings which have been approved by the OIR, we have also included a list of rate filings which have been approved by the OIR subsequent to the passage of SB2D (i.e., reflect the PF promulgated by the OIR).

INSURER NAME	PROGRAM TYPE	INSURER INDICATED RATE NEED*	APPROVED STATEWIDE RATE CHANGE	EFFECTIVE DATE NEW	EFFECTIVE DATE RENEWAL
PRONATIONAL INSURANCE COMPANY	(P&S)	22.0%	17.3%	1/1/2004	1/1/2004
MEDICAL PROTECTIVE COMPANY	(P&S)	69.8%	45.0%	1/1/2004	3/1/2004
FIRST PROFESSIONALS INSURANCE	(P&S)	10.9%	8.0%	1/1/2004	3/1/2004
CHICAGO INSURANCE COMPANY	(Nurses)	106.2%	8.2%	2/15/2004	2/15/2004
MAG MUTUAL INSURANCE COMPANY	(P&S)	15.4%	7.0%	1/1/2004	1/1/2004
GRANITE STATE INSURANCE COMPANY	(P&S)	95.0%	16.8%	2/27/2004	2/27/2004
TRUCK INSURANCE EXCHANGE	(P&S)	45.4%	6.0%	1/1/2004	1/1/2004
CHICAGO INSURANCE COMPANY	(P&S)	110.3%	15.8%	2/15/2004	2/15/2004
NATIONAL CASUALTY COMPANY	(Dental)	-7.8%	-7.8%	1/1/2004	1/1/2004
PODIATRY INS CO OF AMERICA	(Podiatrist)	RRG Conv.	19.9%	1/1/2004	1/1/2004
INSURANCE SERVICES OFFICE (ISO)	(P&S)	41.6%	25.0%	10/1/2004	10/1/2004
CONTINENTAL CASUALTY COMPANY	(Dental)	6.7%	6.7%	1/1/2004	1/1/2004
PHYSICIANS INSURANCE COMPANY	(P&S)	8.7%	6.3%	3/1/2004	3/1/2004
ANESTHESIOLOGISTS PROFESSIONAL	(Anesth.)	13.7%	10.0%	4/1/2004	4/1/2004
THE DOCTORS COMPANY AN	(P&S)	18.6%	8.9%	3/1/2004	3/1/2004
MEDICAL ASSURANCE COMPANY	(P&S)	12.2%	11.8%	1/1/2004	1/1/2004
AMERICAN CASUALTY CO OF	(Nurses)	70.6%	59.8%	1/15/2004	1/15/2004
FORTRESS INSURANCE COMPANY	(Dental)	16.6%	5.0%	12/23/2003	12/23/2003
EXECUTIVE RISK INDEMNITY INC.	(P&S)	no data	-7.8%	1/1/2004	1/1/2004
GUIDEONE MUTUAL INSURANCE CO.	(P&S)	no data	-7.8%	1/1/2004	1/1/2004
NATIONAL FIRE INSURANCE CO	(P&S)	11.7%	11.7%	2/15/2004	2/15/2004
CONTINENTAL CASUALTY COMPANY	(P&S)	no data	-7.8%	2/15/2004	2/15/2004
CONTINENTAL CASUALTY COMPANY	(Hospital)	no data	-7.8%	2/15/2004	2/15/2004
CINCINNATI INSURANCE COMPANY	(Dental)	2.7%	1.3%	1/1/2004	1/1/2004
CINCINNATI INSURANCE COMPANY	(P&S)	-2.3%	-2.3%	1/1/2004	1/1/2004
CINCINNATI INDEMNITY COMPANY	(P&S)	6.4%	3.5%	1/1/2004	1/1/2004
HEALTH CARE INDEMNITY INC.	(P&S)	-1.6%	-1.6%	1/1/2004	1/1/2004
ACE AMERICAN INSURANCE COMPANY	(Podiatrists)	no data	-7.8%	1/1/2004	1/1/2004
ACE AMERICAN INSURANCE COMPANY	(Chiropractors)	no data	-7.8%	1/1/2004	1/1/2004
ACE AMERICAN INSURANCE COMPANY	(Dental)	no data	-7.8%	1/1/2004	1/1/2004
FIRST PROFESSIONALS INS CO	(Dental)	-3.0%	-3.0%	4/1/2004	4/1/2004
MAG MUTUAL INSURANCE COMP	(HC Facilities)	0.0%	0.0%	1/1/2004	1/1/2004
AMERICAN ALTERNATIVE INS CORP	(P&S)	0.0%	0.0%		
GULF INSURANCE COMPANY	(Podiatrists)	17.7%	0.0%	1/1/2004	1/1/2004
AMERICAN CASUALTY CO OF	(P&S)	4.9%	0.0%		
FLORIDA HEALTHCARE PROVIDERS		5.4%	5.4%	4/1/2004	4/1/2004
FLORIDA MEDICAL MALPRACTICE JUA	(P&S)	4.0%	4.0%	7/1/2004	7/1/2004
AIU INSURANCE COMPANY	(P&S)	7.4%	0.0%		
CONNECTICUT INDEMNITY COMPANY	(P&S)	27.5%	0.0%	4/1/2004	4/1/2004

NOTE: * - Reflects the "Presumed Factor"
(P&S) – Physicians and Surgeons

Reflecting the PF

The indicated rate need reflecting the PF and the company's filed rate change are displayed above. A review of the rate filings submitted by insurers indicates that companies mainly reflected the PF in their filings using the following three approaches;

1. The insurer accepted the OIR's PF of 7.8% without modification in their rate filing by explicitly reflecting the PF in the ratemaking calculation and the development of the indicated rate need (i.e., included in the ratemaking calculation and the development of the indicated rate need).
2. The insurer accepted the OIR's PF of 7.8% without modification in their rate filing by implicitly reflecting the PF in the selection of the filed rate change (i.e., not included in the ratemaking calculation and the development of the indicated rate need).

For example, one company noted the following:

"At the time of this filing, the Office of Insurance Regulation has not promulgated the "presumed factor" intended to reflect an estimate of the impact of tort reform. The Company estimates that the "presumed factor" will fall in the range of 8% to 15% of premium."

A comparison of the above Company's indicated rate need to their filed rate change verified that the insurer reduced their filed rate change by more than the PF promulgated by the OIR.

3. The insurer adjusted the OIR's PF of 7.8% to reflect their company's mix of business

For example, one company noted the following:

"The Company's selected base rate increase reflects the presumed factor released by the Office of Insurance Regulation on November 10, 2003. The presumed factor was adjusted to the Company's book of business as prescribed by Deloitte & Touche."

The above company then replicates Deloitte Consulting's calculation of the Section 54 PF illustrated on page 52 of our November 6, 2003 report titled **Review of Florida Committee Substitute for Senate Bill 2-D, Calculation of Section 40 "Presumed Factor"** using their own distribution of policy limits.

The Company walks through the following five steps recommended by Deloitte Consulting on page 54 of the Presumed Factor Report:

1. Apply policy limit distribution* assumptions;
2. Apply claimant/defendant assumptions;
3. Adjust savings for severity injury types 1 through 3;
4. Apply ALAE assumption; and
5. Apply "phase in" assumption.

** - Company substituted their distribution of policy limits for practitioner only, non-practitioner only, or both depending upon the mix of business they wrote in place of Deloitte Consulting's distribution based upon industry.*

On page 79 of the Presumed Factor Report, Deloitte Consulting noted the following in regards to modifying the Section 54 PF:

In the calculation of the presumed factor for the cap on noneconomic damages, we have provided a matrix of indemnity savings shown by policy limit and for practitioner versus non-practitioner. It is conceivable that some medical malpractice insurers with a dramatically different distribution of policy limits or practitioner versus non-practitioner split may attempt to use the matrix to calculate their own presumed factor.

If a company were to calculate their own Section 54 presumed factor, we note the following considerations for the OIR's consideration:

1. *The medical malpractice insurer must walk through the five steps in order to complete the calculation of the presumed factor.*
2. *If the practitioner versus non-practitioner split assumption is changed from our current reliance on the closed claim database mix, the medical malpractice insurer must add an additional step. This step would illustrate their assumed split assumption. The five steps should then be followed.*

3. *It may be in the OIR's best interest to request additional information in future rate filings documenting the distribution of policy limits split out by practitioner versus non-practitioner. Although we don't like to burden insurers with additional data requests, the information would reduce the likelihood of someone making the argument to the OIR that some insurers may be gaming the system by accepting the presumed factor when they should actually be reflecting higher savings.*
4. *Even with the above adjustments, the claims in the closed claim database may not be representative of the claims (e.g., average severity, severity type, and split of damages) an individual medical malpractice carrier may observe. The low risk specialty insurer discussed above is a great example. Changing the assumptions may be of little value if the insurer's book of business focuses only on low risk exposures.*

Based upon our review of the PF Filings, it appears that companies using the third approach adequately addressed the above OIR considerations in the original filing or in responses to detailed questions asked by OIR staff.

OIR Review

During our review of the PF rate filings, Deloitte Consulting also reviewed the correspondence between the OIR and insurance company representative responsible for answering questions regarding the rate filing. Based upon the correspondence we reviewed, we believe the OIR did a thorough job of reviewing the assumptions in the rate filings and asking for additional support.

Their review included some of the following:

- Review of footnotes, titles and line items, including the identification of incorrect items
- Requests for clarification of assumptions, terminology and methodologies and where appropriate, further detailed exhibits supporting the responses
- Request for support on classification and territorial relativity changes including a discussion of the maximum and minimum rate changes in the filing
- Specific focus on the handling of the PF and a discussion of the overall impact on the Company's book of business
- Request for revised exhibits and assumptions

For example, in one PF rate filing approved by the department, the OIR staff asked over thirty questions. In addition, the OIR brought to the Company's attention that their rate filing did not include the 2.5% bad faith savings promulgated by the OIR in Section 56. As a result of the OIR's review, the insurance company revised their filing support to include the 2.5% savings.

For those interested in experiencing the level of review performed by the OIR staff, Deloitte Consulting recommends that the reader visit the on-line filing system and review some of the medical malpractice filings approved by the OIR. The PDF files available from the web site include the Company's original filing, OIR questions, company responses and all exhibits supporting the filed rates.

RATE FILING TREND ANALYSIS

The following analysis compares the current assumptions underlying the PF rate filings to the rate filings in effect before the passage of SB2D. We have included in **Appendix C – Ratemaking Primer** a brief description of the ratemaking process and definitions for readers unfamiliar with the process of ratemaking.

Table PF1 displays the death, disability and retirement loading (DDR).

TABLE PF1					
DDR LOADING					
PF FILINGS			CHANGE FROM PRIOR		
Min	Max	Average	Min	Max	Average
3.50%	6.50%	4.83%	0.00%	1.50%	0.68%

DDR, often referred to as “free tail”, protects the insured physician from claims filed after a policy has expired. The physician receives “free tail” tail coverage upon retirement (assuming the physician reaches retirement age and has been insured by the Company for the required number of years in the policy), if the physician suffers permanent and total disability or in the event the physician dies.

As one can see from above, the DDR loading underlying the individual rate filings vary from a low of approximately 3.5% to a high of 6.5%. On average, the DDR loading increased since last year’s filing, with a maximum increase of 1.5%.

Table PF2 displays the loss trend factor³⁰ assumed in the rate filing to bring historical losses to the current loss level.

TABLE PF2					
LOSS TREND					
PF FILINGS			CHANGE FROM PRIOR		
Min	Max	Average	Min	Max	Average
6.00%	12.40%	8.55%	0.00%	6.40%	2.47%

In developing the loss trend assumptions utilized in the filings, the insurers reviewed used the following approaches:

1. The insurer relied upon their own historical loss data to develop the selected loss trend;
2. The insurer used their own historical loss data credibility weighted with outside sources (e.g., Insurance Services Office (ISO), actuarial consulting firm internal proprietary database, etc.) to develop the selected loss trend; and
3. The insurer relied upon outside sources to develop the selected loss trend.

On page 103 of the Presumed Factor Report, Deloitte Consulting selected the following trend factors for economic and non-economic damages:

The next step in our Phase II data preparation efforts was to trend the claim values to current levels based on the disposition date of the claim. An annual trend of 6% was selected for the economic component of loss. An annual trend of 6% was selected for the non-economic loss component through 1993 with a 10% annual trend selected for the 1994 through 2003 years. The higher trend selection for non-economic loss during the 1994 through 2003 years is intended to be reflective of the faster rate at which non-economic loss has been increasing in recent years. As is often noted in the media, there has been an increase in the "lottery mentality" of jury awards in recent years. We believe the 4% adjustment helps to reflect this fact.

³⁰ For a majority of the rate filings, the "loss" implies a trend factor applied to loss and ALAE combined. In some filings, insurers derived separate trend factors for loss and ALAE. In these filings, loss and ALAE were trended by separate factors then combined in the final ratemaking exhibit.

We believe the trend selections in Table PF2 are directionally consistent with the selections used by Deloitte Consulting in our SB2D PF analysis (i.e., trends in the 6% to 10% range). In addition, we would expect loss trend selections to vary by company depending upon the mix of business written (e.g., specialty mix, county mix, hospital mix if target non-practitioners, etc.).

As one can see from above, the loss trend underlying the individual rate filings vary from a low of approximately 6.0% to a high of 12.4%. On average, the loss trend increased almost 2.2% since last year's filing.

Table PF3 displays the expenses assumed in the rate filings.

TABLE PF2					
EXPENSES					
PF FILINGS			CHANGE FROM PRIOR		
Min	Max	Average	Min	Max	Average
14.84%	29.70%	21.57%	-8.25%	16.70%	2.16%

The expenses shown above include:

1. Commission & brokerage expense
2. Other acquisition expense
3. General expense
4. Premium taxes
5. Misc. Licenses and Fees, other taxes
6. Other expenses
7. Expected profit margin & contingency factor (i.e., Rule 69O-170.003, F.A.C.)

As one can see from above, the expense ratios underlying the individual rate filings vary from a low of approximately 15% to a high of almost 30%. A majority of the differences in expense ratios are explained by the first three items and differences in the expected profit margin & contingency factor. The expense ratios also increased on average since last year's filing, partially

driven by changing assumptions and lower expected profit margin & contingency factors impacted by declining investment returns.

The expected loss ratio, equal to 100% minus the expense ratio, indicates that company expected loss ratios range from 70% to 85%. The impact of the changes in the above assumptions can be seen using the simplified manual rate indication formula discussed in **Appendix C**:

Manual Rate Indication

Sample Calculation:

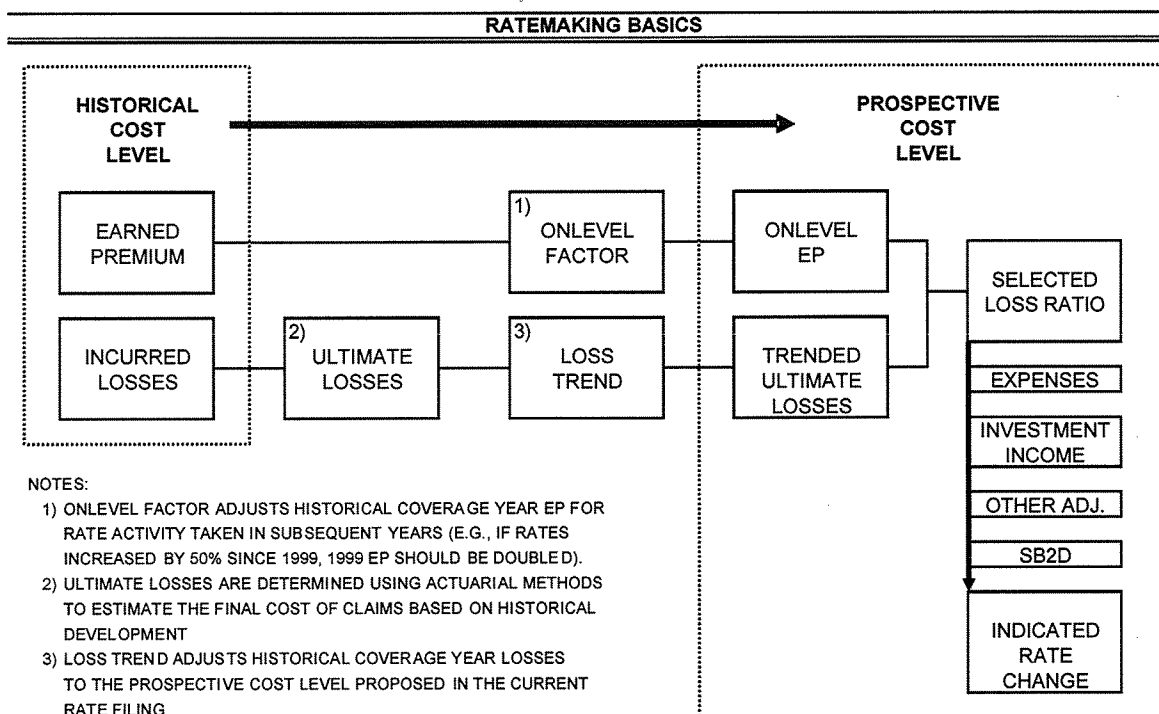
- (1) Ultimate Loss and LAE Ratio
- (2) Death, Disability and Retirement Load (DDR)
- (3) Expected Loss Ratio
- (4) Average Policy Discount

$$\text{Indication} = [(1) \times (2)] / [(3) \times \{ 1.0 - (4) \}] - 1.0$$

	LOW ELR	POINT ELR	HIGH ELR	
(1)	75.0%	75.0%	75.0%	← Impacted by Loss Trend
(2)	<u>1.050</u> 78.8%	<u>1.050</u> 78.8%	<u>1.050</u> 78.8%	= (1) x (2)
(3)	70.0%	77.5%	85.0%	← Impacted by Expense Trends
(4)	0.000	0.000	0.000	
	12.5%	1.6%	-7.4%	= [(1) x (2)] / [(3) x { 1.0 - (4) }] - 1.0

As one can see from above, changes to loss trend directly impact the ultimate loss and LAE ratio underlying the calculation of the indication. If loss trends are increasing, the final manual rate indication will have increased upward pressure. Similarly, if expenses are increasing because of rising costs or lower profit and contingency margins driven by lower investment returns, the final manual rate indication will have increased upward pressure. If loss trend and expenses are decreasing, the final manual rate indication will have increased downward pressure.

By using the below diagram to drill down into the derivation of the ultimate loss and LAE ratio, we can also see how past rate increases, actuarial assumptions, and tort reform impact the final indicated rate change.



As one can see from above, prior year rate increases exert downward pressure on the selected ultimate loss and LAE ratio (i.e., historical premiums have to be grossed up to reflect rate activity taken subsequent to the earning of the premium). Loss trend exerts upward pressure on the selected ultimate loss and LAE ratio (i.e., losses paid three years ago need to be trended to the prospective level underlying the rate filing today). Shown in mathematical form:

$$\text{Ultimate Loss and LAE Ratio} = \frac{\text{Ultimate Loss and LAE}}{\text{Onlevel Earned Premium}}$$

Loss Trend
Rate Changes

The diagram shows two curved arrows pointing from the boxes 'Loss Trend' and 'Rate Changes' towards the denominator 'Onlevel Earned Premium' of the equation, indicating that these factors adjust the denominator.

Based upon our review of the pre-SB2D rate filings and post-SB2D rate filings, we believe the trend in direct incurred losses has increased from last year's rate filings driven by higher loss trend selections. In addition, higher expense ratios driven by rising costs and a lower profit & contingencies have also put some upward pressure on rates. This upward pressure from losses and expenses has been partially offset by the compound effect of recent year rate change activity and the impact of reflecting the PF required by the passage of SB2D.

IV. OBSERVATIONS AND CONCLUSIONS

This section of the report addresses our observations and conclusions regarding the financial information, rate filings, closed claim database analysis and responses to our market leader data request discussed above.

OVERALL COMMENTS

- **“Green” Nature of SB2D**

SB2D was passed on September 15, 2003. As will be discussed below in some of the commentary, it is too early to evaluate and establish the ultimate impact of SB2D. Due to the long tail nature of the medical malpractice line of business, the uncertainty regarding the Berges case and constitutionality of SB2D’s various Sections, and the phase-in time required to impact the data underlying the ratemaking process in Florida medical malpractice rate filings, more time is required to evaluate and establish the ultimate impact of SB2D.

- **Complexity of Report**

We have done our best to document our findings and observations using examples and terminology with the least amount of actuarial and legal terminology. Although we have attempted to do this, certain sections of this report will still require additional attention for those readers unfamiliar with the field of actuarial science or interpretation of Statutes. We have included a ratemaking primer section in the appendices as well as numerous illustrations throughout the report to provide additional color to our written comments.

RATE FILINGS

- Based upon our review of the pre-SB2D rate filings and post-SB2D rate filings, the Office in consultation with Deloitte Consulting believes the trend in direct incurred losses has increased from last year's rate filings driven by higher loss trend selections. In addition, higher expense ratios driven by rising costs and a lower profit & contingencies have also put some upward pressure on rates. This upward pressure from losses and expenses has been partially offset by the compound effect of recent year rate change activity and the impact of reflecting the PF required by the passage of SB2D.

Given the cumulative impact of the large rate increases taken over the past few years and the heavy focus on the medical malpractice crisis in the State of Florida, rate increases should moderate over the next few years driven by the following items:

- Interest rates appear to be on the rise again, as witnessed by recent Federal Reserve activity and current expectations regarding interest rates. As interest rates rise, medical malpractice insurance companies with a majority of their investments in bonds will also see an increase in their average portfolio yield. The increase in average portfolio yield will exert downward pressure on insurance rates as medical malpractice insurers will be able to reflect more investment income in their rate filings. Higher investment income means lower rates charged to Florida healthcare providers. This is a reversal of the trends in the 1990s that saw interest rates drop to multi-decade lows.
- Based on comments made during recent public company earnings calls, some writers in the state of Florida believe that rates have finally reached a level where rates appear to be adequate. Assuming no significant shift in the legal environment or claim settlement patterns, this would imply that some Florida

medical malpractice insurers should only have to keep pace with loss severity trends in future rate filings.

- Patient safety initiatives appear to be gaining additional momentum across the country. Multiple organizations appear to be spearheading the charge on making healthcare safer, less error prone and a more satisfying experience³¹. We believe this momentum (which is driving a change in the healthcare culture), combined with root cause analysis, national patient safety goals, continuing education, and strategies to reduce errors at the entry level (e.g., computerized physician order entry systems) will help lower medical malpractice claims over time.
- A comparison of the rate increases filed before the passage of SB2D, to the rates filed after the passage of SB2D, illustrate the moderation of rate changes on a year over year basis. In addition, we note that the moderation in the filed rates took place at the same time a number of insurers strengthened their ratemaking assumptions. If these assumptions do not strengthen further in future rate filings (e.g., loss severity trend selections remain stable), we would expect rate increases to continue to moderate. The moderation would occur because there would be less upward pressure from assumption changes as we have observed in the recent past, when insurers were forced to play catch up because the companies underestimated the true level of loss trend impacting their Florida policyholders.
- Companies have re-focused their efforts on underwriting and the charging of adequate premium rates. This focus on properly priced business increases the

³¹ We recommend visiting some of the following web sites: National Patient Safety Foundation (www.npsf.org), Joint Commission on Accreditation of Healthcare Organizations (JCAHO) (www.jcaho.org), American Medical

likelihood that insurers will not need to file large rate increases because of the accumulation of poor underwriting decisions and inappropriate pricing driven by competitive market pressures.

- Actuarial Standards of Practice (ASOP) #9 promulgated by the American Academy of Actuaries (AAA) states the following four principles regarding ratemaking:

II. PRINCIPLES

Ratemaking is prospective because the property and casualty insurance rate must be developed prior to the transfer of risk.

Principle 1: A rate is an estimate of the expected value of future costs. Ratemaking should provide for all costs so that the insurance system is financially sound.

Principle 2: A rate provides for all costs associated with the transfer of risk. Ratemaking should provide for the costs of an individual risk transfer so that equity among insureds is maintained. When the experience of an individual risk does not provide a credible basis for estimating these costs, it is appropriate to consider the aggregate experience of similar risks. A rate estimated from such experience is an estimate of the costs of the risk transfer for each individual in the class.

Principle 3: A rate provides for the costs associated with an individual risk transfer. Ratemaking produces cost estimates that are actuarially sound if the estimation is based on Principles 1, 2, and 3. Such rates comply with four criteria commonly used by actuaries: reasonable, not excessive, not inadequate, and not unfairly discriminatory.

Association (www.ama-assn.org), The Leapfrog Group (www.leapfroggroup.org), State patient safety organizations (e.g., Virginia www.vipcs.org); or look at patient safety books (e.g., "The Satisfied Patient" – James W. Saxton).

Principle 4: A rate is reasonable and not excessive, inadequate, or unfairly discriminatory if it is an actuarially sound estimate of the expected value of all future costs associated with an individual risk transfer.

Based upon our review of the market leader rate filings and the correspondence between the OIR and insurance company representatives, Deloitte Consulting believes the OIR has adequately ensured that the four principles of ratemaking are being followed by Florida medical malpractice insurers. The rate filings approved by the OIR are prospective in nature (i.e., do not recoup past costs) as identified in Principle 1, and that rates are reasonable, not excessive, not inadequate, and not unfairly discriminatory.

- During our review of the PF rate filings, Deloitte Consulting also reviewed the correspondence between the OIR and insurance company representative responsible for answering questions regarding the rate filing. Based upon the correspondence we reviewed, we believe the OIR did a thorough job of reviewing the assumptions in the rate filings and asking for additional support (e.g., the OIR asked one insurer for support on over thirty items). For those interested in experiencing the level of review performed by the OIR staff, we recommend that you visit the on-line filing system and review some of the medical malpractice filings approved by the OIR. We believe the documentation demonstrates the thoroughness and professionalism of the OIR staff.

CLOSED CLAIM DATABASE (CCD)

- On page 50 of the Presumed Factor Report, we displayed graphs of the distribution of the number of years between occurrence date and closing date for all NAIC severity codes combined and all NAIC severity codes excluding codes 1, 2, and 3. We also displayed graphs of the distribution of the number of years between the report date and closing date for the two categories. As noted above, since the passage of SB2D, we have yet to see any material shift in either the distribution or the mean lag between the claims specific dates (i.e., occurrence date, report date, close date) tracked in the CCD.
- We did observe a significant increase in the number of reported claims during the month of September 2003. This is consistent with the feedback shared during our analysis of SB2D and the determination of the PF. During our review, a number of plaintiff attorneys had informed the department that they were going speed up the reporting of claims in order to beat the September 15, 2003 effective date of SB2D. A speed up in reporting just before the passage of most medical malpractice tort reform bills is fairly common and is driven by the following:
 - Plaintiff attorneys often want to make sure that they file claims before the passage of tort reform bills, hopefully protecting themselves against new laws that may adversely impact the success rate of their current cases.
 - Up until the final passage of the law, some plaintiff attorneys may have been uncomfortable or did not understand the phase-in period of the law. If a plaintiff attorney believed SB2D would apply to occurrences that were reported on or after the effective date of the law, then a case reported by a plaintiff attorney after the passage of the law would be capped. The filing of claims before SB2D passed would eliminate any uncertainty in the Plaintiff attorney's mind that his/her case would be capped.

In reality, SB2D actually applies to incidents that occur on or after the passage of SB2D. No matter what the law actually does, plaintiff attorneys will still be able to say that "it is better to be safe than sorry."

- It is likely that the increase in reported claims will have an impact on the reporting patterns of claims in the remainder of 2003 and 2004. More specifically, the claims that would have otherwise been reported after September 2003 have now been filed in September 2003. Therefore, fewer reported claims should be expected during the subsequent months (e.g., we note a drop in claims reported during the months of October 2003, November 2003 and December 2003).
- It is difficult to draw significant conclusions on the long term trend in the severity of claims from the passage of SB2D, given the short time frame since the passage of SB2D and limited amount of data reflecting the impact of SB2D in the closed claim database.
- Given the longer claim lag for more severe claims, it is difficult to draw substantial conclusions regarding the impact of SB2D on the nature of errant conduct. We note however, the portion of claim counts in the lower severity codes for those closed claims reported after September 2003 is higher than historical levels.
- Given the application of SB2D to claims that have occurred after September 15, 2003 and the occurrence to closing lag in excess of 3 years per claim, it is difficult at this time to observe any effects of SB2D on non-economic damage costs.

CALENDAR YEAR PROFITABILITY

- From an industry perspective, 54 organizations representing over two-thirds of the 2003 medical malpractice industry net written premium, lost \$439 million in 2003. On \$5.4 billion of earned premium, the 54 organizations produced an after tax operating ratio of 108.1% and a return on average surplus of -7.6%. Stated another way, the industry lost 8.1 cents on every dollar of premium earned after considering investment income, realized capital gains and income taxes.

Over the past three years, the 54 organizations have lost \$1.67 billion. Over the past five years, they have lost \$522 million. As the recently filed rate increases continue to flow into earned premiums, we would expect the net income of the 54 organizations and the industry to continue its favorable trends towards break-even in 2004. If development on prior year reserves continues to stabilize, net income could potentially result in a positive 2004 return on surplus (i.e., net income > 0) for the first time since 2000.

- From a Florida perspective, the top 80% of Florida's medical malpractice insurers lost \$1.2 billion in 2003 with an ROS of -5.7%. Excluding CCC, TIC, LIC and EIC who write 69% or more of their business in non-medical malpractice lines of business, the medical malpractice focused companies (i.e., FPIC, MPC, DCIE, HCII, APAC, PIC and MMIC) earned \$2.1 million in 2003 with an ROS of 0.1%. The medical malpractice focused companies produced an after tax operating ratio ranging from 93.4% to 115.1% in 2003 and from 84.1% to 105.3% in first quarter 2004.

Over the past four years, the medical malpractice focused companies earned \$182.6 million with an average ROS of 2.5%. Removing the impact of the \$52.2 million in adverse development over the four year period, the medical malpractice focused companies produced an adjusted average ROS of 3.0%. From either perspective, the average ROS over the four

year period continues to be in the low single digits and far below the levels which would indicate excessive profits.

- It would appear that the favorable first quarter 2004 operating ratios may indicate that Florida's companies will continue to be profitable through year-end 2004, helping to stabilize the need for future rate changes in the State of Florida.
- Given the long "tail" nature of the medical malpractice market, the strong likelihood of future cycles, and the historically volatile results of the top Florida insurers, it is reasonable to focus on financial results over a time period roughly equal to the average historical medical malpractice cycle (e.g., cycle ranging from seven to nine years). Analysis of profit and ratemaking decisions made based upon a few quarter's profits without considering the cumulative results over the average cycle would not portray the economic realities of the medical malpractice business.
- The calculation of after-tax net income includes net investment income realized on investments (e.g., interest payments on bonds) and realized capital gains/(losses). As one can see from the below chart, Florida's medical malpractice focused companies have almost 85% of their invested assets placed in bonds or cash.

PERCENTAGE OF ASSETS IN BONDS AND CASH

Companies	2003	2002	2001	2000	1999
FPIC	93.2%	83.8%	90.2%	91.3%	94.0%
MPC	99.0%	98.8%	98.4%	98.8%	99.0%
CCC	79.8%	77.4%	63.8%	62.6%	59.1%
TIC	55.1%	40.4%	40.8%	45.3%	52.4%
DCIE	74.2%	63.9%	74.7%	65.4%	69.7%
HCII	63.4%	65.6%	62.5%	70.9%	66.7%
APAC	100.0%	100.0%	100.0%	100.0%	100.0%
PIC	77.1%	76.2%	76.5%	74.6%	82.7%
MMIC	86.3%	90.8%	91.0%	85.3%	82.8%
LIC	80.6%	81.7%	76.7%	81.2%	89.6%
EIC	75.9%	82.0%	81.2%	76.9%	78.1%
ALL COS*	80.4%	78.2%	77.8%	77.5%	79.5%
MM FOCUS*	84.7%	82.7%	84.8%	83.8%	85.0%

*- AVERAGE

Most of the bonds held by these insurance companies fall in the highest rated NAIC classes (e.g., 1, 2) as shown on Schedule D – Part 1A – Section 1 of the annual statement, otherwise known as investment grade bonds (i.e., low risk).

PERCENTAGE OF ASSETS IN STOCKS

Companies	2003	2002	2001	2000	1999
FPIC	5.4%	5.4%	6.6%	7.3%	4.5%
MPC	0.3%	0.4%	0.7%	0.1%	0.0%
CCC	12.6%	14.1%	26.6%	26.7%	34.5%
TIC	38.5%	49.6%	46.7%	54.4%	47.4%
DCIE	22.1%	19.1%	22.6%	31.2%	27.7%
HCII	34.1%	29.2%	33.9%	27.1%	28.1%
APAC	0.0%	0.0%	0.0%	0.0%	0.0%
PIC	22.2%	23.1%	22.7%	24.5%	16.2%
MMIC	11.9%	7.8%	7.4%	12.9%	15.5%
LIC	12.9%	7.5%	8.1%	2.9%	3.0%
EIC	23.8%	17.8%	18.8%	21.6%	21.0%
ALL COS*	16.7%	15.8%	17.6%	19.0%	18.0%
MM FOCUS*	13.7%	12.1%	13.4%	14.7%	13.1%

*- AVERAGE

Less than 14% of medical malpractice focused insurance company assets are in stock investments. As one can see from the above distribution by company, stock investments can range from 0% to 39% of the invested assets. Stock investments typically expose insurers to more risks as stock prices move up and down with the economy, interest rates and political environment.

Other assets (e.g., mortgage loans, real-estate, etc.) represent less than 2.0% of invested assets for the medical malpractice focused companies.

With such a heavy investment of assets in bonds and cash, the medical malpractice focused companies appear to be conservatively invested.

REPORT YEAR/ACCIDENT YEAR LOSS RATIO TREND

- The trend in Schedule P loss ratios and the trend in the assumptions underlying each company's rate filing presents the most relevant picture of the direction that future rates will take for healthcare providers practicing in the State of Florida, since profit is primarily driven by the accident year and report year loss ratios.
- The trend in Schedule P – Part 1 claims-made loss and LAE ratios, Schedule P – Part 1 occurrence loss and LAE ratios, and "Page 14" Florida direct loss and DCC ratios appear to be improving. Adjusting for each company's expense ratio, net investment income and other income ratio, and tax position; the current loss and LAE ratio trends through 2003 and first quarter 2004 results should help to ensure that medical malpractice insurers continue to offer stable and financially sound protection to healthcare providers across the country.

LEVERAGE RATIOS

- The NLSR provides a measure of underwriting leverage, and thus risk. Surplus serves as a financial buffer to guard against adverse events and changes in financial condition, such as can result when reserve strengthening is required. A lower ratio signifies greater financial strength and a greater capacity to absorb adverse development in reserves. In lines of insurance such as medical malpractice that have significant potential for this to occur, it is important that the NLSR be relatively low, especially for companies that are not diversified insurance writers. Excluding PIC which is slightly above the industry composite, the medical malpractice focused companies have NLSR well below the industry composite NLSR of 2.9.
- The NPSR measures the insurer's capacity to write additional business. Of the medical malpractice focused companies, only APAC (1.25) and MPC (1.61) exceed the industry composite NPSR of 0.9. MPC's high ratio is largely driven by the size of the rate increases MPC has filed across the country over the past few years.

RBC RATIOS

- NAIC Risk Based Capital (RBC) requirements calculate the amount of capital an insurer should hold as a function of the types of risks it has assumed. The NAIC RBC formula looks at five different risk charges; fixed income securities, equity investments, credit risk, reserving risk and written premium risk. Insurers whose capital falls below pre-specified percentages of its authorized control level requirement are subject to various actions intended to mitigate insolvency, varying from company action level to mandatory control level where the company is placed under the control of the domiciliary regulator³². The following table displays the RBC ratios for the past five years.

³² The NAIC's RBC Model Act may not be followed by all states (e.g., New York).

RBC RATIO

Companies	2003	2002	2001	2000	1999
FPIC	345.9%	349.0%	360.3%	356.5%	441.9%
MPC	427.5%	437.1%	536.0%	396.6%	334.3%
CCC	292.3%	338.1%	292.3%	397.5%	381.0%
TIC	212.7%	208.0%	240.9%	205.9%	213.1%
DCIE	431.6%	489.3%	941.3%	883.1%	582.4%
HCII	298.4%	240.8%	317.6%	304.2%	260.0%
APAC	234.4%	286.0%	481.6%	509.8%	1039.7%
PIC	299.6%	388.3%	368.7%	613.3%	596.0%
MMIC	418.9%	373.9%	550.2%	808.5%	941.8%
LIC	503.1%	676.5%	805.3%	846.0%	854.7%
EIC	332.0%	265.5%	339.9%	339.1%	317.3%
CAL	200.0%	200.0%	200.0%	200.0%	200.0%
RAL	150.0%	150.0%	150.0%	150.0%	150.0%
ACL	100.0%	100.0%	100.0%	100.0%	100.0%
MCL	70.0%	70.0%	70.0%	70.0%	70.0%

Although the RBC ratios have declined since the 1999 years, the 2003 RBC ratios appear to be stabilizing for most companies. In addition, a majority of the companies are close to an RBC ratio of 300% (i.e., 100% above the company action level (CAL)). Only TIC and APAC are below an RBC ratio of 250%. Given the favorable impact of recent rate changes, rising interest rates, and favorable trend in net income, the 2004 RBC ratios should improve as insurers continue to build surplus.

A.M. BEST RATING

- A.M. Best's Financial Strength Ratings³³ provide an opinion of an insurer's financial strength and ability to meet ongoing obligations to policyholders. The A.M. Best rating scale is comprised of 16 individual ratings grouped into 10 categories, consisting of three secure categories (Superior (A++, A+), Excellent (A, A-), Very Good (B++, B+)) and seven Vulnerable categories. The following table displays the ratings of Florida's to writers:

³³ A.M. Best Company (www.ambest.com)

A.M. BEST RATING

Companies	RATING	
FPIC	B++	VERY GOOD
HCII	A-	EXCELLENT
PIC	A-	EXCELLENT
MPC	A-	EXCELLENT
MMIC	A-	EXCELLENT
LIC	A++	SUPERIOR
EIC	A	EXCELLENT
DCIE	B++	VERY GOOD
CCC	A	EXCELLENT
TIC	B+	VERY GOOD
APAC	B++	VERY GOOD

Florida's top writers all fall in the secure categories. According to A.M. Best, the B+ and B++ ratings are assigned to companies that have, in A.M. Best's opinion, a good ability to meet their ongoing obligations to policyholders. The A and A- ratings are assigned to companies that have, in A.M. Best's opinion, an excellent ability to meet their ongoing obligations to policyholders. The A++ and A+ ratings are assigned to companies that have, in A.M. Best's opinion, a superior ability to meet their ongoing obligations to policyholders.

The above categories demonstrate an absence of any vulnerable ratings (i.e., B, B-, C++, C+, etc.) for Florida's top writers.

MLDR

- It is too early to determine the effect of SB2D. This is consistent with the answers provided by the insurers in response to our MLDR.
- In regards to the constitutionality of the cap on non-economic damages, insurers fell in the following three categories:
 1. No comment or opinion;

2. Commentary on the drafting of SB2D or the historical activity of Florida courts; noting that a couple insurers felt the emergency room cap on non-economic damages had a better chance of being held on public policy grounds; and
 3. One company was willing to provide an estimate for the probability of the cap will be declared constitutional:
 - Non-emergency room – 50% chance
 - Emergency room - > 50% chance
- In regards to the impact of the cap on non-economic damages and the insurer's negotiating position, insurers commenting on this subject generally noted that the cap on non-economic damages didn't help its negotiations. One insurer noted that the plaintiff counsel it encounters refuses to recognize any value in the cap on non-economic damages. During a second quarter earnings call, a Company noted that plaintiff attorneys generally view the law as unconstitutional.
 - The trend towards lower policy limits and doctors "going bare" will likely continue in the near future. Although some new insurers have entered the market, we don't anticipate any drastic differences in the cost of coverage that would create a sudden interest in purchasing higher policy limits in the State of Florida.
 - It is important to repeat the following insurance company response to our MLDR question focused on the impact of SB2D from a financial perspective:

"From a financial standpoint, it should be noted that in the event the constitutionality of the caps is not upheld in court, the effect of the presumed factor rate adjustment and any other consideration of tort reform will most likely render inadequate the rates charged during 2004 and thereafter. Under present law, there will be no way to recoup these shortfalls. However, because the damage caps alter the assumptions that underlie the Company's rate filing, an adverse decision would necessitate an immediate rate filing with appropriate changes in assumptions. It should be noted that the longer it takes for the caps to be tried in the courts, the greater the impact on rates becomes due to annual compounding of the deficiency."

Re-cap of important conclusions:

1. If the cap is declared unconstitutional, medical malpractice rates that reflected the PF will be inadequate by the amount of PF reflected in the rate filings (e.g., 5.3% PF for cap on non-economic damages);
2. Insurance companies will have no way to recoup the lost premium since the ratemaking process is prospective (i.e., insurers cannot go back in time and ask physicians to mail in checks for the incremental amount of PF premium dollars that would have been paid);
3. If the caps are declared unconstitutional, companies in the state of Florida would need to file rates to remove the impact of the PF; and
4. The longer it takes for the constitutionality of the caps to be determined, the greater the deficiency in rates will become. As is noted in the Contingencies article *The Million-Dollar Challenge: Measuring the Impact of Medical Liability Tort Reform*³⁴:

“For example, Ohio reforms enacted in 1975 were challenged in the courts in 1982 and eventually overturned in 1985. Ohio insurance company rates became inadequate the moment the reforms were overturned because the premium collected for their current and most recent policies still reflected the full impact of the tort reform.”

The fourth point is important given our legal expert’s estimate of when the trial court in the Berges case will rule and whether or not the appeal will be “fast tracked” to the Supreme Court. In the event that the Berges case takes another two years to complete, Florida’s insurers will have to reflect the impact of the PF savings for two more years. In the event that the Berges case takes another four years or more to complete, Florida’s insurers would have to reflect the savings for four or more years. In either scenario, Florida’s insurers would have no way of recouping the lost premiums if the cap was declared unconstitutional. The rate filing submitted immediately after the decision would include: the removal of the PF

³⁴ September/October 2003 Contingencies Magazine [The Million-Dollar Challenge: Measuring the Impact of Medical Liability Tort Reform](#), Kevin Bingham.

factor; a review of the loss trend assumptions; and the flowing of uncapped losses into the ratemaking calculations for all incidents occurring on or after September 15, 2003; resulting in significant upward pressure on the rate indications.

CONSTITUTIONALITY

- It is not possible at this time to estimate when the trial court in Berges will rule on the issue of whether the cap is constitutional. The defendants may argue that the issue is not "ripe" for determination unless and until a jury verdict is rendered in excess of the cap. The trial court therefore may postpone a decision on constitutionality until after the case goes to trial, which may take one or two years. Whenever the trial court does rule, however, there is a possibility that the parties will request a "fast track" appeal to the Florida Supreme Court, bypassing the intermediate appellate court. If that occurs (it is within the discretion of the intermediate appellate court to decide), then the appeal time in our original report could be expedited by approximately one year. Accordingly, a final decision on constitutionality from the Florida Supreme Court could occur within 12 to 18 months of a ruling by the trial court.
- The outcome of the Berges case will likely determine if the cap on non-economic damages is constitutional or unconstitutional. If the cap is declared unconstitutional, rates for insurance companies in the state of Florida will essentially be inadequate by the amount of the PF reflected in their most recent rate filing³⁵. Stated another way, insurance companies gave policyholders a credit equal to the PF factor which turned out to be worth less than originally thought (e.g., 5.3% less).

³⁵ On page 54 of the Presumed Factor Report, we selected a PF of 5.3% for Section 54 of SB2D (i.e., cap on non-economic damages). We note that individual companies modified their rate filings to reflect their own mix of policy limits and other assumptions. For companies that modified the OIR published PF for Section 54, one would substitute their PF for the 5.3% PF in the above discussion.

Using a simple analogy, the removal of the PF would be similar to a car dealer who sells a car at a 5.3% discount assuming the auto manufacturer will provide them with a 5.3% rebate. If the rebate is taken away, the car is essentially under priced by 5.3%.

Although Florida companies could submit new rate filings which would remove the impact of the PF from future policies sold in Florida, the PF adjusted premiums collected on their current in force policies would likely be inadequate. This is because ratemaking is a prospective process and does not allow insurers to recoup past losses or the amounts policies are under priced because of unconstitutional tort reforms.

- Going forward, we believe the true impact of SB2D (e.g., cap on non-economic damages, bad faith, patient safety, patient notification, etc.) will phase-in to the policy year data underlying each company's rate filing. The phase-in period will correspond directly with time it takes to defend, litigate and settle claims occurring on or after September 15, 2003 that would reflect savings driven by SB2D.

As Deloitte Consulting noted on page 51 of the Presumed Factor Report:

Based upon the above information, the average delay from the reporting of a claim to the closing of a claim will result in a phased in effect of the savings observed from the cap on non-economic damages. Pre-SB2D claims with no savings will take time to be cleared out of the system. In addition, post-SB2D claims reflecting savings from the cap on non-economic damages will take time to enter the system based upon the above lag distributions.

If the cap on non-economic damages is declared constitutional, we would expect the phase-in to speed up as medical malpractice insurers could use the leverage of a "tested" cap on non-economic damages in current and future settlement negotiations. This would be an important shift from the current environment where most plaintiff attorneys are behaving as if the cap on non-economic damages is going to be declared unconstitutional. Plaintiff attorneys would

have to shift from an environment of giving little or no credit in settlement discussions to full credit for a potential cap on non-economic damages.

If the cap on non-economic damages is declared unconstitutional, we would expect no material change in loss severity trends selected by companies. This is because the historical data underlying the current rate filing process does not include any cases that have been favorably impacted by SB2D reforms. Essentially, Florida insurers would be back to “business as usual”.

Although we do not expect any spike in loss severity trends underlying medical malpractice rate filings, it would be important to monitor trends going forward to see if awards continue to inflate at recent levels or accelerate due to the successful elimination of the cap if it is declared unconstitutional.

V. APPENDIX

APPENDIX A

Medical Malpractice Financial Metrics by Writing Company

Surplus (S)

Net Written Premium (NWP)

NWP to S

NWP to Gross Written Premium

Net L&LAE Reserves (L)

L to S

Calendar Year Combined Ratio

Loss Ratio

LAE Ratio

Expense Ratio

RBC Ratio

Investment Allocation

Bonds

Cash

Stock

Mortgage Loans

Real Estate

Other

FLORIDA SB2D
MEDICAL MALPRACTICE FINANCIAL METRICS BY WRITING COMPANY

WRITING COMPANY (1)	SURPLUS (\$)			NET WRITTEN PREMIUM (NWP)			NWP TO S			NWP TO GWP			NET L&AE RESERVES (LIAB)			LIAB TO S		
	%			%			%			%			%			%		
	2003 (2)	2002 (3)	CHANGE (4)	2003 (5)	2002 (6)	CHANGE (7)	2003 (8)	2002 (9)	CHANGE (10)	2003 (11)	2002 (12)	CHANGE (13)	2003 (14)	2002 (15)	CHANGE (16)	2003 (17)	2002 (18)	CHANGE (19)
CNA INSURANCE																		
Continental Casualty Co	6,045,822	5,115,932	18.2%	7,403,129	7,073,312	4.7%	1,225	1,383	0.690	0.801	16,364,336	12,211,397	34.0%	2,707	2,387			
California % of DWP	9.78%			1,154,599	16%						1 YR Dev:	2,331,312	-167,170					
New York % of DWP	7.91%			19,219	0%						% of Prior S:	45.6%	-3.6%					
Florida % of DWP	6.91%			136,580	2%						2 YR Dev:	2,218,952	1,525,840					
All Other States % of DWP:	75.40%			6,092,731	82%						% of Prior S:	47.2%	24.1%					
TIG INSURANCE																		
Tig Insurance Company	695,928	1,095,257	-36.5%	122,375	699,330	-82.5%	0.176	0.639	0.251	0.670	1,111,441	1,512,234	-26.5%	1,597	1,381			
Hawaii % of DWP	19.00%			20,578	17%						1 YR Dev:	-345	97,359					
California % of DWP	11.27%			53,021	43%						% of Prior S:	0.0%	7.5%					
Florida % of DWP	11.15%			48,060	39%						2 YR Dev:	98,524	88,613					
All Other States % of DWP:	58.58%			716	1%						% of Prior S:	7.6%	8.4%					
MAG MUTUAL INSURANCE GROUP																		
Mag Mutual Insurance Co	177,177	142,978	23.9%	159,355	143,881	10.8%	0.899	1.006	0.550	0.658	299,516	291,431	2.8%	1,690	2,038			
Georgia % of DWP	52.00%			144,174	90%						1 YR Dev:	14,061	20,930					
Florida % of DWP	25.14%			9,987	6%						% of Prior S:	9.8%	13.2%					
North Carolina % of DWP	15.56%			2,161	1%						2 YR Dev:	25,334	-18,176					
All Other States % of DWP:	7.30%			3,033	2%						% of Prior S:	16.0%	-12.1%					
GE GLOBAL INSURANCE																		
Medical Protective Co	442,881	401,726	10.2%	713,505	538,436	32.5%	1,611	1,340	0.840	0.918	1,228,981	943,997	30.2%	2,775	2,350			
Texas % of DWP	16.84%			428,869	60%						1 YR Dev:	43,272	95,720					
Ohio % of DWP	12.63%			281,075	39%						% of Prior S:	10.8%	23.4%					
Pennsylvania % of DWP	8.81%			2,817	0%						2 YR Dev:	153,506	32,710					
All Other States % of DWP:	61.72%			744	0%						% of Prior S:	37.6%	8.8%					
DOCTORS COMPANY																		
Doctors Co An Interinsurance Exchn	350,190	341,412	2.6%	336,426	396,353	-15.1%	0.961	1.161	0.772	0.907	732,649	627,681	16.7%	2,092	1,838			
California % of DWP	32.79%			287,603	85%						1 YR Dev:	78,109	105,014					
Florida % of DWP	8.02%			40,157	12%						% of Prior S:	22.9%	27.3%					
Ohio % of DWP	7.82%			2,725	1%						2 YR Dev:	153,911	96,770					
All Other States % of DWP:	51.37%			5,942	2%						% of Prior S:	40.1%	25.4%					

MEDICAL MALPRACTICE FINANCIAL METRICS BY WRITING COMPANY

WRITING COMPANY	SURPLUS (\$)				NET WRITTEN PREMIUM (NWP)				NWP TO S				NET L&AE RESERVES (LIAB)				LIAB TO S			
	%				%				%				%				%			
	2003	2002	CHANGE	(1)	2003	2002	CHANGE	(2)	2003	2002	CHANGE	(3)	2003	2002	CHANGE	(4)	2003	2002	CHANGE	(5)
	(2)	(3)	(4)		(5)	(6)	(7)		(8)	(9)	(10)	(11)	(12)	(13)	(14)		(15)	(16)		
HEALTH CARE IND																				
Health Care Indemnity Inc	626,526	482,536	29.8%		377,000	318,633	18.3%		0.602	0.660	0.975	0.924	1,399,165	1,259,178	11.1%		2,233	2,609		
Texas % of DWP	34.52%		Med Malpr Occ:		368,384	98%						1 YR Dev:	-10,241	-22,247						
Florida % of DWP	30.41%		Med Malpr Clm:		8,589	2%						% of Prior S:	-2.1%	-3.8%						
California % of DWP	3.21%		Surety:		27	0%						2 YR Dev:	-13,973	-55,257						
All Other States % of DWP:	31.86%		All Other:		0	0%						% of Prior S:	-2.4%	-10.2%						
AIG																				
Lexington Insurance Company	2,116,406	1,763,654	20.0%		2,809,967	1,859,962	51.1%		1,328	1,055	0.462	0.378	2,916,688	1,611,596	81.0%		1,378	0,914		
California % of DWP	15.72%		Fire:		630,770	22%						1 YR Dev:	148,347	159,140						
New York % of DWP	9.65%		Oth Liab Clm:		626,838	22%						% of Prior S:	8.4%	9.1%						
Florida % of DWP	8.38%		Med Malpr Clm:		433,544	15%						2 YR Dev:	305,120	163,523						
All Other States % of DWP:	66.25%		All Other:		1,118,814	40%						% of Prior S:	17.5%	10.0%						
EVANSTON																				
Evanston Insurance Company	457,608	313,850	45.8%		699,445	588,962	22.9%		1,528	1,813	0.689	0.680	876,243	640,272	36.9%		1,915	2,040		
California % of DWP	23.76%		Oth Liab - Occ:		150,953	22%						1 YR Dev:	4,020	5,337						
Texas % of DWP	9.07%		Med Malpr Clm:		137,289	20%						% of Prior S:	1.3%	2.3%						
Florida % of DWP	8.96%		Oth Liab Clm:		124,990	18%						2 YR Dev:	34,803	-3,332						
All Other States % of DWP:	58.21%		All Other:		286,212	41%						% of Prior S:	15.1%	-2.0%						
EPIC																				
First Professionals Ins Co	118,873	110,858	7.2%		103,429	94,011	10.0%		0.870	0.848	0.360	0.318	211,487	190,139	11.2%		1,779	1,715		
Florida % of DWP	80.86%		Med Malpr Clm:		90,765	88%						1 YR Dev:	1,948	1,404						
Pennsylvania % of DWP	7.58%		Med Malpr Occ:		12,370	12%						% of Prior S:	1.8%	1.5%						
Georgia % of DWP	4.67%		Oth Liab Clm:		293	0%						2 YR Dev:	10,111	9,436						
All Other States % of DWP:	6.89%		All Other:		0	0%						% of Prior S:	11.0%	10.3%						
Anesthesiologists Pro Assur Co																				
Tennessee % of DWP	39.65%		Med Malpr Clm:		16,278	87%						1 YR Dev:	68	605						
Florida % of DWP	33.14%		Workers' Comp:		0	0%						% of Prior S:	0.5%	3.9%						
Texas % of DWP	12.37%		Med Malpr Occ:		2,440	13%						2 YR Dev:	2,011	408						
All Other States % of DWP:	14.84%		All Other:		53	0%						% of Prior S:	13.1%	2.6%						

MEDICAL MALPRACTICE FINANCIAL METRICS BY WRITING COMPANY

WRITING COMPANY	SURPLUS (\$)			NET WRITTEN PREMIUM (NWP)			NWP TO S			NWP TO GWP			NET L&AE RESERVES (LIAB)			LIAB TO S		
	2003	2002	CHANGE	2003	2002	CHANGE	2003	2002	CHANGE	2003	2002	CHANGE	2003	2002	CHANGE	2003	2002	CHANGE
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)	(13)	(14)	(15)	(16)			
PROASSURANCE																		
Pronational Insurance Co	187,937	196,955	-4.6%	193,034	148,722	29.8%	1,027	0.755	0.948	0.886	583,439	511,268	14.1%	3,104	2,596			
Florida % of DWP	41.58%			162,170	84%					1 YR Dev:	65	-10,118						
Michigan % of DWP	29.36%			25,112	13%					% of Prior S:	0.0%	-5.8%						
Illinois % of DWP	11.81%			5,615	3%					2 YR Dev:	-13,770	17,833						
All Other States % of DWP:	17.25%			137	0%					% of Prior S:	-7.8%	7.0%						

FLORIDA SB2D
MEDICAL MALPRACTICE FINANCIAL METRICS BY WRITING COMPANY

WRITING COMPANY	RATIO TO EP (2)	CALENDAR YEAR COMBINED RATIO							RBC RATIO (TAC TO ACL)							NET L&AE RESERVES (LIAB)						
		2003 (3)	2002 (4)	2001 (5)	2000 (6)	1999 (7)	2003 (8)	2002 (9)	2001 (10)	2000 (11)	1999 (12)	INVESTMENT (13)	2003 (14)	2002 (15)	2001 (16)	2000 (17)	1999 (18)					
CNA INSURANCE Continental Casualty Co	LOSS LAE EXPENSE	83.7% 33.4% 36.0%	60.2% 16.1% 33.9%	120.4% 22.5% 44.6%	65.7% 13.0% 34.3%	77.0% 15.4% 34.2%	292.3%	338.1%	292.3%	397.5%	381.0%	BONDS CASH STOCKS MORT. LOANS REAL ESTATE OTHER	59.5% 20.3% 12.6% 0.0% 0.0% 7.6%	61.4% 16.0% 14.1% 0.0% 0.0% 8.5%	56.9% 6.9% 26.6% 0.0% 0.1% 9.5%	50.6% 12.0% 26.7% 0.0% 0.1% 10.6%	52.5% 6.6% 34.5% 0.0% 0.1% 6.3%					
TIG INSURANCE Tig Insurance Company	LOSS LAE EXPENSE	67.0% 64.1% 39.4%	72.3% 26.7% 33.7%	60.4% 29.7% 37.7%	54.8% 36.0% 39.4%	76.4% 23.0% 40.3%	212.7%	208.0%	240.9%	205.9%	213.1%	BONDS CASH STOCKS MORT. LOANS REAL ESTATE OTHER	44.2% 10.9% 38.5% 0.0% 0.0% 6.4%	26.0% 14.4% 49.6% 0.0% 0.0% 10.0%	36.0% 4.8% 46.7% 0.0% 0.0% 12.5%	37.6% 7.7% 54.4% 0.0% 0.0% 0.3%	49.2% 3.2% 47.4% 0.0% 0.0% 0.2%					
MAG MUTUAL INSURANCE GROUP Mag Mutual Insurance Co	LOSS LAE EXPENSE	61.9% 37.3% 20.4%	81.3% 28.5% 16.7%	58.4% 37.7% 21.9%	66.8% 33.0% 21.6%	69.5% 24.1% 20.7%	418.9%	373.9%	550.2%	808.5%	941.8%	BONDS CASH STOCKS MORT. LOANS REAL ESTATE OTHER	83.1% 3.2% 11.9% 0.0% 0.0% 1.8%	75.3% 15.5% 7.8% 0.0% 0.0% 1.4%	79.8% 11.2% 7.4% 0.0% 0.0% 1.6%	79.6% 5.7% 12.9% 0.0% 0.0% 1.8%	75.9% 6.9% 15.5% 0.0% 0.0% 1.7%					
GE GLOBAL INSURANCE Medical Protective Co	LOSS LAE EXPENSE	63.0% 26.0% 15.7%	78.9% 30.6% 17.2%	50.4% 27.1% 17.0%	41.1% 27.4% 18.5%	53.8% 35.9% 19.3%	427.5%	437.1%	536.0%	396.6%	334.3%	BONDS CASH STOCKS MORT. LOANS REAL ESTATE OTHER	94.1% 4.9% 0.3% 0.0% 0.6% 0.1%	80.1% 18.7% 0.4% 0.0% 0.8% 0.0%	91.6% 6.8% 0.7% 0.0% 1.0% -0.1%	97.9% 0.9% 0.1% 0.0% 1.1% 0.0%	96.8% 2.2% 0.0% 0.0% 1.1% -0.1%					
DOCTORS COMPANY Doctors Co An Interinsurance Exchn	LOSS LAE EXPENSE	69.4% 40.2% 16.9%	69.1% 35.9% 23.8%	73.5% 25.0% 123.1%	42.5% 35.7% 104.9%	51.1% 35.1% 114.0%	431.6%	489.3%	941.3%	883.1%	582.4%	BONDS CASH STOCKS MORT. LOANS REAL ESTATE OTHER	67.8% 6.4% 22.1% 0.0% 1.1% 2.6%	54.0% 9.9% 19.1% 0.1% 1.1% 15.8%	59.8% 14.9% 22.6% 0.1% 1.1% 1.2%	63.6% 1.8% 31.2% 0.0% 1.4% 1.8%	67.7% 2.0% 27.7% 0.0% 1.6% 1.2%					

MEDICAL MALPRACTICE FINANCIAL METRICS BY WRITING COMPANY

WRITING COMPANY	CALENDAR YEAR COMBINED RATIO										RBC RATIO (TAC TO ACL)					NET L&AE RESERVES (LIAB)				
	RATIO TO EP																			
	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)	(13)	(14)	(15)	(16)	(17)	(18)	(19)	(20)
HEALTH CARE IND Health Care Indemnity Inc	LOSS		89.1%	88.1%	97.2%	74.4%	86.1%	298.4%	240.8%	317.6%	304.2%	260.0%	BONDS	55.1%	60.8%	55.9%	56.6%	62.8%		
	LAE		22.1%	23.9%	13.0%	32.9%	22.4%						CASH	8.3%	5.0%	6.6%	14.3%	3.9%		
	EXPENSE		1.3%	4.6%	4.6%	5.2%	5.4%						STOCKS	34.1%	29.2%	33.9%	27.1%	28.1%		
			112.5%	116.6%	114.8%	112.5%	113.9%						MORT. LOANS	0.0%	0.0%	0.0%	0.0%	0.0%		
AIG Lexington Insurance Company	LOSS		69.7%	70.0%	81.5%	66.1%	80.4%	503.1%	676.5%	805.3%	846.0%	854.7%	BONDS	79.7%	77.6%	71.6%	73.1%	89.4%		
	LAE		12.4%	14.9%	13.4%	19.7%	8.7%						CASH	0.9%	4.1%	5.1%	8.1%	0.2%		
	EXPENSE		11.2%	9.9%	10.7%	15.7%	0.0%						STOCKS	12.9%	7.5%	8.1%	2.9%	3.0%		
			93.3%	94.8%	105.6%	101.5%	89.1%						MORT. LOANS	0.0%	0.0%	0.0%	0.0%	0.0%		
EVANSTON Evanston Insurance Company	LOSS		50.0%	56.2%	58.4%	49.9%	57.6%	332.0%	265.5%	339.9%	339.1%	317.3%	BONDS	73.6%	72.3%	78.0%	71.2%	78.3%		
	LAE		13.9%	14.3%	11.6%	5.4%	6.6%						CASH	2.3%	9.7%	3.2%	5.7%	-0.2%		
	EXPENSE		29.5%	30.4%	34.9%	43.2%	41.4%						STOCKS	23.8%	17.8%	18.8%	21.6%	21.0%		
			93.4%	100.9%	104.9%	98.5%	105.6%						MORT. LOANS	0.0%	0.0%	0.0%	0.0%	0.0%		
FPC First Professionals Ins Co	LOSS		55.8%	64.1%	72.9%	70.6%	52.7%	345.9%	349.0%	360.3%	356.5%	441.9%	BONDS	84.4%	72.2%	76.6%	90.6%	93.8%		
	LAE		36.4%	27.4%	28.6%	34.6%	19.0%						CASH	8.8%	11.6%	13.6%	0.7%	0.2%		
	EXPENSE		16.6%	15.3%	27.0%	27.0%	24.8%						STOCKS	5.4%	5.4%	6.6%	7.3%	4.5%		
			108.8%	106.8%	128.5%	132.2%	96.5%						MORT. LOANS	0.0%	0.0%	0.0%	0.0%	0.0%		
Anesthesiologists Pro Assur Co	LOSS		61.0%	65.0%	63.8%	73.0%	27.8%	234.4%	286.0%	481.6%	509.8%	1039.7%	BONDS	77.6%	81.7%	75.7%	95.4%	93.6%		
	LAE		29.3%	27.9%	27.8%	17.9%	-3.0%						CASH	22.4%	18.3%	24.3%	4.6%	6.4%		
	EXPENSE		18.5%	11.2%	29.4%	26.8%	26.7%						STOCKS	0.0%	0.0%	0.0%	0.0%	0.0%		
			108.8%	104.1%	121.0%	117.7%	51.5%						MORT. LOANS	0.0%	0.0%	0.0%	0.0%	0.0%		
													REAL ESTATE	0.0%	0.0%	0.0%	0.0%	0.0%		
													OTHER	0.0%	0.0%	0.0%	0.0%	0.0%		

MEDICAL MALPRACTICE FINANCIAL METRICS BY WRITING COMPANY

WRITING COMPANY	CALENDAR YEAR COMBINED RATIO							RBC RATIO (TAC TO ACL)							NET L&AE RESERVES (LIAB)						
	RATIO TO EP	2003	2002	2001	2000	1999		2003	2002	2001	2000	1999		INVESTMENT	2003	2002	2001	2000	1999		
(1)	(2)	(3)	(4)	(5)	(6)	(7)		(8)	(9)	(10)	(11)	(12)		(13)	(14)	(15)	(16)	(17)	(18)		
PROASSURANCE																					
Pronational Insurance Co	LOSS	50.8%	61.4%	93.8%	82.4%	29.6%		299.6%	388.3%	368.7%	613.3%	596.0%		BONDS	72.5%	72.1%	65.1%	64.9%	79.8%		
	LAE	52.4%	41.9%	47.7%	43.7%	59.4%								CASH	4.6%	4.1%	11.4%	9.7%	2.9%		
	EXPENSE	16.1%	16.3%	19.1%	16.6%	21.0%								STOCKS	22.2%	23.1%	22.7%	24.5%	16.2%		
		119.3%	119.6%	160.6%	142.7%	110.0%								MORT. LOANS	0.1%	0.1%	0.1%	0.1%	0.0%		
														REAL ESTATE	0.6%	0.6%	0.7%	0.7%	0.8%		
														OTHER	0.0%	0.0%	0.0%	0.1%	0.3%		

APPENDIX B

Market Leader Data Request



Deloitte Consulting LLP
City Place, 33rd Floor
185 Asylum Street
Hartford, CT 06103-3402
USA

Tel: 860-543-7345
Fax: 860-543-7371
www.deloitte.com

Data Request

Date: July 8, 2004

To: Mr. John Doe
XYZ Insurance Company
1000 TBD Street
City, CT 00000

From: Kevin Bingham, ACAS, MAAA, Deloitte Consulting LLP
Richard Simring, Attorney at Law, Stroock

Subject: Request for medical malpractice information (ROI) in regards to Section 54(6)(b) and (c) of CS for SB 2-D, 1st Engrossed (SB2D) – Market Leader Data Request

Background

Deloitte Consulting was engaged by the Office of Insurance Regulation (OIR) to assist the OIR with the completion of Section 45(6)(b) and (c) of CS for SB 2-D, 1st Engrossed which states:

“(b) OIR shall prepare an annual report by October 1 of each year, beginning in 2004, which shall be available on the Internet, which summarizes and analyzes the closed claim reports and the annual financial reports filed by insurers writing medical malpractice insurance in Florida. The report must include: (1) an analysis of closed claim reports of prior years in order to show trends in the frequency and amount of claims payments; (2) the itemization of economic and noneconomic damages; (3) the nature of the errant conduct; and (4) such other information that OIR determines is illustrative of the trends in closed claims. The report must also analyze the state of the medical malpractice insurance market in Florida including: (1) an analysis of the financial reports of those insurers with a combined market share of at least 80 percent of the net written premium in the state for medical malpractice for the prior calendar year; (2) loss ratio analysis for medical malpractice written in Florida; and (3) a profitability analysis of each such insurer. The report shall compare the ratios for medical malpractice in Florida compared to other states, based on financial reports filed with the National Association of Insurance Commissioners and such other information that OIR deems relevant

(c) The annual report shall also include a summary of the rate filings for medical malpractice which have been approved by the office for the prior calendar year, including an analysis of the trend of direct and incurred losses as compared to prior years.”

As part of our proposed work plan, we have been asked by the OIR to prepare a market leader data request (MLDR) that will survey the top medical malpractice writers in the state of Florida. Based upon the actual net written premium in the state for 2003, your company falls in the top eleven insurers necessary to satisfy the 80 percent benchmark established by SB2D.

The purpose of this MLDR is to request financial information and written responses that will help Deloitte Consulting analyze the current state of the medical malpractice market post SB2D. Given the long tail nature of the medical malpractice line of business and the "green" nature of SB2D, we recognize that it may be somewhat early to quantify some sections of SB2D in terms of benefits, savings and court activity. We request that you will do your best to describe your Company's experiences with and concerns regarding SB2D to the best of your ability. We also recognize that certain information may be confidential and may potentially impact the outcome of current litigation. In those situations, we fully understand that general comments may be necessary instead of specific references to specific events.

Data Request

Requested Financial Information

- I. A hard copy of your Company's December 31, 2003 Annual Statement
- II. A copy of your "Page 14" data for all states
 - a. 12/31/2003
 - b. 12/31/2002
 - c. 12/31/2001
- III. Please provide us with a 10-year summary of bad faith payments made by your Company.
 - a. Information displayed by year of closing
 - i. (A) Paid losses limited to policy limits (e.g., \$250,000, \$500,000, etc.)
 - ii. (B) Losses in excess of policy limits (i.e., bad faith payments)
 - iii. (C) Ratio in excess of policy limits = (B) / (A)
 - iv. Please identify in the footnotes the amount of bad faith payments made post-SB2D
 - v. Please identify in the footnotes how paid losses limited to policy limits are calculated (e.g., do you limit all claims to \$250,000, do you use actual policy limits which may vary by claim?, etc.)
- IV. For medical negligence suits filed in court, please provide us with a 5-year history of suits sorted by the following SB2D categories:
 - a. catastrophic vs. non-catastrophic
 - b. death vs. non-death
 - c. number of claimants
 - d. number of defendants
 - e. ER suits sorted by practitioner vs. non-practitioner
 - f. Non-ER suits sorted by practitioner vs. non-practitioner
- V. For "notices of intent to initiate litigation" (SB2D Section 49), please provide us data on how many notices were mailed after September 15, 2003 and whether the incidents described occurred before or after September 15, 2003.
- VI. Please provide us with your current policy limit distribution. A format similar to our "Matrix of Indemnity Savings" shown in Section 54 of our November 6, 2003 PF Report would be helpful.

SB2D Questions

- I. Please discuss how your Company will handle the impact of the "Presumed Factor" (PF) in your next rate filing.
- II. Please discuss how the appointment of a patient safety officer and patient safety committee at each licensed facility as required under Section 6 of SB2D has impacted patient safety in Florida. Please provide any available information on average loss ratio, claim frequency, or claim severity differences between facilities with patient safety officers and those without patient safety officers. Please note if the comparisons are distorted by rate differentials between facilities with or without safety officers, differences in usual geographic location, profit vs. non-profit, charity hospitals vs. all others, etc.
- III. Please discuss (or provide data on) how successful your insured non-practitioners (i.e., licensed facilities) have been notifying patients of "adverse incidents" under Section 7 of SB2D. Please provide data (approximate if need be) on what percentage of inpatient and outpatient patients have been notified of "adverse incidents" under Section 7 of SB2D.
- IV. Please discuss (or provide data on) how successful your insured practitioners have been notifying patients of "adverse incidents" under Section 8 of SB2D. See above
- V. Please list the five most frequently misdiagnosed conditions of your insured practitioners. This is aimed at improving education regarding root-cause analysis, error reduction and prevention, and patient safety discussed under Section 10 of SB2D.
- VI. Please comment on the usefulness of the practitioner profiles shown on the Florida Department of Health website <http://www.doh.state.fl.us/MQA/profiling> discussed under Section 14/Section 15 of SB2D. If possible, please also comment on the following:
 - a. Insured practitioner satisfaction with profile (e.g., readability of explanation for disciplinary action taken, basis to change the profile and frequency)
 - b. Insured practitioner satisfaction with linking of profile to practitioner's web-site
 - c. Insured practitioner satisfaction with update process
 - d. Timeliness of information included in practitioner profile (Section 17 of SB2D)
- VII. Please list and describe any instances where physicians have been suspended for non-payment of awards under Section 23 of SB2D.
- VIII. Please discuss the impact of Section 48 of SB2D dealing with expert witness testimony. Has your Company observed any limitation of plaintiff or defense experts? Has your Company observed the elimination of frivolous claims that can no longer be supported by experts defined under SB2D?

- IX. Please discuss the impact of Section 49 of SB2D dealing with issues such as notice before filing of a claim and pre-suit screening. What percentage of plaintiffs are sending copies of complaints to the DOH and what percentage of plaintiffs are providing pre-suit information regarding all known doctors who have seen the claimant for the relevant injuries?
- X. Please show the ratio of settlements under binding arbitrations to all claims closings both before and after SB2D. Similarly for mediations (See Section 50 of SB2D).

XI. SECTION 54 – CAP ON NON-ECONOMIC DAMAGES

- a. Please list any court cases in the state of Florida that have imposed a cap on non-economic damages? Include any available economic and non-economic dollar information on the total actual cost of the claim
- b. Please list any claims your company is currently litigating that have a high probability of resulting in non-economic damages that exceed the SB2D caps? Show economic and non-economic dollar amount estimates only and do not include claimant name or other information that could allow opposing counsel to obtain information off your submission.
- c. Please discuss your perception of the constitutionality of the non emergency room caps on non-economic damages for practitioners and non practitioners.
- d. Please discuss your perception on the constitutionality of the emergency room cap on non-economic damages for practitioners and non-practitioners.
- e. Please discuss and provide any available data showing whether the cap on non-economic damages has helped your negotiating position in any of your cases you have settled in 2004 in areas such as:
 - i. Speed up in claim settlement (e.g., changing settlement lag)
 - ii. Elimination of frivolous claims
 - iii. Please provide the developed average cost of a settled claim both before and after SB2D
- f. How is your perception of the constitutionality of the cap on damages being reflected in your post SB2D PF rate filings?
- g. How did you reflect the \$150,000/\$300,000 emergency room caps in your recent PF filing required under SB2D?

XII. SECTION 56 – BAD FAITH

- a. Please discuss how many times your company has tendered policy limits since September 15, 2003.

- b. Please provide the approximate number of plaintiff attorney demand letters received both before and after SB2D.
 - c. Please provide the number of claim settlements per policy both before and after SB2D
 - d. Please provide the average severity of settled claims both before and after SB2D
 - e. Have your defense mitigation strategies changed since the passage of SB2D? If so, how?
- XIII. Please comment on the impact of good SAM under Section 56 of SB2D. Can you provide any examples of claims where good SAM has had a favorable impact?
- XIV. Please provide a breakdown of policy limits sold by policy count both before and after SB2D. As we noted in our PF Report, healthcare providers have been purchasing lower policy limits or are choosing not to purchase coverage at all. Can you comment on the current trends regarding the purchase of lower policy limits?
- XV. Are there any other court cases that you think we should be aware of that may impact the constitutionality of SB2D?
- XVI. Are there any other impacts of SB2D that should be noted from a financial perspective that we have not addressed above or you would like to share with us?

Report

Consistent with our "Presumed Factor" report published on November 6, 2003, to the extent possible, we will remove all references to the Company providing the answers. The purpose of our report is not to single out any one individual insurer, but to evaluate how effective SB2D has been for practitioners in the State of Florida.

Timing

In order to meet our tight time frames, we need to receive your written response via email or U.S. mail by August 6, 2004.

Contact Information

Should you have any questions, please feel free to contact Kevin Bingham at (860) 543-7345 or email Kevin at kbingham@deloitte.com.

MLDR information can be emailed to kbingham@deloitte.com or mailed in paper format to:

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185 Asylum Street
Hartford, CT. 06103-3402

APPENDIX C

Ratemaking Primer

On March 13, 2003, Mr. James Hurley presented testimony to the United States Senate titled “Causes of the Medical Liability Insurance Crisis”³⁶. We have included “The Ratemaking Process” section of the written testimony prepared by the Medical Malpractice Subcommittee of the American Academy of Actuaries (Mr. Bingham is a member of the subcommittee):

“Ratemaking is the term used to describe the process by which companies determine what premium is indicated for a coverage. In the insurance transaction, the company assumes the financial risk associated with a future, contingent event in exchange for a fixed premium before it knows what the true cost of the event is, if any. The company must estimate those costs, determine a price for it and be willing to assume the risk that the costs may differ, perhaps substantially, from those estimates. A general principle of ratemaking is that the rate charged reflects the costs resulting from the policy and the income resulting from the anticipated policy covered losses, not what is actually paid or is going to be paid on past policies. It does not reflect money lost on old investments. In short, a rate is a reflection of future costs.

In general, the actuarial process used in making these estimations for medical malpractice insurance starts with historical loss experience for the specific coverage and, usually, for a specific jurisdiction. Rates are determined for this coverage, jurisdiction, and a fixed time period. To the appropriately projected loss experience, a company must incorporate consideration of all expenses, the time value of money and an appropriate provision for risk and profit associated with the insurance transaction.

³⁶ United States Senate Committee on Appropriations Subcommittee on Labor, Health and Human Services, Education, and Related Agencies - Hearing on “Causes of the Medical Liability Insurance Crisis”, Statement of James Hurley, ACAS, MAAA, Chairperson, Medical Malpractice Subcommittee, American Academy of Actuaries

For a company already writing a credible volume of the coverage in a state, the indications of the adjusted ultimate loss experience can be compared to its current premiums to determine a change. For a company entering the line or state for the first time, obtaining credible data to determine a proper premium is often difficult and, sometimes, not possible. In the latter situation, the risk of being wrong is increased significantly.

Additionally, some lines of insurance coverage are more predictable than other lines. The unpredictability of coverage reflects its inherent risk characteristics. Most companies would agree that costs and, therefore, rates for automobile physical damage coverage, for example, are more predictable than for medical malpractice insurance because automobile insurance is relatively high frequency/low severity coverage compared to medical malpractice insurance. In the case of auto physical damage, one has a large number of similar claims for relatively small amounts that fall in a fairly narrow range. In medical malpractice insurance, one has a small number of unique claims that have a much higher average value and a significantly wider range of possible outcomes. There also is significantly longer delay for medical malpractice insurance between the occurrence of an event giving rise to a claim, the reporting of the claim, and the final disposition of the claim. This longer delay adds to the uncertainty inherent in projecting the ultimate value of losses, and consequently premiums.

The following guidelines explain the ratemaking process:

- 1. Historical loss experience is collected in coverage year detail for the last several years. This usually will include paid and outstanding losses and counts. The data is reviewed for reasonableness and consistency, and estimates of the ultimate value of the coverage-year loss are developed using actuarial techniques.*
- 2. Ultimate losses are adjusted to the prospective level (i.e., the period for which rates are being made). This involves an appropriate adjustment for changes in*

average costs and claim frequencies (called trend). Adjustments also would be made for any changes in circumstances that may affect costs (e.g., if a coverage provision has been altered).

- 3. Adjusted ultimate losses are compared to premium (or doctor counts) to determine a loss ratio (or loss cost per doctor) for the prospective period.*
- 4. Expenses associated with the business must be included. These are underwriting and general expenses (review of application, policy issuance, accounting, agent commission, premium tax, etc.) Other items to consider are the profit and contingency provision, reinsurance impact, and federal income tax.*
- 5. A final major component of the ratemaking process is consideration of investment income. Typically for medical malpractice insurance, a payment pattern and anticipated prospective rate of return are used to estimate a credit against the otherwise indicated rate.*

These five steps, applied in a detailed manner and supplemented by experienced judgment, are the standard roadmap followed in developing indicated rates. There are a number of other issues to address in establishing the final rates to charge. These include recognizing differences among territories within a state, limits of coverage, physician specialty, and others. The final rates will reflect supplemental studies of these various other aspects of the rate structure.

Many states have laws and regulations that govern how premium rates can be set and what elements can or must be included. The state regulators usually have the authority to regulate that insurance premium rates are not excessive, inadequate, or unfairly discriminatory. It is not uncommon for state insurance regulators to review the justification for premium rates in great detail and, if deemed necessary, to hold public hearings with expert testimony to examine the basis for the premium rates. In many states, the insurance regulator has some authority to restrict the premium rates that insurance companies can charge.”

The following glossary of terms may be a useful reference guide to the reader:

Accident Year	An annual time period used in the statistical collection of claims data. Data for an accident year consists of all claims arising from events occurring during the particular period (e.g., 1/1/XX through 12/31/XX+1), regardless of time lags in the reporting or payment of claims.
Report Year	An annual time period used in the statistical collection of claims data. Data for a report year consists of all claims arising from events reported during the particular period (e.g., 1/1/XX through 12/31/XX+1), regardless of the occurrence date of the claim.
Paid Losses	The cumulative loss amount paid for a claim as of a particular point in time.
Reserves	An estimate of the unpaid amount of a report/accident year's loss experience as of a particular point in time. It includes all individual claim estimates as provided by the claim adjuster. It also includes any expected future change in those estimates as estimated by an actuary, which is referred to as incurred but not reported or IBNR.
Incurred Losses	The cumulative loss amount paid for a claim as of a particular point in time, plus outstanding unpaid amounts as estimated by a claims adjuster.
Ultimate Losses	Total losses for a particular report year or accident year. This equals the sum of all payments, case reserves and IBNR.
Reported Counts	The cumulative number of claims reported as of a particular point in time.
Loss Components Indemnity-	The portion of a claim relating to compensation for a claimant's economic and noneconomic damages.

<i>ALAE-</i>	The portion of a claim relating to the cost of settlement. This includes defense costs, court costs, medical reports, investigative reports, etc.
Loss Ratio	Ratio of losses (paid, incurred, or ultimate) to net earned premium as a percentage.
Claims Frequency	Ultimate number of claims divided by an exposure base (e.g., occupied beds, net earned premium).
Claims Severity	Ultimate losses divided by ultimate number of claims.
Development Factor	A multiplicative factor applied to either paid losses, incurred losses, reported counts or average severities in order to estimate ultimate losses, ultimate claims or ultimate severities.
Manual Rate Indication	<p>Sample Calculation:</p> <ul style="list-style-type: none">(1) Ultimate Loss and LAE Ratio(2) Death, Disability and Retirement Load (DDR)(3) Expected Loss Ratio(4) Average Policy Discount <p>Indication = [(1) x (2)] / [(3) x { 1.0 - (4) }] - 1.0</p> <p>Note:</p> <ul style="list-style-type: none">a) Format of the formula varies by rate filing.b) Changes to other assumptions (e.g., territorial and class relativities) would also need to be included in order to determine the final base rate change.

APPENDIX D

SB2D Definitions

Claimant means any person who has a cause of action for damages based on personal injury or wrongful death arising from medical negligence.

Health care practitioner means any person licensed under Chapter 457 (acupuncture); Chapter 458 (medical practice); Chapter 459 (osteopathic medicine); Chapter 460 (chiropractic medicine); Chapter 461 (podiatric medicine); Chapter 462 (naturopathy); Chapter 463 (optometry); Chapter 464 (nursing); Chapter 465 (pharmacy); Chapter 466 (dentistry); Chapter 467 (midwifery); part I (speech-language pathology and audiology), part II (nursing home administration), part III (occupational therapy), part V (respiratory therapy), part X (dietetics and nutrition practice), part XIII (athletic trainers), or part XIV (orthotics, prosthetics, and pedorthics) of Chapter 468; Chapter 478 (electrolysis); Chapter 480 (massage practice); part III (clinical laboratory personnel) or part IV (medical physicists) of Chapter 483; Chapter 484 (dispensing of optical devices and hearing aids); Chapter 486 (physical therapy practice); Chapter 490 (psychological services); or Chapter 491 (clinical, counseling and psychotherapy services).

Non practitioner means hospitals, health maintenance organizations (HMOs), hospice providers, and other non-physician entities

Health care provider means any hospital, ambulatory surgical center, or mobile surgical facility as defined and licensed under Chapter 395; a birth center licensed under Chapter 383; any person licensed under Chapter 458, Chapter 459, Chapter 460, Chapter 461, Chapter 462, Chapter 463, part I of Chapter 464, Chapter 466, Chapter 467 or Chapter 486; a clinical lab licensed under Chapter 483; a health maintenance organization certificated under part I of Chapter 641; a blood bank; a plasma center; an industrial clinic; a renal dialysis facility; or a professional association

partnership, corporation, joint venture, or other association for professional activity by health care providers.

Economic damages means financial losses that would not have occurred but for the injury giving rise to the cause of action, including, but not limited to, past and future medical expenses and 80 percent of wage loss and loss of earning capacity to the extent the claimant is entitled to recover such damages under general law, including the Wrongful Death Act.

Noneconomic damages (a/k/a “pain and suffering”) means non financial losses that would not have occurred but for the injury giving rise to the cause of action, including pain and suffering, inconvenience, physical impairment, mental anguish, disfigurement, loss of capacity for enjoyment of life, and other non financial losses to the extent the claimant is entitled to recover such damages under general law, including the Wrongful Death Act.

Contractual obligations (a/k/a “bad faith”) means any matter regarding an insurance claim by an insured that is wrongfully denied by the insurer (e.g., unreasonable delay of payment, unreasonable denial of benefits, failure to thoroughly investigate a claim, etc.).

Helpful abbreviations

AHCA or Agency	Agency for Health Care Administration
DoAH	Division of Administrative Hearings
DOH	Department of Health
HCP	Health Care Professional
OIR	Office of Insurance Regulation
OPPAGA	Office of Program Policy Analysis and Government Accountability

APPENDIX E

BERGES CASE TESTING CAP ON NON-ECONOMIC DAMAGES

Page 1 – Claimants

Page 1 – Defendants

Page 2 – Underlying Facts

Page 5 – Diagnosis

Page 6 – Primary Constitutional Claims

CIVIL COVER SHEET

The civil cover sheet and the information contained herein does not replace the filing and service of pleadings or other papers as required by law. This form is required for the use of the Clerk of Court for the purpose of reporting judicial workload data pursuant to Florida Statute 25.075.

1. STYLE OF CASE

IN THE CIRCUIT COURT OF THE 11TH
JUDICIAL CIRCUIT IN AND FOR MIAMI
DADE COUNTY, FLORIDA

Case No. _____

Judge: _____

FEDERICO BERGES and SONIA
BERGES, as parents and natural
guardians of their minor child,
MARIAELENA BERGES,

Plaintiffs,

vs.

BELLEITHA LAMBKIN-ALEXANDER,
M.D., et al.,

Defendants.

FILED FOR RECORD
2004 AUG 30 AM 11:24
CLERK OF COURT
DADE COUNTY, FLA.

2. TYPE OF CASE (Place an X in one box only. If the case fits more than one type of case, select the most definitive.)

DOMESTIC RELATIONS

- ☐ Simplified dissolution
- ☐ Dissolution
- ☐ Support-IV-D
- ☐ Support-Non IV-D
- ☐ URESA-IV-D
- ☐ URESA - Non IV-D
- ☐ Domestic Violence
- ☐ Other domestic relations

TORTS

- ☐ Professional Malpractice
- ☐ Products liability
- ☐ Auto Negligence
- ☐ Other negligence

OTHER CIVIL

- ☐ Contracts
- ☐ Condominium
- ☐ Real property/Mortgage
foreclosure
- ☐ Eminent domain
- ☒ Other

3. IS JURY TRIAL DEMANDED IN COMPLAINT? ☒ YES ☐ NO

DATE: 8/30/04

ATTORNEY: _____

Neal A. Roth

NEAL A. ROTH
Fla. Bar #220876

IN THE CIRCUIT COURT OF THE 11TH
JUDICIAL CIRCUIT IN AND FOR
MIAMI-DADE COUNTY, FLORIDA

GENERAL JURISDICTION DIVISION

CASE NO.

04-18664-1

FEDERICO BERGES and SONIA
BERGES, as parents and natural
guardians of their minor child,
MARIAELENA BERGES,

Plaintiffs,

vs.

BELLEITHA LAMBKIN-ALEXANDER,
M.D.; ROZALYN H. PASCHAL, M.D.;
ROZALYN H. PASCHAL, M.D., INC.;
AND ROZALYN HESTER PASCHAL,
M.D., P.A.,

Defendants.

236
155
2041
7479

FILED IN RECORD
RECEIVED
JAN 24 2005
CLERK OF COURT
JUDICIAL CIRCUIT IN AND FOR
MIAMI-DADE COUNTY, FLORIDA

COMPLAINT FOR DECLARATORY JUDGMENT

The Plaintiffs, FEDERICO BERGES and SONIA BERGES, as parents and natural guardians of their minor child, MARIAELENA BERGES, sue the Defendants, BELLEITHA LAMBKIN-ALEXANDER, M.D.; ROZALYN H. PASCHAL, M.D.; ROZALYN H. PASCHAL, M.D., INC.; and ROZALYN HESTER PASCHAL, M.D., P.A., and allege the following:

JURISDICTIONAL STATEMENT AND IDENTIFICATION OF PARTIES

1. This is an action for a declaratory judgment brought pursuant to Chapter 86, Florida Statutes. This court has jurisdiction of this action pursuant to Fla. Stat. §86.011 (2003).

2. The Plaintiffs, Federico and Sonia Berges, are the parents and natural guardians of the minor child, Mariaelena Berges.

3. The Berges have a presently pending action in the Circuit Court in the Eleventh Judicial Circuit in and for Miami-Dade County, Florida, General Jurisdiction Division, Case No. 04-15284 CA 09. Because this action challenges the constitutionality of a Florida statute, a copy of this Complaint will be served on the Attorney General, State of Florida.

4. Venue is proper in Miami-Dade County, Florida where the underlying incident, a medical malpractice action, occurred and to which this complaint for declaratory relief is addressed.

5. All of the Defendants are residents of, have offices in, and provide medical services and care in Miami-Dade County, Florida.

UNDERLYING FACTS

6. On October 24, 2003, Mr. Berges took Mariaelena to her pediatrician's office, the offices of Defendants, Rozalyn H. Paschal, M.D., Inc. and Rozalyn Hester Paschal, M.D. P.A. Mariaelena was seen by Defendant Dr. Lambkin-Alexander. Mariaelena presented with a cough and cold which had continued for 6-7 weeks. Mariaelena had complaints of a headache and the cough was wet. Physical examination revealed that Mariaelena's left tympanic membrane had serous fluid. Her lungs had scattered expiratory wheezes and she did have a wet cough.

7. Defendant Dr. Lambkin-Alexander diagnosed Mariaelena with hyperactive airway disease, sinusitis and left otitis media. She prescribed Bactrim, 1½ teaspoons PO BID for 10 days; nebulizers every 6 hours; and Tanafed 1 teaspoon BID for 2 weeks. Mr. Berges was instructed to follow up in 2 weeks.

8. On November 5, 2003, Mr. Berges took Mariaelena back to the same office. Her presenting complaints were that her eye was hurting particularly when she rubbed it. Also, she had thick mucous drainage from her eyes. Mariaelena vomited once before arriving at the doctor's office. Her temperature was at 100.6°. Defendant Dr. Lambkin-Alexander again evaluated Mariaelena. She noted that both eyes were infected; had discharge; and diagnosed her with bilateral conjunctivitis. Defendant Dr. Lambkin-Alexander instructed Mr. Berges to instill 2 drops of Ciprodex TID for one week; to continue the nebulizer treatments until the cough subsided; and to follow up if the eyelids became swollen or there was pain in the eyes.

9. On or about November 6, 2003, Mrs. Berges took Mariaelena back to the Defendant pediatrician's office. Mariaelena had fever, was vomiting, coughing, had "pinkeye", and complained of burning with urination. On this visit, Mariaelena was seen by Defendant Dr. Paschal who documented that the child had a recent history of pinkeye, an ear infection, asthma and fever for 2

days. The night prior to the office visit, Mariaelena had developed dysuria. She had a temperature of 102.3°.

10. Defendant Dr. Paschal's examination revealed erythematous tonsils, supple neck, clear lungs, normal tympanic membranes, but swollen erythematous labia. Defendant Dr. Paschal's impressions included bilateral conjunctivitis, tonsillitis, a history of asthma and urethritis.

11. A urinalysis was normal. A throat C&S was obtained. A CBC with a WBC of 7.9; Hgb 13.9 and Hct 41.1; and platelets of 297 were noted. Defendant Dr. Paschal instructed Mrs. Berges to use mild soap, A&D ointment, Motrin or Tylenol and prescribed Bactrim 2½ teaspoons every 12 hours.

12. On November 7, 2003, Mr. Berges called the Defendant doctors' office. Before the office returned the call, however, Mrs. Berges took Mariaelena to Memorial Hospital West to be evaluated for fever, rash, conjunctivitis and blistered, sore, dry lips. The child was drooling and would not swallow fluids. On examination, she was found to have a temperature of 101.7° with a heart rate of 156. The emergency room physician documented a blanchable erythematous papular rash on her palms, chest and behind her ears. Her oral mucosa was erythematous and ulcerations were on the tongue tip. Her vaginal mucosa was also erythematous. Dr. Greissman was consulted. He evaluated Mariaelena at 15:30. He ordered her transferred to Joe DiMaggio Children's Hospital.

13. Mariaelena was transferred at 17:25 with the diagnosis of erythema multiforme and rule out Kawasaki disease. On arrival to Joe DiMaggio Children's Hospital, Mariaelena was seen and evaluated by numerous specialists who immediately diagnosed Stephens Johnson Syndrome.

14. Subsequently, Mariaelena was admitted to Joe DiMaggio Children's Hospital where she remained from November 7, 2003 through November 29, 2003 where she was treated for Stephens Johnson Syndrome.

15. The Plaintiffs filed the aforementioned medical malpractice complaint based on alleged acts of negligence which occurred after September 15, 2003 against the Defendants for both active negligence and vicarious liability. After compliance with the presuit requirements of Chapter 766 the Defendants and their insurers denied the claims.

16. While in the hospital, Mariaelana suffered from drooling; blistering skin; blistering gastrointestinal tract; eyes swollen shut; severe respiratory complications; papular rash on palms, chest, and ears; tongue ulcerations; erythematous vaginal mucosa; corneal ulcerations; third degree burns over her body; sloughed her skin; placement of a feeding tube; and subsequent hair loss. The Bergeses claimed compensatory damages as follows: bodily injury; pain and suffering; disability; disfigurement; mental anguish; loss of the capacity for the enjoyment of life; medical and other health care related expenses; loss of wage

earning capacity; rehabilitation expenses; and aggravation of a pre-existing condition on behalf of their minor child, Mariaelena Berges.

17. The Bergeses, as parents, also claimed medical, hospital, and related expenses in the past and in the future. A jury trial was also demanded.

PRIMARY CONSTITUTIONAL CLAIMS

18. Prior to September 15, 2003, the recoverable damages in a medical malpractice case were not limited. Consequently, a plaintiff could seek the full measure of damages that a jury might award for any injuries that a jury might find were proximately caused by the negligence of the defendant doctors. The right to recover such unlimited damages as found by the jury reflect that persons who are innocent victims of wrongful conduct have the right and opportunity to obtain recourse and recompense from the tortfeasors.

19. Moreover, Article I, Section 21, of the Florida Constitution provides that the courts shall be open for every person for redress of any injury, and justice shall be administered without sale, denial or delay.

20. It is uncontroverted, therefore, that there existed prior to September 15, 2003 a right to sue on and recover noneconomic damages of any amount and that this right existed from the time the current Florida Constitution was adopted. The right to redress injury does not draw any distinction between economic and noneconomic damages. Article I, Section 21, does not contain any language which would support the proposition that the

right is limited, or may be limited, to suits above or below any given figure. It has, therefore, always been recognized under Florida law that great harm may befall victims of medical malpractice and the corresponding necessity for requiring those that are responsible to compensate such harms.

21. Chapter 2003-416, *Laws of Florida*, however, made far-reaching changes which affect compensable damages to such injured persons. Section 86 of that chapter provides for, among other things, caps on damages, changes to bad faith claims against insurers, and various procedural changes which would take effect September 15, 2003. The legislation purports to state that to the extent allowed by the Florida Constitution, such changes would apply to any prior medical incident for which a notice of intent to initiate litigation has not been mailed before September 15, 2003.

22. The Bergeses sent out their notice of intent on February 19, 2004. Consequently, the Act purports to affect the monetary recovery that Mr. and Mrs. Berges may make on behalf of their severely injured minor child, Mariaelena Berges.

23. In particular, Fla. Stat. §766.118 provides the following limitation on noneconomic damages for the negligence of the Defendant treating physicians:

- (a) With respect to a cause of action for personal injury or wrongful death arising from medical negligence of practitioners, regardless of the number of such practitioner defendants, noneconomic

damages shall not exceed \$500,000 per claimant. No practitioner shall be liable for more than \$500,000 in noneconomic damages, regardless of the number of claimants.

(b) Notwithstanding paragraph (a), if the negligence resulted in a permanent vegetative state or death, the total noneconomic damages recoverable from all practitioners, regardless of the number of claimants, under this paragraph shall not exceed \$1 million. In cases that do not involve death or permanent vegetative state, the patient injured by medical negligence may recover noneconomic damages not to exceed \$1 million if:

1. The trial court determines that a manifest injustice would occur unless increased noneconomic damages are awarded, based on a finding that because of the special circumstance of the case, the noneconomic harm sustained by the injured patient was particularly severe; and

2. The trier of fact determines that the defendant's negligence caused a catastrophic injury to the patient.

(c) The total noneconomic damages recoverable by all claimants from all practitioner defendants under this subsection shall not exceed \$1 million in the aggregate.

3. Limitation on noneconomic damages for negligence of nonpractitioner defendants --

(a) With respect to a cause of action for personal injury or wrongful death arising from medical negligence of nonpractitioners, regardless of the number of such nonpractitioner defendants, noneconomic damages shall not exceed \$750,000 per claimant.

(b) Notwithstanding paragraph (a), if the negligence resulted in a permanent vegetative state or death, the total noneconomic damages recoverable by such claimant from all nonpractitioner defendants under this paragraph shall not exceed \$1.5 million. The patient injured by medical negligence of a nonpractitioner defendant may recover noneconomic damages not to exceed \$1.5 million if:

(1) The trial court determines that a manifest injustice would occur unless increased noneconomic damages are awarded, based on a finding that because of the special circumstances of the case, the noneconomic harm sustained by the injured patient was particularly severe; and

(2) The trier of fact determines that the defendant's negligence caused a catastrophic injury to the patient.

(c) Nonpractitioner defendants are subject to the cap on noneconomic damages provided in this subsection regardless of the theory of liability, including vicarious liability.

(d) The total noneconomic damages recoverable by all claimants from all nonpractitioner defendants under this subsection shall not exceed \$1.5 million in the aggregate.

Pursuant to Fla. Stat. §766.118, catastrophic injury is defined to include second-degree or third-degree burns of 25% or more of the total body surface or third-degree burns of 5% or more to the face and hands. Fla. Stat. §766.118(1)(a)4. Mariaelena Berges sustained Stephen Johnson Syndrome. This is the equivalent of second degree or third degree burns because her entire skin was sloughed off and blistered; and, her gastrointestinal tract was also

burned and blistered.

24. The statute defines practitioner as licensed physicians as well as any entity vicariously liable for such physicians. There are four practitioner defendants: Dr. Bellietha Lambkin-Alexander; Dr. Rozalyn Paschal; Rozalyn H. Paschal, M.D., Inc.; and Rozalyn Hestor Paschal, M.D., P.A. The theories against the latter two defendants are vicarious liability.

25. The Plaintiffs contend that absent the application of Fla. Stat. §766.118, which they maintain is unconstitutional, Mariaelena would be entitled to the full measure of damages from the four practitioners.

26. On the other hand, the defendants will contend that noneconomic damage recovery is capped by Fla. Stat. §766.118 in the amount of \$500,000 total from the four practitioners.

27. The Plaintiffs contend that the limitation on noneconomic damages is unconstitutional as will be more particularly set forth below. The Plaintiffs also contend that if this court finds that Fla. Stat. §766.118 is a constitutional limitation on noneconomic damages, then the plaintiffs are subject to the limits pertaining to catastrophic injury. Therefore, the Plaintiffs are entitled to total noneconomic damages from all four practitioner defendants in the amount of \$1 million in the aggregate.

28. Fla. Stat. §766.118 is unconstitutional inter alia for the following reasons: The statute caps the damages available to injured persons seeking

redress through the courts. It has impermissibly burdened a plaintiff's ability to obtain access to the courts for full redress of all injuries. It has impaired a plaintiff's rights to all common law remedies without either providing an adequate alternative remedy or reflecting an overwhelming public necessity in the absence of less-restrictive alternatives, therefore denying access to courts in violation of Article I, Section 21, of the Florida Constitution, as well as access to courts under the Federal Constitution and the 14th Amendment.

29. The statute also denies equal protection by treating similarly situated natural persons unequally and making invidious and irrational distinctions in violation of Article I, Section 2, and Article III of the Florida Constitution, and the Equal Protection Clause afforded under the 14th Amendment of the Federal Constitution. Among other things, it discriminates against the most seriously injured claimants by providing arbitrary compensation below a certain level of damages and partial compensation above a certain level against those injured persons who are less well off economically than plaintiffs who are able to financially bear the damages for which they are not compensated. The statute also discriminates by virtue of physical disability.

30. Moreover, the statute creates arbitrary classifications to benefit a particular industry, medical practitioners, and their insurers, in violation of Article III, Sections 10 and 11 of the Florida Constitution and the 14th

Amendment of the Federal Constitution. It impairs the right to trial by jury in violation of Article I, Section 22, of the Florida Constitution by turning the jury's determination of damages into an advisory opinion and by assigning to a judge the common-law authority of the jury. It denies due process because there is no compelling state interest effectuated by least restrictive means, as well as no reasonable relation to a legitimate or compelling governmental objective in violation of Article I, Section 9 of the Florida Constitution and the Fourteenth Amendment of the Federal Constitution. It does so in particular by creating arbitrary damage caps; by irrationally and arbitrarily defining various categories of injury; by irrationally and arbitrarily limiting damages recoverable from so-called nonpractitioners; by protecting the medical practitioner rather than the medical practitioner's victim thereby irrationally extending its provisions to protect one class; and by serving no legislative objective related to the reduction of lawsuits against the protected class, medical practitioners, and their insurers.

31. In addition, Chapter 2003-416, *Laws of Florida*, which encompasses Fla. Stat. §766.118 violates the single subject requirement contained in Article III, Section 6 of the Florida Constitution. This is obvious from the description of the Act which is so lengthy that we will not repeat it here. Instead, we will attach it as Exhibit A. Suffice it to say that the Act purports to relate to medical incidents; involves the Agency for Healthcare

Administration with respect to reviewing complaints against hospitals; deletes the requirement that persons act in good faith to avoid liability for disciplinary actions; relates to internal risk management programs; requires licensed facilities to annually report certain health care practitioners; provides for use of patient safety data; eliminates restrictions on licensure renewal fees for health care practitioners; deletes provisions with respect to criminal history checks; revises financial responsibility requirements of physicians; amends Fla. Stat. §624.462; provides guidelines for the formation and regulation of certain self-insurance funds; proscribes a health maintenance organization's right to control the professional judgment of a physician; amends Fla. Stat. §766.106 specifying sanctions for failure to cooperate with presuit investigations; revises requirements for presuit notice; amends Fla. Stat. §766.1115, .1112, .1113, .201, .303, and .21; creates Fla. Stat. §766.118 limiting noneconomic damages; provides legislative findings and intent regarding emergency medical services; creates Fla. Stat. §766.1185; revises guidelines for immunity under the Good Samaritan Act; and many, many other revisions which will be seen in Exhibit A.

32. The statute is also unconstitutional under both the State and Federal Constitutions based on a violation of both substantive and procedural due process and equal protection because there is no rational basis for the caps on noneconomic damages.

33. Fla. Stat. §766.118 also violates the separation of powers

provision of Article II, Section 3, of the Florida Constitution.

34. The legislative enactment is a hodgepodge logrolling form of omnibus legislation that is obviously unconstitutional and embraces in the same bill incongruous matters having no rational relationship to each other or to the subjects specified in the titles. Distinct subjects affecting diverse interests have been combined in order to unite members who favored them. The Act is effectively the most gargantuan logroll in the history of Florida legislation.

35. The Plaintiffs are in doubt as to their legal rights and duties under the Act; and most specifically under Fla. Stat. §766.118 with respect to the applicability, or nonapplicability of the caps on noneconomic damages and the category into which this case fits, and specifically, whether the minor claimant has suffered a catastrophic injury. The Plaintiffs are equally uncertain as to the propriety of making a demand for policy limits from the Defendants or their insurers given the statutory changes to bad faith claims contained within this Act. These provisions are likewise subject to constitutional challenge, including but not limited to the following constitutional violations: (1) Article I, Section 21, Florida Constitution (access to courts); (2) 14th Amendment to the United States Constitution (due process and access to courts); (3) Article I, Section 2 and Article III of the Florida Constitution; and the 14th Amendment of the United States Constitution (equal protection); (4) Article I, Section 22, Florida

Constitution (right to jury trial); (5), Article I, Section 9, and the 14th Amendment to the United States Constitution (due process); (6) Article III, Section 6 of the Florida Constitution (single subject); (7) substantive and procedural due process of both the Florida and United States Constitutions; and (8) Article II, Section 3 of the Florida Constitution (separation of powers).

36. If this court enters a judgment declaring that the statute is unconstitutional and the Plaintiffs are entitled to their common law remedies uncapped, then there may be no need to pursue the case incurring costs of discovery and of trial, because the case may be able to be mediated or settled to conclusion.

37. On the other hand, at this point the Plaintiffs cannot make an intelligent determination as to whether they are entitled to demand \$500,000 for practitioners; or a total of \$1 million from practitioners, assuming a catastrophic injury, or the full value of the case.

38. Accordingly, this is an appropriate case for declaratory relief. It will produce an adjudication of the constitutionality of the caps on noneconomic damages and the bad faith legislation; or alternatively, will produce an adjudication of the category in which the injured Plaintiff falls, and which is critical to the decisions which the Plaintiffs must make including but not limited to claims for bad faith.

WHEREFORE, the Plaintiffs pray for a judgment declaring that Chapter 2003--416, *Laws of Florida*, including of course, Fla. Stat. §766.118, is unconstitutional. Alternatively, the Plaintiffs pray for a judgment declaring that the injuries sustained by the minor Plaintiff fall within the definition of catastrophic injury and that a manifest injustice would occur unless increased noneconomic damages are awarded based on a finding that because of the special circumstances of the case, the noneconomic harm sustained by the injured minor patient was particularly severe; thus, allowing the case to go forward before a jury to determine that the Defendants' negligence caused the catastrophic injury to the minor Plaintiff.

DATED this 30th day of August, 2004.

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(305) 779-6095 - fax

1
2 An act relating to medical incidents; providing
3 legislative findings; creating s. 395.0056,
4 F.S.; requiring the Agency for Health Care
5 Administration to review complaints submitted
6 if the defendant is a hospital; amending s.
7 395.0191, F.S.; deleting a requirement that
8 persons act in good faith to avoid liability or
9 discipline for their actions regarding the
10 awarding of staff membership or clinical
11 privileges; amending s. 395.0197, F.S.,
12 relating to internal risk management programs;
13 requiring a system for notifying patients that
14 they are the subject of an adverse incident;
15 requiring that an appropriately trained person
16 give notice; requiring licensed facilities to
17 annually report certain information about
18 health care practitioners for whom they assume
19 liability; requiring the Agency for Health Care
20 Administration and the Department of Health to
21 annually publish statistics about licensed
22 facilities that assume liability for health
23 care practitioners; repealing the requirement
24 that licensed facilities notify the agency
25 within 1 business day of the occurrence of
26 certain adverse incidents; repealing s.
27 395.0198, F.S., which provides a public records
28 exemption for adverse incident notifications;
29 creating s. 395.1012, F.S.; requiring
30 facilities to adopt a patient safety plan;
31 providing requirements for a patient safety

EXHIBIT A

1 plan; requiring facilities to appoint a patient
2 safety officer and a patient safety committee
3 and providing duties for the patient safety
4 officer and committee; creating s. 395.1051,
5 F.S.; requiring certain facilities to notify
6 patients about adverse incidents under
7 specified conditions; creating s. 456.0575,
8 F.S.; requiring licensed health care
9 practitioners to notify patients about adverse
10 incidents under certain conditions; providing
11 civil immunity for certain participants in
12 quality improvement processes; defining the
13 terms "patient safety data" and "patient safety
14 organization"; providing for use of patient
15 safety data by a patient safety organization;
16 providing limitations on use of patient safety
17 data; providing for protection of
18 patient-identifying information; providing for
19 determination of whether the privilege applies
20 as asserted; providing that an employer may not
21 take retaliatory action against an employee who
22 makes a good-faith report concerning patient
23 safety data; amending s. 456.013, F.S.;
24 requiring, as a condition of licensure and
25 license renewal, that physicians and physician
26 assistants complete continuing education
27 relating to misdiagnosed conditions as part of
28 a continuing education course on prevention of
29 medical errors; amending s. 456.025, F.S.;
30 eliminating certain restrictions on the setting
31 of licensure renewal fees for health care

1 practitioners; amending s. 456.039, F.S.;
2 revising requirements for the information
3 furnished to the Department of Health for
4 licensure purposes; amending s. 456.041, F.S.,
5 relating to practitioner profiles; requiring
6 the Department of Health to compile certain
7 specified information in a practitioner
8 profile; establishing a timeframe within which
9 certain health care practitioners must report
10 specified information; providing for
11 disciplinary action and a fine for untimely
12 submissions; deleting provisions that provide
13 that a profile need not indicate whether a
14 criminal history check was performed to
15 corroborate information in the profile;
16 authorizing the department or regulatory board
17 to investigate any information received;
18 requiring the department to provide an
19 easy-to-read narrative explanation concerning
20 final disciplinary action taken against a
21 practitioner; requiring a hyperlink to each
22 final order on the department's website which
23 provides information about disciplinary
24 actions; requiring the department to provide a
25 hyperlink to certain comparison reports
26 pertaining to claims experience; requiring the
27 department to include the date that a reported
28 disciplinary action was taken by a licensed
29 facility and a characterization of the
30 practitioner's conduct that resulted in the
31 action; deleting provisions requiring the

1 department to consult with a regulatory board
2 before including certain information in a
3 health care practitioner's profile; providing a
4 penalty for failure to comply with the
5 timeframe for verifying and correcting a
6 practitioner profile; requiring the department
7 to add a statement to a practitioner profile
8 when the profile information has not been
9 verified by the practitioner; requiring the
10 department to provide, in the practitioner
11 profile, an explanation of disciplinary action
12 taken and the reason for sanctions imposed;
13 requiring the department to include a hyperlink
14 to a practitioner's website when requested;
15 providing that practitioners licensed under ch.
16 458 or ch. 459, F.S., shall have claim
17 information concerning an indemnity payment
18 greater than a specified amount posted in the
19 practitioner profile; amending s. 456.042,
20 F.S.; providing for the update of practitioner
21 profiles; designating a timeframe within which
22 a practitioner must submit new information to
23 update his or her profile; amending s. 456.049,
24 F.S., relating to practitioner reports on
25 professional liability claims and actions;
26 revising requirements for a practitioner to
27 report claims or actions for medical
28 malpractice; amending s. 456.051, F.S.;
29 establishing the responsibility of the
30 Department of Health to provide reports of
31 professional liability actions and

1 bankruptcies; requiring the department to
2 include such reports in a practitioner's
3 profile within a specified period; amending s.
4 456.057, F.S.; allowing the department to
5 obtain patient records by subpoena without the
6 patient's written authorization, in specified
7 circumstances; amending s. 456.072, F.S.;
8 providing for determining the amount of any
9 costs to be assessed in a disciplinary
10 proceeding; amending s. 456.073, F.S.;
11 authorizing the Department of Health to
12 investigate certain paid claims made on behalf
13 of practitioners licensed under ch. 458 or ch.
14 459, F.S.; amending procedures for certain
15 disciplinary proceedings; providing a deadline
16 for raising issues of material fact; providing
17 a deadline relating to notice of receipt of a
18 request for a formal hearing; excepting gross
19 or repeated malpractice and standard-of-care
20 violations from the 6-year limitation on
21 investigation or filing of an administrative
22 complaint; amending s. 456.077, F.S.; providing
23 a presumption related to an undisputed
24 citation; revising requirements under which the
25 Department of Health may issue citations as an
26 alternative to disciplinary procedures against
27 certain licensed health care practitioners;
28 amending s. 456.078, F.S.; revising standards
29 for determining which violations of the
30 applicable professional practice act are
31 appropriate for mediation; amending s. 458.320,

1 F.S., relating to financial responsibility
2 requirements for medical physicians; requiring
3 maintenance of financial responsibility as a
4 condition of licensure of medical physicians;
5 providing for payment of any outstanding
6 judgments or settlements pending at the time a
7 physician is suspended by the Department of
8 Health; requiring the department to suspend the
9 license of a medical physician who has not
10 paid, up to the amounts required by any
11 applicable financial responsibility provision,
12 any outstanding judgment, arbitration award,
13 other order, or settlement; amending s.
14 459.0085, F.S., relating to financial
15 responsibility requirements for osteopathic
16 physicians; requiring maintenance of financial
17 responsibility as a condition of licensure of
18 osteopathic physicians; providing for payment
19 of any outstanding judgments or settlements
20 pending at the time an osteopathic physician is
21 suspended by the Department of Health;
22 requiring that the department suspend the
23 license of an osteopathic physician who has not
24 paid, up to the amounts required by any
25 applicable financial responsibility provision,
26 any outstanding judgment, arbitration award,
27 other order, or settlement; amending s.
28 458.331, F.S., relating to grounds for
29 disciplinary action against a physician;
30 redefining the term "repeated malpractice";
31 revising the minimum amount of a claim against

1 a licensee which will trigger a departmental
2 investigation; requiring that administrative
3 orders issued by an administrative law judge or
4 board for certain practice violations by
5 physicians specify certain information;
6 creating s. 458.3311, F.S.; establishing
7 emergency procedures for disciplinary actions;
8 amending s. 459.015, F.S., relating to grounds
9 for disciplinary action against an osteopathic
10 physician; redefining the term "repeated
11 malpractice"; amending conditions that
12 necessitate a departmental investigation of an
13 osteopathic physician; revising the minimum
14 amount of a claim against a licensee which will
15 trigger a departmental investigation; creating
16 s. 459.0151, F.S.; establishing emergency
17 procedures for disciplinary actions; amending
18 s. 461.013, F.S., relating to grounds for
19 disciplinary action against a podiatric
20 physician; redefining the term "repeated
21 malpractice"; amending the minimum amount of a
22 claim against such a physician which will
23 trigger a departmental investigation; requiring
24 that administrative orders issued by an
25 administrative law judge or board for certain
26 practice violations by physicians specify
27 certain information; creating s. 461.0131,
28 F.S.; establishing emergency procedures for
29 disciplinary actions; amending s. 466.028,
30 F.S., relating to grounds for disciplinary
31 action against a dentist or a dental hygienist;

1 redefining the term "dental malpractice";
2 revising the minimum amount of a claim against
3 a dentist which will trigger a departmental
4 investigation; requiring that the Division of
5 Administrative Hearings designate
6 administrative law judges who have special
7 qualifications for hearings involving certain
8 health care practitioners; creating ss. 1004.08
9 and 1005.07, F.S.; requiring schools, colleges,
10 and universities to include material on patient
11 safety in their curricula if the institution
12 awards specified degrees; directing the Agency
13 for Health Care Administration to conduct or
14 contract for a study to determine what
15 information to provide to the public comparing
16 hospitals, based on inpatient quality
17 indicators developed by the federal Agency for
18 Healthcare Research and Quality; requiring the
19 Agency for Health Care Administration to
20 conduct a study on patient safety; requiring a
21 report and submission of findings to the
22 Legislature; requiring the Office of Program
23 Policy Analysis and Government Accountability
24 and the Office of the Auditor General to
25 conduct an audit of the health care
26 practitioner disciplinary process and closed
27 claims and report to the Legislature; creating
28 a workgroup to study the health care
29 practitioner disciplinary process; providing
30 for workgroup membership; providing that the
31 workgroup deliver its report by January 1,

1 2004; amending s. 624.462, F.S.; authorizing
2 health care providers to form a commercial
3 self-insurance fund; amending s. 627.062, F.S.;
4 prohibiting the submission of medical
5 malpractice insurance rate filings to
6 arbitration; providing additional requirements
7 for medical malpractice insurance rate filings;
8 providing that portions of judgments and
9 settlements entered against a medical
10 malpractice insurer for bad-faith actions or
11 for punitive damages against the insurer, as
12 well as related taxable costs and attorney's
13 fees, may not be included in an insurer's base
14 rate; providing for review of rate filings by
15 the Office of Insurance Regulation for
16 excessive, inadequate, or unfairly
17 discriminatory rates; requiring insurers to
18 apply a discount based on the health care
19 provider's loss experience; requiring the
20 Office of Insurance Regulation to calculate a
21 presumed factor that reflects the impact of
22 medical malpractice legislation on rates;
23 requiring insurers to make a rate filing
24 reflecting such presumed factor; allowing for
25 deviations; requiring that rates remain in
26 effect until new rate filings are approved;
27 requiring that the Office of Program Policy
28 Analysis and Government Accountability study
29 the feasibility of authorizing the Office of
30 the Public Counsel to represent the public in
31 medical malpractice rate hearings; amending s.

1 627.357, F.S.; providing guidelines for the
2 formation and regulation of certain
3 self-insurance funds; amending s. 627.4147,
4 F.S.; revising certain notification criteria
5 for medical and osteopathic physicians;
6 requiring prior notification of a rate
7 increase; creating s. 627.41495, F.S.;
8 providing for notice to policyholders of
9 certain medical malpractice rate filings;
10 amending s. 627.912, F.S.; revising
11 requirements for the medical malpractice closed
12 claim reports that must be filed with the
13 Office of Insurance Regulation; applying such
14 requirements to additional persons and
15 entities; providing for access by the
16 Department of Health to such reports; providing
17 for the imposition of a fine or disciplinary
18 action for failing to report; requiring that
19 reports obtain additional information;
20 authorizing the Financial Services Commission
21 to adopt rules; requiring that the Office of
22 Insurance Regulation prepare summaries of
23 closed claim reports of prior years and prepare
24 an annual report and analysis of closed claim
25 and insurer financial reports; amending s.
26 641.19, F.S.; revising definitions; providing
27 that health care providers providing services
28 pursuant to coverage provided under a health
29 maintenance organization contract are not
30 employees or agents of the health maintenance
31 organization; providing exceptions; amending s.

1 641.51, F.S.; proscribing a health maintenance
2 organization's right to control the
3 professional judgment of a physician; providing
4 that a health maintenance organization shall
5 not be vicariously liable for the medical
6 negligence of a health care provider; providing
7 exceptions; amending s. 766.102, F.S.; revising
8 requirements for health care providers who
9 offer corroborating medical expert opinion and
10 expert testimony in medical negligence actions;
11 prohibiting contingency fees for an expert
12 witness; requiring certification that an expert
13 witness not previously have been found guilty
14 of fraud or perjury; amending s. 766.106, F.S.;
15 specifying sanctions for failure to cooperate
16 with presuit investigations; requiring the
17 execution of medical release to allow taking of
18 unsworn statements from claimant's treating
19 physicians; imposing limits on use of such
20 statements; deleting provisions relating to
21 voluntary arbitration in conflict with s.
22 766.207, F.S.; revising requirements for
23 presuit notice and for an insurer's or
24 self-insurer's response to a claim; requiring
25 that a claimant provide the Agency for Health
26 Care Administration with a copy of the
27 complaint alleging medical negligence against
28 licensed facilities; requiring that the agency
29 review such complaints for licensure
30 noncompliance; permitting written questions
31 during informal discovery; amending s. 766.108,

1 F.S.; providing for mandatory mediation;
2 amending ss. 766.1115, 766.112, 766.113,
3 766.201, 766.303, 768.21, F.S.; revising
4 references to "medical malpractice" to "medical
5 negligence"; amending s. 766.113, F.S.;
6 requiring that a specific statement be included
7 in all medical negligence settlement
8 agreements; creating s. 766.118, F.S.; limiting
9 noneconomic damages in medical negligence
10 actions; providing legislative findings and
11 intent regarding provision of emergency medical
12 services and care; creating s. 766.1185, F.S.;
13 providing that an action for bad faith may not
14 be brought against a medical malpractice
15 insurer if such insurer offers to pay policy
16 limits and meets other specified conditions of
17 settlement within a specified time period;
18 providing for factors to be considered in
19 determining whether a medical malpractice
20 insurer has acted in bad faith; providing for
21 the delivery of a copy of an amended witness
22 list to the insurer of a defendant health care
23 provider; providing a limitation on the amount
24 of damages which may be awarded to certain
25 third parties in actions alleging bad faith by
26 a medical malpractice insurer; amending s.
27 766.202, F.S.; redefining the terms "economic
28 damages," "medical expert," and "noneconomic
29 damages"; defining the term "health care
30 provider"; creating s. 766.2021, F.S.;
31 providing a limitation on damages against

1 considered agents of a state university board
2 of trustees; amending s. 768.77, F.S.;
3 prescribing a method for itemization of
4 specific categories of damages awarded in
5 medical malpractice actions; preserving
6 sovereign immunity and the abrogation of
7 certain joint and several liability; amending
8 s. 1006.20, F.S.; requiring completion of a
9 uniform participation physical evaluation and
10 history form incorporating recommendations of
11 the American Heart Association; deleting
12 revisions to procedures for students' physical
13 examinations; requiring the Department of
14 Health to study the efficacy and
15 constitutionality of medical review panels;
16 requiring a report; amending s. 391.025, F.S.;
17 adding infants receiving compensation awards as
18 eligible for Children's Medical Services health
19 services; amending s. 391.029, F.S.; providing
20 financial eligibility criteria for Children's
21 Medical Services; amending s. 766.304, F.S.;
22 limiting the use of civil actions when
23 claimants accept awards from the Florida
24 Birth-Related Neurological Injury Compensation
25 Plan; amending s. 766.305, F.S.; deleting a
26 requirement for provision of certain
27 information in a petition filed with the
28 Florida Birth-Related Neurological Injury
29 Compensation Plan; providing for service of
30 copies of such petition to certain
31 participants; requiring that a claimant provide

1 the Florida Birth-Related Neurological Injury
2 Compensation Association with certain
3 information within 10 days after filing such
4 petition; amending s. 766.309, F.S.; allowing
5 for claims against the association to be
6 bifurcated; amending s. 766.31, F.S.; providing
7 for a death benefit for an infant in the amount
8 of \$10,000; limiting liability of the claimant
9 for expenses and attorney's fees; amending s.
10 766.314, F.S.; revising obsolete terms;
11 providing procedures by which hospitals in
12 certain counties may pay the annual fees for
13 participating physicians and nurse midwives;
14 providing for annually assessing participating
15 physicians; requiring that the Office of
16 Program Policy Analysis and Government
17 Accountability study and report to the
18 Legislature on requirements for coverage by the
19 Florida Birth-Related Neurological Injury
20 Compensation Association; providing
21 appropriations and authorizing positions;
22 providing for construction of the act in pari
23 materia with laws enacted during the 2003
24 Regular Session or a 2003 special session of
25 the Legislature; providing for severability;
26 providing effective dates.

27
28 Be It Enacted by the Legislature of the State of Florida:

29
30 Section 1. Findings.--
31

037

OFFICIAL RECEIPT
City of Portland, Oregon
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PAYMENT WORKSHEET
CIRCUIT CIVIL

CHARON SANDS

CLERK ID

CASE NO. 04-18664 CA 3 2

PLAINTIFF Bages

FILING FEE \$ 250

DEPOSITS \$

RECORDING \$

REG. MAIL \$

REFUND \$

OTHER \$

TOTAL \$ 250

ATTORNEY BAR #

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APPENDIX F

Florida Office of Insurance Regulation Medical Professional Liability Closed Claim Database

I. DATA BACKGROUND AND LIMITATIONS

For purposes of this engagement, the State of Florida Department of Financial Services, Office of Insurance Regulation (OIR) made available to Deloitte their historical Medical Professional Liability (MPL) closed claim database (CCD). Deloitte Consulting has made exclusive use of the closed claim data to determine any illustrative trends or observations in closed claim reports from recent years.

The database has been maintained by the OIR and consists of thousands of claim entries submitted primarily by Florida MPL insurers. Deloitte Consulting initially discussed with OIR management their concerns regarding potential limitations on the use of the closed claim data. These limitations are suspected by the OIR to have arisen primarily from known inconsistencies in both the collection and the reporting of the closed claim data.

More specifically, original entries to the OIR database were collected and entered manually until mid-July 1999 when revised forms and instructions became available and electronic submission of data first began. Data has never been audited or checked for accuracy or completeness and OIR management suspects that errors and inconsistencies in the data submitted are likely.

Reliance upon the OIR database is made with the above considerations in mind.

Additional details regarding the OIR closed claim database:

- Until mid-July 1999 closed claim data was manually keyed in as received (the “Archive” file). After mid-July 1999, forms and the data collection system were re-

designed to allow for electronic collection, mainly by diskette. An outside vendor helped to create a revised file layout. The "Current" file resulted, containing all claims submitted for the first time after mid-July 1999.

- For the purposes of this report, Deloitte Consulting has chosen not to use any information from the Archive file and concentrate exclusively on the Current file. It is believed that the Current file is a more credible source of information.
- The MPL database does not provide historical information on the number of claimants associated with each claim (e.g., wife and five kids versus wife and no kids).
- The MPL database does not track the actual dollars paid (i.e., comparative fault) by each defendant. Instead, the database requires the input of the total dollar award for each claimant, regardless of their share of the damages. Therefore, when multiple defendants have inputted their claims into the MPL database, there will be duplicate dollars in the database.
- Until the passage of SB2D, only Florida authorized insurers were required to report closed claims to the OIR database. This would have excluded self-insurers and "unauthorized" insurers such as offshore and surplus lines insurers. Since SB2D, virtually all insurers and self-insureds are required to report claims to the OIR.
 - In September 2004, an Operational Audit of the Closed Claim Database was performed by State of Florida, Auditor General, William O. Monroe, CPA. Including the audit findings, outlined in report number 2005-031, is a recommendation that the department develop and enforce more stringent rules regarding the reporting of closed claims. According to the report, there are indications that all closed claims may not have been reported by insurers. The reader is referred to the aforementioned report for further details.

- The actual occurrence dates of individual MPL incidents are often several years prior to the date of closure. As a result, OIR closed claim data cannot be expected to be representative of current MPL trends and conditions without some adjustment or other consideration. Deloitte Consulting notes that the database has claims closed as recently as summer 2004 and the instructions for the database mandate that claims be reported to the department within 30 days of closing.
- The version of the closed claim database provided to us contained claims closed through August 26, 2004.

II. DATA PREPARATION

In light of the information and limitations outlined above. Deloitte took the following steps to prepare the OIR closed claim database for use in this report.

- Removed duplicate entries flagged by capturing only those records unique across several key data fields, including but not limited to: department file number, accident date, report date, injured party DOB, all loss fields, and injury severity code.
 - During this process, Deloitte Consulting also removed data fields captured by the CCD that were not considered to be relevant for the purposes of this report.
- Manually checked the MPL_INDEMNITY_PAID field for negative entries, which would indicate a situation involving multiple defendants. In such instances, a single record with the total loss values was captured.
- Grouped the capture records according to accuracy of which the individual loss fields (economic versus non-economic) summed to the total indemnity paid as indicated in a separate field. A summary of these groups is outlined in the following table:

TABLE APPENDIX F.1

<u>Group</u>	<u>Portion of Total Counts</u>	<u>Criteria</u>
A	51%	Total Indemnity Paid = the Sum of the Individual Parts
B	2%	Total Indemnity Paid = the Deductible + Sum of Parts OR Deductible + Total = Sum of Parts
C	22%	Total Indemnity Paid > \$0, Sum of Parts = \$0
D	2%	Sum of Parts is >\$0, Total Indemnity Paid = \$0
E	17%	Still Error after A-D and Sum of Parts is larger than Total
F	7%	Still Error after A-D and Total is larger than Sum of Parts

- Grouped records based on the injury severity code. Deloitte Consulting established 4 severity code groups, 1 to 3, 4 to 6, 7, and 8 to 9. The specific description of each severity code is outlined in the following table:

TABLE APPENDIX F.2

<u>Code</u>	<u>Description</u>
1	Emotional Only - Fright, no physical damage
2	Temporary: Slight - Lacerations, contusions, minor scars, rash. No delay.
3	Temporary: Minor - Infections, misset fracture, fall in hospital. Recovery delayed.
4	Temporary: Major - Burns, surgical material left, drug side effect, brain damage. Recovery delayed.
5	Permanent: Minor - Loss of fingers, loss or damage to organs. Includes non-disabling injuries.
6	Permanent: Significant - Deafness, loss of limb, loss of eye, loss of one kidney or lung.
7	Permanent: Major - Paraplegia, blindness, loss of two limbs, brain damage.
8	Permanent: Grave - Quadraplegia, severe brain damage, lifelong care or fatal prognosis.
9	Permanent: Death.

By Kevin M. Bingham

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HEARINGS & APPEALS
MASS. DIVISION OF INSURANCE

The Million-Dollar Challenge

Measuring the Impact of Medical Liability Tort Reform

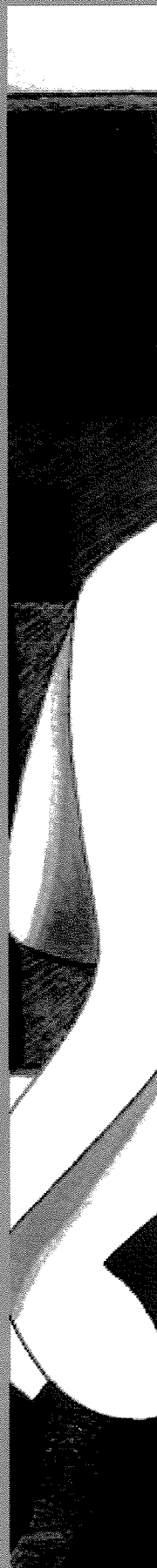
YOU'VE BEEN HEALTHY FOR SO LONG YOU'VE ALMOST FORGOTTEN what your family physician looks like. So when you finally try to make that emergency appointment, it comes as something of a shock to learn your doctor has left the state. Why? Could it have been something you said?

Not even close. Believe it or not, your doctor could no longer afford the ever-increasing cost of medical malpractice insurance.

Understanding the impact of proposed medical liability tort reform is a daunting challenge, particularly considering the many varied legislative, health care provider, insurance company, and patient perspectives.

Legislators need to understand how their proposed reforms may impact the ultimate cost of accessing and delivering affordable health care. In many states, this process requires an in-depth understanding of the key issues facing all sides of the health care equation: Proposed bills often go through numerous iterations based on testimony from medical associations, insurance companies, lawyers, actuaries, and patients.

Health care providers, suffering from an insurance affordability crisis, need reforms that will stabilize and ultimately lower their cost of doing business. Even more important, the relief needs to be immediate, not phased in over many years. Reports of hospitals and practices closing, reducing or eliminating services (e.g., OB/GYN, ER), and physicians relocating or retiring from practice help to illustrate the urgency of the current medical liability crisis.





OCT 14 2008

HEARINGS & APPEALS
MASS. DIVISION OF INSURANCE

Medical liability insurers are having difficulty quantifying a reasonable premium that's fair to health care providers and reasonable enough to ensure their ongoing financial viability and solvency.

Insurance companies, responsible for setting the premiums doctors and hospitals pay, are suffering from increasing loss cost trends, lower investment returns, higher reinsurance costs, and volatile jury awards. When those costs are extremely unpredictable, ratemaking is made more difficult, since rates are determined by using historical loss and exposure information to project future costs.

Non-economic awards are highly subjective, and vary by jury and jurisdiction. As a consequence, medical liability insurers are having difficulty quantifying a reasonable premium that's fair to health care providers and reasonable enough to ensure their ongoing financial viability and solvency.

Patients, the true customers, need to know that health care will be affordable, accessible, and safe. In those situations where something goes wrong, patients also need to be assured that they'll be fairly compensated for their loss.

With these diverse perspectives in mind, it's easy to see why the passage of tort reform across the United States has been so challenging. Current laws (e.g., MICRA) and recently proposed tort reforms vary significantly from state to state. Laws and proposed bills often address areas such as:

- Cap on non-economic damages (e.g., pain and suffering, loss of consortium, loss of companionship, disfigurement, mental anguish)
- Statute of limitations
- Collateral source rule
- Limitations on attorney fees
- Periodic payment rules
- Certification requirements
- Arbitration process
- Definition of expert witness testimony
- Specialized medical malpractice judges

Tort reform proposals are often more than 50 pages or 30,000 words in length; yet a *single word change* can significantly affect a proposed bill's impact. We can illustrate this using the following example, involving a \$250,000 cap on non-economic damages.

The Bedpan Case

Medisure Insurance Co. has provided claims-made coverage to Bedpan Hospital since 1/1/2001. Medisure's claims-made policy provides Bedpan coverage for medical liability claims reported during the policy year, whether the claims happened during the current policy year or in prior Medisure policy years.

Bedpan has three claims a year (see above).

Each claim is settled for a total of \$2 million in damages, 50 percent economic (e.g., lost wages, medical expenses, funeral

Bedpan Has Three Claims a Year

CLAIM	ACCIDENT DATE	REPORT DATE	ECONOMIC	NON ECONOMIC
1	1/1/2001	1/1/2001	1,000,000	1,000,000
2	1/1/2001	1/1/2002	1,000,000	1,000,000
3	1/1/2001	1/1/2003	1,000,000	1,000,000

expenses) and 50 percent non-economic. The first claim is reported immediately, the second claim takes a year to report, and the third claim takes two years to report. Therefore, the first claim is covered under the 2001 claims-made policy (i.e., report year = policy year). The second claim is covered under the next year's claims-made policy (2002). The third claim is covered under the policy provided in 2003. For simplicity, these three claims and the above reporting pattern are repeated in each of the future years.

For providing Bedpan with claims-made coverage, Medisure charges Bedpan for the cost of claims plus a 33.3 percent loading to allow for claim handling costs, staffing expense, and a profit margin.

Bedpan's annual insurance premiums are shown below for three scenarios:

- Table 1—No tort reform enacted (i.e., status quo)
- Table 2—Tort reform passed with a \$250,000 cap on non-economic damages, effective 1/1/2004 for claims with accident dates 1/1/2004 and subsequent
- Table 3—Tort reform passed with a \$250,000 cap on non-economic damages, effective 1/1/2004 for claims with report dates 1/1/2004 and subsequent

As shown in Table 1, Bedpan's first-year claims-made premium is \$2 million \times 1.333. Bedpan's second-year premium is \$4 million \times 1.333. Finally, when Bedpan's claims-made policy matures (i.e., stable reporting of three claims each year), Bedpan's third and subsequent year premium equals \$6 million \times 1.333 or \$8 million.

As shown in Table 2, the impact of the \$250,000 cap on non-economic damages reduces claims with accident dates 1/1/2004 and subsequent from \$2 million to \$1,250,000 (i.e., \$1 million economic plus \$250,000 capped non-economic damages).

Since the bill affects only claims with accident dates 1/1/2004 and subsequent, three claims that are in the pipeline are unaffected by the proposed tort reform. This results in a phased-in benefit from the passage of the tort reform bill.

Although the ultimate cost savings passed on to health care

providers may be 37.5 percent, it takes three years for the savings to be fully reflected in premiums charged by Medisure.

This phase-in period is often miscommunicated and misunderstood during the tort reform debate process. Frequently, the cost savings communicated to health care providers during the tort reform debate reflect the ultimate cost savings, resulting in unrealistically optimistic expectations of the benefits of insurance premium relief.

As shown in Table 3, the impact of the \$250,000 cap on non-economic damages reduces claims with report dates of 1/1/2004 and subsequent from \$2 million to \$1,250,000. Unlike Table 2, the 37.5 percent premium savings is immediate, not phased in over three years. Tort reform proposals structured in this manner offer health care providers the fastest relief.

Although the above examples illustrate the impact of a simple wording change from "accident" to "report," the true quantification of a tort reform's impact is much more difficult.

Continuing with the above example, one must ask the following questions about the cap on non-economic damages to determine if the ultimate savings calculated above are reasonable:

■ *Does the cap apply per defendant or per claimant (i.e., hard cap)?* In recent Texas tort reform activity, it was determined that the \$250,000 cap on non-economic damages for physicians would apply per defendant, up to an aggregate per claimant amount of

\$750,000 (i.e., claimant can recover from multiple defendants).

Therefore, the savings illustrated above would be reduced for two items: first, the probability that additional defendants would be named in the suit; second, the additional legal costs necessary to defend parties with no real liability (e.g., the plaintiff's attorney might name the nurse who brought the plaintiff ice chips as a defendant).

■ *Does the cap vary depending on the classification of the defendant?* For example, are health care institutions (e.g., hospitals, nursing homes, hospice) exposed to higher caps than health care professionals? In these circumstances, it's likely that health care institutions would be named in order to tap the higher cap whether they were at fault or not.

In addition, health care institutions facing higher caps may find it in their best interest to force claims down to the health care professionals with the lower caps. This cost shifting increases litigation expense and may create stress on the critical relationships institutions have developed with their physicians.

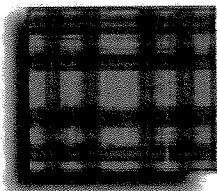
■ *Does the tort reform allow "cap busters"?*

Cap busters include removing caps under certain situations (e.g., severe disfigurement or physical impairment) or waiving the cap on non-economic damages if the jury verdict for non-economic damages is unanimous.

For example, if there's a chance the cap will be waived on a

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TABLE 1. No Cap on Non-Economic Damages

	2001	2002	2003	2004	2005	2006	2007
	2,000,000	2,000,000	2,000,000	2,000,000	2,000,000	2,000,000	2,000,000
	0	2,000,000	2,000,000	2,000,000	2,000,000	2,000,000	2,000,000
	0	0	2,000,000	2,000,000	2,000,000	2,000,000	2,000,000
TOTAL	2,000,000	4,000,000	6,000,000	6,000,000	6,000,000	6,000,000	6,000,000
PREMIUM	2,666,667	5,333,333	8,000,000	8,000,000	8,000,000	8,000,000	8,000,000

TABLE 2. \$250,000 Cap on Non-Economic Damages
Tort reform applies to claims with accident dates 1/1/2004 and subsequent

	2001	2002	2003	2004	2005	2006	2007
	2,000,000	2,000,000	2,000,000	1,250,000	1,250,000	1,250,000	1,250,000
	0	2,000,000	2,000,000	2,000,000	1,250,000	1,250,000	1,250,000
	0	0	2,000,000	2,000,000	2,000,000	1,250,000	1,250,000
TOTAL	2,000,000	4,000,000	6,000,000	5,250,000	4,500,000	3,750,000	3,750,000
PREMIUM	2,666,667	5,333,333	8,000,000	7,000,000	6,000,000	5,000,000	5,000,000
INCREMENTAL SAVINGS				-12.5%	-12.5%	-12.5%	0.0%
CUMULATIVE SAVINGS				-12.5%	-25.0%	-37.5%	-37.5%

THREE-YEAR PHASE-IN

TABLE 3. \$250,000 Cap on Non-Economic Damages
Tort reform applies to claims with accident dates 1/1/2004 and subsequent

	2001	2002	2003	2004	2005	2006	2007
	2,000,000	2,000,000	2,000,000	1,250,000	1,250,000	1,250,000	1,250,000
	0	2,000,000	2,000,000	1,250,000	1,250,000	1,250,000	1,250,000
	0	0	2,000,000	1,250,000	1,250,000	1,250,000	1,250,000
TOTAL	2,000,000	4,000,000	6,000,000	3,750,000	3,750,000	3,750,000	3,750,000
PREMIUM	2,666,667	5,333,333	8,000,000	5,000,000	5,000,000	5,000,000	5,000,000
INCREMENTAL SAVINGS				-37.5%	0.0%	0.0%	0.0%
CUMULATIVE SAVINGS				-37.5%	-37.5%	-37.5%	-37.5%

IMMEDIATE

unanimous verdict, it becomes much more difficult to determine the cost saving of the cap illustrated above. One not only has to analyze historical jury verdicts for the probability of returning a unanimous decision (assuming the data is credible or available), but one must also attempt to estimate the likelihood that jurors may be more likely to render a unanimous verdict if they realize the plaintiff's non-economic damages will be

capped without it.

■ *Does the tort reform require a constitutional amendment?*

If a constitutional amendment is required, there's a possibility that tort reforms could be overturned by the courts in subsequent years, leaving insurers on the hook for higher losses with rates that reflect anticipated future savings.

For example, Ohio reforms enacted in 1975 were challenged

**Without a constitutional amendment in certain states
and a coordinated package of tort reforms,
the true benefit of any tort reform package may take years to determine.**

in the courts in 1982 and eventually overturned in 1985. Ohio insurance company rates became inadequate the moment the reforms were overturned because the premium collected for their current and most recent policies still reflected the full impact of the tort reform. Alabama, Illinois, New Hampshire, Oregon, and Washington have also passed caps that were eventually held to be unconstitutional.

In addition to these states, a number of state constitutions prohibit the enactment of any law that would limit any damages a plaintiff would recover for personal injury or death.

■ *How long does it take for medical malpractice claims to be reported?*

Depending on the types of claims an organization faces, roughly 60 percent to 80 percent of the claims occurring in a policy period will be reported in a subsequent policy period. For some claims, where the patient doesn't realize he or she has been injured, the lag in reporting an accident can span longer than five years. Therefore, the phase-in period described under scenario two would likely take significantly longer than three years.

■ *Will the claim filings of claims speed up in anticipation of the new law?*

Under scenarios two and three, the actual savings might be overstated, assuming plaintiff attorneys decide to speed up claim reporting in order to beat the impact of the proposed tort reform effective date of 1/1/2004.

■ *What is the insurance company's current medical liability position from a profit/loss perspective?*

If an insurance company's indicated premium rate change is +40.0 percent, and the estimated premium savings from tort reform 37.5 percent, insurance consumers in the above example would NOT see a 37.5 percent premium savings but a net premium increase of 2.5 percent (e.g., 40.0 percent - 37.5 percent). This fact is often misunderstood and lost in the communication of tort reform's final impact.

Quantifying the savings from any proposed tort reform bill is a tricky process; one must be very careful to fully understand every word and sentence in the proposed legislation. As illustrated above, a change in one word from "accident" to "report" resulted in a three-year versus one-year phase-in period. If we were to expand our analysis to include other reforms—such as limits on attorneys' fees, statute of limitations, collateral source rule, etc.—one can only imagine the vast number of permutations that might result. Even more daunting is the determination of whether court challenges will result in all or part of the tort reform being overturned.


In the end, the true premium savings for health care providers and health care institutions won't be known until the courts, insurance companies, and lawyers have had time to analyze the impact and develop effective strategies to minimize (or maxi-

mize) every aspect of the legislation. As mentioned above, Ohio's cap on non-economic damages was overturned 10 years after the law was passed. Without a constitutional amendment in certain states and a coordinated package of tort reforms, the true benefit of any tort reform package may take years to determine.


Regardless of these challenges, early and frequent involvement in the tort reform process is the best strategy for influencing future cost savings. Those who have mastered key tort reform issues and prepared effective strategies to support their arguments have the best chance of shaping the outcome of the tort reform debate.

In the meantime, if you live in one of the 18 medical liability crisis states, make sure you have a map and a full tank of gas, just in case you have to visit one of the few remaining OB/GYNs in the state. ●

KEVIN M. BINGHAM IS SENIOR MANAGER AT DELOITTE & TOUCHE IN HARTFORD AND OFFICIAL MEDICAL MALPRACTICE SPOKESPERSON FOR THE AMERICAN ACADEMY OF ACTUARIES IN WASHINGTON.



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Volume I
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COMMONWEALTH OF MASSACHUSETTS
OFFICE OF CONSUMER AFFAIRS AND BUSINESS REGULATION
DIVISION OF INSURANCE
DOCKET NO. M2008-01

OCT 22 2008

HEARING: To receive oral and written statements that will assist the Commissioner of Insurance in conducting an investigation and study of the costs of medical malpractice insurance for health care providers, as defined in General Laws Chapter 175, Section 193U, held at the Division of Insurance, One South Station, Boston, Massachusetts, on Friday, October 3, 2008, commencing at 10:06 a.m.

BEFORE: Jean Farrington, Presiding Officer

* * * *

Carol H. Kusinitz
Registered Professional Reporter

* * * *

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* * * *

P R O C E E D I N G S

PRESIDING OFFICER FARRINGTON: Good morning. Welcome to this informational hearing, which is part of the Commissioner of Insurance's investigation and study of the cost of medical malpractice insurance for health care providers. This study was mandated by recent legislation, and this is the first of two public hearings at which we will be hearing statements from providers and anybody else who wishes to speak.

My name is Jean Farrington. I'm the Presiding Officer in this matter. A hearing notice issued on September 9th, 2008, scheduling both this and the hearing next Wednesday in Worcester. And the docket number in this matter is M2008-01.

As stated in the hearing notice, the purpose of the hearing is to receive oral and written statements that will assist in the examination and analysis of, among other things, the availability and affordability of medical malpractice insurance; the factors medical malpractice insurers consider when increasing premiums; options for decreasing premiums including, but not limited to, establishing a reinsurance pool

1 with additional stop loss coverage, subsidizing
2 premium payments of providers practicing in certain
3 high-risk specialties or in specialties for which
4 the cost of premiums represents a disproportionately
5 high proportion of a health care provider's income,
6 subsidizing premium payments of providers who do not
7 qualify for group coverage rates and pay higher
8 premiums for commercial market insurance, and
9 prorating premiums for providers who practice less
10 than full-time; and finally, funding mechanisms that
11 would facilitate the implementation of
12 recommendations arising out of the study which may
13 include, but not be limited to, charges borne by the
14 health care industry or other entities.

15 The hearing notice invited people who wish
16 to make statements at this hearing to sign up in
17 advance if they wish to obtain priority, and three
18 people have in fact signed up in advance. If
19 anybody else wishes to speak, if you know at this
20 moment that you want to, you could sign up on that
21 list, which is at the end of the table. But after
22 we hear the speakers who signed up in advance, I
23 will certainly give anybody else who wishes to an
24 opportunity to speak.

1 So let us proceed with Mr. Brewer.

2 MR. BREWER: Good morning. My name is
3 Richard W. Brewer, and I'm the President and Chief
4 Executive Officer of ProMutual Insurance Group. We
5 have written testimony, and I will read that this
6 morning. It is addressed to Commissioner Burnes.

7 "Dear Commissioner Burnes:

8 "Please accept this letter as the written
9 testimony of Medical Professional Mutual Insurance
10 Company, doing business as ProMutual, and its
11 subsidiary, ProSelect Insurance Company, so-called
12 ProSelect, in response to the notice of hearing
13 issued by the Massachusetts Division of Insurance to
14 investigate the costs of medical malpractice
15 liability insurance in the Commonwealth. This
16 notice was issued in response to recently enacted
17 legislation," as you pointed out, Attorney
18 Farrington.

19 "While we commend the Legislature for its
20 efforts to improve health care delivery in the
21 Commonwealth and to make health care more accessible
22 to the citizens of Massachusetts, we maintain that
23 the present medical liability insurance system
24 prescribed by the Legislature is not in need of

1 substantial change, as it accommodates legitimate
2 and competing interests while ensuring that coverage
3 is available and affordable."

4 In the way of background, ProMutual writes
5 medical malpractice coverage for physicians,
6 dentists, certified nurse-midwives and hospitals in
7 the Commonwealth. ProSelect, the subsidiary, writes
8 these coverages for caregivers in other states,
9 including Connecticut, Maine, New Hampshire, New
10 Jersey, Pennsylvania, Rhode Island and Vermont. In
11 Massachusetts the subsidiary ProSelect writes such
12 coverage for nursing homes and also writes excess
13 coverage for various health care providers.

14 ProMutual maintains the largest market
15 share within this segment of commercial insurance
16 carriers of medical malpractice in Massachusetts
17 and, together with ProSelect, is the largest writer
18 of this form of insurance in New England.

19 In 1994 the Legislature established
20 ProMutual under the statutes. Its predecessor, the
21 Massachusetts Medical Malpractice Joint Underwriting
22 Association, known as the JUA, was created by the
23 Legislature in 1975 in response to an availability
24 crisis at that time.

1 My testimony does not address all of the
2 issues in the hearing notice, but focuses on several
3 key areas where our input might be of use and may be
4 valuable. It is hoped that these comments will be
5 of use to you and the Legislature as well.

6 Regarding the availability of insurance, by
7 virtue of Massachusetts law, there is essentially no
8 issue relating to the availability of medical
9 malpractice insurance in the Commonwealth. Under
10 the statutes, the so-called take-all-comers statute
11 in particular, every medical malpractice insurer
12 must make available to every health care provider,
13 et cetera, et cetera.

14 In other words, by law, every physician,
15 dentist, certified nurse-midwife and hospital is
16 able to obtain coverage from an admitted carrier in
17 the state. While the law serves a good purpose, it
18 must be kept in mind that the cost of this
19 requirement is reflected in the rates charged for
20 medical malpractice liability insurance.

21 Factors considered when adjusting rates was
22 part of the hearing notice. I would like to address
23 these further comments to that point.

24 PRESIDING OFFICER FARRINGTON: Just a

1 minute.

2 (Brief recess)

3 MR. BREWER: My next comments are addressed
4 to the factors considered when adjusting rates. The
5 current regulatory system for adjusting rates in
6 Massachusetts affects all commercial insurance
7 carriers and was designed to support a competitive
8 market while ensuring that there are important
9 checks and balances so that rates are not excessive,
10 inadequate or unfairly discriminatory.

11 It is a system that is sensitive to the
12 needs of medical providers, who are the most
13 affected by its process. All carriers, all
14 commercial carriers, that is, are required to file
15 their rates with the Division of Insurance, where
16 filings are independently reviewed by the State
17 Rating Bureau.

18 There is also a legal requirement that is
19 unique to ProMutual as a result of its enabling
20 statutes. Prior to making a filing, ProMutual must
21 give notice of its rates to the Massachusetts
22 Medical Society, the Massachusetts Hospital
23 Association, the Massachusetts Dental Society, or
24 the American College of Nurse-Midwives,

1 Massachusetts Chapter, as applicable. In addition,
2 ProMutual's Board of Directors, which is comprised
3 of a majority of practicing health care providers,
4 reviews the rates in advance.

5 ProMutual is in the enviable position of
6 having a 30-year history of providing medical
7 malpractice insurance in Massachusetts, both under
8 the name ProMutual and its predecessors. Because of
9 this history, we have the experience to determine
10 the proper rate for a particular risk while
11 maintaining the financial strength to protect each
12 insured. ProMutual sets its rates based on
13 actuarially accepted methods, using documented claim
14 payments data and an estimate of the projected need
15 going forward.

16 Regarding affordability, the Legislature
17 has suggested that alternative mechanisms to reduce
18 premiums be considered. We agree. However, there
19 are many ways in which health care providers can pay
20 lower premiums than the filed rate if insured by
21 ProMutual or its subsidiary.

22 We offer reduced premiums in the form of
23 loss free credits for those who are claim free,
24 prorated premiums for part-time practice, credits

1 for policyholders who take advantage of certain risk
2 management programs, such as a shoulder dystocia
3 program or a program for ophthalmologists or
4 emergency medicine doctors who can enjoy credits as
5 well. Approximately 80 percent of our policyholders
6 in Massachusetts have some form of credit, and those
7 credits collectively average about 16 percent. The
8 loss free credit itself affects about half of that
9 amount.

10 We also engage in effective risk management
11 to prevent losses from occurring in the first place
12 and to keep also rates as low as possible. We are
13 very, very proud of our long history of devotion to
14 resources in the area of risk management and
15 physician education, and we can assure you and the
16 Legislature that we will continue our emphasis in
17 this area.

18 We also have a history of declaring
19 policyholder dividends when the financial results
20 allow. For example, in 2008, we declared a 5
21 percent dividend for our physician insureds. This
22 is a good way in which a company can reward its
23 policyholders for bringing about good results and
24 can offset their premiums as well.

1 As a mutual insurance company, ProMutual is
2 ultimately responsible to its owners, who are our
3 Massachusetts policyholders. This is important in
4 that it serves to remind all of us at ProMutual that
5 we must take the best interests of our policyholders
6 very seriously at all times. While being a mutual
7 insurance company is not necessarily unique to
8 ProMutual, it does serve as another check and
9 balance when determining how we will charge our
10 rates to make sure they are fair for the coverage we
11 afford to our insureds.

12 In the area of other comments, it is worth
13 noting that a large segment of the medical
14 malpractice market is unregulated; that is,
15 comprised of captives and risk retention groups.
16 These entities are not regulated in terms of their
17 ability to set rates for their own groups, nor are
18 they bound by the statutory requirement to take all
19 comers. Any change to the existing balanced system
20 of setting rates could have an effect on the
21 regulated market and threaten the ability of
22 traditional commercial insurers like ourselves to
23 compete effectively against the unregulated market
24 segment. This we must keep in mind.

1 Now, additionally, another way to look at
2 reduction of premiums, as suggested in the notice,
3 is for the Legislature to look at meaningful tort
4 reform efforts. We suggest there are ways to reduce
5 costs without impeding the rights of the victims of
6 medical malpractice errors, and to that end, we
7 continue to recommend eliminating joint and several
8 liability and further reducing the rate of judgment
9 interest.

10 In conclusion, we understand the
11 frustration of health care providers and the effect
12 that the cost of medical malpractice liability has
13 on their practices. We will continue to devote our
14 efforts to keeping premiums as low as possible,
15 while also ensuring the ongoing financial strength
16 of the company.

17 We hope that you agree that the present
18 system is effective and not in need of any change,
19 because it ensures that medical malpractice
20 insurance is availability and affordable. We hope
21 that you will encourage the Legislature to proceed
22 cautiously when considering making changes to the
23 regulated market in the Commonwealth.

24 Thank you for letting me present our

1 comments today.

2 PRESIDING OFFICER FARRINGTON: Thank you
3 very much.

4 The Massachusetts Academy of Trial
5 Attorneys, Mr. Boyle.

6 MR. BOYLE: With the court's permission,
7 Mr. Angoff is going to precede me, if that's
8 acceptable.

9 PRESIDING OFFICER FARRINGTON: Certainly.

10 MR. ANGOFF: Thank you, Madam Hearing
11 Officer. Do you have a copy of my outline?

12 PRESIDING OFFICER FARRINGTON: No, I do
13 not.

14 (Document handed to the Hearing Officer
15 by Mr. Angoff)

16 MR. ANGOFF: My name is Jay Angoff. I'm
17 here on behalf of the Massachusetts Academy of Trial
18 Attorneys, and I would like to thank you very much,
19 Madam Hearing Officer, for having this hearing
20 today. I think that this is a terrific time to have
21 this hearing. Every 10 or 15 years or so,
22 malpractice rates shoot up, and there's a lot of
23 hysteria and there's a lot of pressure to do things,
24 and then the issue goes away for the next 10 or 15

1 years.

2 We're now all lucky that we're at a point
3 in the insurance cycle where profits are very high
4 and rates are coming down, so there's very little
5 pressure to do anything. And that's why I think
6 that this is exactly the right time to look at
7 things that could be done with the medical
8 malpractice insurance system that would have the
9 effect of lowering rates.

10 I would like to talk about two broad
11 issues. One is the overall medical malpractice rate
12 level and how that overall rate level can be brought
13 down; and second, how medical malpractice rates --
14 how the premium might be distributed differently in
15 order to have a more equitable distribution.
16 Obviously equity is in the eye of the beholder, but
17 that's a separate issue from the question of the
18 overall rate level.

19 Just a little background on where we are
20 now, today, in the medical malpractice insurance
21 cycle. The malpractice industry has never done
22 better. Profits are at an all-time high. Loss
23 ratios and combined ratios are at an all-time low.
24 Surplus is at an all time-high. Risk-based capital

1 ratios are at all-time highs, premium-to-surplus
2 ratios are at all-time highs, and reserve
3 redundancies are at all-time highs.

4 If you will turn, Madam Hearing Examiner,
5 to Exhibit A of my testimony, that's just some of
6 the key data for ProMutual from their 2007 annual
7 statement, and ProMutual is typical of the industry.
8 They have done very well, maybe a little better than
9 some, maybe not quite as well as others, but I would
10 just like to, without just repeating all these
11 numbers, I would just like to go through a few of
12 them.

13 The bottom line, net income, if you can
14 see, over the last five years -- this is right from
15 the five-year historical data pages -- in 2003 their
16 net income was 21 million, it went up to 25 million
17 the next year, then 39 million, then 63 million, and
18 108 million in 2007. If you translate that into a
19 return on premium, last year that was almost a 35
20 percent return on premium.

21 And those figures actually understate to a
22 certain extent how well ProMutual is doing, because
23 of that 108 million in net income, as you know,
24 typically malpractice carriers will lose money on

1 underwriting, they will have an underwriting loss,
2 because they make so much on investment income.

3 So, if ProMutual were to make 10 million or
4 20 million on underwriting, that would be a huge
5 underwriting profit. But what they did last year
6 was they made 54 million in underwriting profit
7 alone before even getting to investment income. So
8 ProMutual is doing very, very well. They have done
9 well for the last several years, but this year, this
10 past year, 2007, is a record year.

11 Let's look at their surplus. In 2003 their
12 surplus was 342 million, went up to 504 million in
13 2006, then it went up another hundred million in
14 2007. Their surplus is now at an all-time high, 602
15 million. Their RBC ratio, again, is almost twice as
16 high in 2007 as it was in 2003.

17 And their premium-to-surplus ratio, and
18 this really is extremely striking, you know, it used
19 to be that when you had a premium-to-surplus ratio
20 of anything less than 2 to 1, that was considered
21 good, then it went down to 1 1/2 to 1, and then some
22 carriers began going to 1 to 1. Well, ProMutual is
23 at 1/2 to 1. For each premium -- or looked at
24 another way, for each dollar of premium they write,

1 they've got \$2 of surplus. So they're just
2 exceptionally well capitalized.

3 And then all this comes down to what their
4 ultimate -- what their loss ratio is, which, I
5 guess, is what many people at the Insurance
6 Department think is the most important. And you can
7 see in the last five years it's cut in half. So
8 today, it's less than -- it's less than 50 percent.
9 It's 45 percent. That means they project that they
10 will pay out only 45 cents of each premium dollar
11 that they take in.

12 Finally, their loss development, their
13 reserves are extremely redundant. As you know, they
14 talk about -- companies talk about how, when they
15 overreserve, and it turns out, when they realize
16 that they've overreserved, that they've got
17 favorable loss development. Well, their reserves
18 have been redundant for the last five years, and
19 they just get more and more redundant. That is, it
20 turns out that they've overreserved more and more as
21 time goes on.

22 So the company has done very, very well,
23 and I would like to talk about -- so rates clearly
24 are excessive, and I would like to talk about some

1 things that the Department could do under current
2 law, and also some legislative changes that could be
3 enacted that might, I think would, help bring down
4 rates and in particular give the Department the
5 authority to bring down excess -- to roll back
6 excessive rates.

7 But before going into them, I would just
8 like to very briefly ask you to turn to Exhibit B,
9 which just -- this just shows that ProMutual is not
10 an exception. What I've got there is exactly the
11 same data for the largest malpractice carrier in the
12 country, they write a tiny bit in Massachusetts, The
13 Doctors Company.

14 And you can see there the trends are
15 exactly the same. Their return on premium was 30
16 percent, ProMutual's was 34. They have more than
17 doubled their surplus in the last five years.
18 ProMutual about doubled their surplus. Their
19 premium-to-surplus ratio is also far less than 1.
20 It was .64. ProMutual was .52 last year. Their
21 loss ratio is even lower than ProMutual's. Just as
22 with ProMutual, their reserves are way, way
23 redundant.

24 So the only point, Madam Hearing Officer,

1 of bringing these up is to show that ProMutual is
2 not an exception. The companies today are doing
3 very, very well. That's great for the companies;
4 it's not so good for the policyholders. Rates are
5 excessive. There is no question that rates are
6 excessive today.

7 Okay. So the question is, what do we do
8 about that, or what can be done about that? Well,
9 there are couple of approaches. And let's first
10 look at a nonregulatory approach or a deregulatory
11 approach.

12 By the way, I guess I should have mentioned
13 this when I began. I was the Insurance Commissioner
14 in Missouri between '93 and '98, and in Missouri we
15 have a very different system than Massachusetts.
16 Massachusetts is known as being one of the most
17 regulatory if not the most regulatory state in the
18 country. Missouri is very, very deregulatory. The
19 companies have to file their rates, but the
20 Commissioner is completely impotent as to what
21 action he can take. They simply make informational
22 filings, and they can charge what they want whenever
23 they want.

24 That's not all bad, and particularly in an

1 environment like this, with profits being so high
2 and rates so high, I know it's completely
3 antithetical to the current rate regime in
4 Massachusetts, but it might be worth considering
5 going to exactly that type of approach, where
6 companies could raise or lower their rates at will.
7 I believe today, again, because profits are so high,
8 companies would -- there would be very substantial
9 price competition.

10 I don't know what the situation is in
11 Massachusetts with new entrants. In Missouri there
12 have been eight new entrants in the last couple of
13 years, and rates in the last few years have gone way
14 down. One company entered five years ago. They're
15 now the largest company -- they've got the largest
16 market share in Missouri. There are five companies
17 in Missouri which each have over 10 percent of the
18 market. This company is now the leading carrier.
19 It was at nothing five or six years ago.

20 So another deregulatory approach that the
21 Department could consider would be simply to
22 publicize aggressively the new entrants that are
23 entering. I think the laws -- I was going to say
24 conceivably the law could be amended to make it

1 easier for companies to start up, but I think there
2 have been enough new start-ups that that is
3 unnecessary. So if the Department didn't want to
4 go all the way toward deregulation, it could simply
5 aggressively publicize the new companies that are
6 coming in.

7 Another thing that it could do would be to
8 disseminate comparative price information. It would
9 be -- I know several state insurance departments
10 have done this for auto and homeowners. One or two
11 have done it for Medigap insurance. It would be a
12 relatively simple thing, especially because the
13 medical malpractice rating methodology is relatively
14 simple, to actually put on the Internet the prices
15 charged by the carriers, the leading carriers in the
16 state. I know ProMutual has most of the market, but
17 there are others.

18 You could put right on the Internet the
19 prices charged by the leading carriers in the state,
20 and it could be -- I mean, it could be an
21 interactive website where a doctor could just come
22 to the site, punch in his rating characteristics,
23 and out would come the prices charged by each of the
24 leading carriers in the state.

1 That is something -- obviously private
2 companies do that. I used to work for a private
3 company that did that for auto and homeowners and
4 life and health. I don't think any private
5 companies do it for medical malpractice, and I don't
6 think it would be cost effective, because there are
7 so relatively few malpractice policyholders. But
8 that might be something that the Department could
9 consider.

10 So those are all deregulatory approaches.
11 Now I would like to suggest a few regulatory
12 approaches.

13 The first is, and I know this would be very
14 controversial, and actuaries, whether they work for
15 the industry or work for the Department, aren't
16 going to like it, but I do think that this is a very
17 significant issue, and it's really -- I think it
18 really gets to the bottom of why rates today are so
19 excessive.

20 And I think the reason is or one of the
21 biggest reasons is that actuaries have virtually
22 unfettered discretion as to what assumptions they
23 make in calculating rates. They can look at what
24 the actual trend has been in the past, and they can

1 nevertheless use a higher trend. They can look at
2 what the actual investment yield has been in the
3 past, and they can nevertheless assume a lower
4 investment yield. They can look at how losses have
5 developed in the past, and rather than using the
6 real loss development factor that the data
7 indicates, they can use a lower loss development
8 factor.

9 So they've got an inordinate amount of
10 judgment. They're allowed -- they're allowed to use
11 an inordinate amount of judgment, notwithstanding
12 what the actual data show. And on the one hand you
13 don't want to be too prescriptive, but when -- and
14 I've seen rate filings like this -- when an actuary
15 will say that the trend is a positive 7, yet a
16 couple of years later, you see that what the real
17 trend has been is close to zero, I mean, that's a
18 shockingly inaccurate estimate.

19 And you can argue about, you know, how much
20 is intentional and how much is simply inadvertent,
21 but when there are no standards that actuaries must
22 follow when they estimate what the trend is going to
23 be or what the loss development factor is going to
24 be or what the investment yield is, it really means

1 that insurance companies can raise rates at will.
2 And unless at the back end there's a mechanism for
3 refunding those excessive rates -- and I'll get to
4 that in a second -- policyholders really lose, and
5 there is no way to get that money back.

6 So I think that, again, it's controversial.
7 I don't think the Department should be too heavy-
8 handed, but I think the Department should take a
9 serious look at whether there are certain
10 guidelines, certain standards the Department could
11 establish that actuaries would have to follow in
12 making rate filings.

13 Second, another highly controversial area
14 is surplus. As you know, the NAIC, in the '90s,
15 established the RBC standards. Every state or
16 virtually every state has adopted them. And so
17 there are now minimum surplus standards, but no
18 maximum surplus standards.

19 Minimum surplus standards are very
20 important. Obviously, you want to know that the
21 company is going to be around to pay claims, no
22 matter what happens. And from a financial
23 examiner's perspective, there is no such thing as
24 too much surplus.

1 But there's a tension between the financial
2 examiner's perspective, who would want as much
3 surplus as possible, and the rate filing area or the
4 people in the rate bureau's perspective, who want
5 rates to be reasonable. And when you see jumps in
6 surplus like we've seen over the last five years,
7 when surplus for most companies has doubled, that's
8 one indication, obviously, that rates are excessive
9 and that reserves were -- and that the companies
10 were overreserving.

11 Traditionally insurance departments have
12 not wanted to consider surplus as all when they look
13 at rates. But that's breaking down a little bit.
14 In several states the departments do look at surplus
15 when they're considering Blue Cross rates.

16 And, again, I don't think the Department
17 should rush into this, but I think that the
18 Department should consider whether there is some
19 level at which surplus -- at which enough is enough.
20 And by that I mean above a certain level, insurers
21 would not be entitled to earn a rate of return on
22 that amount of surplus. It doesn't mean they
23 couldn't raise rates, but they couldn't get a return
24 on surplus above a certain level.

1 Or another way to approach it would be to
2 say you couldn't have -- if surplus is above a
3 certain level, they couldn't have a factor for
4 contingencies in the rate filing. That is, the
5 concept is that if surplus exceeded a certain level,
6 rates would automatically be limited one way or
7 another.

8 Now, the most extreme version of a rate
9 limitation based on surplus would be simply to say
10 that above a certain level -- would be simply to
11 have an absolute maximum surplus standard, and to
12 say to companies, if your surplus is this level,
13 say, 500 percent of authorized control level or 600
14 percent or whatever level you'd pick, above that
15 level you couldn't raise rates above that level, and
16 if your surplus was above that level, that surplus
17 would have to be distributed to policyholders.

18 So, to give an example of how that worked,
19 ProMutual last year declared a dividend of between
20 2 million and 3 million bucks. They had a net
21 profit of 104 million. There might be something the
22 Department would want to look at that would require
23 companies, when they had a certain level of surplus,
24 in addition to the profit, to require them to

1 distribute a certain amount of that, rather than a
2 de minimus amount.

3 Third, Massachusetts, like Missouri and
4 like most other states, does not give the Insurance
5 Commissioner the power to order refunds of excessive
6 rates. Now, the Commissioner here has much more
7 power than the Commissioner in Missouri, because the
8 Commissioner here -- because you've got prior
9 approval. It's much more highly regulatory. The
10 Commissioner here does have the authority to find
11 rates excessive before they take effect and after
12 they take effect. In Missouri we've got neither.

13 But the larger point is, in neither state
14 does the Commissioner have the authority to say to a
15 company, after you've found a rate to be excessive
16 and after you've found that people have paid that
17 excessive rate for years and years, you've still got
18 no authority to tell the company to refund the rates
19 it's charged to the extent those rates are
20 excessive.

21 So that's another area that I think the
22 Department should look at, giving the Commissioner
23 the authority not to just find rates excessive, but
24 if she does find rates excessive, to order refunds

1 to the extent that she's found those rates
2 excessive.

3 And then finally, you can't do this, I
4 don't think, under current law, but the Legislature
5 could and I think should enact a law that would give
6 individuals the authority to prove -- to come in and
7 prove that a rate is excessive and, if they could so
8 prove, to obtain refunds on behalf of themselves and
9 the class of policyholders that they represent.

10 Okay. So all those reforms, Madam Hearing
11 Officer, go to the overall rate level. Now, I would
12 like to talk briefly about how the premium is
13 distributed among different specialties, and this --
14 I think this is a terrific area for the Department
15 to be having a hearing on, because it's an area
16 that's received virtually no attention.

17 During the periods when rates go way up for
18 certain specialties, there's never any talk, either
19 during the last insurance crisis or during the one
20 in the mid-'80s or during the one in the mid-'70s, I
21 don't recall any talk about how different
22 specialties are impacted, and particularly how the
23 incomes of different specialties relate to the
24 premiums that those specialties pay.

1 So if you will turn to Exhibit C, what I've
2 done there is to set forth premiums -- set forth the
3 premium that's paid by about 12 of the leading
4 specialties, and then the percentage of net income
5 that this premium accounts for, and then the average
6 net income of the specialty.

7 And so just to go through a few of them,
8 and they're arranged from the highest premium to the
9 lowest premium -- the premiums that I used are the
10 premiums that Medical Protective has been charging
11 in Missouri. They're probably a little high -- I
12 believe they're probably a little bit higher than
13 the Massachusetts premiums, but they're probably
14 about the same ballpark.

15 I should point out, though, that there are
16 premiums that are much lower than this in Missouri.
17 I would think there are in Massachusetts too. But
18 the relativities are the same. Neurosurgeons are
19 always going to pay more than dermatologists. So I
20 think this is a fair representation.

21 And let's just look at the first -- the
22 highest rated specialty. That's neurosurgeons, and
23 they pay 129,000 bucks. Obviously, that's a lot of
24 money. That's a big malpractice premium, and that

1 feels big because that's a big percentage of the
2 neurosurgeon's net income. That's a quarter of his
3 net income, 25.2 percent.

4 But even after that premium, even after
5 he's paid that premium, he is still left with a net
6 income of over half a million dollars. So on the
7 one hand, yes, a neurosurgeon pays a very high
8 premium. You see that in that first column on the
9 left, the 129,000?

10 PRESIDING OFFICER FARRINGTON: Yes.

11 MR. ANGOFF: And that's a big percentage of
12 his income, but he's still left with a very large
13 income, 512,000.

14 Let's go down to the bottom, the very
15 bottom, and there you see a dermatologist who pays a
16 very low malpractice premium of about \$10,000,
17 really a very low premium, and his premium is a tiny
18 percentage of his income, 3.4 percent. His average
19 net income is about \$300,000, \$298,799. The net
20 income figures here come from the American Medical
21 Group Association 2007 survey.

22 So on the one hand, you've got
23 neurosurgeons at the top paying a very big
24 malpractice premium, but making over 500,000 net.

1 On the other hand, you've got dermatologists at the
2 bottom as far as premiums are concerned, paying only
3 10,000, but their net income is much less than
4 neurosurgeons. It's 300,000.

5 In between those you see -- there are a lot
6 of specialties that make less than dermatologists,
7 but their premium is slightly more. And you see
8 other specialties, like neurosurgeons, whose
9 premiums are very high. For example, a cardiac
10 surgeon pays a premium of about 97,000, but his
11 average net income is 442,000. So in considering
12 equity among specialties, you've got to consider the
13 premium that the specialty pays plus also the income
14 that the specialist makes.

15 Now, there are a handful of states which
16 have enacted legislation which is, I think,
17 extremely regressive, which makes no sense -- there
18 is no equity in it. They have passed legislation
19 that would subsidize neurosurgeons. It would
20 subsidize people making over half a million dollars
21 a year, just because their malpractice premiums are
22 high. The legislation says, to oversimplify, to the
23 extent that your malpractice premium exceeds a
24 certain amount, you will get a subsidy from the

1 taxpayers.

2 And for somebody making half a million
3 bucks, I just don't think that makes sense, because
4 there are specialties -- pediatricians, for example,
5 they pay a very low malpractice premium of about,
6 according to this data, about 20,000, but their
7 average net income is only 173,000. So why would
8 you want to subsidize somebody who is making half a
9 million and not subsidize someone or give a much
10 lower subsidy to someone who is making a third of
11 that 500,000?

12 So if you look at these -- at this data or
13 any other similar data, what you find, really, is
14 most specialties fit into one of two categories.

15 Either they have low to moderate incomes,
16 based on physician standards, and by that I mean
17 incomes between 150,000 and 300,000 a year. So by
18 physician standards, I would say that's low to
19 moderate, and people in those, in general -- I mean,
20 there are exceptions, but in general the people in
21 those specialties pay a premium of somewhere between
22 10 and 20 percent of their income. It's not that
23 big. It doesn't feel that big. It's usually closer
24 to 10, sometimes less than 10.

1 And then on the other hand you've got
2 specialties that pay very high premiums, like
3 neurosurgeons and like cardiac surgeons, but they've
4 also got very high incomes, incomes of over 400,000,
5 in some cases, with neurosurgeons, over 500,000.

6 There are only one or two specialties that
7 have relatively low to moderate incomes but pay a
8 substantial percentage -- but looked at in
9 percentage term, percentage of their net income, the
10 malpractice premium they pay is very high. And the
11 biggest, by far, are OB/GYNs.

12 According to this data, their average net
13 income is only about 255,000. That seems to me a
14 little low, but that's what this data says. And
15 their premiums are typically, anyway, according to
16 the Medical Protective Missouri premiums, over
17 100,000. So as a percentage of their net income,
18 their medical malpractice premium is over 40
19 percent. That is real big. It feels real big and
20 it is real big.

21 So to the extent there's a problem, the
22 problem is focused on OB/GYNs and to a lesser extent
23 emergency room docs. As a percentage of their
24 incomes, they don't pay as much as OB/GYNs, but they

1 do pay a substantial percentage of their income.
2 Those are the two specialties, those are the only
3 two specialties that make less on the average than
4 400,000 net, yet pay a premium of over -- that is
5 more than 20 percent of their net income.

6 So to the extent that the Department or the
7 Legislature thought that it made sense to subsidize
8 malpractice premiums, I would suggest that the only
9 specialties that merit such a subsidy would be those
10 two specialties, those that are relatively low to
11 moderate incomes, but a very high percentage of
12 that -- but their premium is equal to a very high
13 percentage of their net income.

14 Where could this subsidy come from? Again,
15 this is a controversial area, and I don't think it
16 should be rushed into, but one possibility, if there
17 were to be such a subsidy, would be to take it from
18 the surplus of health insurers.

19 I think the Department would have to take
20 extreme care to make sure that there was no way the
21 companies could pass on or pass through any part of
22 that -- any part of the amount that was taken from
23 surplus to the policyholders, but if the Department
24 were satisfied that money could come out of surplus

1 and not be passed through to policyholders, that's
2 one way to look -- that's one place to look.

3 Another place to look is the surplus of
4 other property/casualty carriers. But, again, I
5 think it's just critically important that if any
6 such subsidy were enacted, that it couldn't be
7 passed through to the ratepayer, it couldn't be
8 passed through to the policyholder, because, if it
9 were, you would have a reverse subsidy. You would
10 have poor people subsidizing rich people.

11 You would have -- I mean, in the worst
12 case, and there has been legislation considered like
13 this in certain states, I don't think any of it has
14 passed, but there has been legislation considered
15 under which all property/casualty policyholders
16 would pay into a fund to fund -- to subsidize
17 malpractice premiums.

18 Now, look at what that means. That means
19 you have poor people paying auto insurance premiums
20 and homeowner's premiums which go to subsidize
21 neurosurgeons making half a million dollars a year.

22 So I think if a surplus can -- if a subsidy
23 can come from surplus and isn't passed through to
24 the ratepayers, I think that's something that the

1 Department or the Legislature could look at. But I
2 think it's very important not to, under any
3 circumstances, allow this reverse subsidy, where
4 low-income people are subsidizing high-income
5 people.

6 So in conclusion, Madam Hearing Officer,
7 again, I think this is a terrific time to be having
8 this hearing. You've got the luxury of time and no
9 real pressure to do something immediately.

10 I was lucky enough to be Insurance
11 Commissioner in Missouri for almost six years when
12 we didn't hear a peep about medical malpractice
13 rates, and of course we tried to take credit for it,
14 but it had nothing to do with anything we had to do,
15 nothing to do with anything we did.

16 What it had to do with was I was lucky
17 enough to come there at a time when rates were
18 wildly excessive. Rates had been jacked way up in
19 the late '80s, and reserves were way, way redundant.
20 So for the entire six years that I was Commissioner,
21 there were no complaints about malpractice premiums.
22 Premiums were either level or going down. Profits
23 were still high.

24 And you and the Commissioner and the

1 Department now are in the same position I was in
2 1993. I wish I could have gone back and done some
3 things there when there was no pressure. I didn't,
4 but you have that opportunity.

5 And I hope that you take your time, but
6 that you do look at some of these potential changes
7 and do make some changes that can reduce the
8 likelihood that rates will be excessive in the
9 future, and if they do turn out to be excessive, to
10 give the Commissioner the authority -- I think this
11 is the most important thing -- if the Commissioner
12 finds rates excessive, she should have the authority
13 to give money back to policyholders to make up for
14 the excessive rates that they've paid in the past.

15 Thank you very much. I'm happy to answer
16 any questions.

17 PRESIDING OFFICER FARRINGTON: Thank you.

18 Mr. Boyle?

19 MR. BOYLE: Good morning. Thank you for
20 allowing Mr. Angoff to precede me, and thank you for
21 the opportunity to come in here today and talk about
22 an issue which it seems like I've been talking about
23 the entire 37 years that I've been trying cases here
24 in Massachusetts.

1 My name is Leo Boyle. I'm a trial lawyer.
2 I specialize in the trial of cases involving people
3 who have been hurt through the fault and negligence
4 of others, and a large percentage of what I do is
5 medical malpractice work. So the people I interact
6 with on a daily basis are the victims of malpractice
7 and other harms.

8 I've also served as the president of the
9 Massachusetts Bar Association in 1990-'91. I served
10 as president of the Association of Trial Lawyers of
11 America in 2000 and 2001. That organization is now
12 known as the American Association for Justice. And
13 following that, I served as the President of Trial
14 Lawyers Care, which was a legal services
15 organization based in Manhattan that represented
16 free of charge about 2000 victims of the disaster of
17 September 11th, 2001. So I've spent a lot of time
18 both in court and working with legal organizations.

19 The essential message I would like to leave
20 with you and to leave on the record today is a
21 constant which hasn't changed since the 1970s. And
22 that constant is that what moves premiums is one
23 thing and one thing only, and that's the investment
24 income.

1 Insurance companies can make money in two
2 ways. They can charge premiums, and they can get
3 investment income. And if you take a historical
4 perspective on where we have been, we've been
5 talking about the rubric for this debate is tort
6 reform. We've been talking about it now for over 30
7 years. And let's go back in time to the 1970s.

8 And if you will recall, in the 1970s we had
9 some things going on that are hauntingly similar to
10 what we're seeing currently. We had something
11 called stagflation, inflation that was high. We had
12 oil costs rising. We had a shortage of gasoline,
13 food costs were going up, and the real estate market
14 essentially crashed.

15 And what that meant was the insurance
16 industry lost money on its investments, and that was
17 the beginning of the so-called tort reform fight.
18 And the insurance industry blamed the people who are
19 injured in accidents and make claims, and they came
20 to the legislatures and Insurance Commissioners
21 around the country and attempted to limit the rights
22 of people who get hurt, blaming them for the rising
23 premium bills.

24 Now, of course, what was driving the rise

1 was what was happening in the economy. And that has
2 proved itself out at least two more times and
3 probably three. We come into the period of 1980s,
4 and rates -- the economy settled down, and rates
5 flattened out, and insurance became very profitable
6 business.

7 We come to the end of 1980s, and there was
8 a phenomenon, the Hula Hoop of the investment world
9 at the time was junk bonds, and about 30 percent of
10 junk bonds were owned by insurance companies. And
11 I'm not suggesting our insurance companies or Med
12 Mal insurance companies, but the insurance industry
13 owned about 30 percent of junk bonds. We all know
14 what happened to that in 1988, '89 and '90. They
15 crashed, and they took down insurance investments.

16 Again, the insurance industry turned on the
17 people who are supposed to benefit by insurance when
18 they are hurt, and we had our second tort reform
19 fight, and we had the insurance industry coming in
20 attempting to limit the rights of victims, again,
21 utterly misplacing fault for what had happened.

22 We got through that shakeout in the very
23 late 1980s, and we entered the 1990s. Commissioner
24 Angoff was Commissioner of Insurance in Missouri

1 during that time, and it was a sunny time for
2 insurers throughout the 1990s. In Massachusetts,
3 from 1990 to 2000, rates -- premiums remained
4 essentially flat or went down.

5 Now, in the same decade the cost of medical
6 care, so-called medical inflation, rose by 75
7 percent. So everything else having to do with
8 medicine rose by 75 percent, and premiums stayed
9 flat.

10 Well, what was going on? What was going on
11 was investment opportunities, but this time the
12 panacea, the investment of the decade, was the
13 dot-com, was the Nasdaq and the dot-coms. So the
14 1990 went fine for the insurance companies, and
15 investments were great. And then the dot-com
16 collapse came. Nasdaq lost something like 70
17 percent of its value; the stock market plunged 3,000
18 or 4,000 points over several months.

19 And we had another, in '99, 2000, 2001,
20 another call for reform and taking away of people's
21 rights, an, again, utterly misplaced effort to blame
22 the people who were supposed to benefit from
23 insurance for improvident investments, unfortunate
24 economic turns of events, aggressive pricing and

1 aggressive risk taking.

2 We then entered this decade, and things got
3 better, and Mr. Angoff has clearly demonstrated the
4 wonderful profits that are taking place.

5 The point of history here is that when
6 premiums rise and when profits of insurance
7 companies fall, it has nothing to do with what
8 American jurors are doing in court. In fact, claims
9 are dropping. Claims nationally, medical
10 malpractice claims are down 30 percent. In some
11 areas they're down a higher percentage than that.

12 ProMutual, in a book called Folio's Medical
13 Directory, which lists all the medical specialists
14 in Massachusetts, back in 2002, used as one of its
15 enticements in an advertisement to get doctors to
16 buy insurance from them, "We closed over 60 percent
17 of our claims without payment and won over 95
18 percent of our trials."

19 Now, a lot of people don't realize that
20 that's what happens in court. You try a medical
21 malpractice case, you try 100 of them, and the
22 doctor wins between 90 and 95 percent. If they're
23 having a bad year, it's 90, if they're having a good
24 year, it's 95, according to their own statistics.

1 So inevitably what's playing out now, the
2 problems in the stock market, in the investment
3 community, my suspicion is a year from now the
4 carriers will be back in front of you, and once
5 again, as they did in the '70s, and they did in the
6 '80s, and they did in the late '90s, try to blame
7 the patients. We expect to see that.

8 Now, when you talk about limiting people's
9 rights in court, what you're essentially trying to
10 do is two things. You're trying to relieve
11 yourself, the insurance companies, and by
12 association the physicians who back up the insurance
13 companies on most of these arguments -- I don't
14 think they should, but they do. You're attempting
15 to, No. 1, relieve yourself from accountability, and
16 No. 2, deprive people who have been harmed by your
17 insureds of a remedy against you and against your
18 insureds.

19 That's exactly what the investment banks
20 and the brokerage houses and Wall Street fought for
21 over the last 15 years and got. They got
22 deregulation, they got relief for accountability,
23 they got limitations on the ability of people to
24 have a remedy against them. And I would just ask

1 you, Madam Hearing Officer and the Commissioner, to
2 look where we are today having followed that road
3 map.

4 If you like what is happening in the
5 economy right now, and if people think that what's
6 happening in the economy is good for the average
7 citizen, then maybe it appeals to you to start
8 taking away the rights, the legal rights of patients
9 and innocent victims of malpractice, and relieving
10 insurance companies of accountability and depriving
11 people of remedies.

12 If one thinks that what is happening in the
13 economy is a model that should not be emulated, I
14 would urge that we leave people with the rights that
15 they're constitutionally entitled to and have had
16 since the beginning of our civil justice system.

17 We submitted as part of our papers a
18 research report by Joanne Doroshow, who is the
19 Executive Director of the Center for Justice and
20 Democracy. She founded also the Americans for
21 Insurance Reform. And it dates to November of 2003,
22 when we were having this discussion, again, on a
23 cyclical basis, and it's a wonderful dissertation
24 about the insurance cycle and how that is the driver

1 of what goes on with premiums.

2 So, in closing,, I want to touch upon one
3 point that was brought up, one specific point that
4 was brought up on so-called legal reform that
5 apparently will be sought by ProMutual, and that is
6 joint and several liability, which is an amazingly
7 arcane legal theory which is fairly hard to
8 understand but is of enormous importance to ordinary
9 people.

10 If I could give you an example, if I go to
11 the hospital and there is a nurse caring for me, and
12 that nurse is either uninsured or doesn't have
13 adequate insurance, and a doctor caring for me, and
14 through their joint negligence I am severely injured
15 or killed, and a jury listens to all the facts and
16 finds that had it not been for the negligence of
17 each of those two people separately, I wouldn't have
18 been injured or killed, they are jointly and
19 severally liable to me.

20 What the insurance company would like these
21 jurors to do is to apportion the liability and say,
22 well, who was more liable, the nurse or the doctor?
23 And let's say a law like that passed, and the nurse
24 was found to be 25 percent -- I'm sorry, 75 percent

1 at fault, and the doctor 25 percent at fault.

2 There's a surface equity that appeals to
3 some people, but when you scratch below the surface,
4 what that means is I'm totally innocent, I have 100
5 percent damages, and I am only going to collect from
6 the nurse, and she has got either no or limited
7 insurance, and the doctor will be limited to 25
8 percent.

9 That would be a dramatic reversal of long-
10 standing common law principles in the Commonwealth,
11 because the jury has already found that if the
12 doctor hadn't done what he or she had done, I
13 wouldn't have been harmed. But this gimmick of
14 doing away with joint and several liability means
15 that the doctor avoids 75 percent of the damages,
16 and I, as the innocent victim, don't get to collect.

17 So, again, it's arcane, it might seem to a
18 lot of people as a small point, but in real life and
19 in the lives of real people, it has enormous
20 payout.

21 So with that I will close. I thank you
22 very much for hearing me out. And on behalf of the
23 Massachusetts Academy of Trial Attorneys, if there
24 is any other research or data or witnesses that we

1 can provide to you or to the Commissioner going
2 forward and before your due date, we would be more
3 than happy to do so.

4 PRESIDING OFFICER FARRINGTON: Thank you,
5 Mr. Boyle.

6 Does Mr. Riccio intend to testify as well
7 on behalf --

8 FROM THE AUDIENCE: No.

9 PRESIDING OFFICER FARRINGTON: Mr. O'Brien.

10 MR. O'BRIEN: Good morning, Madam Hearing
11 Officer. My name for the record is Frank O'Brien.
12 I'm Vice-President, Regional Manager and Counsel for
13 the Property Casualty Insurers Association of
14 America.

15 PCI is a national property/casualty trade
16 association comprised of over 1,000 member
17 companies. A number of our member companies do
18 business here in Massachusetts. Several are located
19 here. One of our member companies that is located
20 here is ProMutual. ProMutual is the largest medical
21 malpractice insurer in Massachusetts.

22 Madam Hearing Officer, I intend to be quite
23 a bit shorter than the preceding two witnesses. I
24 have provided to you a short statement relative to

1 PCI. Suffice to say that PCI supports and agrees
2 with many of the comments, if not all of the
3 comments, submitted by Mr. Brewer.

4 I would also like to suggest to you, Madam
5 Hearing Officer, that we agree with at least one of
6 the comments made by the two witnesses that have
7 immediately preceded me, and that is that the
8 Division of Insurance of the Commonwealth of
9 Massachusetts does indeed have the luxury of time to
10 consider this issue and that there is no real
11 pressure to do anything at the moment.

12 Madam Hearing Officer, I find it
13 extraordinary in these unsettled times that one of
14 the witnesses immediately preceding me took pains to
15 criticize and to essentially argue that the largest
16 medical malpractice writer in the state is too
17 solvent, too strong, and that he is indeed critical
18 of this conservatism.

19 I would suggest to you, Madam Hearing
20 Officer, that for an insurance company whose whole
21 reason for being is to manage and to deal with risk,
22 it is the very ethos of an insurance company to
23 indeed be conservative.

24 I also suggest to you that I find it

1 somewhat extraordinary that critics of the industry,
2 critics of where we are at the current time in the
3 Massachusetts marketplace, are also essentially
4 advocating aggressive price cutting and aggressive
5 risk taking. Madam Hearing Officer, that is
6 certainly not the prescription that policyholders
7 and others in Massachusetts should be supportive of.

8 With that, Madam Hearing Officer, I'll
9 complete my testimony. I will be happy to answer
10 any questions.

11 PRESIDING OFFICER FARRINGTON: Thank you,
12 Mr. O'Brien.

13 Mr. Harrington.

14 MR. HARRINGTON: Ms. Farrington, for the
15 record, Jim Harrington, Executive Director of the
16 Massachusetts Insurance Federation. The
17 Massachusetts Insurance Federation is pleased as
18 well to submit comments on some of the issues
19 referenced by this hearing notice. The Federation
20 is a single-state trade association comprised of
21 insurers writing all principal lines of
22 property/casualty coverage in the Commonwealth.

23 My comments are -- my written comments are
24 rather redundant to those of Mr. O'Brien, so rather

1 than offer those, I would simply like to briefly
2 suggest, in terms of the one of the previous
3 witnesses, that in terms of the subsidy issue of
4 malpractice premium, he volunteered that you and the
5 Legislature look at the possibility of surplus in
6 property/casualty insurance and health insurance.
7 And for the record, we would strongly recommend
8 against such review and potential adoption.

9 I would be happy to answer any questions
10 beyond that.

11 PRESIDING OFFICER FARRINGTON: Thank you,
12 Mr. Harrington.

13 Is there anybody else here who wishes to
14 make a statement at this time? Please come forward.

15 DR. ASLAMI: Good morning.

16 PRESIDING OFFICER FARRINGTON: Good
17 morning.

18 DR. ASLAMI: My name is Angela Aslami, and
19 I am a practicing OB/GYN physician in Brockton,
20 Massachusetts, and I appreciate the opportunity to
21 come and testify and that you are actually holding
22 these hearings.

23 There are a couple of issues related to
24 medical malpractice pricing that haven't been

1 discussed yet, and I think they're important to
2 consider.

3 The first issue is related to insurance
4 tails. Right now, there are generally two kinds of
5 insurance policies for physicians. One is the
6 Cadillac, and one is the Chevy, so to speak. And
7 the Chevy, of course, is cheaper, and it's certainly
8 more available, and it's what is called a claims
9 made policy, and that's what the majority -- I'm
10 going to speak, by the way, about OB/GYNs because
11 that's what I know about. I don't know really,
12 truly about what all the other specialties
13 experience. The other policy is called an
14 occurrence policy.

15 The difference is that when you as a
16 physician change jobs and change malpractice
17 insurance carriers, the new carrier does not want
18 liability for things that you might have done in
19 your previous job. So there is a policy called a
20 tail. You buy this tail policy to cover yourself
21 for all the stuff that happened prior to your new
22 job. And the price of that policy is between three
23 and four times the annual normal policy. So for an
24 OB/GYN, an annual normal policy is between \$80,000

1 and \$100,000, so the tail is three to four times
2 that, and you have to pay that before you go to your
3 new job, which is a lot of money.

4 And I will tell you from a personal
5 experience, when I finished my training program, I
6 found what I thought was the perfect practice to
7 join in a small town in Connecticut, a nice group of
8 doctors and a stable practice in a nice community
9 and close to my family. And six months after I
10 joined them, their malpractice insurance doubled,
11 and the other partners decided they didn't want to
12 practice OB anymore.

13 So I had to find another job and pay, after
14 doing about ten deliveries, an \$80,000 tail. And I
15 said, "I will never do that again."

16 So in looking for a new job and in coming
17 to Massachusetts, one of the first questions I asked
18 on job interviews was, "What kind of insurance
19 policy do you have? Because I don't want the kind
20 where you get stuck with a tail again." And that
21 makes recruiting physicians very difficult, because
22 a majority of practices do not offer the kind of
23 policy where you don't have to pay a tail.

24 So I would encourage you, when you're

1 looking at investigating the cost of malpractice
2 insurance, to look at the tail issue as well,
3 because it's very important, for younger physicians
4 who are finishing their training program and looking
5 for jobs, to be able to find a job where, if they're
6 not happy or if for some other reason they have to
7 leave or the practice environment changes, they
8 don't have to pay \$300,000, \$400,000 to get out of a
9 job. Most people can't afford that kind of
10 situation. And it's not an option to go bare or not
11 buy the tail, because your next hospital will not
12 grant you privileges if your tail is not covered.

13 So that's one issue, the insurance tail.
14 The other issue I wanted to bring up is the lack of
15 availability of part-time insurance policies for
16 physicians who want to practice part-time. And
17 currently, in OB/GYN, about 75 percent of the
18 medical students who are choosing OB/GYN as a career
19 are women, and 50 percent of the currently
20 practicing OB/GYNs are women, and many of them are
21 interested in what we consider part-time positions.

22 Part-time for an OB/GYN is still 30 to 40
23 hours a week, which is generally full-time for most
24 other sectors of the economy. And generally that

1 schedule consists of about one day a week on call
2 and 20 or so hours a week seeing patients. And the
3 one day on call is a 24-hour shift, and when it
4 involves the weekend, it's 48 or 72 hours. When
5 it's holidays, it's the same thing.

6 I just looked into this yesterday with
7 respect to ProMutual's part-time insurance coverage,
8 and it's essentially not going to work for OBs,
9 because you have to practice less than 20 hours a
10 week. So therefore, you can't be on call as an OB
11 on a 24-hour shift and have a part-time policy,
12 because they won't sell it to you.

13 Many women choose to do job sharing or
14 between two physicians share a full-time practice,
15 and, again, you have to pay the full-time
16 malpractice insurance rate with the majority of the
17 malpractice carriers, because they will not sell it
18 at a discount if you're working half time.

19 So what that translates into with people,
20 when physicians have to make the decision, do they
21 want to work full time in order to cover that
22 malpractice bill, or do they want to work part time,
23 and if they work part time, the economics don't make
24 sense to pay the full-time rate and see half as many

1 patients and do half as many deliveries and half as
2 much surgeries, so ultimately many of them choose to
3 give up the obstetrics.

4 I just was at a conference about a month
5 ago where the statistics on career longevity in
6 OB/GYN were presented, and the average age of
7 physicians dropping OB was 48 years, and the average
8 age where they went to less than 20 hours a week of
9 work was 53, and retirement was 63. And those
10 numbers keep going down as the percentage of
11 practicing OB/GYNs increases as females.

12 I can tell you, as the mother of three
13 young kids, it's extremely difficult to entertain
14 the idea of an 80-hour work week. So I have chosen
15 to do the part-time route and still pay the
16 full-time rate. And every year I say, "Why I am I
17 doing this? I should just give up obstetrics." It
18 would make my life much easier, I wouldn't have to
19 be on call, and I could trade in the income for the
20 peace of mind that would bring, and a lot of women
21 physicians feel the same way.

22 So I would urge you to look at the issue of
23 the lack of availability of part-time insurance
24 policies and the cost of the insurance tails. The

1 things that go into the cost -- some of the factors
2 that go into the pricing of a tail include what the
3 annual premium is, so everything that you have
4 already heard testimony about regarding what it
5 costs to buy a regular premium would also affect the
6 tail price. In addition to that, the statute of
7 limitations.

8 Lastly, what I would like to say is, in
9 response to some of the other testimony, I don't
10 believe that you have the luxury of time, because
11 what happens when you have recruiting problems and
12 make it difficult to offer positions to physicians
13 in the state is certain areas have shortages and
14 other areas don't.

15 The entities within Massachusetts that are
16 most likely to be able to offer part-time policies
17 or flexible job sharing are large academic medical
18 centers and large hospital corporations. And
19 smaller communities that don't have those types of
20 institutions are obtaining their medical malpractice
21 insurance from ProMutual and similar carriers, and
22 if they don't have the opportunity to have part-time
23 rates or flexible rates, it becomes difficult to
24 recruit physicians to those communities.

1 So that the distribution of physicians
2 within the state then becomes a little unbalanced,
3 and women in some parts of the state have very short
4 wait times to get appointments, and women in other
5 parts of the state are waiting four to five months,
6 and you will hear testimony from one of my
7 colleagues regarding that.

8 The last thing I would like to say is on
9 the subject of lawsuits. I believe we heard
10 testimony that 90 to 95 percent of the cases that
11 are actually tried in court are won by the
12 physician. It makes me think, well, if the Red Sox
13 won 90 to 95 percent of their games every year, we
14 would think there was something a little lopsided
15 about the competition.

16 And when the cases are such as he
17 presented, where 90 to 95 percent of the doctors are
18 winning, maybe it's because the majority of the
19 lawsuits that are coming forth shouldn't have come
20 forth, and some tort reform on what can actually
21 constitute a medical malpractice case might change
22 that, so that the courts wouldn't be spending so
23 much time on cases that shouldn't have gotten
24 anywhere to begin with.

1 Thank you for your time. I'm happy to
2 entertain any questions. This is the first time
3 I've ever testified as a hearing like, so I didn't
4 come with written testimony, but I would be happy to
5 submit that later if you require that.

6 PRESIDING OFFICER FARRINGTON: We don't
7 require it, and there will be a transcript. Just
8 since we have our stenographer here, I just would
9 like you to be sure that she has the spelling of
10 your name correctly.

11 DR. ASLAMI: I'll write it down for you.

12 PRESIDING OFFICER FARRINGTON: Thank you
13 very much for coming.

14 DR. COHN: Good morning, Madam Hearing
15 Officer. Thank you for allowing me to testify this
16 morning. My name is Dr. Gabriel Cohn, C-o-h-n, and
17 I am Chair of the Massachusetts Section of the
18 American College of Obstetricians and Gynecologists.

19 I appreciate the testimony of my colleague
20 and some of the earlier testimonies this morning. I
21 would like to focus in my testimony on the fact
22 that, while we may not perceive there to be an
23 insurance crisis, there is a crisis in health care,
24 which is immediate, and it is necessary for us to

1 address. And I would like to talk about the impact
2 that medical malpractice has had, not only on the
3 physicians and the obstetricians and gynecologists
4 within the state, but more importantly on the
5 patients we take care of.

6 In 2004 the Massachusetts Department of
7 Public Health surveyed obstetrical chiefs within the
8 state, and they surveyed about 50 OBGs, and
9 specifically they asked about the change of the
10 number of obstetricians between 2002 and 2004. What
11 they found was in western Massachusetts, and that's
12 the part of the state that I live in, 25 percent of
13 those hospitals lost 25 percent of obstetrical
14 providers -- excuse me. There was a decline of 25
15 percent of obstetrical providers within western
16 Massachusetts over a two-year period of time.

17 The most common reason cited by the OB/GYN
18 chiefs for that loss was difficulties recruiting and
19 retaining physicians, in large part because of the
20 cost of professional liability as well as the filing
21 of lawsuits. So that contributed significantly to
22 the significant decline in the number of OB/GYNs
23 that we have in western Mass.

24 This data is also complemented by data

1 provided by the Mass. Medical Society. The Mass.
2 Medical Society performs a yearly work force study.
3 And in 2007, again, they surveyed all the physicians
4 within the state, and they found that 69 percent of
5 OB/GYNs reported that their professional liability
6 rates increased. So while we've heard that there is
7 actually a decrease in the number of lawsuits, 69
8 percent reported an increase. Now, the average rate
9 of increase other the past year was 38 percent.

10 The cost of malpractice has actually
11 prompted about 60 percent of all OB/GYNs to consider
12 career changes, and in particular, some of the areas
13 that are affected include teaching hospitals. The
14 significance of teaching hospitals, of course, is to
15 not only be responsible for providing education to
16 our new and upcoming OB/GYNs, but they're also
17 oftentimes responsible for the care of the poor and
18 the neediest within our society.

19 In fact, teaching hospitals report that
20 among the highest vacancy rates within the various
21 departments include OB/GYN specialities, where that
22 represents -- where there's a vacancy rate of about
23 12 percent, or about one in eight positions remain
24 open.

1 Statewide there's been additional surveys
2 which, again, have found the same thing, that OB/GYN
3 specialty rates have vacancy rates of 12 percent,
4 and I believe that's performed by the Mass. Medical
5 Society, and this is independent of the physician
6 surveys performed.

7 Now, what does this all translate to in
8 terms of health care? Over the past year we've seen
9 that women who are trying to get a new patient
10 appointment have had an increase in their wait time
11 by about 30 percent. So whereas about a year ago it
12 took about 34 days to get a new appointment,
13 currently, on average, it takes 46 days. And if one
14 goes to Berkshire County, that rate is as high as
15 119 days, or four months. So from one-month to
16 four-month difference.

17 And I would like everyone in this room to
18 think about that the next time you see a Mark E.
19 Salomone commercial. If you were to call your
20 doctor for a new appointment at the time you see
21 that commercial, it would take a woman in Berkshire
22 County four months to be able to get to be seen by
23 an OB/GYN.

24 So there is a malpractice insurance crisis,

1 which impacts again patient access, and there are
2 some possible ways of at least beginning to address
3 some of these issues.

4 First of all, there are areas of physician
5 shortages as in western Massachusetts, as in the
6 underserved. We know that the perinatal mortality
7 rates, for example, in western Massachusetts among
8 African-American women is significantly higher than
9 it is in the eastern part of the state. So there
10 need to be adjustments in the rates that adjust to
11 the unique needs in areas of physician shortages.

12 As you heard in the prior testimony, there
13 are many specialists now who wish to work part time,
14 so there has to be an adjusted rate based on hours
15 of practice.

16 We really have to review how it is that
17 providers can receive or sign up for coverage. For
18 example, is there an option for private providers to
19 utilize hospital malpractice coverage or group
20 purchases, which currently is very limited in
21 western Massachusetts.

22 And, yes, we need to continue to work on
23 tort reform as well. We heard pro and con testimony
24 for joint and several. Well, one of the new

1 movements in terms of reducing patient injury, which
2 we're all in the business and we're all concerned
3 about, one of the new movements afoot is really to
4 provide teamwork. And this is based on the military
5 model, which shows that teamwork does reduce errors.

6 Well, if we continue to have joint and
7 several, it's very difficult to convince providers
8 to provide support for members of their team. So
9 this is really counter to movements shown to improve
10 the quality of health care for our patients and
11 reduce errors. So ultimately, if we're concerned
12 about providing care to patients and providing
13 quality care with a reduction in errors, we do need
14 to seriously look at joint and several.

15 There was a discussion earlier about
16 reducing exorbitant interest rates, and we certainly
17 endorse that as well. And finally the business
18 about expert witness. I don't know of anybody here
19 who would suggest that their wife, their daughter or
20 their sister go to a rheumatologist if they have a
21 high-risk pregnancy, and yet currently any expert --
22 any person claiming to be an expert, even if they
23 have no expertise in OB/GYN, can currently testify
24 in a OB/GYN malpractice case, and that makes no

1 sense. So we really need to require that expert
2 witnesses be board certified in the field in which
3 they're testifying.

4 I thank you very much, and I'm happy to
5 address any questions you might have.

6 PRESIDING OFFICER FARRINGTON: Thank you
7 very much. Is that a written copy of your testimony
8 you want to leave with us?

9 DR. COHN: I don't have a -- I'm sorry. I
10 apologize.

11 PRESIDING OFFICER FARRINGTON: Thank you,
12 Doctor.

13 Is there anybody else here this morning who
14 wishes to make a statement at this time?

15 (No response)

16 PRESIDING OFFICER FARRINGTON: I would just
17 remind you that there is a second hearing next
18 Wednesday in Worcester, and that the record in this
19 case, in this hearing, will remain open for a period
20 of time, so that if you wish to submit a written
21 statement, certainly within the next week, you may
22 certainly do so. Thank you all for coming.

23 (Whereupon the hearing was
24 adjourned at 11:28 a.m.)

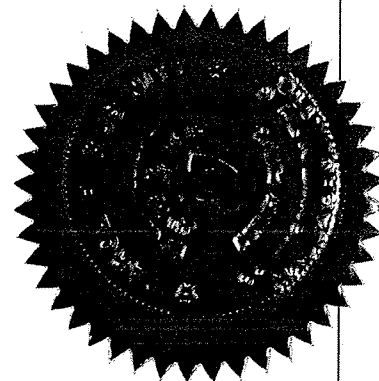
C E R T I F I C A T E

I, Carol H. Kusinitz, Registered
Professional Reporter, do hereby certify that the
foregoing transcript, Volume I, is a true and
accurate transcription of my stenographic notes
taken on October 3, 2008.

Carol H. Kusinitz

Carol H. Kusinitz

Registered Professional Reporter



OCT 22 2008

Volume II
Pages 2-1 to 2-43

COMMONWEALTH OF MASSACHUSETTS
OFFICE OF CONSUMER AFFAIRS AND BUSINESS REGULATION
DIVISION OF INSURANCE
DOCKET NO. M2008-01

HEARING: To receive oral and written statements that will assist the Commissioner of Insurance in conducting an investigation and study of the costs of medical malpractice insurance for health care providers, as defined in General Laws Chapter 175, Section 193U, held at the Division of Insurance, One South Station, Boston, Massachusetts, on Wednesday, October 8, 2008, commencing at 11:16 a.m.

BEFORE: Jean Farrington, Presiding Officer

* * * * *

Nancy M. Kingsbury,
Registered Professional Reporter

* * * * *

This image shows a single sheet of white paper with horizontal ruling lines. The lines are evenly spaced and run across the width of the page. There are no margins, text, or other markings on the paper.

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29	30	31				

I N D E XSPEAKER:PAGE

Joel D. Whitcraft,
Medical Protective

5

Matt Rearwin
www.erikslaws.com

30

Maryanne Bombaugh, M.D.
Massachusetts Section of the
American College of Obstetricians
and Gynecologists

37

* * *

P R O C E E D I N G S

1
2 PRESIDING OFFICER FARRINGTON: Good
3 morning. I want to welcome you all to the second
4 session of this informational hearing which the
5 Commissioner of Insurance is conducting as part of
6 her investigation and study of costs of medical
7 malpractice insurance for health care providers.
8 This is the study which was mandated by recent
9 legislation. The docket number for this proceeding
10 is M2008-01.

11 My name is Jean Farrington. I am the
12 presiding officer in this matter. We held our first
13 session last Friday in Boston, so this is the second
14 and last of the open hearings. The purpose of the
15 hearings, as stated in the hearing notice, is to
16 receive oral and written statements that will assist
17 in the examination and analysis of, among other
18 things, the availability and affordability of
19 medical malpractice insurance; the factors medical
20 malpractice insurers consider when increasing
21 premiums; options for decreasing premiums, including
22 but not limited to, establishing a reinsurance pool
23 with additional stop loss coverage, subsidizing
24 premium payments of providers practicing in certain

1 high-risk specialties or in specialties for which
2 the cost of premiums represents a disproportionately
3 high proportion of a health care provider's income,
4 subsidizing premium payments of providers who do not
5 qualify for full coverage rates and pay higher
6 premiums for commercial market insurance, and
7 prorating premiums for providers who practice less
8 than full-time; and, finally, funding mechanisms
9 that would facilitate the implementation of
10 recommendations arising out of the study which may
11 include, but not be limited to, charges borne by the
12 health care industry or other entities.

13 Three people had so far indicated that they
14 would like to make a statement today. If you have
15 not identified yourself as a speaker, do not worry.
16 You will have an opportunity.

17 Would the first person on the list please
18 come forward.

19 MR. WHITCRAFT: My name is Joel Whitcraft.
20 I'm vice president and actuary for the Medical
21 Protective Company. I am responsible for pricing
22 for the company for our medical malpractice
23 products.

24 The handout I have provided today will

1 serve as a guide for the comments that I am going to
2 be making regarding medical malpractice insurance
3 and hopefully will facilitate some of the discussion
4 points that I want to touch on.

5 PRESIDING OFFICER FARRINGTON: Can you hear
6 back there? Maybe you should come forward. It
7 might be easier.

8 MR. WHITCRAFT: What I'd like to do today
9 is touch on the points that were outlined in the
10 notice of the hearing which really dealt with the
11 availability of medical malpractice insurance,
12 affordability, factors influencing rate increases
13 and options for decreasing premiums. And I'd like
14 to start first with availability.

15 And really availability deals with the
16 interest that insurers take in writing a particular
17 line of business in a jurisdiction and what the
18 degree of, or what volume of, business they are
19 interested in writing. And as we look at a
20 particular jurisdiction, a company will typically
21 consider four primary factors. One is the current
22 market conditions, which can be described as market
23 concentration and competitiveness, also the
24 competitor's strength and weaknesses in considering

1 their own ability to write business in that
2 jurisdiction;

3 The capital constraints of that particular
4 company, its financial condition, the factors that
5 would influence its deployment of that capital;

6 The legal environment of that jurisdiction,
7 the current tort law as well as recent judicial
8 rulings;

9 And the regulatory environment that would
10 relate to the rating laws, related provisions, as
11 well as the oversight of rate adequacy and solvency.

12 First I'd like to touch on the availability
13 of in regards to market conditions. There is a
14 number of factors that can be examined. One is
15 illustrated on Page 5 of my handout, and that is the
16 Massachusetts market concentration.

17 This particular page separates medical
18 malpractice premiums into four categories which are
19 identified in the supplemental Schedule P of a
20 company's financial statements. And those four
21 segments are hospitals, physicians and surgeons,
22 other facilities, and other health care providers.
23 Each graph represents that particular segment of the
24 med-mal industry.

1 As an example, hospitals for 2007
2 represented \$118 million of written premium of which
3 it represented 39 percent of the total medical
4 malpractice market. The graph illustrates the
5 market share of the top five writers in that
6 particular segment of the industry. In total, there
7 are approximately nine insurers that are actively
8 doing business in Massachusetts, so that the first
9 five are represented on the chart; the remainder
10 represents the remaining four companies.

11 You can see that there is a very high
12 concentration within the first one or two writers.
13 In fact, the first writer of hospitals writes almost
14 80 percent of the market.

15 If you move over to physician's and
16 surgeons, you see that there is a similar pattern in
17 the graph in which the leading writer of physicians'
18 medical malpractice insurance writes slightly over
19 80 percent of the market.

20 The dispersion of premiums is somewhat
21 better for other facilities and other health care
22 providers, illustrating that the companies have
23 taken more interest in writing -- a more diverse
24 group of companies have taken an interest in writing

1 those particular segments of the business and for
2 some reason have taken a less active view for
3 hospitals and physicians and surgeons.

4 If you turn the page, another consideration
5 for an organization is its financial condition and
6 how it wants to deploy its capital. The financial
7 condition of an organization or its ability to write
8 business is often viewed in terms of its surplus and
9 in many cases is related as a function of
10 premium-to-surplus ratio, which is simply the
11 premium that it's writing divided by that surplus in
12 a given calendar year.

13 Direct premium to surplus represents that
14 company's leverage, if you will, and net premium to
15 surplus after reinsurance is that net leverage,
16 assuming that the reinsurers are able to absorb the
17 liability that they have contractually accepted.

18 A strict adherence to these ratios can
19 often be deceiving, as we see in these two charts to
20 the left. The first chart represents a number of
21 companies' direct premium-to-surplus ratio. The
22 graphs are a little odd in the sense that you can
23 see a dispersion of those lines anywhere from a
24 ratio of 0.5 up to as high as 3.5. The companies A

1 through E are companies that formerly wrote medical
2 malpractice insurance, and these are the ratios that
3 they were experiencing shortly before they either
4 withdrew from the market or became insolvent. The
5 red line that runs from 1993 through 2007 is a
6 contrast to those companies in that that is one of
7 the leading writers of medical malpractice insurance
8 in Massachusetts.

9 The point of the illustration is really to
10 demonstrate that the premium-to-surplus ratio in and
11 of itself does not describe a company's financial
12 position or its financial condition or its ability
13 to write business in a single jurisdiction or expand
14 into other jurisdictions. It's simply one measure.
15 This graph obviously illustrates that the leading
16 writer in Massachusetts is currently writing at
17 ratios similar to what some of the companies that
18 have since become insolvent were writing at.

19 Now, when a company is thinking about going
20 into a new jurisdiction or expanding its writing in
21 a particular jurisdiction, it's going to consider
22 how it's deploying its capital. That capital is
23 what supports its ability to write business and to
24 absorb the ups and downs of the financial

1 performance of that business. This illustration
2 hopefully provides some insight into how a company
3 might think about that. There is a number of other
4 factors that need to be considered above and beyond
5 just premium-to-surplus ratio, but obviously the
6 company itself has to consider how it's going to use
7 that surplus, what jurisdictions will it look at,
8 and how will it view those jurisdictions to decide
9 where is it best to deploy the capital. Obviously
10 competitiveness and market conditions are one.

11 The next, if you turn the page, is that
12 particular jurisdiction's legal environment. And
13 there is a number of factors that I have listed here
14 that a company might look at in terms of determining
15 how attractive a particular legal environment might
16 be for medical malpractice insurance, things such as
17 statute of limitation, joint and several liability,
18 vicarious liability, the expert testimony
19 requirements, damage caps, collateral source rule,
20 prejudgment and interest provisions.

21 There is a couple here I would like to
22 highlight simply because of particular nuances in
23 the state of Massachusetts. First is vicarious
24 liability, and this is further outlined in the

1 subsequent Page 8. There was a ruling by the
2 Supreme Court in Dias vs. Brigham in which it
3 extended vicarious liability to an employer or
4 medical group for any employed physician acting
5 whether or not that physician was under their strict
6 control and direction at the time the malpractice
7 occurred. Now, it's not to say that that particular
8 interpretation is substantially different or unusual
9 from another state. It's simply to point out that
10 that was something that changed in 2002, and as a
11 result, if you look down below, there is a statement
12 made by a leading writer in Massachusetts that they
13 noted in one of their rate filings that they
14 responded to this commencing with their July 1,
15 2003, rates by increasing the per
16 physician/dentist/nurse/midwife charge. In fact,
17 the charges for partnerships and corporations
18 increased by 50 to 100 percent; so the point being
19 that rulings such as those can have a significant
20 impact on the particular market or a particular
21 company's view of that market.

22 The second item that I wanted to point out
23 was damage caps. In this particular case, in the
24 state of Massachusetts there is a cap of \$500,000

1 for noneconomic damages, and a number of states have
2 caps similar to that. The caps range anywhere from
3 \$250,000 to as high as \$1 million. Some states have
4 no cap at all. In this particular case, though,
5 while the cap is \$500,000 -- and I have illustrated
6 some of the provisions of the cap for pain and
7 suffering and so forth -- that cap could be waived
8 if it's determined that there are other special
9 circumstances which warrant finding such limitation
10 would deprive the plaintiff of just compensation.
11 And what that means to an insurance carrier is that
12 there are a number of situations that are not
13 clearly defined that could result in a waiver of
14 that cap, which means that the expectation of
15 losses, the size of the losses, becomes less
16 predictable. So that again becomes another issue
17 for a carrier in determining how to deploy its
18 capital; whether to write in a particular
19 jurisdiction, what type of business to write, and
20 how much volume or how much premiums to write in
21 that particular jurisdiction.

22 If you skip over Page 8, there's another
23 Supreme Court ruling that came out in 2007 that
24 again modifies the potential liability for carriers.

1 In this particular case, it had to do with a
2 interpretation of what contemplates or what
3 constitutes informed consent by a physician
4 prescribing medications in the case of Coombes vs.
5 Florio. In and of itself the case does not seem
6 unusual or that substantially different from perhaps
7 the rulings in other states, but what it means is it
8 changes the exposure for companies writing medical
9 malpractice insurance in the state. And it brings
10 into question how will this decision influence the
11 delivery of health care and how will it affect
12 potential exposure to those writing medical
13 malpractice insurance.

14 So again, another factor that plays into
15 the determining how much should a carrier write in
16 the state, how predictable will the frequency of
17 claims and severity of claims be in that particular
18 jurisdiction. Those factors play into determination
19 of affordability of medical malpractice insurance.
20 One is the company estimates the decision that they
21 do want to write, and you get sufficient companies
22 making that decision.

23 The affordability really has to do with the
24 level of the rates relative to that particular

1 market. What I have provided here on Page 11 is a
2 comparison of Medical Protective's rates ranked
3 across the country, and have highlighted five states
4 in particular: Massachusetts, Maine, Connecticut,
5 New Hampshire and Rhode Island.

6 Now, the rankings go from highest on the
7 left to lowest on the right. So No. 1 would be the
8 highest rate for Medical Protective in the 45 states
9 that we do business. The further to the right that
10 particular rate goes the lower it is relative to the
11 other states.

12 So as an example, if we look at the very
13 bottom comparison for neurosurgery, we would see
14 that the highest rate is the white bar, which
15 represents Connecticut. If you look up, it
16 consistently tends to be the highest rate. The
17 bright blue, which goes out to approximately 35th
18 rank, is Maine, and it consistently tends to be the
19 lowest rate among these states. The red bar is
20 Massachusetts. It tends to be somewhere in the
21 tenth to twentieth position as far as highest rate
22 for Medical Protective. Relative to these five
23 states is probably -- obviously not the highest --
24 it is somewhat comparable to New Hampshire, although

1 those two states tend to alternate which one is
2 higher across the specialties.

3 You will find that companies view medical
4 classifications differently in terms of setting
5 their rate structures. That would influence the
6 magnitude of the rates relative to one state to
7 another.

8 If you turn the page, what I want to do is
9 spend just a moment taking a very simplistic view of
10 rate making for medical malpractice insurance.
11 There are really three primary components to the
12 rates: the cost of claims, company expenses and
13 profit and contingency load.

14 The cost of claims is represented by the
15 frequency of reported and paid claims and the
16 severity of losses and the severity of defense costs
17 for each claim.

18 Expenses can be categorized as variable,
19 which would represent commissions, premium tax,
20 other acquisition costs; and fixed expenses,
21 representing the operating overhead of the
22 organization.

23 The profit and contingencies represents a
24 provision for return on equity and a contingency for

1 variability of risk as well as an offset for the
2 investment income.

3 I want to pause for just a moment on that
4 particular provision because that's something that
5 is particular to each company. But it's important
6 to note that virtually every insurance company
7 recognizes this profit and contingency in two ways.
8 One is a profit lower or a rate of return that the
9 company wants to achieve, and in doing so, the
10 company recognizes the return on its investments.

11 When you look at this from a rate-making
12 perspective, the cost of claims is really -- it's a
13 prospective value, but it's based on historical
14 patterns and costs. When you are looking at
15 expenses, those are prospective costs. They may or
16 may not be based on historical values.

17 For example, a company that typically or
18 historically wrote on a direct basis may go into a
19 new jurisdiction and now write on an indirect basis
20 or through independent agents, in which case it will
21 now incur a commission, where in the past it had no
22 commission in its expenses.

23 The profit and contingency load is a
24 prospective value. Often there is an accusation, if

1 you will, that insurance companies are recouping
2 investment losses from prior years in the
3 rate-making prospectively. And really if you look
4 at the mechanism or the methods that are used,
5 that's virtually impossible to do, because
6 prospectively what an insurance company is doing is
7 anticipating what the return on the investment for
8 the reserves and the earned premium will be in the
9 future. And that's going to be a particular value,
10 such as 4 percent. So by applying that 4 percent to
11 those particular reserves, they then provide an
12 offset to some of the costs for the claims and
13 allocated expenses.

14 That offset is a positive value. It's not
15 a -- as some might allude without actually saying
16 it, they almost imply that it's a negative value,
17 something being added into the rate to capture
18 perhaps capital losses from prior periods. The
19 summation of those things represents the rate. The
20 rate recognizes various characteristics for medical
21 specialties in geographic distinctions. It's also
22 intended to recognize other coverage distinctions
23 such as the policy type, the policy limit.

24 Now, the factors that are influencing rate

1 increases, or really the rate level, can really be
2 highlighted in two ways. If you look at Page 14, I
3 kind of give you a sample of rate-making components.
4 In this pie chart, we can see obviously that the two
5 largest components of the rate are the indemnity or
6 the losses that are paid on behalf of the health
7 care providers, and the other part is loss
8 adjustment expenses. And this component represents
9 the allocated loss adjustment expenses that a
10 company pays through to its defense attorneys, and
11 there is also a component referred to as unallocated
12 loss adjustment expenses, which is the cost
13 internally to the company to manage those claims.
14 Typically the vast majority of the loss adjustment
15 expense is the allocated expense or that fee paid to
16 its defense attorneys.

17 One of the largest components obviously,
18 though, is the indemnity. And what I would like to
19 do, if you turn the page, is speak to some of the
20 factors that will influence the indemnity. It's
21 obviously the largest component. And in evaluating
22 it, there are many challenges for medical
23 malpractice insurance because typically most
24 jurisdictions do not have a large number of writers

1 in the state and there is typically not a one
2 particular source of data for medical malpractice
3 claims in a state.

4 We had to look at external sources. In
5 this particular case, we might look at the National
6 Practitioner Data Bank, which is a federal data
7 source that all insurers report to. We would look
8 at competitors' rate filings to try to assess their
9 evaluation of loss costs. And in some situations
10 where the data is available, we will look to the
11 state data calls or similar aggregate data. The
12 rate level that a company is able to set in a
13 particular jurisdiction is accuracy, and hopefully
14 it's reasonableness. It's got to be influenced by
15 the quality and the quantity of data that the
16 company has at hand.

17 If you turn the page, this graph represents
18 the physicians and surgeons paid claims based on
19 National Practitioner Data Bank information. The
20 data is organized in terms of close year or the year
21 in which the claim was paid. And on the left-hand
22 side, that axis represents the volume of paid claims
23 that are closed in each particular year. The green
24 bar is that volume you can see that generally runs

1 between 200 and 300 claims per year. The blue line
2 is the actual paid claim severity or indemnity that
3 has been paid on behalf of health care providers.

4 Now, these losses have been capped at
5 \$1 million per payment, so that's to be able to
6 compare them with other jurisdictions and also be
7 able to use the data appropriately. You see the
8 red, line which represents a trend line based on the
9 actual data that we have observed from the National
10 Practitioner Data Bank. You can see the severities
11 have moved from approximately \$225,000 in 1994 to
12 \$450,000 in 2007. The trends range anywhere from 4
13 percent to as high as 7 percent, depending on what
14 periods of time you observe.

15 If you turn the page, what we have done is
16 we have aggregated six states in the Northeast
17 region of the United States, those states of
18 Connecticut, New Hampshire, Maine, Massachusetts,
19 Rhode Island and Vermont, and we created the same
20 type of chart. You can see now that claim counts or
21 paid counts generally run somewhere between 500 and
22 600 claims for this aggregate group of states. The
23 severity runs from approximately \$250,000 up to
24 \$400,000 by 2007. So it's running at a slightly

1 lower trend than that of Massachusetts, and the
2 absolute values are running a little bit less than
3 Massachusetts.

4 If you turn the page further to 18, we
5 created a similar chart for the countrywide less
6 Massachusetts. Again, you can see that there is a
7 much more substantial volume. And against
8 severities, though, there are substantially lower
9 than what we have seen in the Northeast or in
10 Massachusetts. The severities are running anywhere
11 from about \$175,000 up to just under \$300,000 by
12 2007.

13 The other thing that's interesting to note
14 here is that while the number of paid claims
15 generally ran between 12,000 to 14,000 up until
16 about 2001 to 2002, by 2003 onward the volume of
17 paid claims began to drop fairly substantially to
18 the point where it's down to about 10,000 in 2007 on
19 a countrywide basis. We have seen this similar
20 pattern in a number of states, some where tort
21 reform had been passed and there were some obvious
22 changes in the legal environment there. Others
23 there were not substantial reforms, yet we still saw
24 noticeable decreases in paid claims. We have not

1 seen that similar pattern in Massachusetts or really
2 in the Northeast states up to this point.

3 Page 19 gives you a representation of
4 Massachusetts relative to the Northeast states and
5 to countrywide. We are simply indexing these,
6 taking them as a ratio of the Massachusetts severity
7 to the Northeast severity in the blue line and
8 Massachusetts countrywide in the red line. You can
9 see in the blue line, Massachusetts from time to
10 time is running a bit higher than the Northeast
11 states, generally somewhere in the 5 to 15 percent
12 range. And for Massachusetts relative to
13 countrywide typically is running anywhere from 25 to
14 50 percent higher than the countrywide average.

15 Again, these are things that a company
16 would consider in terms of evaluating the indemnity
17 portion of the rate, trying to look at values,
18 trends, what would it anticipate in terms of loss
19 costs going into the future to set the rate.

20 If you turn one more page, this provides
21 another view of another factor that would also be
22 considered in evaluating indemnity. This particular
23 graph is looking at a segment of National
24 Practitioner Data Bank claims. These are claims

1 that are greater than \$1 million. And on the
2 left-hand side we have a frequency or percentage.
3 That is the ratio of claims that were closed greater
4 than \$1 million to all claims paid in that year. So
5 in 1994, 3 percent of all paid claims were greater
6 than \$1 million dollars.

7 If you look at that pattern across there,
8 those green bars are not universally growing but
9 pretty steadily growing from 3 percent to a high in
10 2007 of 10 percent. At the same time, the red line
11 represents the severity of the losses greater than
12 \$1 million. You can see while that line is somewhat
13 volatile, generally it is running between \$1.5
14 million and \$2.5 million.

15 The increase in the frequency would be
16 something that a company would be concerned about in
17 terms of trying to estimate the volatility of loss,
18 the severity of the loss that they would anticipate
19 for its insureds and would be a factor in its
20 determination of trying to set rates. The more
21 volatile a particular jurisdiction can be, the
22 greater the concern; and certainly the greater the
23 difficulty in predicting what the indemnity portion
24 of the claims will be. And that indemnity portion

1 can also influence the allocated loss adjustment
2 expenses or those dollars that are being spent to
3 defend those claims..

4 Page 21 provides really just kind of an
5 outline of factors that would be considered in
6 determining what might influence rate increases. On
7 the indemnity side, inflationary pressure and
8 medical costs and wages, which ultimately become
9 components of the damages; volatility of those
10 losses, which influences the predictability of
11 indemnity; the changes in the frequency of the paid
12 claims; if there is a particular court ruling or
13 statutory change that would either expand liability,
14 potential liability or reduce it, that could have an
15 impact on the number of paid claims; obviously
16 legislative changes and any other rulings; also the
17 quality and the quantity of the data is going to
18 influence a company's ability to evaluate and
19 project indemnity costs.

20 On the loss adjustment expense side,
21 obviously the legal environment, the process and the
22 time involved in resolving cases, will have an
23 impact on the costs. Obviously the longer it takes
24 for a case to be resolved, the greater the defense

1 costs to resolve that case. The expertise and the
2 experience of the defense attorneys will also have
3 an influence on those costs, as well as any changes
4 in the frequency of reporting claims.

5 Now, in this particular case, I am making
6 the distinction between a claim that is reported to
7 a company versus a claim that is paid. In many
8 cases, we have the claims that are reported to the
9 company that ultimately resolve in the health care
10 provider's favor; but yet there is substantial
11 allocated or defense costs incurred by the insurance
12 company. In many cases -- most of the
13 jurisdictions, for example -- Medical Protective
14 participates in the ratio of paid claims to total
15 reporting claims is generally about 25 percent,
16 which means that 75 percent of the cases that we
17 handle are resolved in the health care provider's
18 favor, but we incur substantial allocated loss
19 adjustment expense dollars to resolve those cases.

20 If you turn the page, we put together a
21 brief outline of some considerations for ways in
22 which premiums could be decreased. There are
23 obviously the one option most direct and specific is
24 subsidization of rates. New Jersey, as an example,

1 provides subsidies for high-risk classifications,
2 such as OB/GYNs and emergency medicine physicians.
3 Maryland, their legislature created a rate subsidy
4 plan which was available to all insurers. That plan
5 will be expiring the end of this year, but for the
6 last three years I believe it has provided subsidies
7 for all health care providers.

8 Another option is comprehensive tort
9 reform. I use the word "comprehensive" specifically
10 because often tort reform has been approached as a
11 way to kind of dissect issues, and I think what's
12 lost in many of the arguments is that tort reform
13 really is a comprehensive approach to the particular
14 legal environment and the issues that address that
15 particular state. Reform similar to MICRA is
16 something I would characterize as a comprehensive
17 tort reform because it addresses a number of issues.
18 Texas is a good example.

19 If you will please make a note, I reference
20 "Texas reforms 2005." It should have been "2003."
21 It provides us some insight into how tort reform
22 could be structured and also how it can address
23 particular issues in a jurisdiction and what its
24 benefits might be.

1 Just to highlight a couple things, the
2 Texas reforms included a constitutionally guaranteed
3 cap on noneconomic damages to \$250,000. They
4 modified expert witness testimony requirements.
5 They also modified venue requirements or what we
6 simply call venue reform. And since 2003, Medical
7 Protective, as well as other carriers in the state,
8 have reduced rates approximately 27 percent in that
9 period of time.

10 Now, a third option is a compensation fund.
11 A number of states currently employ these types of
12 funds. Examples would be Indiana, Kansas,
13 Wisconsin, Louisiana, New Mexico. Each has its own
14 unique characteristics. Essentially the
15 compensation funds provide coverage excess of some
16 defined primary limit. For example, in Indiana, its
17 primary limit is \$250,000; in Wisconsin, it's
18 \$1 million; in Louisiana it's currently \$100,000 but
19 their legislature is considering changing that and
20 increasing the primary limit. A fund would be
21 created to provide liability excess of that primary
22 limit, so it would provide some predetermined
23 coverage for a particular layer of insurance, access
24 to that primary limit.

1 Now, the effect of a fund is less obvious
2 and less direct in the sense that the fund can
3 provide coverage for a layer that insurance
4 companies may view as being significantly volatile,
5 difficult to predict, less desirable to write, and
6 so the fund accepts that volatility in that
7 particular layer. Perhaps it subsidizes the cost of
8 covering the layer, and it would in a sense do this
9 with no profit motive in mind, whereas insurance
10 companies typically have, whether it's a direct
11 profit motive or simply they have to generate some
12 retained earnings to put back into surplus to
13 support writings as they go forward and to be able
14 to have sufficient surplus to recognize inflationary
15 pressures on premiums. The fund would be there
16 simply to step in as an alternate or alternative to
17 the standard voluntary market, and in some cases the
18 funds operate totally independently of the primary
19 markets.

20 In other cases, the primary market is
21 involved in some of the administration of that
22 process. Wisconsin is a good example where the fund
23 provides coverage access of \$1 million. It makes
24 its own determination as to how it would adjudicate

1 claims. The underlying carrier makes the
2 determination as to whether they will defend the
3 case. They will accept the fact or accept liability
4 for the first million, and then it's up to the fund
5 to make its own determination. Other states have
6 determined that the fund will simply negotiate or
7 adjudicate with the plaintiff to determine
8 liability, the dollar value of liability rather than
9 trying to adjudicate the actual liability to the
10 health care provider himself, whether malpractice
11 actually occurred or not.

12 So there are distinctions as to how this
13 fund will function, and it's debatable as to whether
14 or not that particular mechanism has the ability to
15 lower rates. It's going to really depend on the
16 unique characteristics of each jurisdiction.
17 Hopefully what I have described provides some
18 insight into how I think companies would look at a
19 malpractice market.

20 Some specifics to the state of
21 Massachusetts: Medical Protective is an active
22 writer in the state of Massachusetts. We recognize
23 that each state has its own unique characteristics,
24 its own unique challenges, and we continue to really

1 do everything we can to address those challenges and
2 to continue to be a solution for health care
3 providers in each of the states in which we are
4 operating.

5 PRESIDING OFFICER FARRINGTON: Thank you
6 very much. I have one very technical question for
7 you. On Page 23 you refer to reform similar to
8 MICRA. So if you could just explain the acronym.

9 MR. WHITCRAFT: I am sorry. MICRA is the
10 tort reform law that was passed in California.

11 PRESIDING OFFICER FARRINGTON: Oh.

12 MR. WHITCRAFT: So to be honest with you, I
13 have used MICRA for so long I don't know if I
14 remember all the references.

15 PRESIDING OFFICER FARRINGTON: That's fine.
16 You have given us -- I think we can could find it.
17 Thank you very much.

18 MR. WHITCRAFT: Sure. Any other questions?

19 PRESIDING OFFICER FARRINGTON: No. Thank
20 you very much. Thank you.

21 MR. REARWIN: Good morning, Ms. Farrington.
22 Thank you for the opportunity to speak before the
23 hearing. We are here today because of my state
24 senator, Moore of Sutton, was the principal author

1 of Chapter 305 of the Acts of 2008, which indicated
2 that this hearing should be held.

3 I became passionate about the medical
4 malpractice issue because of what was done to my
5 son. It is my belief the laws of the Commonwealth
6 encourage some forms of medical malpractice, and I
7 would like to address two specific state laws which
8 are, I believe, causing that to happen.

9 As part of the big picture of why I am
10 here, part of the instructions of the legislature is
11 that this hearing feed on a deliberative process by
12 way of recommendations are made back to the
13 legislature. I have some information from the
14 Supreme Judicial Court rulings on certain cases that
15 are made to the SJC whereby they are saying if the
16 legislature wants changes to be made, they should be
17 sure the legislature would address. I really wish
18 that had happened in the last legislative session,
19 but I am very happy that they are tasking a state
20 agency with making recommendations for what should
21 be done.

22 I believe that what is in the state law is
23 often counterproductive to both the good health care
24 of the children of the Commonwealth, to the doctors

1 within the hospitals, and also to the medical
2 malpractice insurers themselves. What has happened
3 is, I believe, that there has been a transference of
4 costs because of the way certain aspects of the
5 health care system are run instead of to, from the
6 doctors making various mistakes in the course of
7 care, to the medical insurance companies for the
8 families involved, to the state legislature itself
9 by addressing additional care needs for the children
10 that are harmed, and I really hope that we can look
11 at more about what has happened and what we can do
12 to change things.

13 Every day my family pays a price for what
14 has happened, and I know many families that do also
15 because of the malpractice. There are kids with
16 crippled arms, kids with intestines taken out, kids
17 that are deaf like my son, kids with needless
18 invasive procedures done, kids that are blinded. I
19 know of one case that made it to the SJC where a kid
20 was left in a vegetative state and the parents have
21 no recourse. There are kids have been killed.

22 Part of what is ongoing here is a statute
23 of repose law which was passed in 1986, which has
24 given more of a shield to the medical community.

1 This indicates that for a child under the age of 9,
2 there is a seven-year time limit upon which legal
3 proceedings can commence upon -- after the date of
4 an incident.. In cases like my son and many other
5 children in the Commonwealth, the fact of what was
6 done was not determined at the time of the incident.
7 So another reason why I like the Acts of 2008,
8 Chapter 305, in that there is never a required
9 reporting procedure for medical errors to occur with
10 the risk of loss of license and daily fines for what
11 was done in cases like mine and other families.

12 There is also a charitable exemption law,
13 which is rooted in SJC rulings from 1876 and a law
14 passed in 1971 which was championed by Governor
15 Sargent presumably to benefit or protect leaders of
16 charitable organizations who are taking vows of
17 poverty. I won't go read word by word what the
18 statute of repose or the charitable exemption law
19 is, but there is information in the documents here
20 that give that fact, to give more about that.

21 Basically to summarize, though, if doctors
22 hide the facts for seven years, they are in the
23 clear.. In the case of my son, I had gone through a
24 series of doctors, 40 of them all allied with the

1 same medical institution. None of them brought
2 forth the fact that my son had been treated with a
3 drug that the drug should have its blood serum
4 levels monitored with each dose and that they were
5 not monitored at all. A lot of the tests that
6 should have been done weren't done, as a result of
7 the use of gentamicin were not done at all, and the
8 records are missing.

9 In the case of the charitable exemption,
10 the state has a \$20,000 limit on the judgment which
11 can be levied against a person or an institution if
12 they are organized as a charity. Right now some of
13 the largest businesses in the state of Massachusetts
14 are organized as charities in the medical care
15 system. If you are to look at what it would cost a
16 CEO for one of these organizations if he were to be
17 found on the wrong side of a \$20,000 judgment, it
18 would be roughly three days' pay. In cases of when
19 there is unethical behavior found, it's usually
20 after the time in which the state Board of
21 Registration in Medicine would do anything. The
22 licensing or agency for the hospitals would not do
23 anything. In the case of my son, the state picks up
24 the tab. My son's special education is costing the

1 Commonwealth over \$100,000 a year. I could start
2 naming names of other kids who this has happened to
3 as well.

4 Part of what is interesting about this is
5 how Massachusetts differs from other states.
6 Basically, if my son had been born in 43 different
7 states, I'd have at least a day in court to address
8 what was done to him. Massachusetts is very unique
9 with this type of statute of repose. Virtually
10 every other state has what is called a statute of
11 limitations, upon which after discovery of an
12 incident, a parent can have two or three years to
13 address it.

14 I just would like to talk a little bit
15 about the nature of the charities in this state.
16 Take here in Worcester, the UMass Memorial Health
17 Care system. I really don't think it was to protect
18 someone making \$2 million a year as CEO is what
19 Governor Sargent had in mind. We have got -- the
20 vice president of the organization, Wendy Warring,
21 came to her position after working as a state
22 Medicare director. She is doing well at 700 K a
23 year. The organization also has got \$100 million in
24 an account in the Grand Caymans. That is found in

1 their filings. I don't think that's really what the
2 legislature had in mind when they provided a
3 charitable immunity in 1971. I am just really upset
4 to think that if I had lived in other states or if
5 my son had been born to 90 percent of the other
6 fathers in this country, he would have had a chance
7 at getting the care due to him rather than being
8 continually directed on a course of invasive
9 procedures, sedations, biopsies, which were totally
10 irrelevant to his eventual course of care.

11 And I will tell you for the insurance
12 companies involved and family insurance, this
13 situation is definitely not benefitting them, and I
14 don't see how it benefits medical malpractice
15 insurance companies either. We have a code of
16 silence among medical communities. This hurts kids,
17 and it sure doesn't do anything good to keep the
18 rates of medical malpractice, down.

19 What concerns me about the charitable
20 exemption and the limitation of \$20,000 is that the
21 CEO of medical organizations is in the best position
22 to make positive changes to their operating
23 environment to make sure that there are checks and
24 balances in place; to make sure that the particular

1 drug is used, that the parents were informed of it;
2 that the particular drug that's used's side effects,
3 that tests need to be done to make sure that
4 overdose does not occur; that those procedures are
5 in place. I really think that the laws that are on
6 the books are counterproductive and don't help the
7 insurance companies or the Commonwealth.

8 In the remaining pages, I do have some
9 anecdotal evidence and quotes from the Supreme
10 Judicial Court as to what they would like to see the
11 legislature do. The SJC says it is not their point
12 to change laws no matter how distasteful they find
13 them, but they would like to have the legislature
14 address them. I am hoping that this center for
15 hearings the legislature mandated the Division of
16 Insurance to take on is the first step towards that.
17 Thank you.

18 PRESIDING OFFICER FARRINGTON: Thank you
19 very much.

20 MR. REARWIN: Thank you.

21 DR. BOMBAUGH: Good morning. I'm Maryanne.
22 Thank you for having me speak this morning. I
23 appreciate it.

24 I am Maryanne Bombaugh. I am an

1 obstetrician/gynecologist, and I am coming as a
2 representative from Mass. ACOG, the Massachusetts
3 section of the American College of Obstetricians and
4 Gynecologists, to give follow-up testimony that was
5 presented last week at the hearing.

6 We are very, very concerned with
7 professional liability insurance and its impact on
8 practices, physicians and as well as patients. It
9 was brought up in past testimony that there was no
10 crisis at the present time, that we don't really
11 need any changes because we aren't in crisis.
12 Perhaps we are not in crisis, but we certainly are
13 heading in that direction, specifically in
14 obstetrics and gynecology. That's what I would like
15 to speak to today.

16 We need to try to act proactively if we
17 can, if it's possible. Our big concern is with
18 access to care, and by this it means that patients
19 have physicians in OB/GYN and that there are enough
20 OB/GYNs to safely provide care to patients. The
21 Department of Public Health and the MS data have
22 shown that liability insurance rates have resulted
23 in significant decreases in the number of OB/GYNs in
24 the state, specifically in the western part of the

1 state where to the point that patients have really
2 no access at times to an obstetrician if they need
3 it for their prenatal care. Teaching programs are
4 being affected. There are vacancies in teaching
5 programs as we also are not therefore able to train
6 physicians to subsequently come from these programs
7 to take care of patients. So this is a large
8 concern.

9 Also it's very difficult in the private
10 practices to recruit physicians to come and stay in
11 Massachusetts because of the volatility of the
12 climate as well. We don't have enough doctors. We
13 can't take care of patients well, and I think that
14 is a concern that we all have.

15 In terms of access with reference to
16 continuing to practice, the physicians also have
17 financial responsibility as business people, so to
18 speak. And right now as an obstetrician, up to 40
19 percent of one's income is going towards
20 professional liability insurance. That can vary, of
21 course. No one has the same rates, but it's
22 disproportionately high compared to other
23 specialties. It is a concern we have.

24 We often back up other specialties. For

1 example, family practitioners who might do
2 obstetrics or midwives, they might back them up as
3 well so far as providing care should they come into
4 a situation that they need help with handing in
5 general. But it's our -- ultimately it's our
6 policy, if there is any untoward event, that is
7 looked at.

8 So again, we are just asking that perhaps
9 look at more proportionally sharing the costs of
10 this malpractice across the specialty arenas.

11 There are also extensive tails as well,
12 which I think has been brought up in past testimony.
13 What we are asking is consideration that, one,
14 perhaps rates be more proportionally shared across
15 the specialty; that, two, that we explore part-time
16 practice options. This is very important.
17 Sometimes there may be insurers who do not provide
18 that or provide adequately.

19 More and more women are going into the
20 field of obstetrics and gynecology. Women have
21 families. They want that work part-time, at least
22 for certain parts of their career. If you don't
23 have that option there with the insurers, it becomes
24 onerous and you can't practice if you have to

1 continually full policy when you are practicing
2 part-time.

3 Also there are newer models as well of
4 practices coming into place, such as the laborist
5 model where an obstetrician-gynecologist, perhaps
6 for six months or a year, will solely do obstetrics
7 with minimal gynecology. It's a field that is in
8 evolution right now where an
9 obstetrician-gynecologist may primarily stay in the
10 office and have a laborist do births at the
11 hospital. This needs to be taken into account
12 because it certainly could present opportunities to
13 be creative with how we write policies. For
14 example, with automobile you can do that. You can
15 take your auto out for six months of the year and
16 put it back on if you need to. Perhaps we should
17 try to be flexible in the types of policies we can
18 offer in this specialty because of a need there.

19 Also to the look at the gynecology
20 practices if a gynecologist helps with C-section,
21 just helps with a C-section, they can be put in an
22 entirely different category with reference to their
23 premium. I think again how can we work this such
24 that this could be just assisting at surgery versus

1 creating a whole new category for cost here.

2 Then fifth, as I mentioned before, that we
3 do hope that the legislature will look towards as
4 practice, that is, as medicine evolves, look towards
5 changing laws that need to be changed just to remain
6 current for the protection of the patients as well
7 as to hopefully encourage access to care by having
8 adequate physician representation in the state.

9 Thank you.

10 PRESIDING OFFICER FARRINGTON: Thank you
11 very much. Do you have the names of everybody who
12 has testified?

13 Is there anybody else here who wishes to
14 make a statement at this time? All right. Having
15 no response, we will close this session in which we
16 have taken oral statements. The record will remain
17 open until October 15. That's a week from today.
18 If anybody wishes to submit written testimony, or if
19 you know of anybody else who wishes to make, file a
20 written statement. Thank you all very much.

21 (Whereupon, the public hearing was
22 adjourned at 12:12 p.m.)

23

24

C E R T I F I C A T E

I, Nancy M. Kingsbury, Registered
Professional Reporter, do hereby certify that the
foregoing transcript, Volume II, is a true and
accurate transcription of my stenographic notes
taken on October 8, 2008.

Nancy M. Kingsbury

Nancy M. Kingsbury

Registered Professional Reporter

