

**FLORIDA'S MEDICAL MALPRACTICE INSURANCE CRISIS:
AN EXAMINATION OF STRATEGIC PUBLIC POLICY ISSUES**

A POLICY ANALYSIS RESEARCH REPORT

of The Florida Center for Public Policy and Leadership
at the University of North Florida

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PREFACE

The Florida Center for Public Policy and Leadership at the University of North Florida is an interdisciplinary public policy research and leadership enterprise. Founded in 2001, it has been charged by the State of Florida to search for answers to some of the most significant public policy issues and challenges confronting the State of Florida and the First Coast region.

Consistent with this mandate, The Florida Center conducts research on both emerging and persistent problems that require effective public sector responses and seeks to identify and assess the potential impact of pursuing alternative responses that might address those problems. It also provides a neutral forum for discussion, debate and deliberation that enhances leadership capacity and development across a wide array of political, institutional and educational sectors.

In the conduct of its research activities, The Florida Center draws heavily upon four essential resources. The most important of these is the deep intellectual capital and strong analytical skills available in its cadre of Faculty Fellows and research staff. To take advantage of the breadth of experience and knowledge brought to the Center's policy analysis efforts by these scholar/practitioners, research panels of multiple Fellows and research staff conduct Center research projects.

Second, Center researchers are able to draw upon the extensive research resources available at the University of North Florida and the member institutions of the State University System of Florida. To supplement these assets, The Florida Center has established a comprehensive Data Warehouse containing extensive national, state and local level data that facilitate high-quality quantitative analysis.

Third, The Florida Center has created a Geographic Information Systems Laboratory to support and facilitate its analytical research activities. In addition to a statewide reference GIS database, the Laboratory also has specific databases to support on-going Center research in multiple policy study areas.

Finally, The Florida Center has created a Public Opinion Research Laboratory to conduct high quality survey research through which the voice of the public can become a more powerful factor in shaping public policy decisions.

This POLICY ANALYSIS RESEARCH REPORT reflects The Florida Center's commitment to conduct research on significant problems that require effective public sector responses. It has been prepared with a strong commitment to both objectivity and comprehensiveness in the search for data that will assist policymakers in developing strategies to address Florida's medical malpractice insurance crisis.

This study is the first of several in The Center's Medical Malpractice Study Project. A second Project study initiative is currently being conducted under the leadership of Visiting Center Fellow and Florida State University law professor Talbot "Sandy" D'Alemberte. That study effort focuses on a national review and comparative analysis of medical malpractice legislation and constitutional amendments in the 50 states. A third study, led by Center Fellow and University of North Florida political science professor Terry Bowen, will focus on the challenges of policing the medical profession based upon experiences in Florida and other states that have sought to address malpractice issues.

The authors acknowledge, with particular appreciation, the assistance of several Florida Center research staff in this study effort, including Sarah Vaughn, Jill Bauer, Tim Cheney, Sue Downs and Lucy Hamilton-Duncan. We also appreciate the efforts of the Creative Services staff, John Johnson and Francesca Blanco, for the production of this report.

TABLE OF CONTENTS

	Page
PREFACE	i
FIGURES	iv
EXECUTIVE SUMMARY	
CHAPTER ONE INTRODUCTION	
The Issue and Conflicting Perspectives	1
The Medical Malpractice Insurance Crisis: A Conceptual Framework	2
CHAPTER TWO METHODOLOGY	
Analytical Approach	6
Data Sources	6
Definitions	7
Legal Issues	8
CHAPTER THREE THE CALIFORNIA REFORM STRATEGY	
MICRA (Medical Injury Compensation Reform Act)	9
Proposition 103: An Insurance Reform Initiative	10
Important Insights from the California Experience	11
CHAPTER FOUR THE FLORIDA MEDICAL MALPRACTICE CRISIS	
Historical Overview	12
Limits on Medical Negligence Payments	13
Medical Malpractice in Florida: Court Cases	14
Successfully Defended Cases	17
Medical Malpractice in Florida: Closed Claims Cases	20
Medical Malpractice Payments in Florida	26
Distribution of Closed Claims Cases by Payment Amounts	28
CHAPTER FIVE REGULATING THE INSURANCE INDUSTRY	
Non-Economic Caps and Insurance Rates	29
How Healthy Are Florida Medical Malpractice Insurers?	30
The Potential for Abuse as Caps are Applied	34
CHAPTER SIX POLICING THE PROFESSION	
Enhancing Medical Practice in Florida	36
The Quality of Medical Care in Florida	37
Is There a Case for Greater Shared Risk?	42

CHAPTER SEVEN	CONCLUSION	
	The Issues in Perspective	43
	Capping Non-Economic Judgments:	
	Summary Facts	43
	Regulating the Insurance Industry:	
	Summary Facts	45
	Policing the Profession: Summary Facts	47
	Other Factors for Consideration	48
	Constitutional Considerations	48
	The Limitations of Fixed Dollar Caps	49
	The Need for a Systemic Approach	49
APPENDIX		
	About The Authors	50

FIGURES

	Page
Figure 1	Influence of the External Environment on Quality.....2
Figure 2	Access to Quality Medical Care vs. Cost of Medical Malpractice Premiums4
Figure 3	Bringing Balance to the Medical Malpractice Crisis in Florida5
Figure 4	California Medical Malpractice Aggregate Premiums 1976-2001 (Adjusted for Inflation)9
Figure 5	California Malpractice Defense Costs vs. Malpractice Payments11
Figure 6	Medical Malpractice Cases, by Result All Cases, 1998-2002.....14
Figure 7	Total Number of Non-Economic Medical Malpractice Awards, by Specialty, 1998-200216
Figure 8	Percentage of Cases Successfully Defended Medical Malpractice Suits County, 1998-200217
Figure 9	Count of Total Medical Malpractice Cases, by County, 1998-200218
Figure 10	Count of Total Successful Defenses, Medical Malpractice Suits, by County, 1998-200218
Figure 11	Count of Non-Economic Medical Malpractice Awards 5-year Total, by Amount of Award, 1998-200219
Figure 12	Number of Medical Malpractice Closed Claims Cases per County, Total for Period 1991-200220
Figure 13	Count of Total Medical Malpractice Closed Claims cases by County, 1991-200221
Figure 14	Medical Malpractice Closed Claims, Average Claim Amount, by County, 1991-200222
Figure 15	Medical Malpractice Closed Claims, Average Claim Amount by County, 1991-2002 (graphic representation of data in Fig. 14)23
Figure 16	Professional Liability Closed Claims, 1991-200224
Figure 17	Professional Liability Closed Claims by Amount of Claim, 1991-200225
Figure 18	Florida Medical Malpractice Payments, 1991-200226

Figure 19	Florida Medical Malpractice Payments, 1991-2002 (Adjusted for Inflation, 2002 Dollars)	27
Figure 20	Distribution of Closed Claim Cases, Selected Types, 1991- 2002	28
Figure 21	Cumulative Distribution Closed Claims Cases Payments, 1991-2002	28
Figure 22	Florida Medical Malpractice Premiums Earned, 1991-2001	30
Figure 23	Florida Medical Malpractice Premiums Earned, Amount for Payments and Excess, 1991-2001	31
Figure 24	Florida Medial Malpractice Premiums in Excess of Malpractice Payments, 1991-2001	32
Figure 25	Florida Medical Malpractice Premiums in Excess of Payments as a Percent of Premiums, 1991-2001	33
Figure 26	Florida Medical Malpractice Insurance Payments vs. Incurred Losses, 1991-2001	34
Figure 27	Florida Medical Malpractice Cases per Practitioner, September 1, 1990 thru September 30, 2002	38
Figure 28	Florida Medical Malpractice Acts with 200 or more Cases, 1991-2002	40
Figure 29	Chances of Having One or More Malpractice Claims Exceeding \$250,000 Increases with the Total Number of Claims Paid per Practitioner	41

EXECUTIVE SUMMARY

In states throughout the nation, a medical malpractice insurance crisis has become increasingly prevalent and Florida is no exception to this growing trend. The critical public policy issue examined in this study is: How can Florida ease the medical malpractice insurance premium challenges confronting its healthcare delivery system?

There is considerable lack of agreement on the cause of the current crisis. Depending on whom you ask, the cause of the crisis will likely be either insurance companies, the legal system, the investment market, clinicians and institutions with a history of committing malpractice acts or some combination of the four.

This report presents empirical information to help the reader better understand the broad issues surrounding the current medical malpractice insurance crisis in Florida, as well as the policy options that could be implemented to help resolve it.

This study is specifically designed to identify the critical issues policymakers must consider in addressing Florida's medical malpractice challenges. The research methodology employed in the study consisted of the following elements:

- Data on every court action related to medical malpractice over the past five years (county, dollar amount, nature of judgment, area of medical specialty) was collected and analyzed;
- National data related to malpractice insurance premiums as well as payments and incurred losses in Florida were analyzed over a twelve-year period;
- Florida Department of Financial Services data on closed liability claims contained in the Professional Liability Closed Claims Data Bank were analyzed to determine the depth and breadth of Florida's medical malpractice crisis;
- Data on actual medical malpractice cases were analyzed by individual, medical specialty, type of malpractice, county in which the malpractice case was filed;
- Data related to the California experience in adopting both caps on non-economic judgments associated with medical malpractice cases and insurance regulation were collected and analyzed;
- Data on experiences in three additional states related to the impact of caps on non-economic judgments and medical malpractice premiums; and
- A literature search related to caps on medical malpractice, insurance premiums and the quality of healthcare service delivery.

Four major public policies are considered in this report. California used the first two in the list below and other states have used the first one in an effort to curb the increase in medical malpractice premiums. It is not currently known the extent to which states have used the third policy to stem rising malpractice premiums. However, an additional project study is focusing on that specific issue. The four policies are:

- Tort reform that typically involves establishing caps or limits on the maximum value of a non-economic award given for compensation for pain and suffering.

- Insurance industry regulation to monitor and approve increases in malpractice insurance premiums.
- Increased attention to the monitoring of healthcare practitioners.
- Shared risk associated with elective medical procedures.

In California, non-economic caps were imposed in 1975, but that did not solve the problem of escalating malpractice premiums. Thirteen years later, in 1988, California adopted Proposition 103, that brought insurance industry regulation to the state. The result of insurance regulation appears to be a much higher degree of premium stability in the malpractice insurance market and, premiums, adjusted for inflation, have actually declined over the period from 1988 to 2001. In other states, including West Virginia, Missouri and Nevada, caps have been implemented and malpractice insurance premiums have continued to rise despite this expected corrective action. Finally, in such states as Florida, Washington, Oregon, Texas and Illinois, caps have been found to be unconstitutional.

Policing Florida practitioners may be an effective policy that could help stem rising malpractice premiums. Florida has many practitioners with multiple malpractice cases. Closer scrutiny and sanctioning of such practitioners may well make it possible for all practitioners to obtain malpractice insurance at reduced rates.

Finally, this report examines the notion of shared risk. That is, a practitioner is currently held responsible for all risk associated with a medical procedure, regardless of whether it is elective or non-elective. Patients may need to share more of the risk for elective procedures.

CHAPTER ONE

INTRODUCTION

The Issue and Conflicting Perspectives

Throughout the nation, growing public policy attention is being devoted to the rising costs of medical malpractice insurance. More physicians are closing their practices. Others are moving from their states to different states with lower insurance premiums. Still others are forced to take the risk of continuing their practices without malpractice insurance because of rapidly rising premium costs. Hospitals are finding it more difficult to provide emergency services as physicians refuse to provide medical services. Pregnant mothers cannot find physicians to provide prenatal care or deliver their babies. Clearly these conditions suggest that a healthcare delivery crisis is becoming increasingly more prevalent.

Unfortunately, Florida is in the forefront of this crisis. The critical public policy question is: How can Florida ease the medical malpractice insurance liability challenges confronting Florida's healthcare delivery system?

It is commonly said that there are always two sides to every argument. In the case of the current medical malpractice insurance crisis, there are more than two sides being argued.

Insurance companies argue that extraordinary losses coupled with decreasing returns on investments are forcing them to increase malpractice premiums just to stay in business. Further, they say, if a cap were placed on non-economic payments together with increases in premiums, the problem would be solved.¹

The American Medical Association (AMA) argues that tort reform like that implemented by California more than 25 years ago is the reason malpractice insurance rates are lower there than in other states like Florida, New York, New Jersey, Pennsylvania and Nevada. Without tort reform, the AMA argues, doctors will be unable to afford malpractice insurance and, as a result, will discontinue certain procedures, retire early or move to other states.²

The non-profit consumer group, Public Citizen, contends that the problem in Florida is bad doctors who are not disciplined and the insurance companies. They argue that the legal system is not the problem.³

The Foundation for Tax Payer and Consumer Rights argues that, in the case of California, it was insurance reform and not tort reform that has helped to hold down the cost of medical malpractice premiums.⁴

The Association of Trial Lawyers of America argues that the cap on non-economic damages is unfair to housewives, children and the poor, who would be unable to show any loss of wages.⁵

This report will present empirical information to help the reader better understand the broad issues surrounding the current medical malpractice insurance crisis in Florida along with policy options that could be implemented.

¹ "Did Investments Affect Medical Malpractice Premiums?" Raghu Ramachandran, Insurance Asset Management Group, January 23, 2003, <http://salsa.bbh.com/news/Articles/MedMal.html>.

² J. Edward Hill, Chair, American Medical Association, in letter to the editor of *The Wall Street Journal*, July 5, 2002.

³ "Florida's Real Medical Malpractice Problem: Bad Doctors and Insurance Companies, Not the Legal System", Public Citizen, Congress Watch, September 2002.

⁴ "How Insurance Reform Lowered Malpractice Rates in California and How Malpractice Caps Failed," The Foundation for Tax Payer and Consumers Rights, February 10, 2003.

⁵ "Doctors Press for Insurance Overall", Janelle Carter, Associate Press, March 3, 2003.

The Medical Malpractice Insurance Crisis: A Conceptual Framework

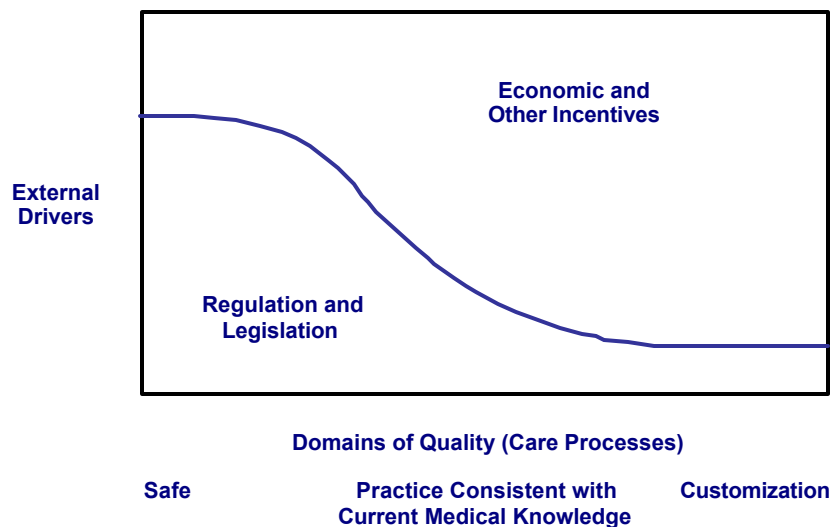
In determining the range of issues for which data would be collected, an initial effort was made to place the medical malpractice insurance crisis into a broader conceptual framework that would facilitate our analytical efforts. A recent publication by the National Institute of Medicine, "To Err is Human: Building a Safer Health System," provided the initial point of departure for the development of the study framework used herein.⁶

Particularly helpful in this book was a general model of the influence of the external environment on the quality of healthcare services. The model is presented in Figure 1, below.⁷ Its significance in the context of this report is that all discussions of healthcare reforms, including those related to medical malpractice premiums, must focus on the maintenance of a high-quality healthcare delivery system.

The model in Figure 1 stresses the influence of two categories of external drivers that directly impact the delivery of quality healthcare. The first category of these drivers refers to regulation and legislation. This includes any form of public policy or legal influence, such as licensing or the liability system.⁸

The second category of external drivers is comprised of economic and other incentives such as collective and individual actions by purchasers and consumers, the norms and values of health professionals and the social values of the nation and local communities.⁹

Figure 1. Influence of the External Environment on Quality



Source: "To Err is Human: Building a Safer Health System," Linda T. Kohn, Janet M. Corrigan, and Molla S. Donaldson, Editors; Committee on Quality of Health Care in America, Institute of Medicine, 2000, Figure 1.1, page 18.

⁶ "To Err is Human: Building a Safer Health System," Linda T. Kohn, Janet M. Corrigan, and Molla S. Donaldson, Editors; Committee on Quality of Health Care in America, Institute of Medicine, 2000.

⁷ Ibid, Figure 1.1, page 18.

⁸ Ibid, pp. 18-19.

⁹ Ibid, p. 19.

With regard to the quality domain, the model refers to three levels of care. The “safe” level refers to freedom from accidental injury. It requires a larger role for regulation and oversight authority. The “Practice Consistent with Current Medical Knowledge” level refers to the use of best practices, incorporating evidence-based medicine. Finally, the “Customization” level of care refers to meeting customer-specific values and expectations. It requires a larger role for creative, continuous improvement and innovation within organizations and marketplace reward.¹⁰

The dynamics of this model were best summarized by the Institute of Medicine committee when it articulated the belief that,

“...regulation and legislation play a particularly important role in assuring a basic level of safety for everyone using the health system. Economic, professional and other incentives can, and should, reinforce that priority. On the other hand, the customization of care to meet individual needs and preferences is more driven by economic and other incentives, with regulation and legislation potentially playing a supportive or enabling role. Encouraging practice consistent with current medical knowledge is reflected as a joint responsibility.”¹¹

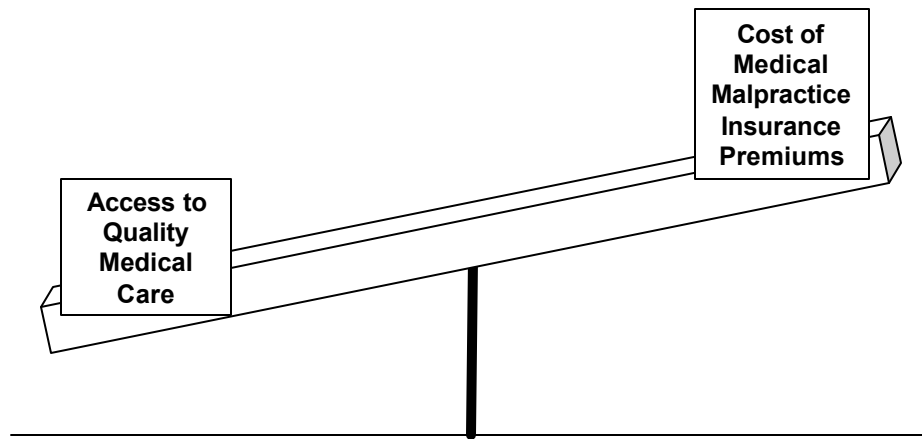
It is in the context of assuring at least a basic level of “safe” healthcare services that public policymakers must examine the current malpractice crisis in the state of Florida and make appropriate regulatory and legislative decisions. The challenge is to assure that these public policy decisions are made with full understanding of the wide range of complex economic forces and ramifications associated with each decision option. These economic factors impact all actors in the healthcare delivery and insurance chain, as well as individual patients. Moreover, policy decisions related to the healthcare medical malpractice crisis must not overlook the importance of the norms and values of healthcare providers.

The manner in which these factors interact in Florida are best reflected in Figure 2. As we will demonstrate through the research presented in this report, the challenges confronting Florida today are both complex and interrelated. Solutions will require a multifaceted strategy that takes into account a number of external drivers, as well as a set of fundamental determinations about quality of care levels.

¹⁰ Ibid, p. 19.

¹¹ Ibid, p. 20.

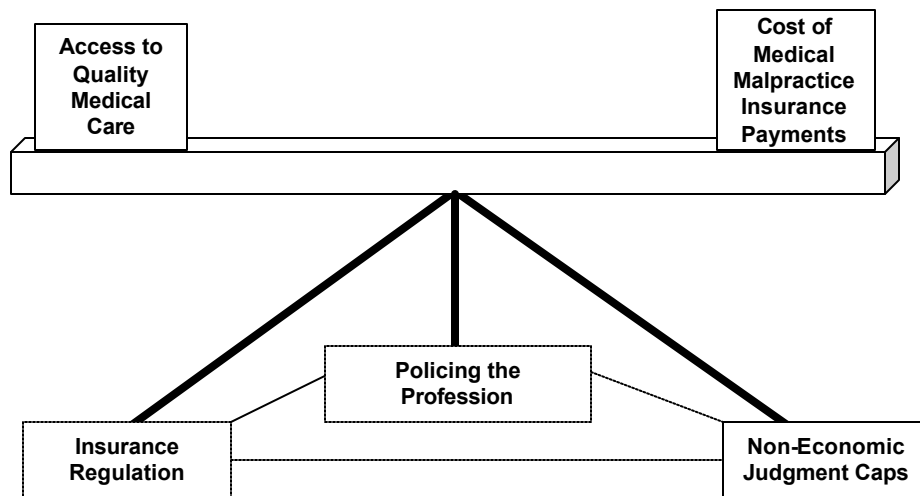
Figure 2. Access to Quality Medical Care vs. Cost of Medical Malpractice Premiums



Although simple in nature, we find the teeter totter to be a particularly useful foundation for the development of a dynamic model that depicts the public policy context for decision making in addressing the malpractice crisis. We see a direct relationship between the rising costs of medical malpractice insurance and the levels of access to safe but quality healthcare services. As rates continue to rise, more physicians will either leave the state or restrict the nature of their practice to lower the costs of insurance premiums. This reality is particularly evident among physicians practicing in areas such as obstetrics. As a result of these medical practitioner decisions, growing numbers of Floridians will have reduced access to medical services in this and many other medical specialty areas.

The challenge is to balance these dimensions such that there are fewer disincentives for physicians and other health service professionals to limit or discontinue their practices. Complicating the achievement of this goal is the reality that, to the extent that one of the primary goals of insurance companies is to make a profit, the interests of medical malpractice insurance companies are not totally aligned with the best interests of patients and healthcare professionals. Figure 3 depicts the critical elements of the

Figure 3. Bringing Balance to the Medical Malpractice Crisis in Florida



medical malpractice premium crisis that must be considered as resolution decisions are made.

It is not our intent to present specific elements of potential legislation related to malpractice premiums. Rather, through a careful review of the data accumulated and evaluated herein, we have concluded and will demonstrate that this crisis cannot be addressed without specifically addressing the relationships between each of the teeter totter anchors -- non-economic judgment caps, insurance regulation and expanded policing of the medical profession.

Subsequent reports from The Florida Center for Public Policy and Leadership will provide more in-depth information related to other dimensions of this important topic.

CHAPTER TWO METHODOLOGY

Analytical Approach

This policy analysis study was designed to identify the critical issues policymakers must consider in addressing Florida's medical malpractice challenges. The research methodology employed in this study consisted of the following elements:

- Data on every court action related to medical malpractice over the past five years (county, dollar amount, nature of judgment, area of medical specialty) was collected and analyzed;
- National data related to malpractice insurance premiums as well as payments and incurred losses in Florida were analyzed over a twelve-year period;
- Florida Department of Financial Services data on closed liability claims contained in the Professional Liability Closed Claims Data Bank were analyzed to determine the depth and breadth of Florida's medical malpractice crisis;
- Data on actual medical malpractice cases were analyzed by individual, medical specialty, type of malpractice, county in which the malpractice case was filed;
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- Data on experiences in three additional states related to the impact of caps on non-economic judgments and medical malpractice premiums; and
- A literature search related to caps on medical malpractice, insurance premiums and the quality of healthcare service delivery.

Data Sources

The majority of the malpractice data in this report came from four sources: (1) Florida Legal Periodicals, Inc.; (2) the National Association of Insurance Commissioners; (3) the National Practitioner Data Bank Public Use Data File, September 30, 2002; and (4) The Florida Department of Financial Services Professional Liability Claims Paid Database, March 13, 2003. Throughout this report, the source of the data has been identified.

The Florida Legal Periodicals, Inc. reports Florida medical malpractice cases with detail by county, the specialty of the practitioner as well as whether the award was given for "economic" or "non-economic" reasons. It does not report cases in which the outcome is stipulated as private. In addition, if a malpractice payment is structured over a period of years, the amount reported by Florida Legal Periodicals, Inc. is the amount paid in the first year. As a result, its data tend to under-report the actual incidence and magnitude of medical malpractice in Florida.

Data from the National Association of Insurance Commissioners was obtained from its website.¹² Specifically, data on direct premiums earned and direct losses incurred were obtained from "Table 2,

¹² The main NAIC web site is: <http://www.naic.org/>. Data for this report was taken from a table on their web site: http://www.naic.org/1research/Research_Division/Stats/MEDMAL07-18-02.pdf.

Medical Malpractice Insurance Data: NAIC Annual Statement Database” of their publication, “Medical Malpractice Insurance Net Premium and Incurred Losses Summary.” This table provides detail, by state, for each year from 1991 through 2001.

A copy of the National Practitioner Data Bank Public Use Data File, September 30, 2002, was obtained from the U.S. Department of Health and Human Services. Malpractice payers, state licensing agencies, hospitals, other entities, and professional societies are required to report data to the National Practitioner Data Bank under the provisions of Title IV of P.L. 99-660, the Health Care Quality Improvement Act of 1986, as amended. This database is considered the most comprehensive source on medical malpractice acts. It contains information about doctors and other healthcare practitioners who have settled medical malpractice claims or have had adverse action taken against them. The data in this file contains detail by state from September 1990 through September 30, 2002. Information about payment of medical malpractice claims is reported in ranges as opposed to the exact amount. The effect of reporting in ranges tends to slightly under-report the actual amount of medical malpractice payments. However, the magnitude of under-reporting is only about 1.3 percent, and therefore, is not significant for our purpose.¹³ Finally, this database does not distinguish between “economic” and “non-economic” awards.

Section 627.912, Florida Statutes, requires insurance companies, self-insurance funds and joint underwriting associations to report to the Florida Department of Financial Services (until recently, the Florida Department of Insurance) alleged error, omission or negligence by insured doctors, dentists, hospitals, health maintenance organizations (HMOs), abortion clinics, ambulatory surgical centers, crisis stabilization units and lawyers. Data from these reports are compiled by the Department of Financial Services and stored in an on-line database.¹⁴ These data were analyzed to determine the number and value of claims by county as well as to obtain information on other issues.

Definitions

There are several terms used throughout this study that are defined below to facilitate understanding and to prevent confusion. While these definitions may lack legal rigor, they will provide for a good comprehension of malpractice issues.

Economic payments refer to payments made to patients who have or will suffer loss of wages or salaries and for current and future medical costs.

Non-economic payments are those made to patients to compensate for pain and suffering.

Premiums earned are dollars from insurance premiums that have been assessed and received by an insurance company.

Closed claims are medical malpractice cases that are closed in the sense that final resolution has been reached and payment has been made, regardless of whether the settlement was part of a court action.

Payments for medical malpractice claims include only the amount paid directly to medical patients.

¹³ The U.S. Department of Health and Human Services compared the mean (average) payment in a 1999 version of the file, \$163,561 with the actual mean of \$165,744. This is a difference of 1.317 percent.

¹⁴ The Florida Department of Financial Services Professional Liability Closed Claims Database can be accessed through the following web site: <http://www.fldfs.com/Data/Liability/byname.asp>

Direct (or paid) losses represent payments made by insurance companies to patients related to malpractice claims plus what insurance companies pay their own lawyers to fight claims.

Incurred losses include direct (or paid) losses plus reserves for possible future losses that may or may not ever occur and profit.

Legal Issues

While conducting research on the study topic, it became clear that there are a number of critical legal issues that must be considered by public policymakers as they determine how the State of Florida will address the state's malpractice insurance premium crisis. Some of those legal issues relate to current Florida law (766.207 Florida Statutes) concerning non-economic judgment determinations resulting from voluntary binding arbitration of medical negligence claims.

It also was clear that the Florida policymakers also would benefit from lessons learned in all other states that have addressed the non-economic payment cap issue. Such an analysis would review cap laws in all 50 states, with specific attention devoted to three categories: economic judgments; non-economic judgments and punitive damages. In addition, it would review: court decisions related to the legality of the caps, dollar limits, cost-of-living or other periodic adjustments to the caps; related insurance regulation; and professional peer review expectations.

Recognizing that this study would be both more comprehensive and useful to policymakers with information such as that outlined above, Visiting Center Fellow Talbot "Sandy" D'Alemberte was asked to convene a research team to compile this additional information. A second report on these legal issues will be released following the compilation of this important information.

A third study, led by Center Fellow and University of North Florida political science professor Terry Bowen, will focus on the challenges of policing the medical profession based upon experiences in Florida and other states that have sought to address malpractice issues.

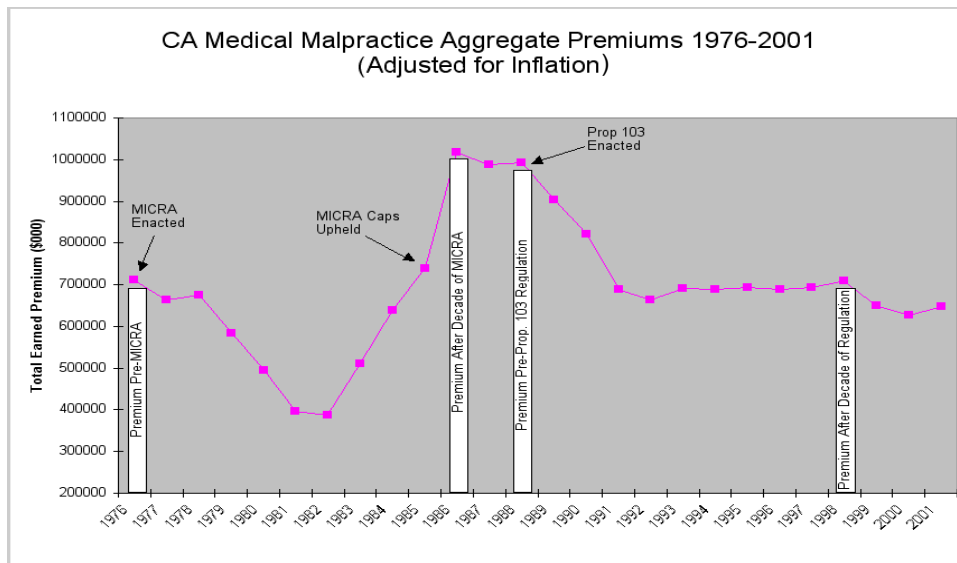
CHAPTER THREE THE CALIFORNIA REFORM STRATEGY

MICRA (Medical Injury Compensation Reform Act)

Most discussions of medical malpractice problems refer to the California experience as an example of how high malpractice insurance problems can be effectively addressed. The California effort to address the challenge of rapidly rising costs of medical malpractice insurance actually began in 1975, with the adoption of a statutory amendment that capped non-economic medical malpractice judgments at \$250,000. Referred to as MICRA (Medical Injury Compensation Reform Act), the amendment was immediately challenged in the courts and the outcome was resolved finally after a period of almost ten years.

It was assumed at the time that the adoption of these caps would materially reduce malpractice insurance premiums. As Figure 4 reflects, the actual result of implementing this statutory amendment was mixed. The data in this Figure have not been adjusted for increases in population; thus, they tend to understate the actual decline in medical malpractice premiums.

Figure 4.¹⁵



Source: "Five Dangerous Myths About California's Medical Malpractice Restrictions," The Foundation for Taxpayer and Consumer Rights, <http://www.consumerwatchdog.org/healthcare/fs/fs003009.php3>

Although there was an initial reduction in premium rates, within six years there was a significant reversal of that downward trend. Suddenly the solution to the tort reform strategy to lower insurance premiums was described as inadequate. Additional actions were demanded as the citizens of California accepted the proposition that legal caps on non-economic judgments alone would not lead to the results they desired.

¹⁵ "Five Dangerous Myths About California's Medical Malpractice Restrictions," The Foundation for Taxpayer and Consumer Rights, <http://www.consumerwatchdog.org/healthcare/fs/fs003009.php3>

Proposition 103: An insurance Reform Initiative

It was in this context that the State of California began to focus greater attention to the manner in which insurance companies established their rates. Some have pointed to the two-pronged attack on rapidly rising malpractice insurance rates implemented in California, claiming that medical malpractice insurance premiums continued to increase until Proposition 103, an insurance reform initiative, was adopted in 1988. A graph prepared by The Foundation for Taxpayer and Consumer Rights indicates that, adjusted for inflation, insurance premiums in California have not only stabilized but also actually decreased since 1988 (see Figure 4, above).¹⁶

Approved by California voters on November 8, 1988, the Insurance Rate Reduction and Reform Act, known as Proposition 103, addressed many forms of insurance. The purposes of the Act were to:

- Protect consumers from arbitrary insurance rates and practices;
- Encourage a competitive insurance marketplace;
- Provide for an accountable Insurance Commissioner; and
- Ensure that insurance is fair, available and affordable.

It is important to note that provisions of the Act apply to several types of insurance, including malpractice policies. Among the Act's most important provisions are the following:

- Premiums on property-casualty insurance, including medical malpractice insurance, and automobile insurance were rolled back to their level on November 8, 1987 (one year earlier) and reduced no less than an additional 20 percent.
- Insurance rates were frozen at the 1987 levels through November 8, 1989 (two years) with a provision that the Insurance Commissioner could allow an increase if, after a hearing, the insurer was found to be threatened with insolvency.
- After November 8, 1989, the Commissioner approves insurance rates prior to implementing.
- Automotive insurance rates are to be determined primarily by the driver's safety record and mileage driven, using the following factors in decreasing order of importance:
 - The insured's driving safety record;
 - The number of miles he or she drives annually;
 - The number of years of driving experience; and
 - Other factors adopted by the Commissioner.
- Insurance companies are required to justify all future premium increases.
- Insurance Commissioner is established as an elected official.
- Insurance companies must pay a fee to cover the costs of administering the new laws.

¹⁶ Ibid.

- Any person may:
 - Initiate or intervene in any proceeding involving the insurance laws; and
 - Challenge any action of the Commissioner.

Important Insights from the California Experience

Based upon the data we have reviewed, together with analysis of other documents and publications, several lessons from California’s reform efforts are worthy of consideration.

First, while caps on non-economic medical malpractice judgments appear to have had an impact on medical malpractice premiums in the short-term, this strategy could not sustain these reductions over the long-term and the reduction in premiums may be more directly the result of other factors such as investment earnings and the well-documented “insurance cycle.”

Second, over a period of 13 years, non-economic medical malpractice awards failed to halt the run-away cost of insurance premiums. The subsequent enactment of insurance industry reform appears to have both reduced the cost of malpractice insurance and stabilized malpractice premiums. Significantly, the effect of insurance industry reform was both immediate and has been long-standing.

Third, caps on medical malpractice awards led to increases in the amount spent by insurance companies to defend cases of medical malpractice. The reason for the increase in defense costs is that insurance companies are more likely to seek settlement of a claim through the judicial system, where they know their maximum liability, rather than settling for an amount that may exceed the cap on non-economic awards. An analysis by the Foundation for Taxpayer and Consumer Rights demonstrates that a few years after the imposition of the non-economic medical malpractice award caps, the amount of money spent by insurance companies fighting malpractice claims exceeded that spent paying claims.

As can be seen in Figure 5, during 1992 and 1993, the amount paid to insurance company attorneys to defend malpractice cases exceeded that paid to victims, by as much as \$11.8 million (5.5 percent).

Figure 5.¹⁷
California Malpractice Defense Costs vs. Malpractice Payments

Year	Payments	Defense Costs	Difference
1992	\$209,545,400	\$216,389,850	\$6,844,450
1993	\$214,504,520	\$226,327,600	\$11,826,080

Fourth, the implementation of caps on non-economic judgments almost immediately reduced potential insurance company malpractice liability exposure. If insurance companies had not felt the pressure to lower their malpractice premiums to coincide with their declining potential liability, trend data suggest that insurance premiums would have continued to increase in California, even with its caps in place.

¹⁷ From Figure 9 of “How Insurance Reform Lowered Doctors’ Medical Malpractice Rates in California and How Malpractice Caps Failed,” The Foundation for Taxpayer and Consumer Rights, February 10, 2003, page 7.

CHAPTER FOUR

THE FLORIDA MEDICAL MALPRACTICE CRISIS

Historical Overview

Although the state of Florida is in the midst of what has been described as a major malpractice crisis, it is ironic that almost twenty years ago, the 1985 Florida Legislature provided a description of the state's medical malpractice situation that closely mirrors conditions in 2003. Among those conditions set forth in the Whereas Preamble to Chapter 85-175, Laws of Florida were the following:

- High-risk physicians in this state sometimes pay disproportionate amounts of their income for malpractice insurance;
- Professional liability insurance premiums for Florida physicians have continued to rise and, according to the best available projections, will continue to rise at a dramatic rate;
- The maximum rates for essential medical specialists, such as obstetricians, cardiovascular surgeons, neurosurgeons, orthopedic surgeons, and anesthesiologists have become a matter of great public concern;
- These premium costs are passed on to the consuming public through higher costs for healthcare services in addition to the heavy and costly burden of "defensive medicine" as physicians are forced to practice with an overabundance of caution to avoid potential litigation;
- This situation threatens the quality of healthcare services in Florida as physicians become increasingly wary of high-risk procedures and are forced to downgrade their specialties to obtain relief from oppressive insurance rates;
- This situation also poses a dire threat to the continuing availability of healthcare in our state as new young physicians decide to practice elsewhere because they cannot afford high insurance premiums and as older physicians choose premature retirement in lieu of a continuing diminution of their assets by spiraling insurance rates;
- Our present tort law/liability insurance system for medical malpractice will eventually break down and costs will continue to rise above acceptable levels, unless fundamental reforms of said tort law/liability insurance system are undertaken; and
- The magnitude of this compelling social problem demands immediate and dramatic legislative action.

The 1985 Legislature clearly understood the nature of a continuing problem and took a number of concrete actions to address them. In retrospect, those actions were insufficient in providing a long-term solution to the core problems behind the continuing malpractice premium crisis. Just as this compelling social problem demanded immediate and dramatic legislative action in 1985, a similar case can be made in 2003. The challenge before Florida policymakers is to craft a comprehensive response that deals with the root causes of the problem.

In August 2002, Governor Jeb Bush appointed the Select Task Force on Health Care Professional Liability Insurance to review the availability and affordability of medical malpractice insurance and to make recommendations to protect Florida citizens' access to high-quality healthcare. Among the 60 recommendations of the task force is one to limit non-economic payments to \$250,000. In addition to the \$250,000 cap, the task force recommends creating a patient safety authority and a statewide system for ordering prescription drugs. Their report also deals with the way doctors are disciplined.¹⁸

Limits on Medical Negligence Payments

The state of Florida has continued to discuss the imposition of caps on non-economic judgments for almost 20 years. In 1986, Florida actually adopted such legislation, although it was subsequently found to be unconstitutional. Moreover, in 1988 the voters of the state rejected a proposed amendment to the state Constitution that would place a \$100,000 cap on non-economic judgments. (See the discussion below about constitutional considerations.)

While discussions regarding the possible imposition of a cap on non-economic judgments continue, the Legislature has taken action to restrict payment for non-economic medical malpractice to \$250,000 per incident when both parties agree to voluntary binding arbitration. It established a voluntary binding arbitration process for medical negligence claims with a cap component. Section 766.207(7)(b), Florida Statutes, specifically provides that:

(7) Arbitration pursuant to this section shall preclude recourse to any other remedy by the claimant against any participating defendant, and shall be undertaken with the understanding that:

(b) Non-economic damages shall be limited to a maximum of \$250,000 per incident, and shall be calculated on a percentage basis with respect to capacity to enjoy life, so that a finding that the claimant's injuries resulted in a 50-percent reduction in his or her capacity to enjoy life would warrant an award of not more than \$125,000 non-economic damages. (Section 766.207, Florida Statutes)

It must be stressed, however, that the above-cited existing statutory limits on non-economic medical malpractice payments apply only when both sides agree to voluntarily enter into binding arbitration.

In 2001, Florida passed a nursing home liability law that limits awards and raises the standards of care.¹⁹ The law, which went into effect in January 2002, caps punitive damages at three times the amount of compensatory damages, or \$1 million, whichever is greater. However, if the wrongful conduct was motivated primarily by unreasonable financial gain, the cap is four times the amount of compensatory damages or \$4 million. Nursing homes are required to increase the hours of nursing care per resident and develop quality assurance programs. A similar law pertaining to medical doctors and hospitals has not been adopted in Florida.

¹⁸ Governor's Select Task Force on Health Care Professional Liability Insurance, Final Report, January 29, 2003.

¹⁹ Section 400.0238, Florida Statutes.

Medical Malpractice in Florida: Court Cases

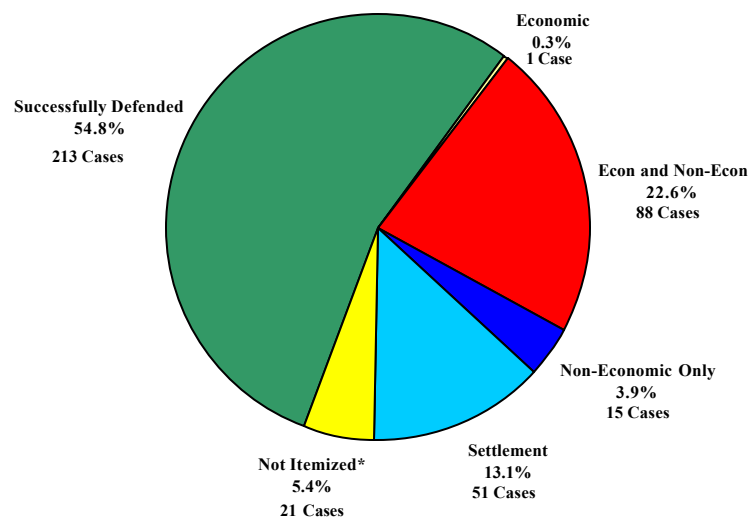
Although it is generally assumed that there are large numbers of court cases related to medical malpractice in Florida, our examination of court actions reveal that during the period from 1998 through 2002, there were only 389 medical malpractice cases in Florida. This was an average of just fewer than 78 cases per year over the 5-year period.²⁰ On the other hand, as of March 13, 2003, the Florida Department of Financial Services (FDFS) Professional Liability Closed Claims Database contained 17,521 closed medical malpractice cases for the 12-year period from 1991 through 2002. Dividing by 12, that figure represents an average of just over 1,460 cases per year.

The huge difference between these two yearly averages is largely accounted for by the fact that the Florida Legal Periodicals' database includes only those cases that make it into the court system. Also, that database excludes cases, the conclusions of which are, categorized as "private." The FDFS database, on the other hand, represents nearly ALL medical malpractice cases in Florida with the exception of those involving entities, which are self-insured or carry no insurance.

An examination of every case considered by Florida courts, during the five-year period from 1998 through 2002, revealed that all malpractice cases do not result in payments to patients. In fact, of the 389 total medical malpractice cases considered by the courts in the five-year period, 213 (54.8 percent) were successfully defended.

Figure 6 (below) displays information about the number and percentage of cases by result, based on data from the Florida Legal Periodicals, Inc. Note that 51 (13.1 percent) of the cases ended with a settlement before the conclusion of the legal process. Of the 103 cases involving "non-economic"

Figure 6. Medical Malpractice Cases, by Result
All Cases, 1998-2002
389 Total Cases



*"Not itemized" cases are those which resulted in a payment to a patient, but the award was not categorized by "economic" or "non-economic".
Source: Florida Legal Periodicals Inc. database.

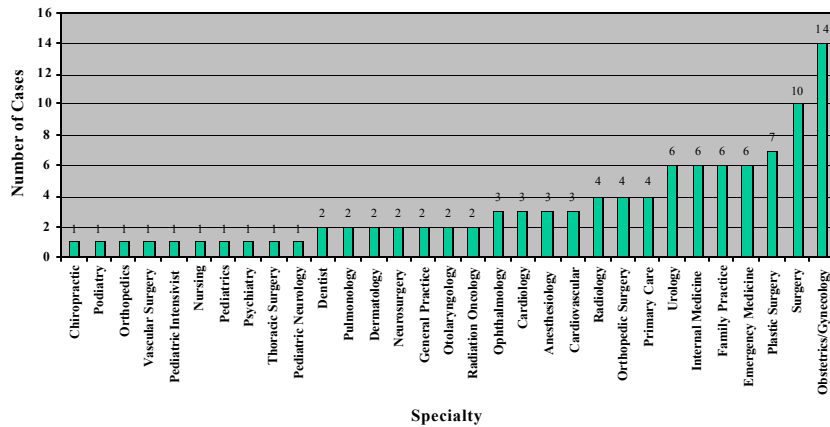
²⁰ Database received from the Florida Legal Periodicals, Inc., February 2003.

awards, 88 cases (22.6 percent of the 389 total cases) had both “economic” and “non-economic” components. Another 15 cases (3.9 percent) were categorized as solely non-economic. Just one case had an award that was categorized as solely “economic”. The remaining 21 cases (5.4 percent) had awards that were not categorized as either “economic” or “non-economic”.

While these data certainly do not reflect the total number of medical malpractice cases, they can provide insight into the relative distribution of malpractice cases that go through the courts system. What is instructive here is the fact that more cases involve “non-economic” payments as opposed to “economic” payments, although at least one-half of those involving a payment include both.

In recognition of the fact that several medical specialty areas are more likely to be the subject of malpractice lawsuits, an examination of court actions taken against practitioners by medical specialty area also was conducted. A total of 103 medical malpractice cases resulted in an award that included a “non-economic” component during the five-year period from 1998 through 2002. Figure 7 displays the number of such cases by medical specialty.

Figure 7. Total Number of Non-Economic Medical Malpractice Awards, by Specialty, 1998-2002
103 Total Cases



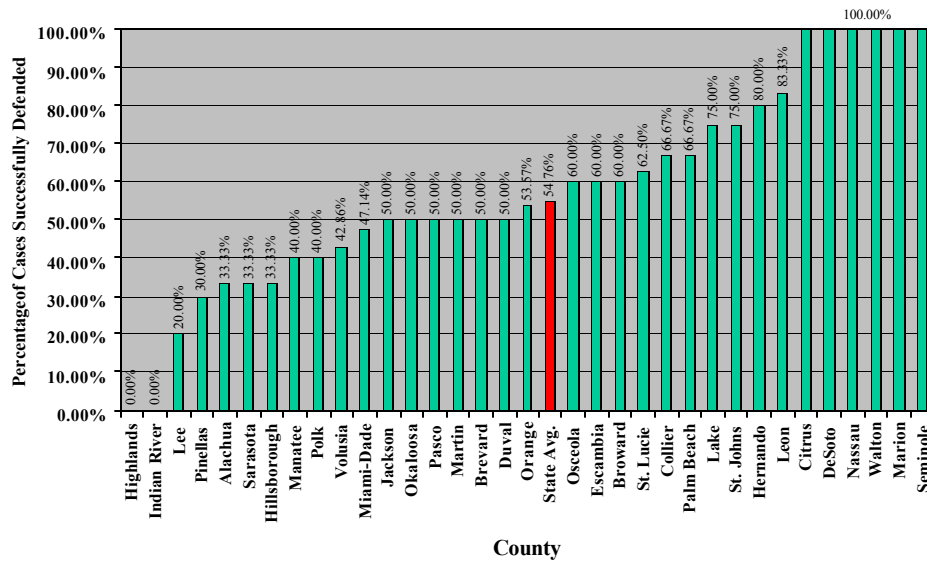
Source: Florida Legal Periodicals, Inc. database.

Physicians in the Obstetrics/Gynecology specialty area had the largest number of cases resulting in awards (14), followed by Surgery with 10 cases and Plastic Surgery with 7 cases. At the low end of non-economic award cases, there were 10 specialties that had just one non-economic award each during the five-year period and another seven specialties each of which had two cases.

Successfully Defended Cases

The percentage of medical malpractice court cases that were successfully defended during the five-year period from 1998 through 2002 varied substantially from county to county (see Figure 8). Based on data from Florida Legal Periodicals, Inc, in six counties -- Citrus, DeSoto, Nassau, Walton, Marion and Seminole -- all medical malpractice cases were successfully defended. It is important to recognize, however, that among these six counties, none had more than two medical malpractice cases during the five-year period (see Figure 9). Two counties, Highlands and Indian River, had no medical malpractice case successfully defended. Successful defense of medical malpractice cases does not appear to be closely related to the size of the county.

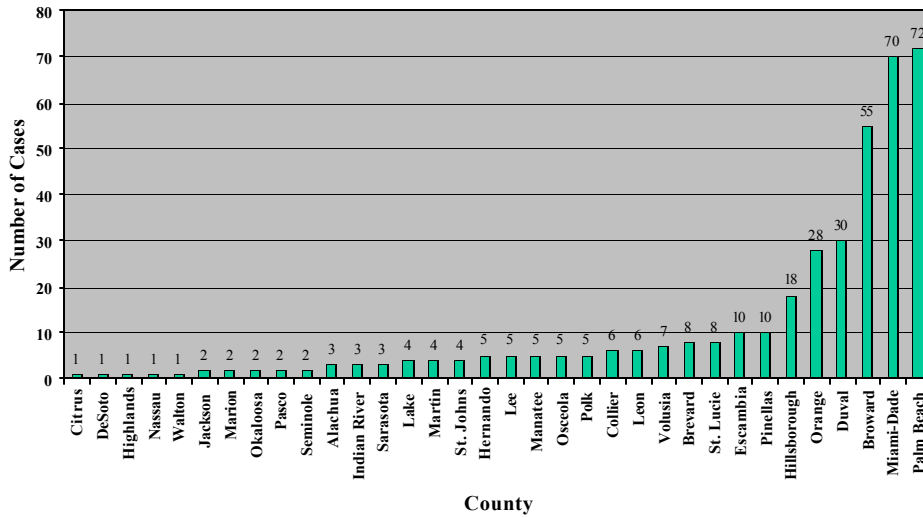
Figure 8. Percentage of Cases Successfully Defended Medical Malpractice Suits County, 1998-2002



Source: Florida Legal Periodicals, Inc. database.

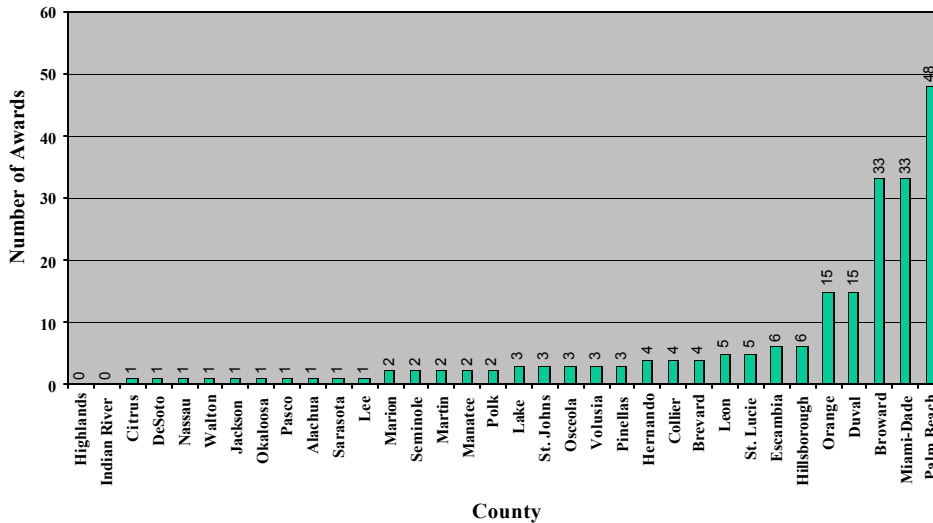
Palm Beach County had the highest number of medical malpractice cases in the state during the five-year period from 1998 through 2002 (see Figure 9, below). Simultaneously, it also had a substantially larger percentage of those cases successfully defended. Specifically, Palm Beach County had 48 cases successfully defended cases (see Figure 10, below). It also ranked high in the percentage (66.67 percent), of cases successfully defended (see Figure 8, above). Miami-Dade had only two fewer total cases (72 for Palm Beach vs. 70 for Miami-Dade), but only 33 of its cases were successfully defended.

Figure 9. Count of Total Medical Malpractice Cases, by County, 1998-2002
389 Total Cases



Source: Florida Legal Periodicals, Inc. database.

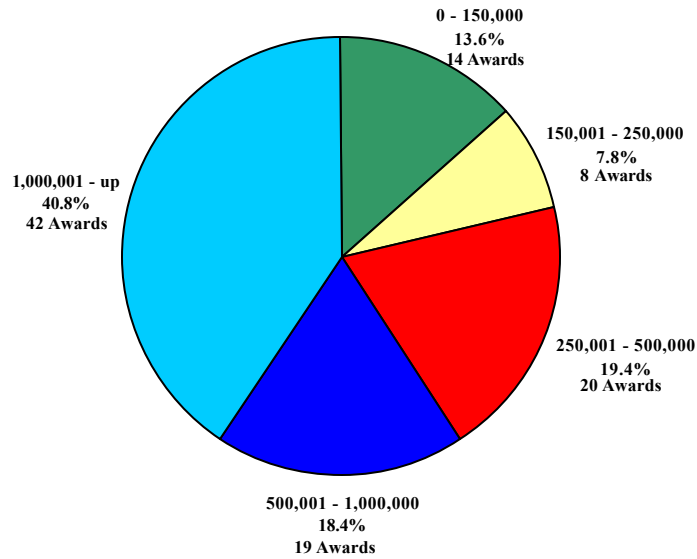
Figure 10. Count of Total Successful Defenses, Medical Malpractice Suits, by County, 1998-2002
103 Total Successful Defenses



Source: Florida Legal Periodicals, Inc. database.

Figure 11 displays the proportion of non-economic medical malpractice awards, with detail by the size of the award, for the five-year period from 1998 through 2002.²¹ Of the 103 total awards, 22 (21.4 percent) were \$250,000 or less. Nearly twice that many, 42 awards (40.8 percent) exceeded \$1.0 million. The remaining 39 awards were nearly equally divided between those in the range from \$250,001 through \$500,000 and those in the range from \$500,001 through \$1.0 million.

Figure 11. Count of Non-Economic Medical Malpractice Awards 5-year Total, by Amount of Award, 1998-2002
103 Total Awards



Source: Florida Legal Periodicals, Inc. database.

²¹ Florida Legal Periodicals, Inc. database.

Medical Malpractice in Florida – Closed Claims Cases

Data from the Florida Department of Financial Services (FDFS), Professional Liability Closed Claims Database also were analyzed to gain greater insight into the full array of medical malpractice cases in Florida. Figure 12 displays the distribution of closed claims cases, by Florida County, based on data from the FDFS database. (Note: A closed claim is one for which final resolution has been reached and payment has been made.) All but three Florida counties (Lafayette, Liberty, and Wakulla) had medical malpractice cases listed in the database during the 12-year period from 1991 through 2002.

Figure 12. Number of Medical Malpractice Closed Claims Cases per County, Total for Period 1991-2002
17,391 Total Cases, Statewide

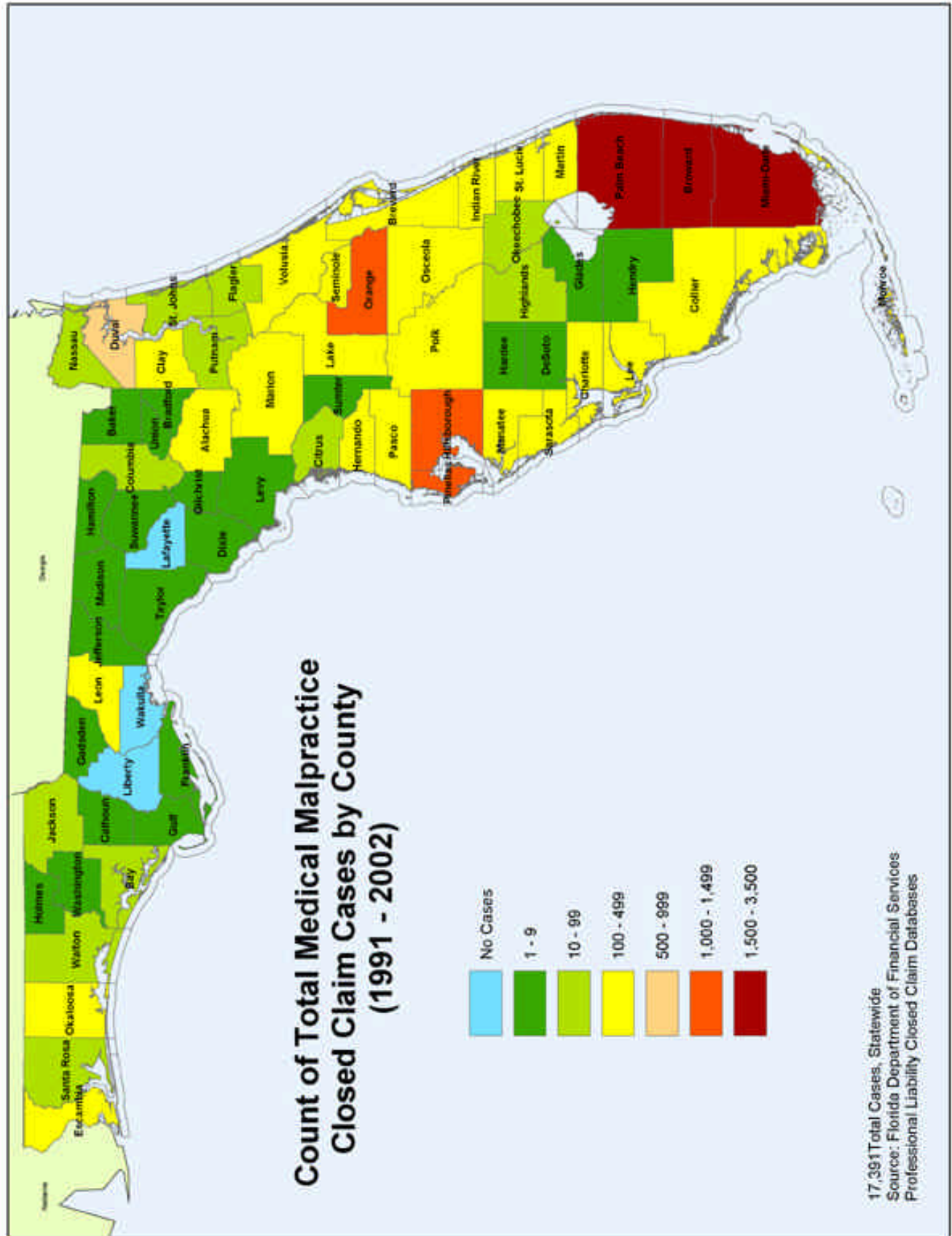
County	Cases	County	Cases	County	Cases
Glades	1	Gadsden	9	Osceola	170
Unknown	1	Walton	11	Manatee	186
Dixie	2	Nassau	14	Collier	191
Hardee	2	Jackson	16	St Lucie	229
Jefferson	2	Flagler	20	Leon	231
Sumter	2	Okeechobee	28	Escambia	233
Washington	2	Putnam	41	Alachua	254
Madison	3	Santa Rosa	44	Seminole	327
Taylor	3	Columbia	45	Volusia	336
Union	3	Highlands	63	Sarasota	342
Baker	4	St Johns	77	Polk	347
Bradford	4	Bay	80	Pasco	355
Gilchrist	4	Citrus	92	Brevard	384
Holmes	4	Monroe	102	Lee	468
Franklin	5	Charlotte	115	Duval	753
Gulf	5	Indian River	116	Orange	1,040
Levy	5	Martin	120	Pinellas	1,207
Calhoun	6	Clay	122	Hillsborough	1,292
DeSoto	6	Okaloosa	127	Palm Beach	1,532
Hendry	6	Lake	145	Broward	2,344
Hamilton	7	Hernando	150	Dade	3,398
Suwannee	8	Marion	150		

Source: Florida Department of Financial Services, Professional Liability Closed Claims Database, March 13, 2003. Excludes closed claims against Lawyers.

As might be expected, the counties with the largest number of cases are, in general, also those with the largest population. For example, with 3,398 cases over the 12-year period, Dade County leads all other counties in the state in closed claims medical malpractice cases. Orange, Pinellas, Hillsborough, Palm Beach and Broward counties round out the top six counties, each with in excess of 1,000 closed cases over the 12-year period.

To provide a clearer visual perspective of these data, the map below provides a graphic distribution by county of the total closed claims medical malpractice cases in Florida over the 12-year period from 1991 through 2002.

Figure 13.



Of the 17,391 total medical malpractice closed claims cases in the 12-year period from 1991 through 2002, the average award varied considerably from one county to another. Overall, the statewide average value of a closed claims medical malpractice case was \$213,060. Figure 14 provides information on the average value of those closed cases, by county. The accompanying map below (Figure 15) graphically presents these data by county.

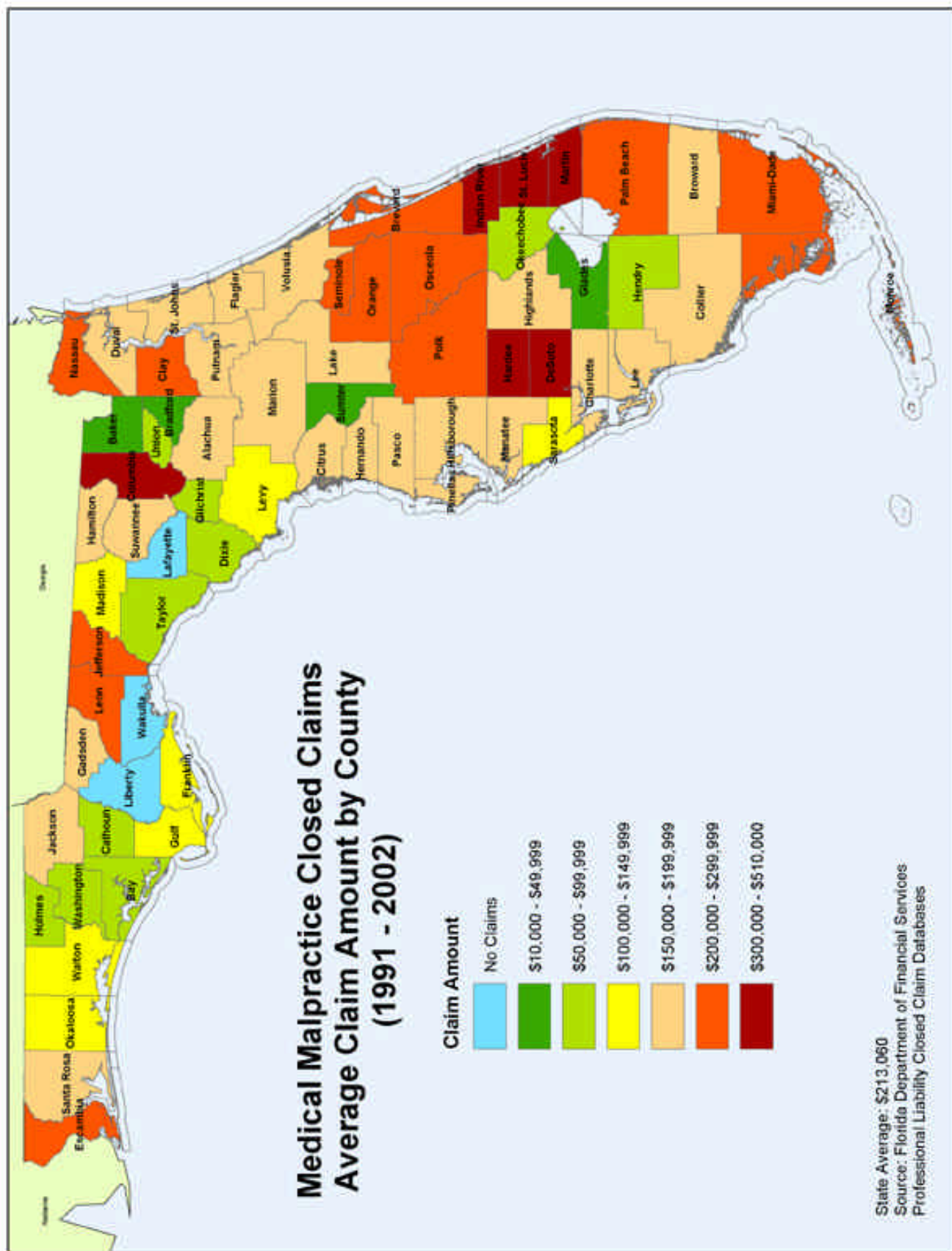
Figure 14. Medical Malpractice Closed Claims, Average Claim Amount, by County, 1991-2002
State Average: \$213,060

County	Average	County	Average	County	Average
Glades	\$10,000	Citrus	\$152,809	Lake	\$199,731
Sumter	\$18,750	Charlotte	\$155,509	Osceola	\$202,936
Bradford	\$36,250	Volusia	\$158,790	Seminole	\$205,014
Baker	\$45,938	Pasco	\$160,259	State Avg.	\$213,060
Holmes	\$57,250	Suwannee	\$162,500	Monroe	\$215,054
Dixie	\$59,657	Jackson	\$169,677	Polk	\$215,539
Taylor	\$63,667	Lee	\$169,986	Clay	\$220,571
Calhoun	\$70,583	Hernando	\$177,972	Escambia	\$222,520
Union	\$73,333	Gadsden	\$178,889	Unknown	\$225,000
Gilchrist	\$76,250	Putnam	\$180,683	Brevard	\$228,918
Hendry	\$80,625	Marion	\$181,773	Dade	\$243,080
Okeechobee	\$93,484	Broward	\$182,311	Leon	\$249,808
Washington	\$95,842	Duval	\$183,762	Jefferson	\$254,000
Bay	\$99,204	Pinellas	\$185,850	Palm Beach	\$255,691
Franklin	\$111,309	Santa Rosa	\$186,089	Nassau	\$257,521
Gulf	\$115,824	Collier	\$187,697	Orange	\$270,965
Madison	\$116,667	Highlands	\$189,726	Martin	\$318,699
Walton	\$117,284	Flagler	\$189,874	Indian River	\$328,865
Sarasota	\$132,704	Manatee	\$192,703	St Lucie	\$343,723
Levy	\$145,200	Hamilton	\$193,071	DeSoto	\$436,667
Okaloosa	\$147,776	Alachua	\$193,394	Columbia	\$454,837
St Johns	\$150,714	Hillsborough	\$196,176	Hardee	\$509,488

Source: Florida Department of Financial Services, Professional Liability Closed Claims Database, March 13, 2003.
 Excluded closed claims against Lawyers.

It is important to understand that the data in Figure 14 represent a simple average of all medical malpractice closed claims cases in a particular county during the 12-year period, regardless of how many such cases existed within the county. Those data are not the total value of the closed claims cases divided by 12, which would represent an annual average, rather they are the average of the county's cases in that period.

Figure 15.



**Figure 16. Professional Liability Closed Claims
1991 - 2002**

Year	Ambulatory Surgical Centers			Crisis Stabilization Centers	Dentists	HMOs	Hospitals	Other			Total
	Abortion Clinics	Surgical Centers	Centers					Facilities	Physicians	Podiatrists	
1991		\$7,500	\$500,000	\$8,305,862	\$7,900,844	\$67,003,863	\$60,000	\$147,004,333	\$709,433	\$231,491,835	
1992		\$437,000	\$20,000	\$6,067,820	\$2,149,981	\$80,103,525	\$4,025,000	\$133,554,404	\$776,700	\$227,134,430	
1993		\$1,255,000		\$7,034,351	\$1,850,000	\$94,294,206	\$20,000	\$126,455,382	\$1,463,499	\$232,372,438	
1994		\$12,500		\$6,364,470	\$4,168,363	\$81,356,433		\$160,912,328	\$1,157,519	\$253,971,613	
1995		\$883,250		\$5,470,145	\$3,382,714	\$128,756,643	\$402,500	\$208,227,256	\$2,260,555	\$349,383,063	
1996		\$299,180	\$60,000	\$4,666,966	\$2,854,000	\$153,670,697	\$93,460	\$240,095,335	\$1,920,496	\$403,660,134	
1997	\$100,000	\$294,000	\$460,000	\$6,303,139	\$5,440,307	\$158,002,778	\$90,420	\$207,248,817	\$1,570,500	\$379,509,961	
1998		\$1,001,039	\$1,209,559	\$4,086,412	\$1,002,000	\$122,037,250	\$290,000	\$183,926,176	\$1,807,502	\$315,359,938	
1999		\$512,461	\$2,520,000	\$6,815,423	\$3,260,000	\$137,067,094	\$2,873,499	\$200,526,687	\$2,070,319	\$355,645,483	
2000		\$626,500		\$3,605,769	\$76,000	\$118,704,758	\$6,686,214	\$175,095,958	\$2,430,233	\$307,225,431	
2001		\$781,630		\$5,000,532	\$700,000	\$108,728,614	\$1,818,000	\$158,166,764	\$1,424,999	\$276,620,539	
2002	\$20,000	\$4,309,000		\$3,841,291	\$1,000,000	\$129,266,688	\$10,195,556	\$223,611,161	\$716,501	\$372,960,197	
Total	\$120,000	\$10,419,060	\$4,769,559	\$67,562,180	\$33,784,209	\$1,378,992,549	\$26,554,649	\$2,164,824,601	\$18,308,256	\$3,705,335,062	

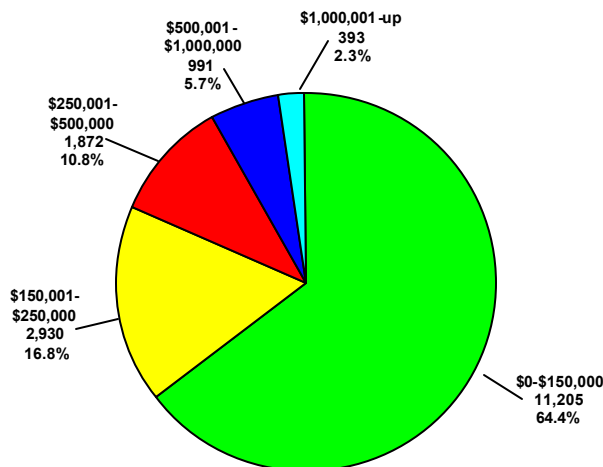
Source: Florida Department of Financial Services Professional Liability Closed Claims Database, March 13, 2003.

To provide a comprehensive view of all medical malpractice closed claims during the period from 1991 through 2002, Figure 16 (above) lists, by year and category of provider, the total dollar amount of payments for closed claims cases. These data, from the Florida Department of Financial Services' Professional Liability Closed Claims Database, depict the variation among different types of medical service providers as well as fluctuation in the level of payments from one year to the next.²² Of the nearly \$4.0 billion in total closed claims cases, nearly 59 percent is associated with physicians and podiatrists and more than 37 percent is associated with hospitals.

These numbers are not adjusted for inflation but do provide a clear picture of the dollar value of settlements over time. It is clear that physicians and hospitals are the categories that are consistently the major drivers of rising claims costs.

Examining the closed claims data by size of award provides yet another view of the distribution of awards. It is interesting to note the marked differences in the distribution of the size of claims between that depicted in Figure 11 (above) and Figure 17 (below). In Figure 11, approximately 21.4 percent of claims processed through the court system were less than \$250,000. In contrast, 81.2 percent of closed claims data presented in Figure 16 are below that same threshold (see Figure 17 below). Clearly, a substantial proportion of claims that are not going through the courts system are being resolved for less than \$250,000.

**Figure 17. Professional Liability Closed Claims
by Amount of Claim, 1991-2002**
17,391 Total Claims



Source: Florida Department of Financial Services, Professional Liability Closed Claims Database, March 13, 2003. Excludes closed claims against Lawyers.

²² For detailed information about these data and their host database, it is recommended that the reader view the Florida Department of Financial Services' web site: <http://www.fldfs.com/Data/Liability/disclaimer.htm>

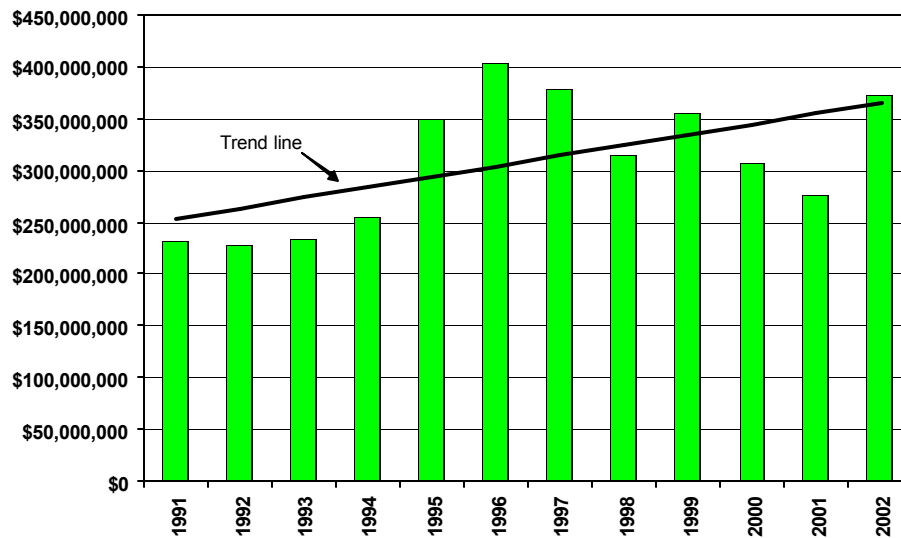
Medical Malpractice Payments in Florida

The court cases referenced above provide a partial picture of the scope of what occurs in the medical malpractice payment area. They demonstrate that defendants win more than half of all cases filed and suggest that the vast majority of legal actions taken related to malpractice occur in the large urban areas of the State, particularly in South Florida.

To capture the actual monetary volume of all payments made related to malpractice, additional analysis was necessary. Data from the Florida Department of Financial Services, Professional Liability Closed Claims Database, March 13, 2003, revealed that the amount of medical malpractice payments in Florida has increased by more than 60 percent from 1991 to 2002. This growth is equivalent to an annual average increase of approximately 4.43 percent.

Figure 18 depicts the growth of those payments, starting with a value of \$232.5 million in 1991 and reaching an estimated level of \$373.0 million in 2002.

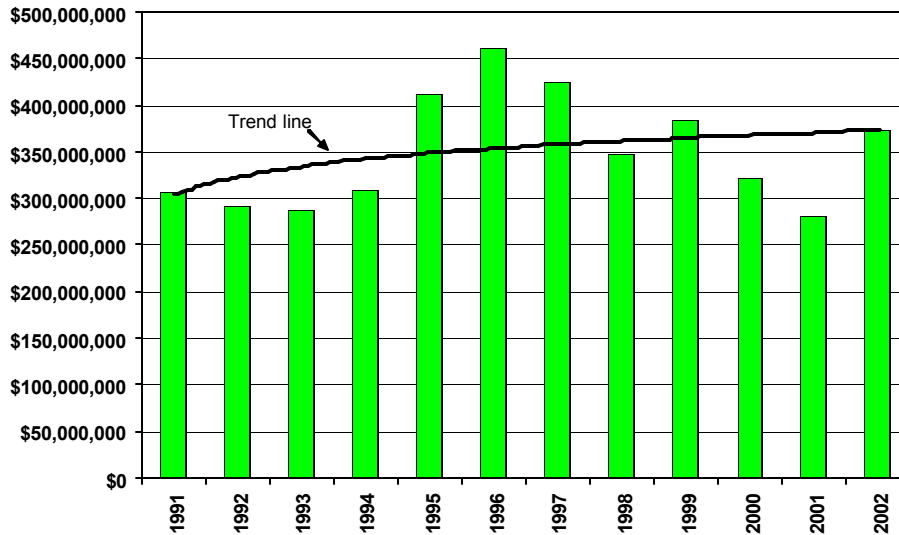
Figure 18. Florida Medical Malpractice Payments 1991-2002



Source: Florida Department of Financial Services Professional Liability Closed Claims Database, March 13, 2003.

Adjusting for the effects of inflation, Figure 19 depicts the annual medical malpractice payments in Florida from 1991 through 2002, in 2002 dollars. (These are the same data used for Figure 18, but they have been adjusted for inflation.) The payment growth, adjusted for inflation, is equivalent to an annual average increase of approximately 1.82 percent. Note that the value of payments in 2002, adjusted for inflation, has decreased by nearly \$90 million from its peak in 1996.

**Figure 19. Florida Medical Malpractice Payments
1991-2002
Adjusted for Inflation, 2002 Dollars**



Source: Florida Department of Financial Services Professional Liability Closed Claims Database, March 13, 2003, and US Department of Labor, Bureau of Labor Statistics, for consumers price index on medical services.

Distribution of Closed Claims Cases by Payment Amounts

The data in Figure 17 (above) represent all of Florida's medical malpractice closed claims cases for the years 1991 through 2002. In Figure 20 (below) those data are repeated in the last three columns on the extreme right. Figure 20 also includes similar data for physicians and podiatrists, grouped together, and for hospitals. It is interesting to note that of the 5,471 total cases for hospitals, 4,493 (82.12 percent) are for amounts of \$250,000 or less. In other words, over the 12-year period, just 978 (17.88 percent) hospital medical malpractice cases exceeded \$250,000 and just 269 (4.92 percent) exceeded \$1.0 million. For physicians and podiatrists, out of the 10,307 total closed claims cases, just 119 (1.16 percent) exceeded \$1.0 million.

Figure 20. Distribution of Closed Claim Cases Selected Types, 1991-2002

Size of Claim	Physicians and Podiatrists			Hospitals			All Closed Cases		
	Number of Cases	Percent	Cumulative Percent	Number of Cases	Percent	Cumulative Percent	Number of Cases	Percent	Cumulative Percent
0- \$250,000	8,120	78.78%	78.78%	4,493	82.12%	82.12%	14,135	81.28%	81.28%
\$250,001 - \$500,000	1,385	13.44%	92.22%	434	7.93%	90.06%	1,872	10.76%	92.04%
\$500,001 - \$1 million	683	6.63%	98.85%	275	5.03%	95.08%	991	5.70%	97.74%
\$1,000,001 - \$5 million	114	1.11%	99.95%	244	4.46%	99.54%	363	2.09%	99.83%
\$5,000,001 - up	5	0.05%	100.00%	25	0.46%	100.00%	30	0.17%	100.00%
Total	10,307	100.00%		5,471	100.00%		17,391	100.00%	
Average value	\$211,811			\$252,055			\$213,060		

Source: Florida Department of Financial Services, Professional Liability Closed Claims Database, March 13, 2003.

Further analysis of the Professional Liability Closed Claims Database for the period from 1991 through 2002 revealed an interesting relationship between the number and size of the payment versus the total amount paid. While the percentage of all closed claims cases with payments of \$250,000 or less is about 81.2 percent, the percentage of total dollars associated with those claims is only about 32.1 percent of the total payments of all closed claims cases (see Figure 21). The remaining 18.8 percent of the payments exceeded \$250,000 and accounted for 67.9 percent of the total value of the payments. In other words, of those cases with payments exceeding \$250,000, less than one case in five (18.8 percent) accounts for more than two-thirds (67.9 percent) of the total closed claims case payments. That fact provides considerable insight into the insurance industry's desire to limit non-economic claims to \$250,000.

Figure 21. Cumulative Distribution Closed Claims Cases Payments 1991-2002

Size of Claim	Total Value of Claims	Percent	Cumulative Percent
0- \$250,000	\$1,189,101,515	32.09%	32.09%
\$250,001 - \$500,000	\$723,173,651	19.52%	51.61%
\$500,001 - \$1 million	\$795,638,062	21.47%	73.08%
\$1,000,001 - \$5 million	\$751,754,321	20.29%	93.37%
\$5,000,001 - up	\$245,667,513	6.63%	100.00%
Total	\$3,705,335,062	100.00%	

Source: Florida Department of Financial Services Professional Liability Closed Claims Database, March 13, 2003.

CHAPTER FIVE REGULATING THE INSURANCE INDUSTRY

Non-Economic Caps and Insurance Rates

Perhaps the most significant policy question that must be considered in the context of this study is whether it is reasonable to assume that capping non-economic judgments will lead to significant reductions in the cost of medical malpractice insurance.

California is most frequently offered as the classic illustration that caps will lead to reductions in medical malpractice insurance. As demonstrated earlier in Chapter 2 of this report, although California insurance rates did drop initially, they subsequently increased rapidly within a few years despite the enactment of caps on non-economic judgments. It was only after the enactment of insurance reform brought about by passage of Proposition 103 that insurance premiums were substantially reduced and began a prolonged period of stabilization.

In short, merely capping non-economic payments was insufficient to substantially change the malpractice insurance climate. Thirteen years after caps were enacted in California, premiums had increased 450 percent and then 13 years after enactment of insurance reform, malpractice premiums had decreased by two percent.²³

In several other states, similar patterns appear evident. In Nevada, although insurance providers argued that caps would enable them to reduce malpractice rates, they subsequently raised their rates, causing many physicians to close their practices and leave the state. "The largest Nevada doctors group has counted 76 medical specialists who have closed their practices since March (2002) because of sky-high malpractice insurance premiums."²⁴

In Missouri, the number of claims "closed with payment" has declined by 42 percent during the period from 1988 to 2001.²⁵ The number of claims filed has also declined by 29 percent from 1987 to 2001. Adjusted for inflation, the average value of malpractice claims paid decreased by 20 percent in the past 10 years.²⁶ In spite of these reductions in both the number of claims and the cost of those claims, insurance rates have increased. In the past three years, Missouri's four largest malpractice insurance providers have raised their premiums by 28 to 97 percent.²⁷

In West Virginia, although non-economic judgment caps were adopted in 1986, insurers also did not reduce their rates. West Virginia's Insurance Commissioner approved 2001-2002 rate increases for medical malpractice insurers ranging from 17.9 percent to 26.4 percent.²⁸

The experiences of these four states suggest that capping non-economic judgments MAY, but will not NECESSARILY lead to significant reductions in the cost of medical malpractice insurance premiums. The primary rationale for not implementing premium reductions in the face of declining levels of risk would logically be that, notwithstanding the availability of caps at \$250,000, insurers remain

²³ "Assessing the Need to Enact Medical Liability Reform," by Harvey Rosenfield, February 27, 2003, see URL www.consumerwatchdog.org/healthcare/rp/rp003155.pdf, page 2.

²⁴ "Group: 76 Medical Practices Have Closed," *Las Vegas Review – Journal*, January 29, 2003.

²⁵ "Medical Malpractice in Missouri: The Current Difficulties in Perspective," Missouri Department of Insurance, February 2003, pages 14-15.

²⁶ *Ibid*, page 16.

²⁷ *Ibid*, page 30.

²⁸ "Ninety-Third Annual Report Of The Insurance Commissioner Of the State Of West Virginia Year Ending December 31, 2001," October 2002. See at: http://www.state.wv.us/insurance/WVICOnline/adobe_files/annual_report_2001.pdf

concerned about their remaining risk levels. Alternatively, they simply may desire to achieve much higher profits levels, particularly during economic cycles in which their investment income does not generate “sufficient” revenue to meet profit expectations.

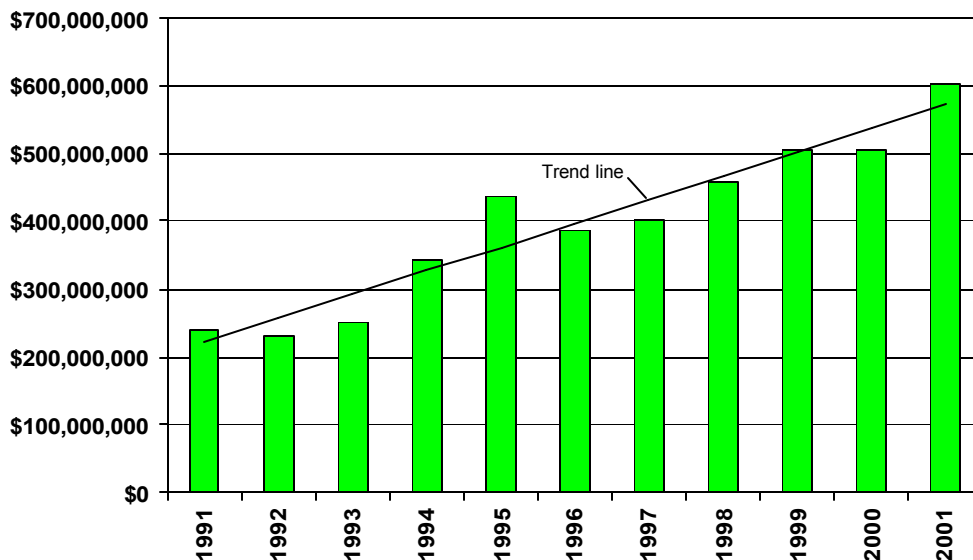
How Healthy Are Florida Medical Malpractice Insurers?

As Florida begins to consider the possibility of implementing caps on non-economic judgments, it is important to assess the health of insurers doing business in Florida. We attempted to make this assessment through an examination of malpractice premium revenues in relation to claims payments and incurred losses.

An analysis of medical malpractice premiums earned during the period 1991 - 2001 showed a continuing upward trend. During this eleven-year period, there were only two years in which premium earnings did not increase over the previous year. By 2001, insurers were earning premiums in Florida totaling over \$600 million dollars.

(Note: Figures 22 through 24 document premiums earned by medical malpractice insurance providers in Florida from 1991 through 2001. All three of these figures are based on data from the National Association of Insurance Commissioners. In addition, Figures 23 and 24 include data from the Florida Department of Financial Services, Professional Liability Closed Claims Database, March 13, 2003.)

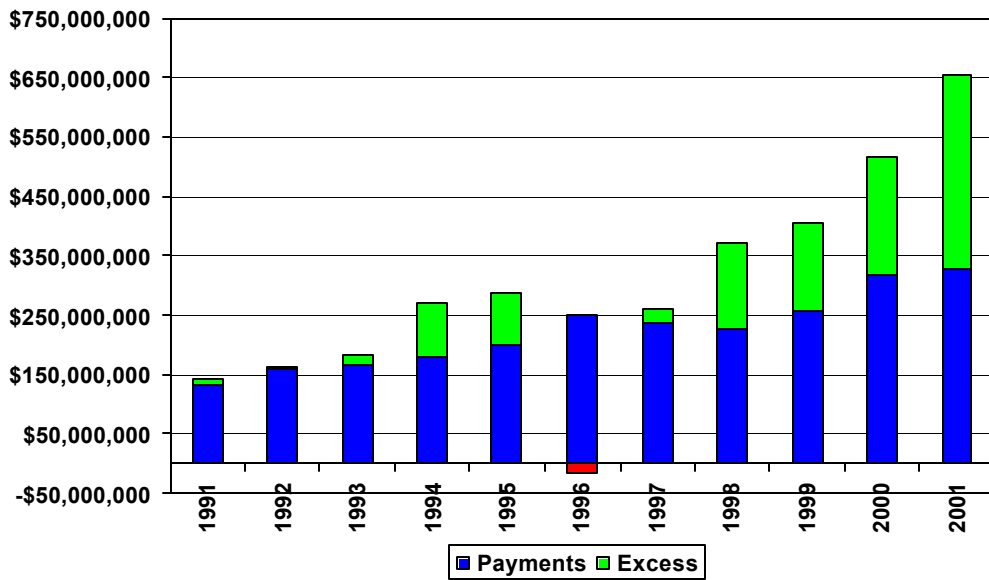
Figure 22. Florida Medical Malpractice Premiums Earned, 1991 - 2001



Source: National Association of Insurance Commissioners (NAIC).

The significance of these premium-earning levels can best be understood when placed into the context of payment expenses experienced by insurers. Figure 23 depicts the relationship between premiums earned, as depicted in Figure 22, and two categories of expenses: (a) those necessary to make malpractice payments and; (b) those in excess of the amount needed for malpractice payments. Although these data do not single out specific companies, they do confirm that collectively, with the exception of one year over the 1991 - 2001 period of analysis, earned revenues were in excess of all malpractice payments.

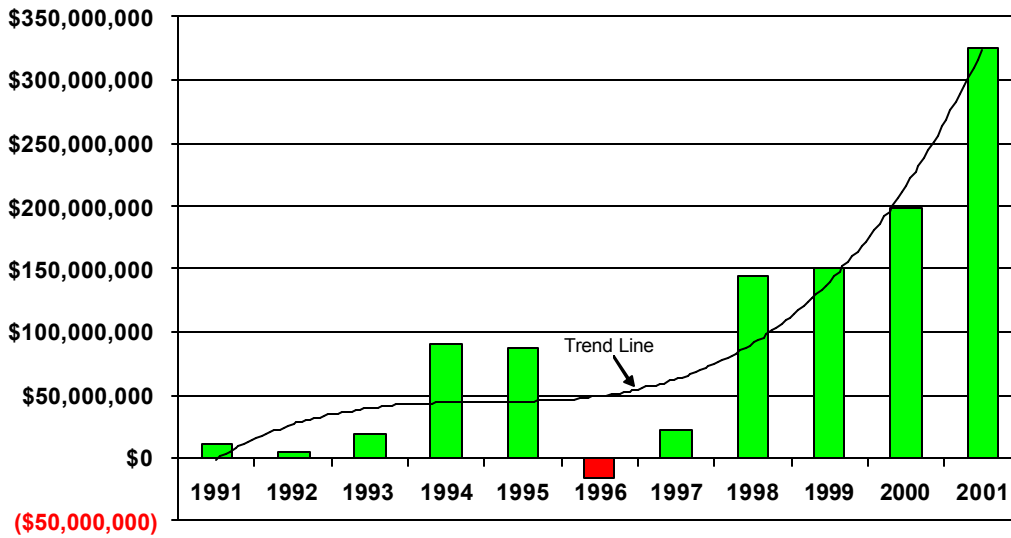
Figure 23. Florida Medical Malpractice Premiums Earned Amount For Payments and Excess, 1991 - 2001



Source: Florida Department of Financial Services, Professional Liability Closed Claims Database, March 13, 2003, for payments, National Association of Insurance Commissioners (NAIC) for premiums earned.

This growth in the portion of malpractice premiums earned in excess of that necessary to make malpractice payments is referred to herein as the excess in malpractice premiums earned. These earnings are depicted in Figure 24 (below).

Figure 24. Florida Medical Malpractice Premiums in Excess of Malpractice Payments, 1991-2001

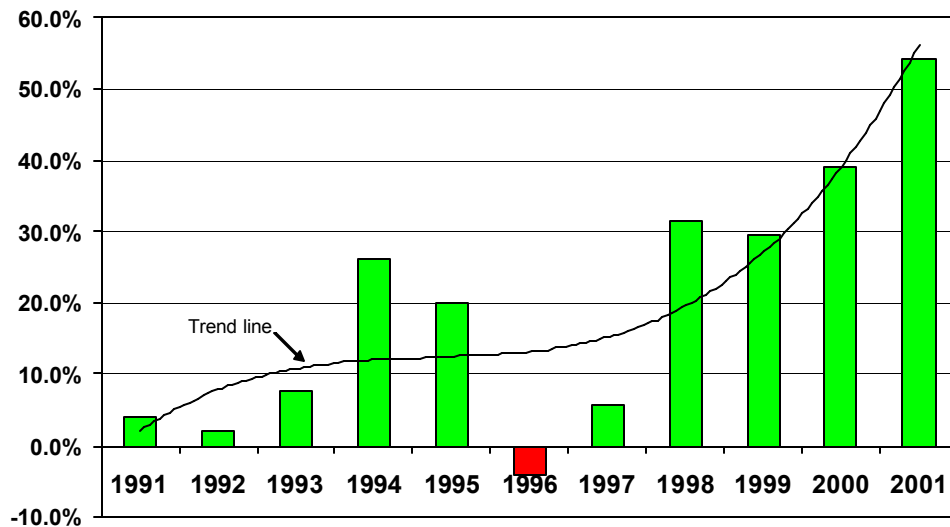


Source: Florida Department of Financial Services, Professional Liability Closed Claims Database, March 13, 2003, excluding closed claims against Lawyers, for payments and the National Association of Insurance Commissioners (NAIC) for premiums earned.

Premiums in excess of payments have fluctuated in Florida during the study period, although the trend line shows an overall upward growth pattern. The average annual rate of premium increases in excess of payments was approximately 41.9 percent over the period from 1991 through 2001.

The significance of these premium payments in excess of payments can be understood more clearly when placed into a percentage context as presented in Figure 25. As a percentage of premiums earned, the amount of premiums received beyond that necessary for payment of medical malpractice claims has varied from a low of a negative 4.3 percent in 1996 to a high of 54.1 percent in 2001. Although there are clear fluctuations in these percentages, they do reflect a strong upward trend in recent years.

Figure 25. Florida Medical Malpractice Premiums In Excess of Payments as a Percent of Premiums, 1991 – 2001

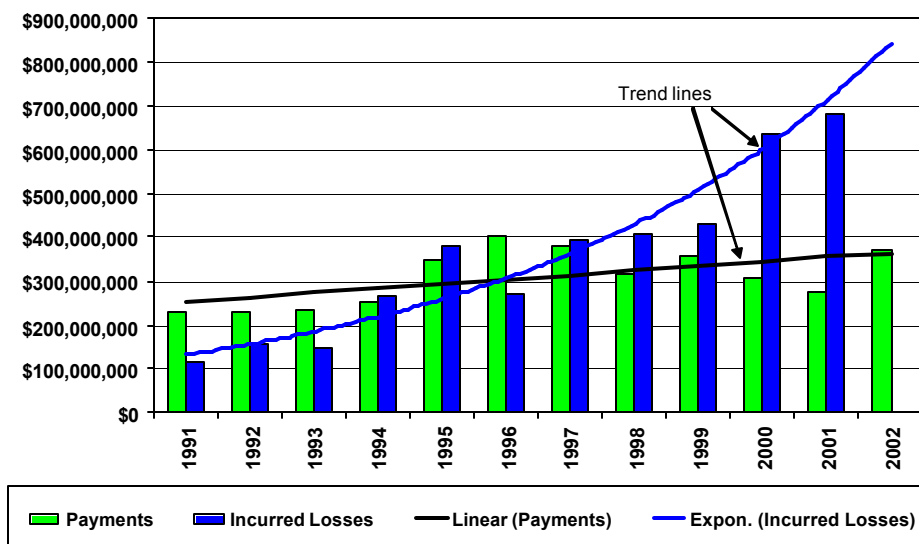


Source: Florida Department of Financial Services, Professional Liability Closed Claims Database, March 13, 2003, excluding closed claims against Lawyers, for payments and the National Association of Insurance Commissioners (NAIC) for premiums earned.

Complicating the apparent picture of reasonable insurance company profitability in Florida in recent years as suggested by these “revenues in excess of profits” figures is another factor raised by malpractice insurance companies. The National Association of Insurance Commissioners prefers to use “incurred losses” as opposed to “payments” of medical malpractice claims for the purposes of showing the pressure on insurance companies to increase premiums. As mentioned in the Methodology chapter, “incurred losses” include paid losses plus reserves for “possible” future losses that may or may not ever occur, as well as profits.

Figure 26 shows the relationship of those two different metrics for the years 1991 through 2001. Over the first 11 years studied, incurred losses increased an average of approximately 19.3 percent annually, whereas actual payments for malpractice claims increased an average of approximately 4.4 percent annually from 1991-2002.

Figure 26. Florida Medical Malpractice Insurance Payments vs. Incurred Losses, 1991-2002



Source: Florida Department of Financial Services, Professional Liability Closed Claims Database, March 13, 2003, excluding closed claims against Lawyers, for payments National Association of Insurance Commissioners (NAIC) for incurred losses (NAIC data for 2002 not available).

It is important to recognize the difference between “incurred losses” and “paid losses”. Management of incurred losses is critical to the overall performance of an insurance company and may also affect its competition. They can be used to fairly anticipate probable losses or provide a growing resource base that can be used ultimately to increase company profits.

The Potential for Abuse as Caps are Applied

The significance of this category of losses and the potential for its abuse was most clearly illustrated in an article published in the June 24, 2002, issue of the *Wall Street Journal*.²⁹ This article describes a case involving St. Paul Companies in which its reserves were mismanaged.

Up until 2001, St. Paul had a 20 percent share of the medical malpractice insurance market and subsequently pulled out because they mismanaged their reserves. They had set aside large reserves in the 1980s and then released \$1.1 billion of them, allowing those resources to flow through their income statements with the appearance of profit. Enticed by an apparently profitable market, many smaller companies entered the market and offered cut-rate premiums to attract customers. Rates fell to the extent that malpractice claims could not be covered and many companies, including St. Paul, pulled out of the market, causing a critically short supply of medical malpractice insurance providers. Since St.

²⁹ “Insurers’ Missteps Helped Provoke Malpractice Crisis,” *Wall Street Journal*, Christopher Oster and Rachel Zimmerman, June 24, 2002.

Paul provided medical malpractice insurance in 49 states and the District of Columbia, its withdrawal from the market had a substantial effect on practitioners' malpractice coverage throughout the nation.

These data suggest that the control of insurance premium rates in Florida, as in other states, is a very complex process. It is generally assumed that there is a direct, positive relationship between premium levels and insurer expenses, i.e. as payment expenses rise or fall, so too should premiums follow in the same direction.

That reality is not necessarily the case. Projected out-year losses, legal fees related to malpractice cases, investment earnings and profits desired by the insurer all contribute to the ultimate insurance premiums charged. These facts suggest that any serious policy discussion of malpractice premium cost controls must include an analysis of insurance company profit levels, with particular emphasis on the relative increases over time in both direct and incurred losses versus actual premium levels.

In addition, consideration also must be given to the potential impact of capping non-economic payments on the potential behavior patterns of medical care professionals and institutions if rates do not drop as in the states referenced above. Will the current crisis become even more acute if rates do not decline, but continue to rise? How would such a continuing crisis further impact the quality of healthcare services, including access to a number of specialists in high cost specialty areas?

In short, the potential failure of insurance providers to respond to caps on non-economic payments by lowering their fees and/or stabilizing their prices could worsen Florida's current malpractice crisis. Experiences in the states discussed above suggest that it is only through the use of legislation or the regulatory process that government can assure that the desired insurance premium outcome has potential for implementation.

CHAPTER SIX POLICING THE PROFESSION

Enhancing Medical Practice in Florida

As suggested in Chapter 1, our research indicates that most political discussions related to lowering the costs of medical malpractice premiums focus on capping non-economic judgments. This is not surprising as there is a natural tendency to look for a simple solution to complex problems. Moreover, the perception that plaintiff's attorneys are reaping too many resources from these decisions generates even greater interest in curbing non-economic judgments.

As demonstrated earlier in this report, however, it is clear in California's experience that caps, in isolation of additional actions, did not solve the problem of rapidly rising insurance premiums. Other states, including Nevada, Missouri and West Virginia, have had similar experiences over the past decade. California then added insurance regulation as the caps proved increasingly more ineffective over time in stabilizing lower premium rates. The regulation of insurance rates can have a major impact on lower premium rate increases, as the California experience demonstrates.

It is clear from looking at Florida data that there is a third ingredient in the larger cost containment mosaic that must be considered – the quality of care provided by healthcare professionals and institutions. As the quality of care improves, the number of medical accidents declines, the incidents of improper surgery are reduced, and cases of failure to diagnose are improved, the rate of medical malpractice actions should decline. Ultimately, the healthcare community can and must become part of the solution to the medical malpractice premium problem.

A committee of the National Institute of Medicine has stated the case for this argument very effectively:

Historically, the health system has not had effective ways of dealing with dangerous, reckless or incompetent individuals and ensuring they do not harm patients. Although the health professions have a long history of work in this area, current systems do not, as a whole, work reliably or promptly. The lack of timeliness has been a special problem. Numerous reasons have been advanced for the lack of more timely and effective response by professions and institutions. Requirements posed by legal due process can be very slow and uncertain; the need for, but difficulty in arranging, excellent supervision has stymied efforts at retraining; and matching individual needs to adult learning principles and retraining that is tailored to specific deficits has been problematic. With this acknowledged, the committee believes that healthcare organizations should use and rely on proficiency-based credentialing and privileging to identify, retrain, remove, or redirect physicians, nurses, pharmacists, or others who cannot competently perform their responsibilities...If these systems are working properly, unsafe professionals will be identified and dealt with BEFORE they cause problems.³⁰

This message from the National Institute of Medicine provides a clear blueprint for Florida to consider. In developing a comprehensive approach to dealing with rapidly rising medical malpractice premiums, the State must focus on the issues outlined above by the committee. To the extent that the profession does a better job of policing the practices of its colleagues, they will be the ultimate beneficiaries.

³⁰ "To Err is Human: Building a Safer Health System," Linda T. Kohn, Janet M. Corrigan, and Molla S. Donaldson, Editors; Committee on Quality of Health Care in America, Institute of Medicine, 2000, page 169.

The Quality of Medical Care in Florida

The citizens of Florida are very fortunate to have access to some of the highest quality medical professionals in the nation. As of March 17, 2003, there were 45,960 physicians, plus 4,563 chiropractic physicians, 4,584 podiatric physicians and 10,559 dentists licensed in Florida.³¹

In its document, "Florida's Real Medical Problem: Bad Doctors and Insurance Companies, Not the Legal System," the non-profit consumer organization, Public Citizen, states that six percent of Florida's doctors account for more than 50 percent of all malpractice payments.³² The data in Figure 27 indicate that the situation may have improved slightly, in that 7,500 of the 13,968 cases (53.7 percent) involved practitioners with just one malpractice case resulting in a payment. The Public Citizen report also states that, "The Florida Board of Medicine is dangerously lenient with doctors, repeatedly letting serious and sometimes repeat offenders off the hook."

Recognizing that such an allegation is reflective of the concerns voiced by the National Institute of Medicine Committee, we looked more closely at data that might confirm or discredit the allegation.

Figure 27 provides a count of the number of practitioners by the number of medical malpractice cases in which they have been engaged. These data came from the National Practitioner Data Bank Public Use Data File, September 30, 2002 and demonstrate several important realities:

- The overwhelming majority of medical practitioners have never been involved in a medical malpractice case.
- Of the 9,982 practitioners who have been party to a malpractice case, 7,500 have only had one instance of involvement in such a case.
- A total of 9,475 of the 9,982 practitioners were involved in two or fewer cases.
- A total of only 807 practitioners were involved in malpractice cases ranging in numbers from 3 to 32.

³¹ E-mail communication from the Florida Department of Health, March 18, 2003.

³² "Florida's Real Medical Malpractice Problem: Bad Doctors and Insurance Companies, Not the Legal System", Public Citizen, Congress Watch, September 2002, page 4.

**Figure 27. Florida Medical Malpractice Cases
per Practitioner, Sept 1, 1990 thru Sept 30, 2002
9,982 Practitioners, 13,968 Total Cases**

Number of Cases	Number of Practitioners
0	55,684
1	7,500
2	1,675
3	498
4	173
5	68
6	26
7	14
8	8
9	6
10	3
11	1
12	1
13	2
14	2
15	1
16	1
18	1
32	2

Source: National Practitioner Data Bank Public Use Data File, September 1, 1990 to September 30, 2002, and Florida Department of Health. The number of practitioners with zero cases was calculated from the total number of physicians (45,690), chiropractic physicians (4,563), podiatric physicians (4,584) and dentists (10,559) licensed in Florida as of March 17, 2003. From that total sum (65,666) the number of practitioners (9,982) who have had one or more malpractice cases was subtracted.

In considering these numbers we also were sensitive to the fact that practitioners in certain medical specialty areas are more likely to be the subject of a malpractice allegation. Unfortunately, current state and national databases do not contain data elements that allow such an analysis.

To develop a clearer sense of the backgrounds of practitioners who have committed malpractice acts in Florida, we again reviewed information contained in the National Practitioner Data Bank Public Use Data File, September 30, 2002. That analysis revealed some disturbing facts about the comprehensiveness of medical practice oversight in Florida. The following brief vignettes depict different types of situations involving practitioners who have committed malpractice acts in Florida that resulted in payment of malpractice claims.

First, there are several practitioners who have committed a large number of malpractice acts in Florida and they have also been cited with adverse actions by regulatory agencies or societies.

- Practitioner number 7706 committed 32 malpractice acts, nearly all of which involved either unnecessary or improper surgery, resulting in malpractice payments in Florida. In addition, this practitioner was cited with 10 adverse actions by regulatory agencies or societies. This is a total of 42 malpractice issues involving \$3.3 million in claim payments. After committing malpractice acts over an eight-year period, his/her license was finally revoked.
- Practitioner number 85927 committed 16 malpractice acts, all of which involved improper behavior of a sexual or assault nature, resulting in malpractice payments in Florida. In addition, this practitioner was cited with 8 adverse actions by regulatory agencies or

societies. This is a total of 24 malpractice issues along with more than \$260,000 in claim payments. Finally, his/her license was permanently revoked.

A second group involves practitioners who have committed a large number of malpractice acts in Florida and, in some instances, additional acts in other states. Here are a few examples:

- Practitioner number 22350 has committed two malpractice acts in Florida and 175 malpractice acts, part of which were in New Jersey and others for which “work state” was not specified. In total, this practitioner had 177 malpractice acts, all of which involved either improper administration of medication or ordering the wrong medication. Total malpractice claims paid for this practitioner amounted to nearly \$1.0 million. There is no record in the National Practitioner Data Bank Public Use File of this individual having ever been reprimanded nor is there a record of his/her license having been revoked.
- Practitioner number 7539 has committed 32 malpractice acts in Florida, all of which involved the failure to maintain infection control. Total malpractice claims for this physician amount to more than \$1.4 million. There is no record in the National Practitioner Data Bank Public Use File of this individual having ever been reprimanded nor is there a record of his/her license having been revoked.
- Practitioner number 33304 has committed just one malpractice act in Florida but he/she committed 20 similar acts prior to arriving in Florida, 8 in Pennsylvania and 12 in New York, for a total of 21 acts for which more than \$2.25 million in malpractice claims was paid. This practitioner committed a variety of malpractice acts, including 6 involving either unnecessary or improper surgery along with an additional 9 acts involving an unspecified surgical malpractice. There is no record in the National Practitioner Data Bank Public Use File of this individual having ever been reprimanded nor is there a record of his/her license having been revoked.
- Practitioner number 24573 committed 12 malpractice acts in New York prior to practicing in Florida. Upon arriving in Florida he/she committed another 5 malpractice acts here and is still in business. Eleven of this practitioner’s malpractice acts involved improper, unnecessary or other surgical acts. In total, more than \$2.75 million in malpractice payments have been made in association with this physician’s 17 medical malpractice acts over an 11-year period. There is no record in the National Practitioner Data Bank Public Use File of this individual having ever been reprimanded nor is there a record of his/her license having been revoked.
- Practitioner number 27901 committed 7 malpractice acts in Florida and 10 in New York prior to moving to Florida. Of this practitioner’s 17 total malpractice issues, 13 involved a failure to diagnose the patient’s medical problem. After committing more than \$7.0 million in malpractice acts, this practitioner was reprimanded in Florida and finally surrendered his/her license.

As can be seen from the examples above, a number of medical practitioners are involved in multiple malpractice cases. Also, there are certain acts that are committed with higher frequency than others. Figure 28 lists 14 different malpractice acts committed in Florida, each of which had more than 200 occurrences during 1991 through 2002. These 14 different acts account for nearly 80 percent of all malpractice cases in Florida over the 12-year period.

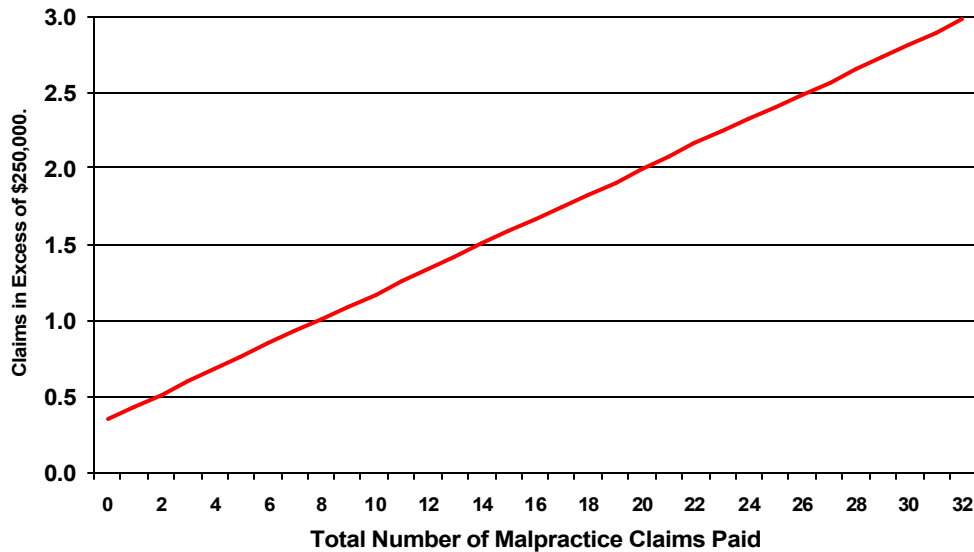
**Figure 28. Florida Medical Malpractice Acts
with 200 or more Cases, 1991-2002**
11,012 of 13,968 (78.8%) of all Cases

Cases	Malpractice Act
2,522	Diagnosis - Failure to Diagnose
1,704	Treatment (Not Otherwise Coded)
1,213	Surgery (Not Otherwise Coded)
903	Diagnosis - Delay in Diagnosis
886	Surgery - Improper Performance of Surgery
744	Treatment - Improper Performance of Treatment/Procedure
705	Diagnosis (Not Otherwise Coded)
530	Diagnosis - Wrong Diagnosis
447	Treatment - Improper Management of Course of Treatment
320	Anesthesia (Not Otherwise Coded)
269	Obstetrics (Not Otherwise Coded)
266	Treatment - Failure to Treat
254	Surgery - Improper Management of Surgical Patient
249	Treatment - Delay in Treatment

Source: National Practitioner Data Bank Public Use Data File, September 1, 1990 to September 30, 2002.

Analysis of the National Practitioner Data Bank Public Use Data File, September 30, 2002, indicates that once a practitioner has committed three or more malpractice acts, the chances are very good that he/she will have a malpractice case involving a payment in excess of \$250,000. Figure 29 depicts the relationship between the number of medical malpractice acts committed and the number of such acts involving a payment in excess of \$250,000. Linear regression was used to establish this relationship.

Figure 29. Chances of Having One or More Malpractice Claims Exceeding \$250,000 Increases With the Total Number of Claims Paid per Practitioner



Source: National Practitioner Data Bank Public Use Data File, September 1, 1990 to September 30, 2002. The relationship in the above graph was developed by using linear regression. Both the slope and intercept are statistically significant at the 0.01 level.

The critical challenge confronting policymakers in Florida is to determine whether these instances of multiple malpractice claims is a function of the medical specialty of the practitioner or actual patterns of poor medical practice. As the aforementioned committee of the National Institute of Medicine has also observed in this regard:

The committee recognizes, however, that some individuals may be incompetent, impaired, uncaring, or may even have criminal intent. The public needs dependable assurance that such individuals will be dealt with effectively and prevented from harming patients...Registration boards and licensure discipline is appropriately reserved for those rare individuals identified by organizations as a threat to patient safety...³³

The data reviewed in assessing the nature of both governmental and practitioner efforts in Florida to police the profession revealed that very few practitioners are sanctioned in Florida. Over the 12-year period from 1991 through 2002, of those Florida practitioners who had three or more malpractice paid claims, less than one in five (173 of 956 practitioners, or 18.1 percent) had a licensing action imposed. The vignettes above demonstrate the failure to take such actions even in the face of a large number of malpractice cases. These experiences warrant much more in-depth analysis to determine the

³³ "To Err is Human: Building a Safer Health System," Linda T. Kohn, Janet M. Corrigan, and Molla S. Donaldson, Editors; Committee on Quality of Health Care in America, Institute of Medicine, 2000, page 169.

extent to which they impact actuarial calculations in determining premium rates in Florida. To the extent that they do, this becomes an even more important factor in the quest to control malpractice premiums.

Is There a Case for Greater Shared Risk?

Another issue arising from our analysis relates to the issue of risk. At the present time, medical practitioners and/or institutions assume most of the risk for their medical decisions and actions. The malpractice system is based upon that expectation. The current regulatory and legal environment is built on the assumption that all medical treatments will be safe and meet accepted "standards of care."

As Florida becomes an increasingly more litigious state, medical practitioners are increasingly the subject of malpractice allegations, even when they have met the expected standards of care. This has led increasingly to a much more defensive approach to the provision of medical care. More tests are ordered than needed to protect the practitioner. Fewer natural births are the rule because of the greater perceived risks associated with such deliveries. Surgeons are increasingly more reluctant to perform complicated procedures because of the risks associated with them, irrespective of need.

An interesting and no doubt controversial notion must be raised in this context that might be helpful in developing a new model of "shared risk" in dealing with some medical procedures. As noted in Figure 1, in the domains of quality-of-care that can be provided for Floridians, there are options ranging from "safe" to "customized" care. There is little question that some procedures are non-elective in nature and should generally offer greater certainty of freedom from accidental injury. There are other procedures, however, that are elective in nature and may carry greater patient risk, as well as demand significantly greater patient actions to assure success. The question is whether medical practitioners should be the only ones bearing risk in those cases.

Currently, if a practitioner advises a patient that the chances of success for a particularly high risk surgical procedure are only 10 to 20 percent, and it is subsequently performed, that professional has a high probability of becoming the subject of a medical malpractice allegation, particularly in South Florida. Even if the patient signs a form acknowledging the risky nature of the procedure, the medical practitioner assumes all the risk. The question is whether a malpractice proceeding is reasonable in such a case if appropriate standards of care are met. If so, should the level of exposure for the practitioner reflect the joint decision making of the two parties involved in the decision making process? It is certain that the current system relieves the patient of any responsibility for his/her decisions. In virtually every other area of our society, each of us would be expected to assume much greater responsibility for our individual decisions after receiving professional assistance or support.

This issue further demonstrates the complexity of the current climate in which medical malpractice premiums are established. The manner in which state policymakers sort out all of the dimensions of this perplexing problem will determine the ultimate success of the effort to control the rising costs of medical malpractice premiums.

CHAPTER SEVEN CONCLUSION

The Issues in Perspective

It is generally accepted that Florida is in the midst of a major medical malpractice crisis linked directly to the rising costs of medical malpractice premiums. As a result of these rising premium costs, more physicians are closing their doors and leaving the state. Others are practicing without insurance and transferring their personal assets in case of future litigation. Others are modifying their practices to exclude procedures that are frequently the subject of malpractice allegations. As a result of these practitioner decisions, hospitals are closing obstetrics units and are unable to schedule complex surgery cases. Access to high quality medical care for many forms of non-elective medical procedures is diminishing.

The immediate response to these conditions is to attack what is perceived to be the major precipitator of the crisis – non-economic medical malpractice judgments. The primary rationale for efforts to cap non-economic judgments is that such an action will lead to significant reductions in medical malpractice premiums.

As documented in this report, the assumption that caps will lead to the desired premium reductions outcome continues to be the subject of considerable debate throughout the nation. Our research revealed that implementation of non-economic judgments caps in such states as Missouri, Nevada, West Virginia did not lead to premium reductions. In fact, in each of those states premiums actually increased in spite of the imposition of caps on non-economic judgments. Even in the showcase state of California, premiums dropped for only a brief period before rising over 400 percent. It was only after additional actions were taken in the form of insurance regulation that California was able to control a highly unstable pattern of premium increases.

Capping Non-Economic Judgments: Summary Facts

This report has documented several clear trends in Florida that collectively have had an impact on the current insurance premium crisis. Collectively, the following facts provide considerable insight into the insurance industry's desire to limit non-economic claims to \$250,000:

- Although the defense was successful in 54 percent of all court actions related to medical malpractice, in at least one-half of those cases in which the plaintiff prevailed, non-economic judgments were awarded.
- Of the medical malpractice cases resulting in a court awards involving a non-economic component, physicians in the Obstetrics/Gynecology specialty area had the largest number of cases, followed by General Surgery and Plastic Surgery. The large number of procedures performed by practitioners in these areas makes them particularly vulnerable to malpractice actions.
- The trend line for payments to settle Florida medical malpractice cases has continued to rise over the period from 1991-2002, even when adjusted for inflation.
- The largest number of court actions and closed claims cases related to medical malpractice occur in the largest urban areas of the state with the greatest numbers of physicians and lawyers.

- The total cost of all professional liability closed claims related to medical malpractice during the period from 1991-2001 totaled \$3.71 billion. Physicians accounted for \$2.16 billion of that amount and hospitals for \$1.38 billion.
- Although the number and percentage of cases with payments exceeding \$250,000 are not extraordinarily high at less than one case in five (18.8 percent), the total value of those cases is quite significant -- more than two-thirds (67.9 percent) of the total closed claims case payments.

Pros

- Reduces the amount insurance companies would potentially pay to settle claims involving pain and suffering, a direct contributor to the amount insurance companies charge for premiums.
- Ends the “Lottery Winnings” or “Jackpot Justice” aspect of medical malpractice claims.

Cons

- Caps may be unfair to the small number of patients with the most extensive injuries as well as those with low or no income. For example, loss of one’s eye sight or mental faculties should not be equated to the loss of a finger or a toe.
- Creates a “one-size-fits-all” mentality to resolving medical malpractice claims.
- Rigid caps may make it more difficult for victims to obtain legal representation and prosecute a case since legal firms would rather expend their resources on those cases which have possibilities for greater outcome.
- Since caps limit insurance companies’ exposure, they are more likely to withhold claims payment as a negotiating tactic.
- Caps can lead to a smaller percentage of insurance premiums going to pay victims and a larger percentage going to profit as well as defense costs and other administrative items.

Regulating the Insurance Industry: Summary Facts

These factors help to explain partially the reasons for rising malpractice premium costs in Florida. There are other trends and facts that suggest the problem leading to premium increases may be linked, instead to the policies and practices of insurance companies. Among the most important factors of those we observed are the following:

- In three states examined in the context of this study, non-economic payment caps were adopted for the purpose of reducing malpractice premiums. In each case, insurers raised their rates, even as the number and average value of claims paid decreased.
- In California, malpractice premium increases were not implemented immediately following the enactment of caps. Within a few years after the adoption of caps, however, there were significant malpractice premium rate increases. It was only after the imposition of greater insurance regulation, including a mandated premium reduction, that rates decreased and subsequently stabilized.
- During the period from 1991 - 2001, there were only two years in which insurance company premium collections in Florida did not increase over the previous year. By 2001, insurers were earning premiums in Florida totaling over \$600 million dollars.
- Collectively, each year over the 1991 - 2001 period of analysis, companies providing malpractice insurance in Florida earned revenues in excess of all malpractice payments. The average annual rate of premium increases in excess of payments was approximately 41.9 percent over the period from 1991 through 2001.
- As a percentage of premiums earned, the amount of premiums received beyond that necessary for payment of medical malpractice claims has varied from a low of a negative 4.3 percent in 1996 to a high of 54.1 percent in 2001.
- Over the 11-year study period, incurred losses increased an average of approximately 19.3 percent annually, whereas actual payments for malpractice claims increased an average of approximately 4.4 percent annually. The funds generated in excess of the 4.4 percent annual growth can be used to fairly anticipate probable losses and/or to increase company profits.

Pros

- Can have a direct impact on premiums paid and help to minimize excess profit.
- Can stabilize the level of insurance premiums, eliminating large shifts in the annual amount charged to practitioners.
- Less pressure on practitioners to increase the cost of healthcare.
- If implemented similar to California's Proposition 103
 - Provides for citizen input into proposed insurance rate increases.
 - Requires insurance companies to rollback insurance premiums by at least 20 percent.
 - Requires prior approval before implementing insurance premium increases.

- Requires insurance companies to refund excess premiums collected in recent years, amounting to more than \$135 million.³⁴

Cons

- Care must be exercised to assure that restrictions are not so severe as to cause insurance companies to flee from the State.
- May interfere with the free-market for insurance providers.
- If not properly implemented, may limit the capacity of insurance companies to make a reasonable profit in the state.

³⁴ "How Insurance Reform Lowered Doctor's Medical Malpractice Rates in California and How Malpractice Caps Failed," The Foundation for Taxpayer and Consumers Rights, February 10, 2003, page 5.

Policing the Profession: Summary Facts

Finally, there are some factors related to the medical profession itself that are important factors impacting this crisis. We have referred specifically to the lack of sufficient policing of the profession. This failure has a potential negative impact on the quality of healthcare services available to Floridians. It also has potential pricing implications for malpractice insurance. Among the most important facts related to policing the profession that we have identified during the course of this research are the following:

- Historically, the health system has not had effective ways of dealing with dangerous, reckless or incompetent individuals and ensuring they do not harm patients. Although the health professions have a long history of work in this area, current systems do not, as a whole, work reliably or promptly.³⁵
- The problem goes beyond reckless or incompetent practitioners. Many believe that there is a significant problem of well meaning practitioners being involved in mistakes and accidents that are never reported.
- A total of only 807 Florida medical practitioners were involved in malpractice cases ranging in numbers from 3 to 32.
- Once a practitioner has committed three or more malpractice acts, the chances are very good that he/she will have a malpractice case involving a payment in excess of \$250,000.
- Over the 12-year period from 1991 through 2002, of those Florida practitioners who had three or more malpractice paid claims, less than one in five (173 of 956 practitioners, or 18.1 percent) had a licensing action imposed.
- There are certain acts that are committed with higher frequency than others. Figure 28 lists 14 different malpractice acts committed in Florida, each of which had more than 200 occurrences during 1991 through 2002. These 14 different acts account for nearly 80 percent of all malpractice cases in Florida over the 12-year period. Almost 50 percent of those cases fit into three categories. The three categories with the largest number of cases, in order of occurrences were: diagnosis (failure to diagnose); treatment; and, surgery

Pros

- Improvement in the quality of healthcare to Florida's citizens.
- Reduction in the number of medical malpractice cases.
- Would likely result in a reduction in the cost of medical malpractice insurance and stabilization of healthcare costs.

Cons

- May cause temporary, localized shortages in access to healthcare when practitioners are prevented from continuing their practice.

³⁵ "To Err is Human: Building a Safer Health System," Linda T. Kohn, Janet M. Corrigan, and Molla S. Donaldson, Editors; Committee on Quality of Health Care in America, Institute of Medicine, 2000.

Other Factors for Consideration

In addition to the factors referenced above, several other factors emerged from our research that warrant consideration by policymakers as they determine how to balance those mentioned above.

Constitutional Considerations

One of the major challenges confronting states that have adopted caps is the inevitable constitutional challenge. Although we are conducting a more in-depth analysis study of this topic, we have found that in several states (Florida, Washington, Oregon, Texas and Illinois) caps were ruled to be unconstitutional.

There are several constitutional questions that should be resolved regarding the current caps linked to use of the voluntary arbitration process. If policymakers decide to implement caps, a careful analysis of relevant constitutional factors should be considered.

To develop a clearer understanding of caps in Florida and all 50 states, a second study related to this topic is being conducted for The Florida Center by a team lead by Visiting Center Fellow and Florida State University Law Professor Talbot “Sandy” D’Alemberte. The study will devote particular attention to the history of court decisions and include an examination of potential constitutional questions that must be considered in the review of non-economic judgment caps in Florida. To illustrate the importance of conducting such an analysis related to Florida law, consider this observation from our project team leader:

“The tort reform bill passed by the Florida House of Representatives on March 21, 2003, contains many of the proposals recommended by the Governor’s Select Task Force on Health Care Professional Liability Insurance, but it raises significant constitutional issues. House Bill 1713 contains a provision that reads:

Section 28. Section 766.118, Florida Statutes, is created to read:
766.118 Determination of noneconomic damages.—With respect to a cause of action for personal injury or wrongful death resulting from an occurrence of medical negligence, including actions pursuant to s. 766.209, damages recoverable for noneconomic losses to compensate for pain and suffering, inconvenience, physical impairment, mental anguish, disfigurement, loss of capacity for enjoyment of life, and all other noneconomic damages shall not exceed \$250,000, regardless of the number of claimants or defendants involved in the action.

“In addition to the per incident language which raises equal protection questions, there are several other constitutional issues which ought to be examined. The research team will conduct a survey of damage caps imposed in other states, including various successful and unsuccessful constitutional challenges to these caps. The result will be a report of medical malpractice caps on non-economic and punitive damages in the fifty states.”

The Limitations of Fixed Dollar Caps

The adoption of caps with an amount certain embeds a fixed dollar amount into Florida Statutes that would require an act of the Florida Legislature to change as well as the need to overcome the previous declaration of the courts as to its constitutionality. This can cause several problems that must be considered before adoption. A fixed dollar limit results in a continuing reduction in the value of an award each year unless they are adjusted for inflation.

Unless automatic annual adjustments are made for inflation, the fixed amount would soon deteriorate in real value. Several states, including Colorado, Missouri and Utah, make annual adjustments to medical malpractice caps for the effects of inflation. Idaho adjusts its malpractice cap annually using the annual average wage as an index. To demonstrate the long-term effects of inflation on a fixed cap, \$250,000 in 1975 is equivalent to a cap of \$74,023 today (January, 2003) when adjusted for inflation by using the Consumers Price Index.

The Need for a Systemic Approach

The data and related analysis presented herein reinforce the reality that reducing medical malpractice insurance premiums is not a simple task. The development of a comprehensive, four-pronged strategy offers the best hope of making the permanent changes that would stabilize premium rates over time in Florida. The rationale for such an approach is based upon the integrated nature of the major elements of the problem. This approach would be similar to that adopted by California, but would add the additional dimensions of demanding greater practitioner accountability and shared risk in the process of system change.

We cannot say that the implementation of any one of the four elements of this systemic strategy should come before another. It is clear, however, that they will be most effective in addressing the premium increase challenge if implemented as part of a comprehensive package.

It also can be reasonably assumed that a failure to address this matter in a systemic fashion will lead to the need for further legislative actions to address easily anticipated problems experienced in other states searching for solutions to the challenges confronting Florida.

APPENDIX ABOUT THE AUTHORS

Dr. Adam W. Herbert, Regents Professor of Public Administration and Executive Director of The Florida Center for Public Policy and Leadership, earned a Ph.D. from the University of Pittsburgh in Urban Affairs and Public Administration. Dr. Herbert has been associated with the State University System (SUS) of Florida since 1979. Prior to his current position, he served as the sixth Chancellor of the SUS of Florida from January 1998 until March 2001 and as president of the University of North Florida for nearly 10 years. He previously held faculty/administrative positions at the University of Southern California, Virginia Tech and Florida International University. In addition, he is a former White House Fellow and served as special assistant to the Secretary of the U.S. Department of Health, Education and Welfare. He subsequently served as special assistant to the Undersecretary of the U.S. Department of Housing and Urban Development.

Dr. George R. Perkins, Director of Data Analysis and Research Support Services at The Florida Center for Public Policy and Leadership, earned a Ph.D. from Michigan State University in Agricultural Economics. Dr. Perkins has been employed in the State University System of Florida since 1971, starting with a Faculty appointment at the University of Florida where he taught graduate production economics and conducted applied research. Subsequently, he joined the Planning and Budgeting staff of the Florida Board of Regents in 1975 and continued working there for nearly 12 years. From 1987 through 1990, Dr. Perkins was Vice President for Administration and Special Assistant to the President at Florida Atlantic University. Prior to joining the Center staff in January 2003, Dr. Perkins served twelve years as Director of Research and Policy Analysis with the Board of Regents and the Division of Colleges and Universities.