Florida Office of Insurance Regulation

July 1, 2005
Closed Claim Database
Statistical Summary

Paragraph 627.912(6)(a),
Florida Statutes

Deloitte.

JULY 1, 2005

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July 1, 2005

Mr. Lee Roddenberry
Director, P&C Product Review
Office of Insurance Regulation
J. Edwin Larson Building
200 East Gaines Street, Suite 121
Tallahassee, FL 32399-0326

Dear Mr. Roddenberry:

Deloitte Consulting is pleased to submit our report completing Paragraph 627.912(6)(a), Florida Statutes.

It was a pleasure working with you and we look forward to serving the Office of Insurance Regulation in the future. Please do not hesitate to call either Jan at (860) 543-7350 or Kevin at (860) 543-7345 if we can be of any further assistance.

Sincerely,

Jan Lommele, FCAS, MAAA, FCA
Principal – Deloitte.

Phil Zakas
Senior Manager – Deloitte.

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Joshua Merck
Senior Consultant – Deloitte.

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I. EXECUTIVE SUMMARY

PURPOSE AND SCOPE

Deloitte Consulting LLP (Deloitte Consulting) has been retained by the Florida Department of Financial Services Office of Insurance Regulation (OIR) to complete the requirements of Paragraph 627.912(6)(a), Florida Statutes, which states:

> *"The office shall prepare statistical summaries of the closed claims reports for medical malpractice filed pursuant to this section, for each year that such reports have been filed, and make such summaries and closed claim reports available on the Internet by July 1, 2005."*

Appendix B displays 3 tables; an unadjusted statistical summary of the closed claim database (CCD) for all records from the Archive data file, an unadjusted statistical summary of the CCD records from the Current data file for all records (i.e., physicians, hospitals, etc.) and an unadjusted statistical summary of the CCD records from the Current data file for physicians records only. Although this Appendix satisfies the intent of Paragraph 627.912(6)(a), F.S, Deloitte Consulting strongly believes that the raw data of the CCD must be prepared and processed to some degree before using it as a basis for analyzing trend indications or for other statistical purposes. For example, we found it necessary to purge duplicate entries, eliminate or limit the use of records with suspected input errors, etc. Please refer to Appendix C for details of our data processing efforts. As such, Deloitte Consulting's analysis and review of closed claim information as presented in this report is based upon the raw data of the CCD after it has been processed and prepared accordingly.

BACKGROUND

Medical Malpractice Synopsis[1]

A claim for medical malpractice means a claim arising out of the rendering of, or the failure to render medical care services. An "action for medical malpractice" is a tort or breach of contract claim for damages due to the death, injury, or monetary loss to any person arising out of any medical, dental, or surgical diagnosis, treatment, or care by any provider of healthcare.

In any action for recovery of damages based upon medical malpractice, the claimant has the burden of proving the alleged actions of the healthcare provider represented a breach in the prevailing standard of care for that type of healthcare provider. The prevailing professional standard of care for a given healthcare provider is that level of care, skill and treatment which, in light of all relevant surrounding circumstances, is recognized as acceptable and appropriate by reasonably prudent, similar healthcare providers.

Medical Malpractice Industry Overview

The medical malpractice market is going through its third medical malpractice crisis or "hard" insurance market (i.e., period of rising rates) in thirty years. The first medical malpractice crisis occurred in the mid -to- late 1970s. The second medical malpractice crisis occurred in the mid-1980s. The current medical malpractice crisis began in early 2001. As is noted in the Contingencies Magazine article *The Medical Malpractice Market: From National Dominance to Regional Focus,* the current hard insurance market has been driven by a number of factors:

- Rising loss trends;
- Higher and more volatile jury awards;
- Adverse reserve development on prior accident/report year loss reserves;
- Reduced carrier capacity;
- Rising cost of reinsurance;
- Varying success of tort reform packages in multiple states (e.g., constitutionality, ability to pass tort reform); and
- Declining investment returns[2].

[1] 2003 University of Central Florida Governor's Select Task Force on Healthcare Professional Liability Insurance, Chapter 2

In order to address the "medical malpractice insurance crisis of unprecedented magnitude[3]", the Florida Legislature passed Senate Bill 2-D (SB2D) during its 2003 Special Session D (Vote: Senate 32-4; House 87-2). The legislation, effective September 15, 2003, addressed many issues affecting the quality and availability of health care, as well as the availability and affordability of medical malpractice insurance in Florida. SB2D addressed issues such as:

- Patient safety and improved quality of health care (e.g., regulations regarding healthcare facilities, licensure requirements, state agency duties, agency studies);
- Medical malpractice insurance; and
- Medical malpractice liability and litigation (e.g., presuit process, suit, caps on non-economic damages, bad faith actions against insurers, immunity);

For a complete history of the medical malpractice industry, the state of the medical malpractice market in Florida, cases addressing the constitutionality of recent tort reforms, Florida market leader responses regarding the impact of reforms through October 1, 2004, and rate filing trend analysis, please refer to Deloitte Consulting's October 1, 2004 report titled "Medical Malpractice Financial Information, Closed Claim Database and Rate Filings – Paragraph 627.912(6), Florida Statutes, as amended by Senate Bill 2-D (Ch. 2003-416)" available from the Florida Department of Financial Services web site: www.fldfs.com/companies/pdf/Med_Mal_2004_Rpt.pdf.

DISTRIBUTION AND USE

Deloitte Consulting understands that all records or data produced by Deloitte Consulting in response to this engagement are subject to applicable public records law(s). OIR personnel are available to respond to any questions with respect to this report. Deloitte Consulting will direct all third party requests for information to the OIR.

[2] July/August 2004 Contingencies Magazine (www.contingencies.org), The Medical Malpractice Market: From National Dominance to Regional Focus, Kevin Bingham.
[3] Section 1 of SB2D - "Findings", Legislature finding number 1.

RELIANCE AND LIMITATIONS

Deloitte Consulting's analysis of 627.912(6)(a), F.S., is based on background information, publicly available information, and financial data provided by the OIR. A specific audit of the data and background information is beyond the scope of this project. Deloitte Consulting has conducted such reasonableness tests of the data as we felt appropriate. In all other respects, Deloitte Consulting has relied without audit or verification on the data and background information provided. Any assumptions, adjustments or modifications made to the data by Deloitte Consulting will be documented in detail throughout the remainder of this report or by referencing prior Deloitte Consulting reports prepared for the OIR.

A complete copy of Senate Bill 2-D (Ch. 2003-416) may be obtained from the Office of Secretary of State, website www.dos.state.fl.us (under Elections, Laws) or directly from the website of the Florida Senate at www.flsenate.gov.

DATA CONSIDERATIONS

The Florida OIR Department of Financial Services collects closed claim reports filed by insurers. This information is stored in the CCD and a copy of it, valued as of March 2005, has been provided to Deloitte Consulting for the purposes of analyzing closed claim reports for those claims closed prior to March 2005. The CCD consists of two separate files, an Archive file containing closed claims with accidents occurring prior to 1994 and a Current file containing closed claims occurring in years 1994 and subsequent. It should be noted that the State of Florida takes no responsibility for the accuracy, completeness, or usefulness of the information filed by insurers and captured in the CCD. Deloitte Consulting has made reasonable efforts to scrutinize data entries and otherwise test the CCD in order to capture only those entries that may prove to be useful to the analysis. Appendix C of this report outlines the steps used to perform the data preparation process.

For the purposes of this report we have concentrated our analysis on claims closed in calendar years 1990 through 2004[4]. We believe this fifteen-year period represents a reasonable period for reviewing and discussing trends in frequency, severity and other claim characteristics underlying Florida medical malpractice claims. Additionally, these years provide the most useful insight into the current medical malpractice crisis. Appendix A has been included to illustrate some of the trends using all years available in the CCD.

It is also important to note that the CCD does not include information on claims that have not been closed (e.g., open medical malpractice claims in the discovery stage, undergoing investigation, negotiating a settlement, or processing through a trial). Since medical malpractice claims in Florida take several years on average from the occurrence date to closing date (see Chart 9, Chart 10 and Table 1), the vast majority of claims that will eventually be impacted by the 2003 tort reform will not be reflected in our analysis. The March 2003 Select Committee on Medical Liability Insurance Report states[5]:

> *"The database reflects claims that have been closed as of any one point in time. The injuries occurred many years prior to the claims' closures. So, when one looks for changes in severity or for frequency trends, looking at the number and size of claims that have recently been closed evidences an incomplete picture. Better data would be the inclusion of the number of claims, and the associated reserves established thereon, that are currently being realized by insurers. Rate filings include data that reflect claims paid in prior years and the reserves that have been set relative to claims filed in those years, but not yet paid or closed."*

[4] Given the age of the data prior to 1990 and publicly documented concerns regarding the data input into the older years of the Archive file, we do not believe that reviewing and discussing trends prior to 1990 will add significant value to this report. A detailed discussion of the comments made by organizations and individuals regarding the integrity of the Florida CCD can be found in the November 6, 2003 Deloitte Consulting report titled "Review of Florida Committee Substitute for Senate Bill 2-D, Calculation of Section 40 "Presumed Factor". The report can be obtained from the Florida Department of Financial Services web site:
www.fldfs.com/companies/pdf/OIR_Report_Final_110620031.pdf

[5] March 2003 Florida House of Representatives Select Committee on Medical Liability Insurance Report

Therefore, it is too early to evaluate and identify trends resulting from the passage of tort reform in September 2003. As claims close over the next few years (and enter the CCD) and the constitutionality of the cap on non-economic damages is decided, we would expect trends to emerge in future statistical studies.

II. ANALYSIS OF TRENDS

TRENDS IN FREQUENCY

Typically, the term "frequency" is used to define the ratio of numbers of claims to some base unit of exposure. The CCD however, does not lend itself to a meaningful comparison of claim counts to exposures in its present form. Therefore, when discussed in the Closed Claim Database section of this report, "frequency" will simply be defined as numbers of claims.

Claim Counts

The following set of charts displays the number of claims closed with an indemnity payment since 1990. It is important to note that the OIR did not require entities to submit claims without indemnity payments for a period of time between 1998 and 2003. As a result, we did not attempt to include claims with no indemnity payments, since inconsistent observations would likely result.

The first chart shows closed claim counts for all severity codes[6]. Chart 2 displays the counts for severity codes 1 to 3, Chart 3 displays the counts for severity codes 4 to 6, Chart 4 displays the counts for severity code 7, and Chart 5 shows the counts for severity codes 8 and 9. Chart 6 shows the percentage of total closed claim counts by severity group code, and the trend in distribution over time.

[6] Severity Code means the severity of injury scale found in the National Association of Insurance Commissioners (NAIC) medical professional liability insurance uniform claims report:
1. Emotional only – Fright, no physical damage Temporary
2. Temporary: Slight – Lacerations, contusions, minor scars, rash. No delay.
3. Temporary: Minor – Infections, misset fracture, fall in hospital. Recovery delayed.
4. Temporary: Major – Burns, surgical material left, drug side effect, brain damage. Recovery Permanent
5. Permanent: Minor – Loss of fingers, loss or damage to organs. Includes no disabling injuries.
6. Permanent: Significant – Deafness, loss of limb, loss of eye, loss of one kidney or lung.
7. Permanent: Major – Paraplegia, blindness, loss of two limbs, brain damage.
8. Permanent: Grave – Quadriplegia, severe brain damage, lifelong care or fatal prognosis.
9. Permanent: Death

Chart 1

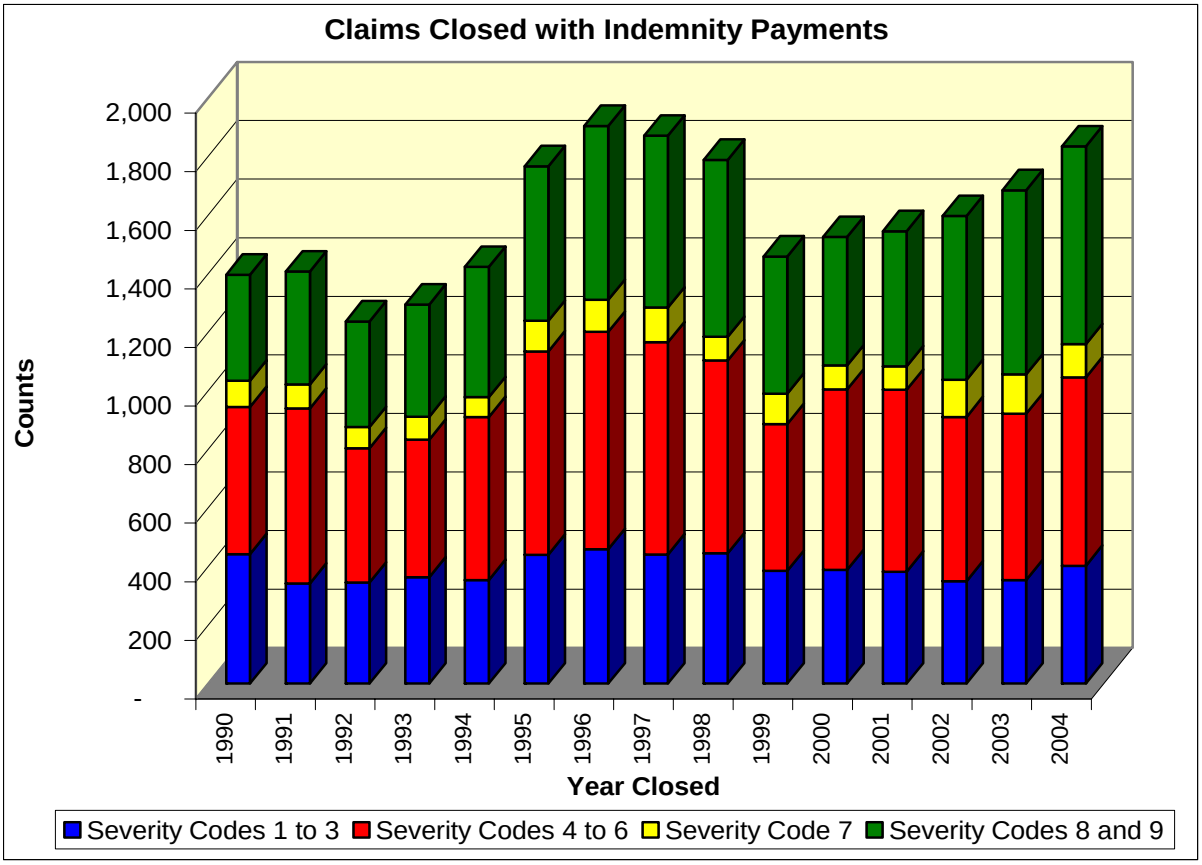


Chart 2

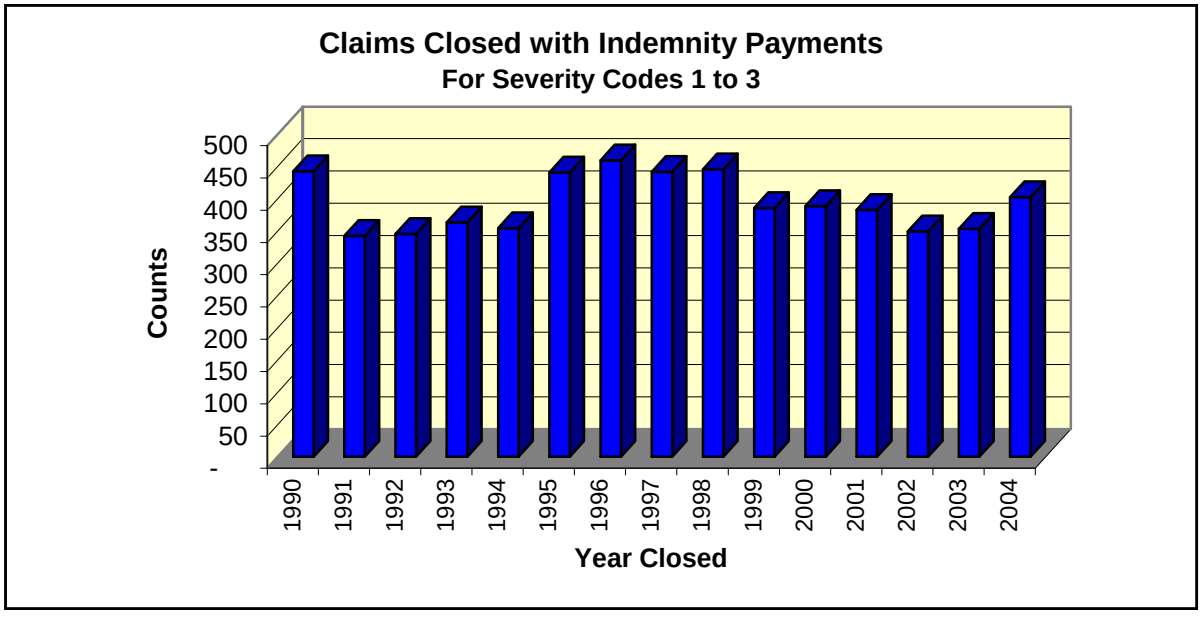


Chart 3

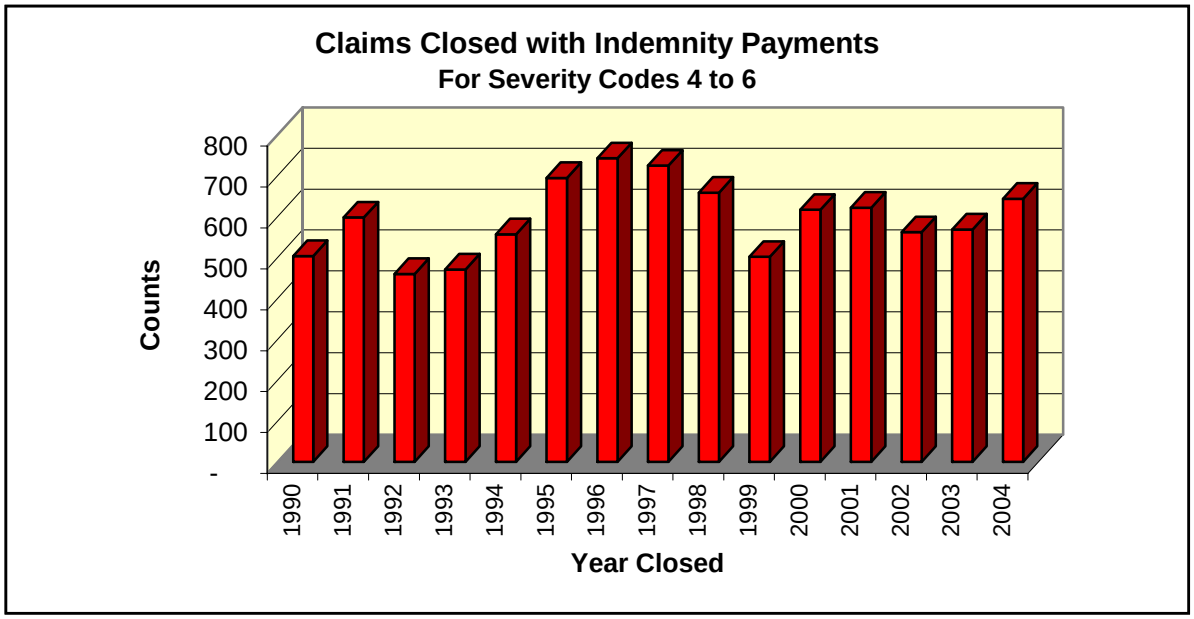


Chart 4

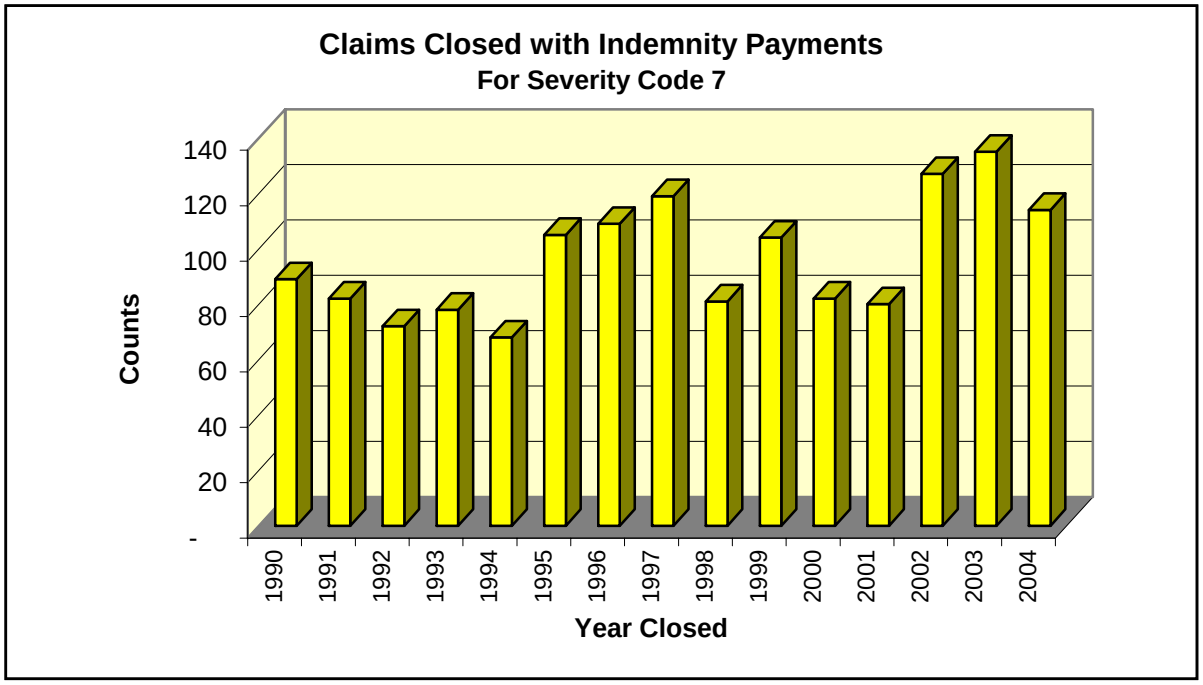


Chart 5

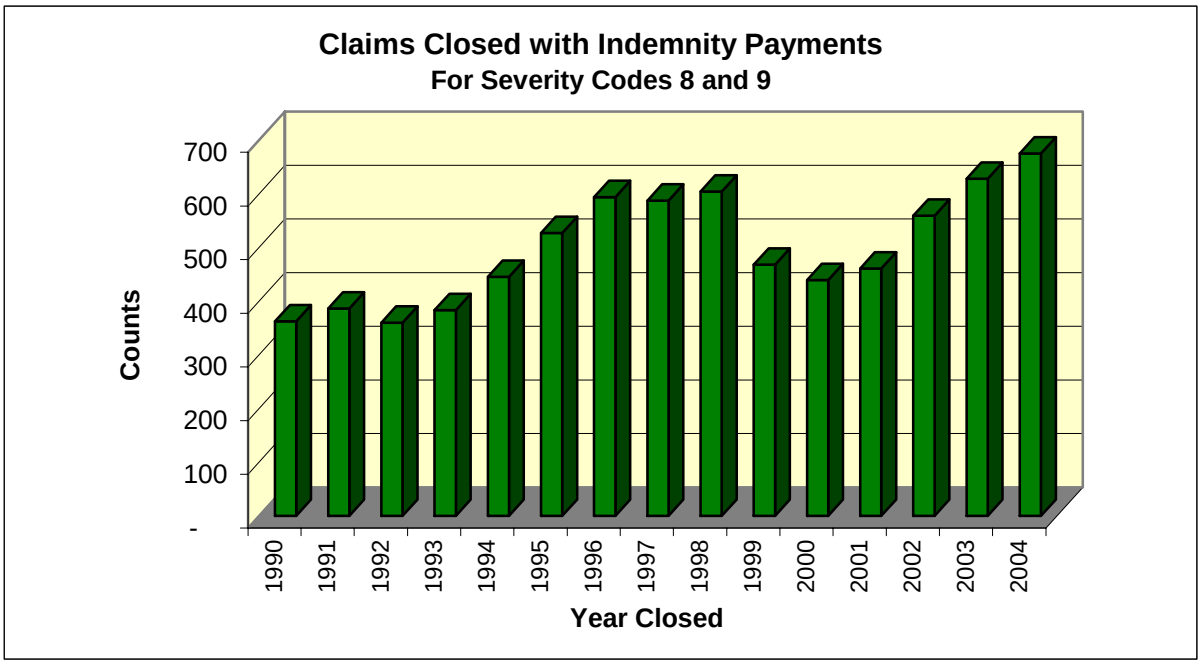
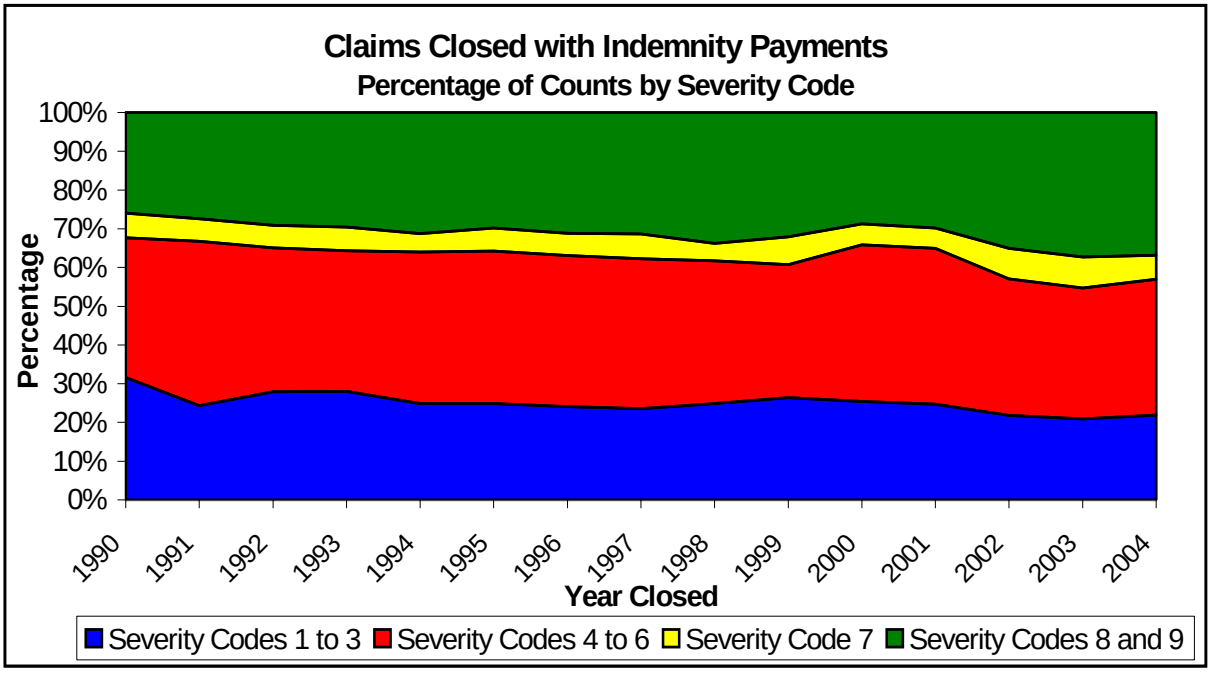


Chart 6



As displayed on Chart 6, the minor and insignificant NAIC severity codes 1 to 3 have become a smaller percentage of the claim counts since 1990. Severity codes 8 (grave – quadriplegia, severe brain damage, lifelong care or fatal prognosis) and 9 (death) have become a larger percentage of the claim counts since 1990.

Lag Times

When discussed in this report, lag time refers to the amount of time, in years, between significant dates in the life of a claim. We have focused primarily on the accident (i.e. occurrence) date, the date the claim is reported and the date the claim is closed. Review of lag times can allow insight into the average length of time claims spend in different stages of the claim process. Charts 7, 8 and 9 display the various lag time distributions which have been compiled from the CCD. In comparison to our prior report, issued October 1, 2004, we have not noticed any material difference in the lag time distributions shown below.

Chart 7

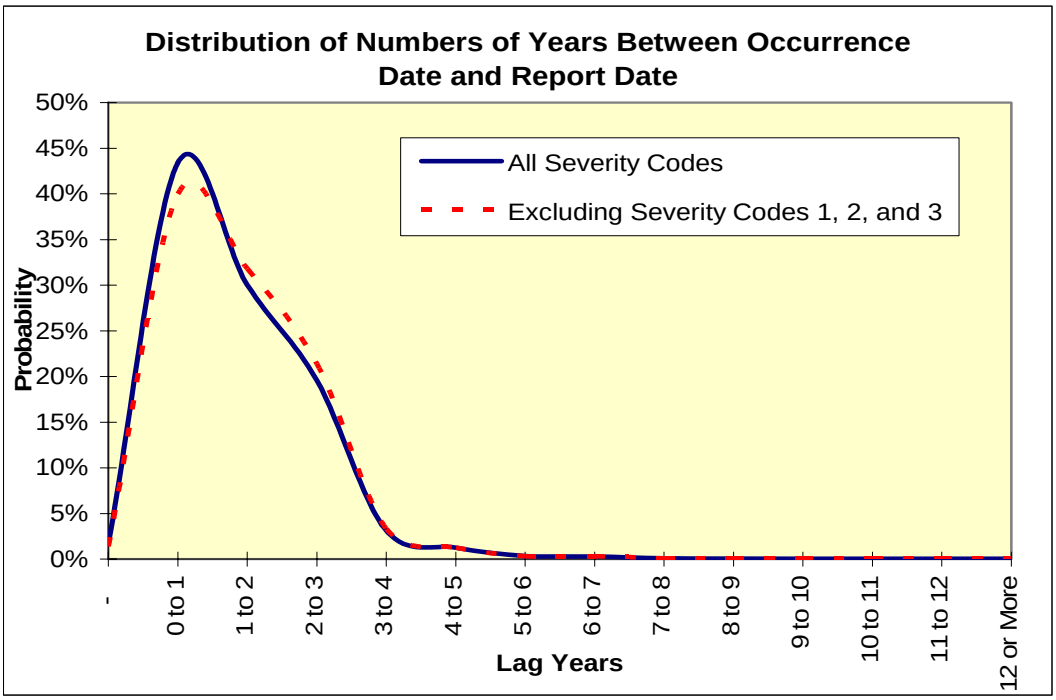


Chart 8

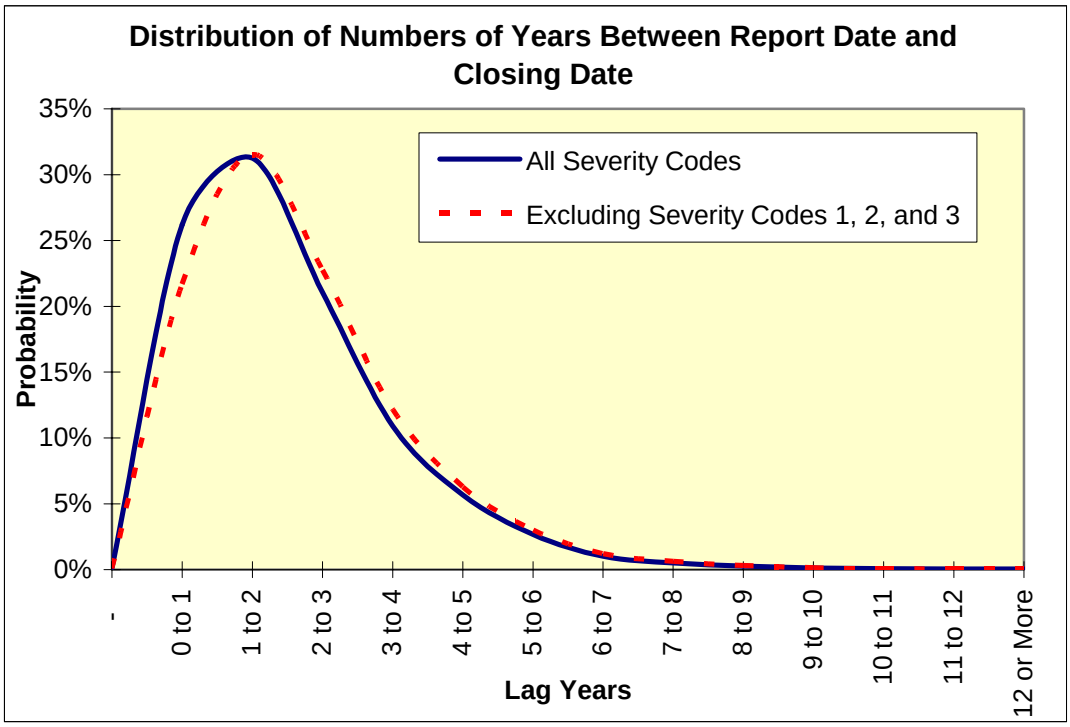


Chart 9

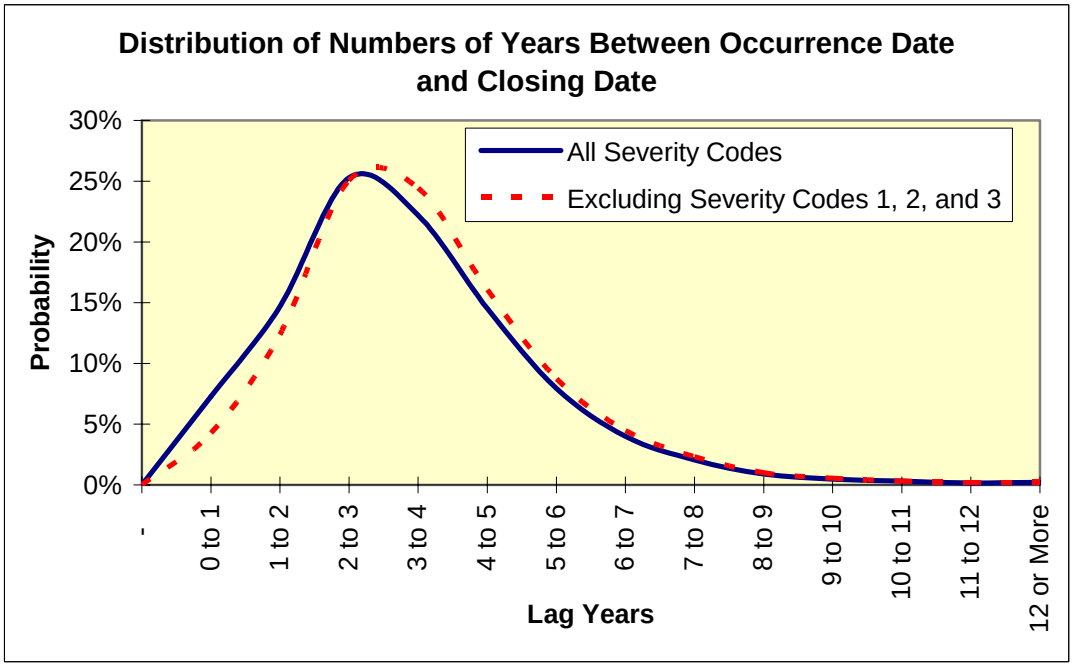


Table 1 displays lag time distributions for claims, excluding claims with a severity code of 1, 2, or 3.

Table 1

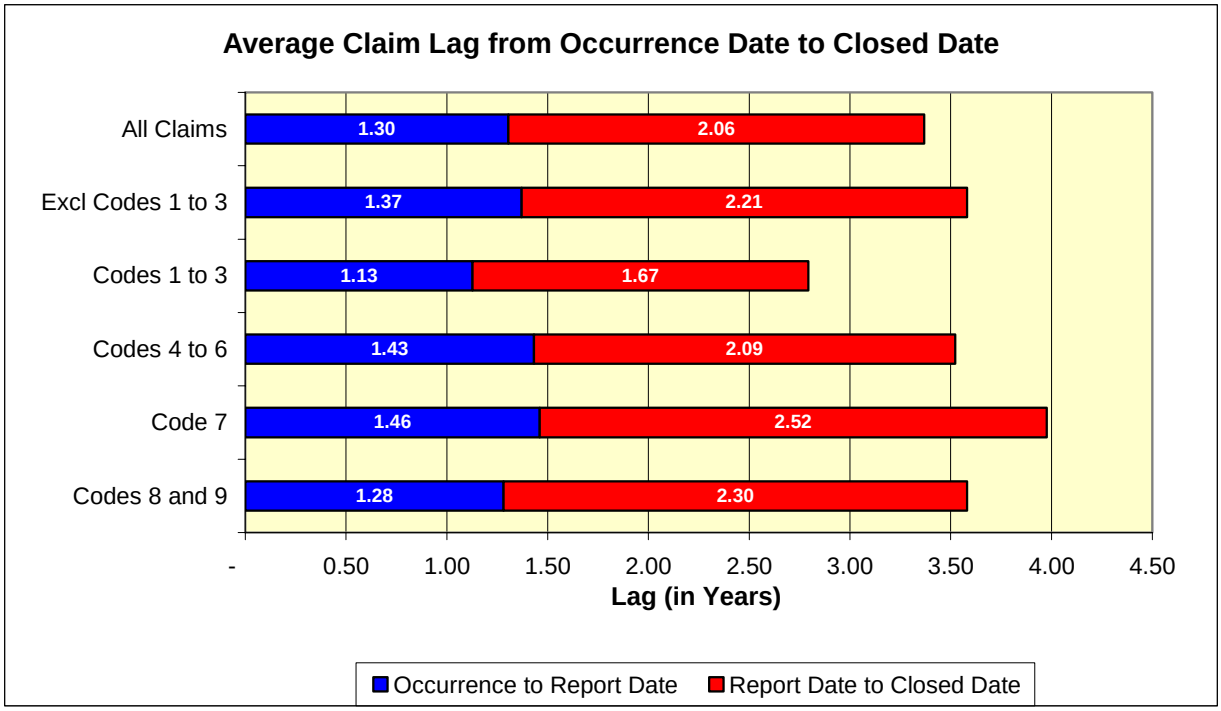
Lag Years	Distribution of Numbers of Years Between Occurrence Date And Report Date	Report Date and Closing Date	Occurrence Date and Closing Date
-	1.4%	0.1%	0.0%
0 to 1	40.0%	21.7%	4.3%
1 to 2	31.8%	31.5%	12.4%
2 to 3	21.4%	22.8%	25.1%
3 to 4	3.3%	12.1%	24.5%
4 to 5	1.3%	6.3%	16.1%
5 to 6	0.3%	3.0%	8.7%
6 to 7	0.3%	1.2%	4.5%
7 to 8	0.1%	0.6%	2.3%
8 to 9	0.1%	0.3%	1.0%
9 to 10	0.0%	0.2%	0.6%
10 to 11	0.0%	0.1%	0.3%
11 to 12	0.0%	0.1%	0.2%
12 or More	0.0%	0.1%	0.2%
	100.0%	100.0%	100.0%
Mean*	1.37	2.21	3.58

**The Above Distributions Exclude Claims with Severity Codes 1, 2, and 3*

As displayed in Table 1, the mean or average time between occurrence date and the closing date for a claim with a severity code of 4 or greater is more than three and a half years. Chart 10 below displays the average lag times for different severity groups.

The minor and insignificant severity codes 1 to 3 have the shortest lag from both the occurrence date to report date and report date to closed date. The more serious categories have higher lags for both statistics. Severity code 7 (major – paraplegia, blindness, loss of two limbs, brain damage) has the longest lag from both occurrence date to report date and from report date to closed date, totaling almost 4 years.

Chart 10



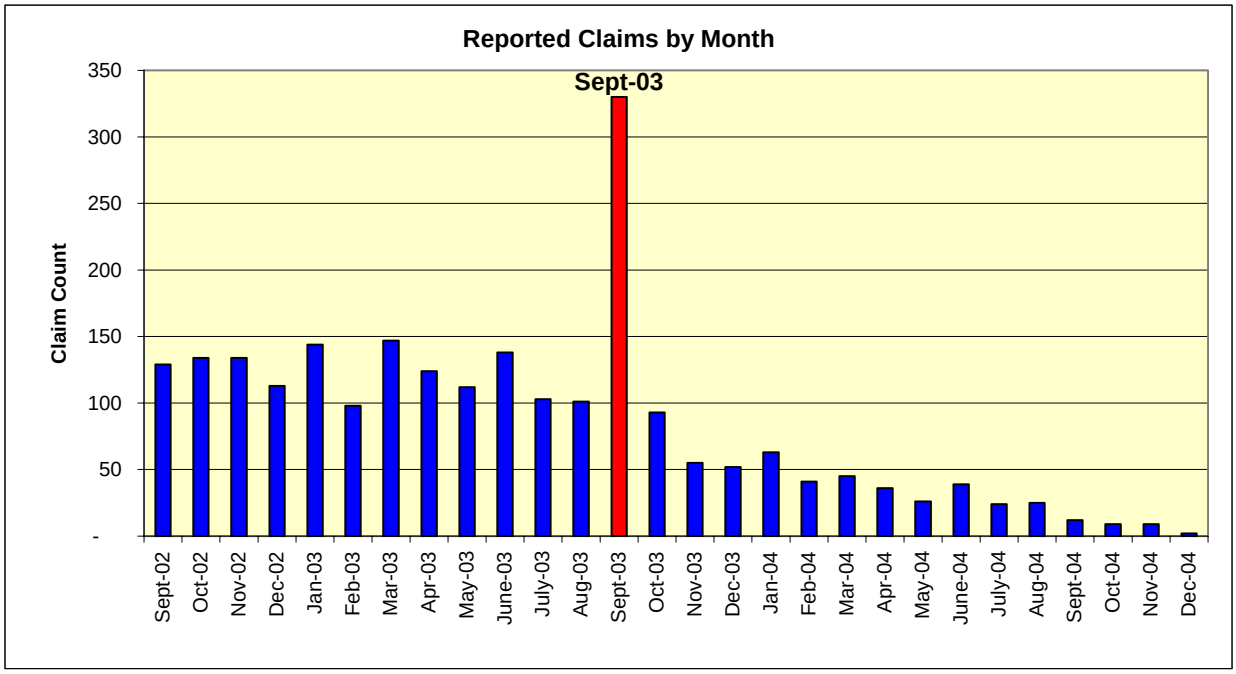
September 2003

We observed a significant increase in the number of reported claims during the month of September 2003. This is consistent with the feedback shared with Deloitte Consulting during our analysis of the recent tort reforms and the determination of the Presumed Factor.

The increase in reported claims is displayed in Chart 11 which shows the number of claims reported by month from September 2002 to December 2004. This increase in reported claims is likely the result of plaintiff attorney's "better safe than sorry" approach to filing the claims which could potentially be impacted by the cap on non-economic damages. This "rush" to report claims in September 2003 has already affected the number of claims reported in the months following. More specifically, we noted in our October 1, 2004 report that we expected many of the claims that would have otherwise been reported after September 2003 had been filed in September 2003.

As of this report, we have confirmed our expectation that fewer reported claims have occurred during the subsequent months (e.g., in Chart 11 we note a drop in claims reported in the months immediately following September 2003).

Chart 11



It is important note that reported claims are added to the CCD as claims close, impacting some of the months displayed in Chart 11. We would expect the reported claims in the more immature months (e.g., December 2004, November 2004, September 2004, etc.) to increase more than the mature months (e.g., September 2002, October 2002, etc.) in future studies as the current pool of open medical malpractice claims close and enter the CCD.

Given the lags discussed above, we expect that monthly claim counts will eventually return to the levels observed before the passage of the 2003 tort reform as the impact of the filing speed up clears out of the system.

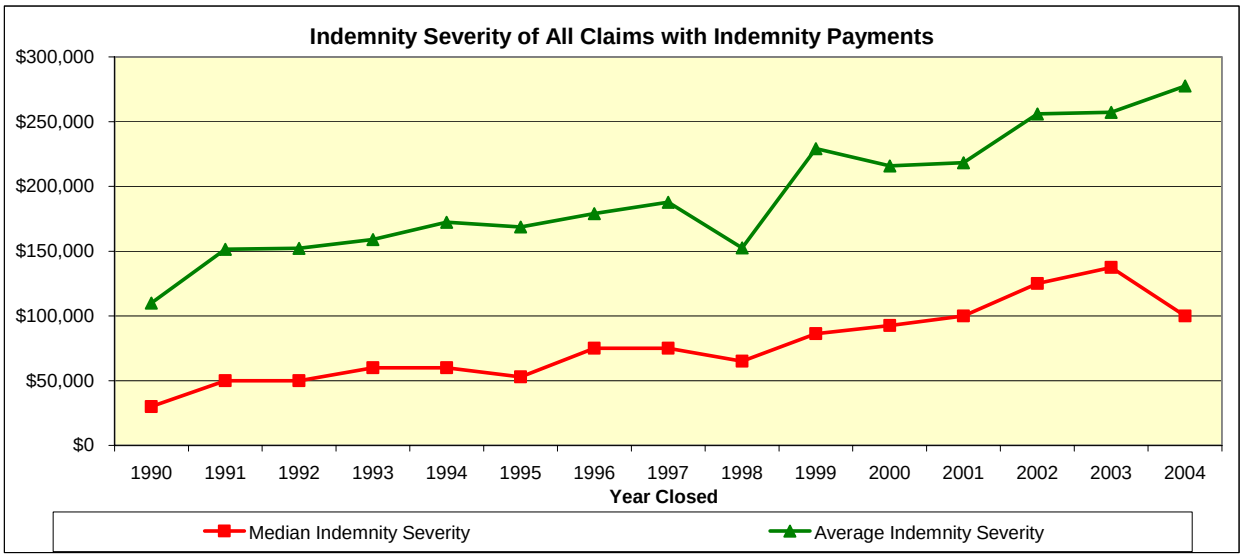
TRENDS IN SEVERITY

When observing severity indications in the CCD, we took additional steps to insure that claim data selected for these purposes contained reasonable and relevant loss information. As a result, it is important to note that our severity indications are based on fewer claims than our frequency indications. An example of one of our reasonability checks is the comparison of total loss amounts for each claim record to the sum of the loss components (i.e. lost wages, medical costs, non-economic damages, etc). Further details regarding our data preparation efforts are contained in the Appendix C.

Total Indemnity Payments

Chart 14 displays the average and median indemnity payments of claims closed with indemnity payments from 1990 through 2004. Chart 14 includes all severity codes.

Chart 14



It is important to note that prior to the passage of tort reform in September 2003, only Florida authorized insurers were required to report closed claims to the CCD. In 2004, the CCD was changed to include data from self-insurers and "unauthorized" insurers such as offshore and surplus lines insurers. Therefore, over time, the above trends will be impacted by the inclusion of claims from additional entities that may not have been reported in the past.

Charts 15 through 18 display the average and median indemnity payments of claims closed with indemnity payments over time for each severity code group. It is important to note that stratifying the data into these finer groups causes a wider swing in results because of the reduction in data points underlying the graphs.

Chart 15

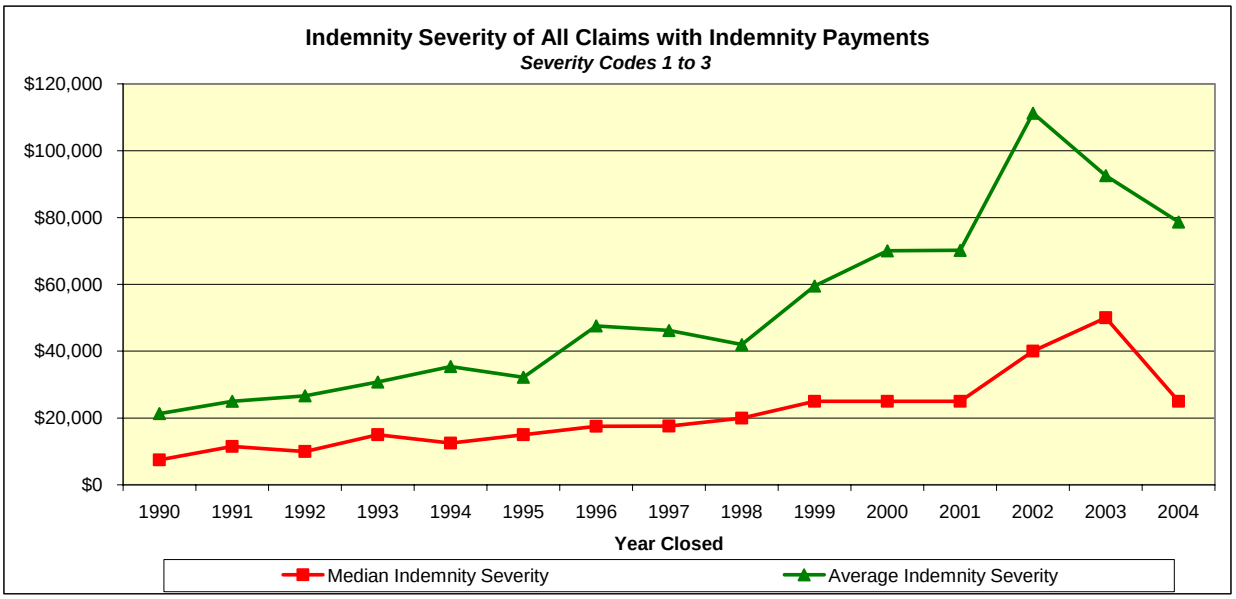


Chart 16

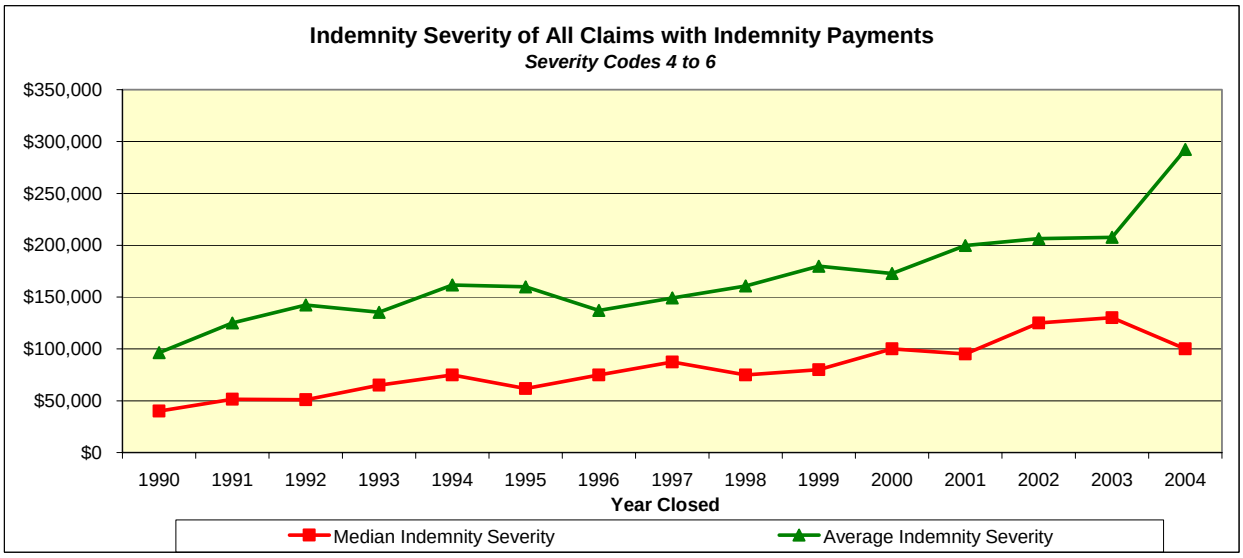


Chart 17

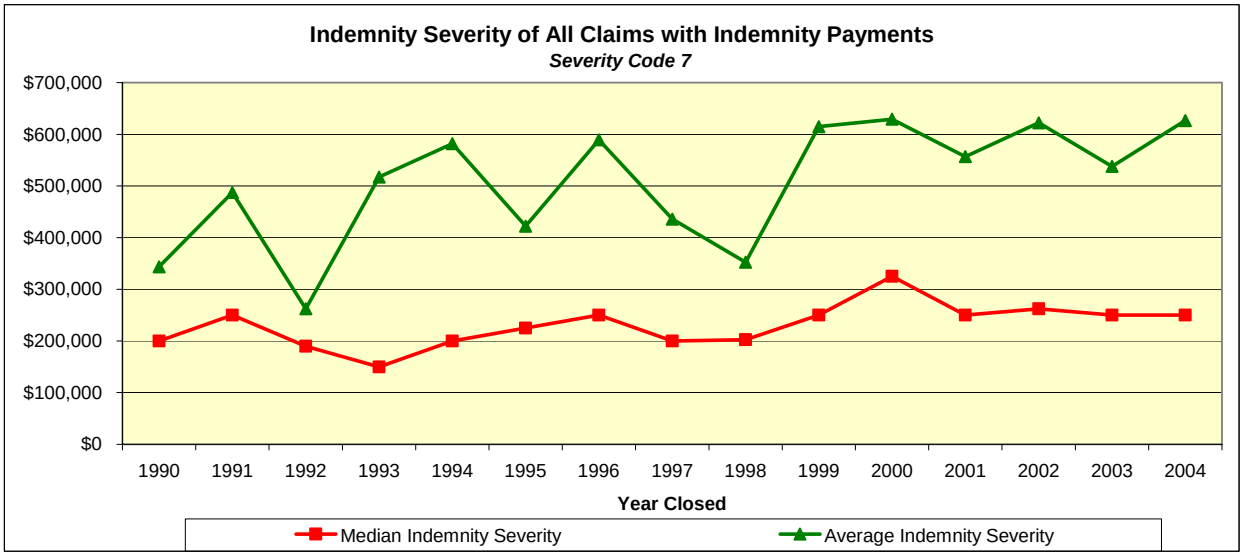
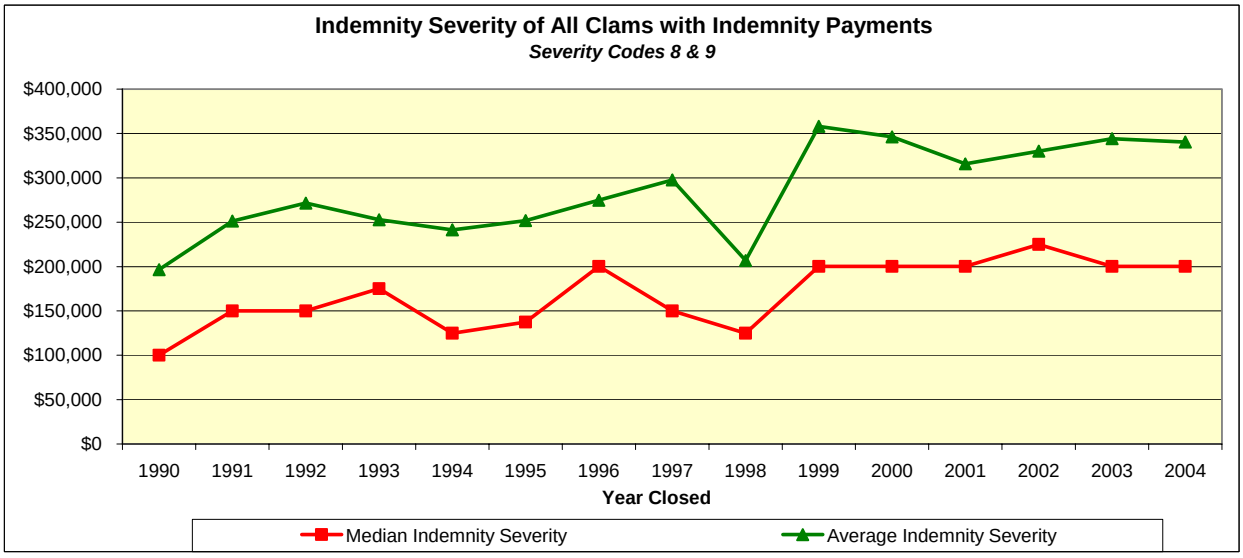


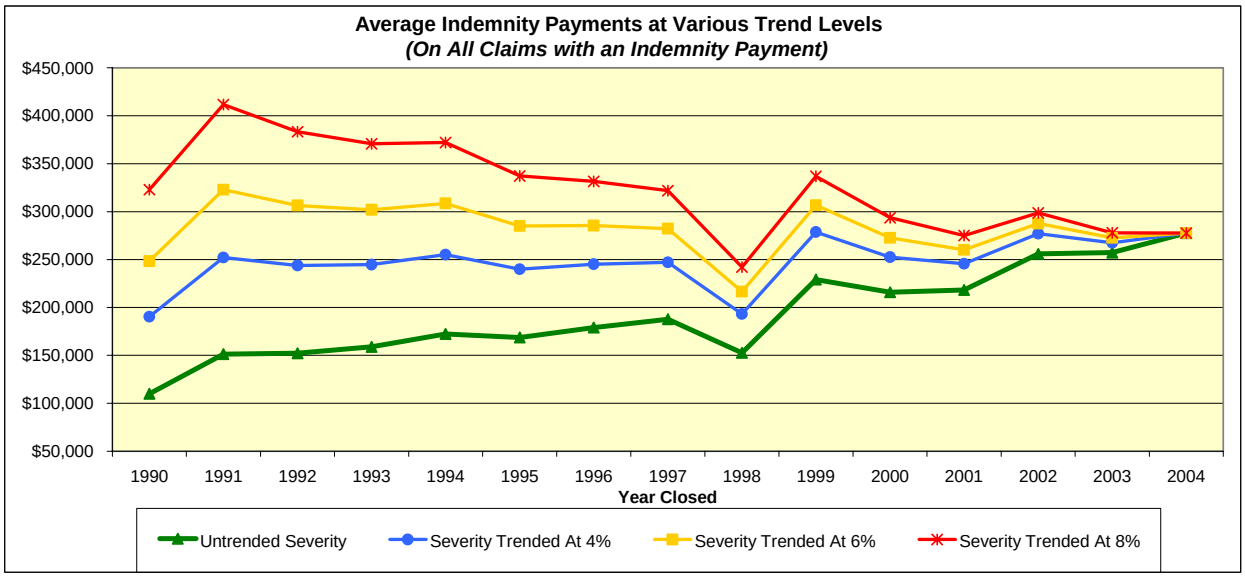
Chart 18



It is important to note that the severity indications shown in Charts 15 through 18 (and any subsequent chart, not otherwise noted) have not been adjusted for trends in medical costs and /or other items of a time sensitive nature.

Chart 19 displays the impact of various trend assumptions (4%, 6%, and 8%) applied to the average indemnity payment pattern from Chart 14. Each alternate pattern displays results trended to a 2004 level.

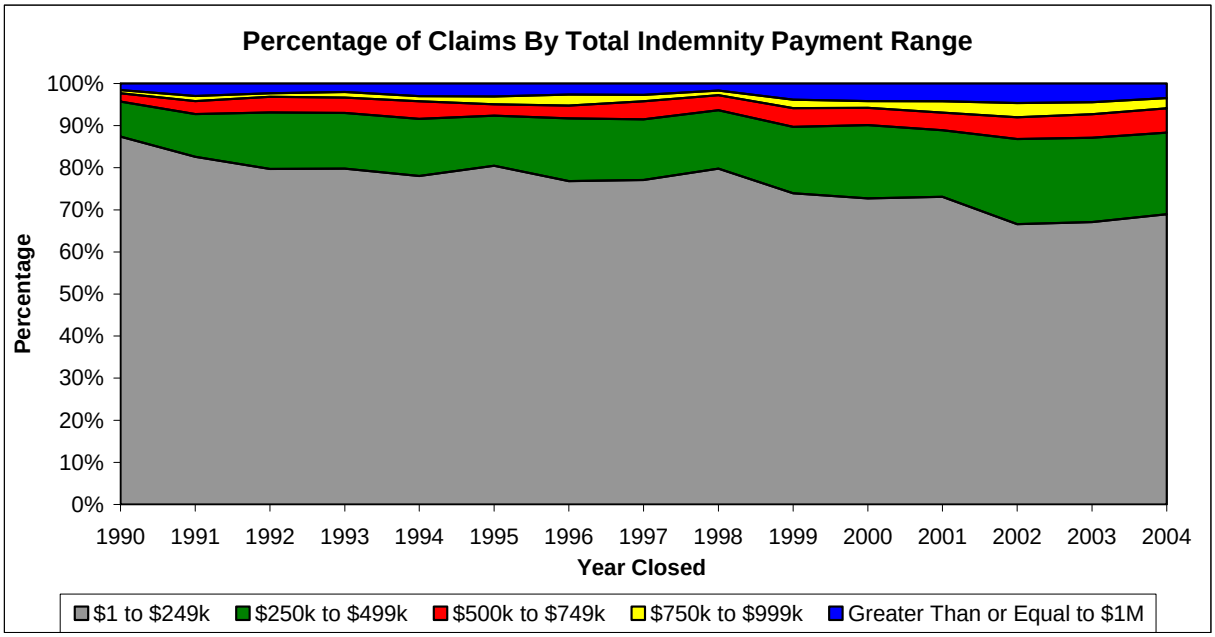
Chart 19



This chart illustrates that these severity indications are very sensitive to the level of trend selected to adjust the data. Using sources such as the Bureau of Labor Statistics (BLS) Consumer Price Index (CPI) – All Urban Consumers, BLS CPI Medical Inflation, severity trends assumed in rate filings, or other judgmental trend factors used to estimate trends in either economic or non-economic damages should be undertaken with this sensitivity in mind. The above information is shown for illustrative purposes, and Deloitte Consulting does not recommend any one trend factor or source to adjust economic damages (e.g., lost wages, medical expense, funeral expense) or non-economic damages (e.g., loss of companionship, loss of consortium, mental anguish, etc.) to current cost levels.

Chart 20, displays the percentage of claim counts grouped in various loss ranges over time. Claims have been grouped into five ranges, specifically $1 to $249,999, $250,000 to $499,999, $500,000 to $749,999, $750,000 to $999,999, and greater than or equal to $1,000,000. Chart 20 includes all severity codes.

Chart 20



Consistent with the trends in the median and average indemnity payments, larger awards represent a larger share of the closed claims in the CCD's more recent years.

Loss Adjustment Expense Payments

Loss adjustment expense (LAE) is typically defined as expenses paid in the course of settling claims, including the costs of defense attorneys' fees, expert witnesses, investigation fees, etc. Chart 21 shows the average LAE payment for each severity code group by year closed. It is important to note that the average LAE payments shown in the Chart 20 does not include claims with LAE payments only (i.e., we have excluded claims with LAE payments but no corresponding indemnity payment). As mentioned earlier, the OIR did not require entities to report claims without indemnity payments for a period of time between 1998 through 2003. As a result, we did not attempt to include claims without indemnity payments, since inconsistent observations would result. In 2004, the OIR began requiring entities to report claims with only LAE payments again. Chart 22 shows average LAE payments over time for claims with only LAE payments. For reasons explained above, it excludes years 1998 through 2003. We expect

that future analyses of the CCD will enable us to continue to observe average LAE payments over time for claims without an indemnity payment.

Chart 21

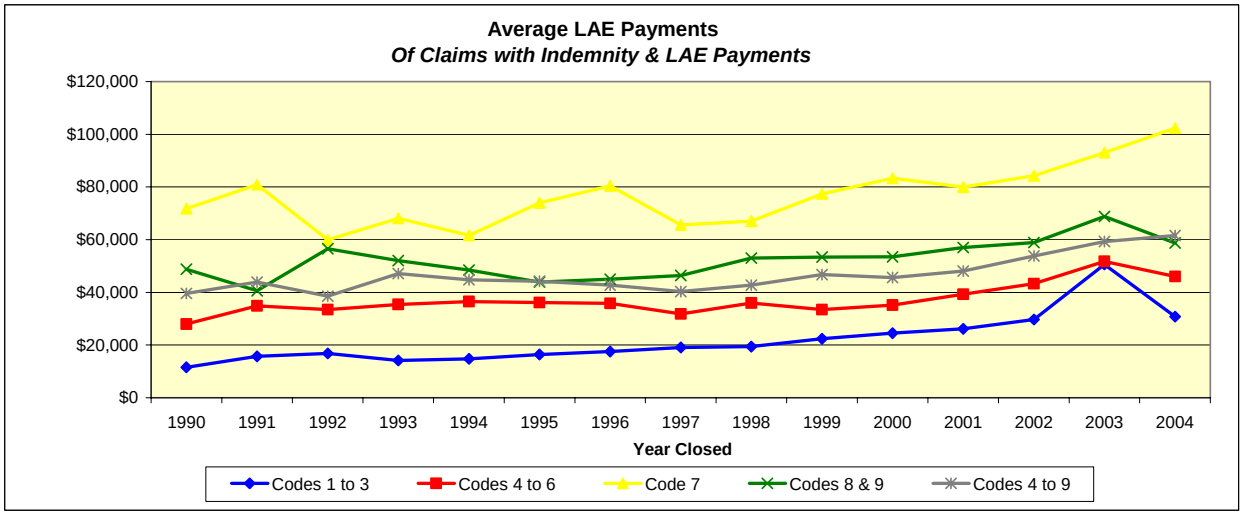
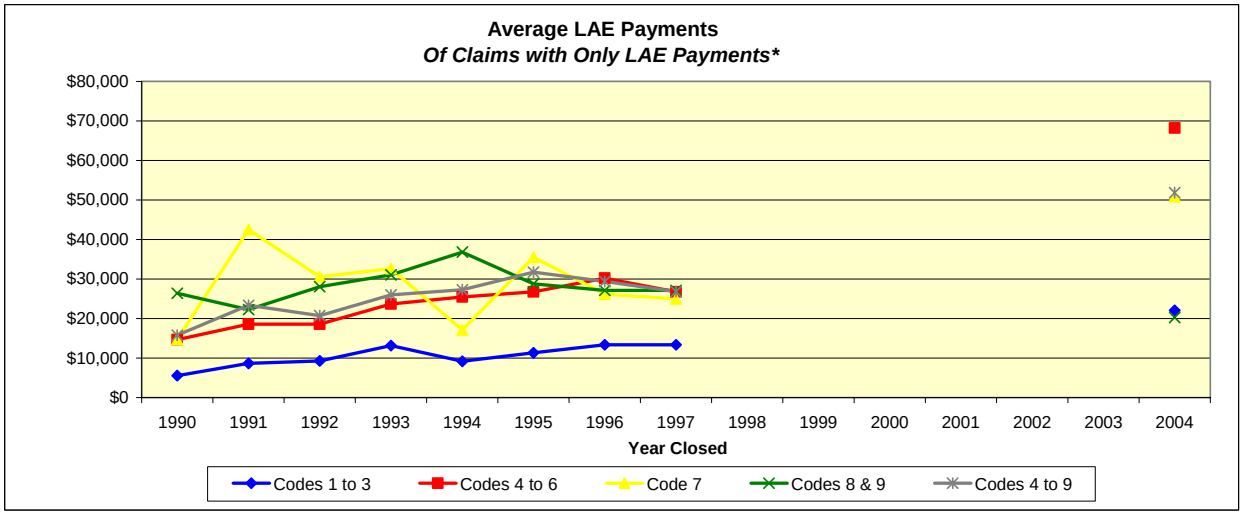


Chart 22



Itemization of Damages

Despite the limitations of the closed claim database with regard to certain claim entries which do not allocate loss costs among economic and non-economic components, we have been able to isolate those CCD records that itemize these loss amounts for use in analyzing trends in economic and non-economic damages. Charts 23 (severity codes 1 to 3), Chart 24 (severity

codes 4 to 6), Chart 25 (severity code 7), Chart 26 (severity codes 8 to 9), and Chart 27 (severity codes 4 to 9) display the average cost of non-economic damages, economic damages, and average LAE (on a secondary axis) for those closed claims with non-economic damages paid and with loss amounts itemized in the CCD.

Chart 23

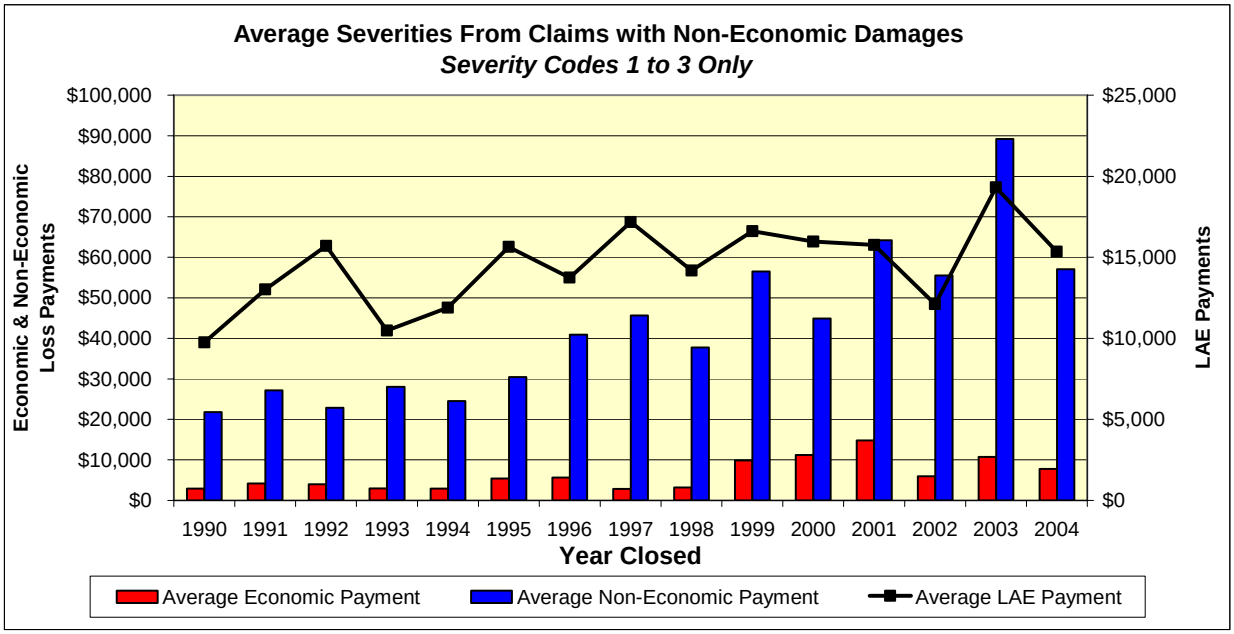


Chart 24

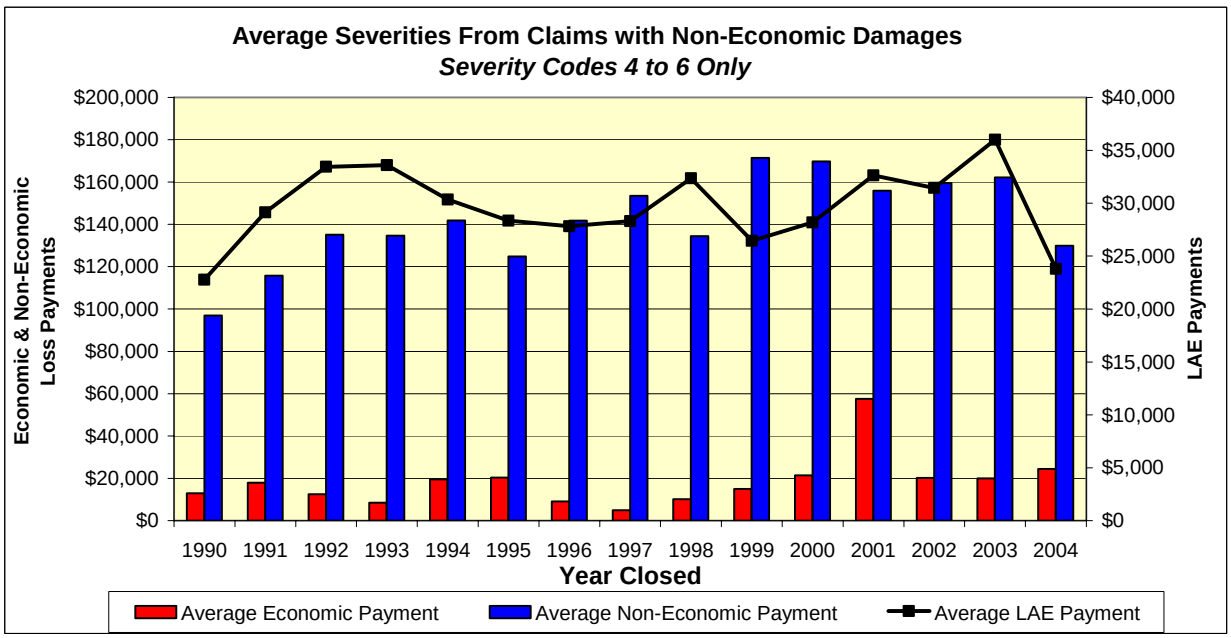


Chart 25

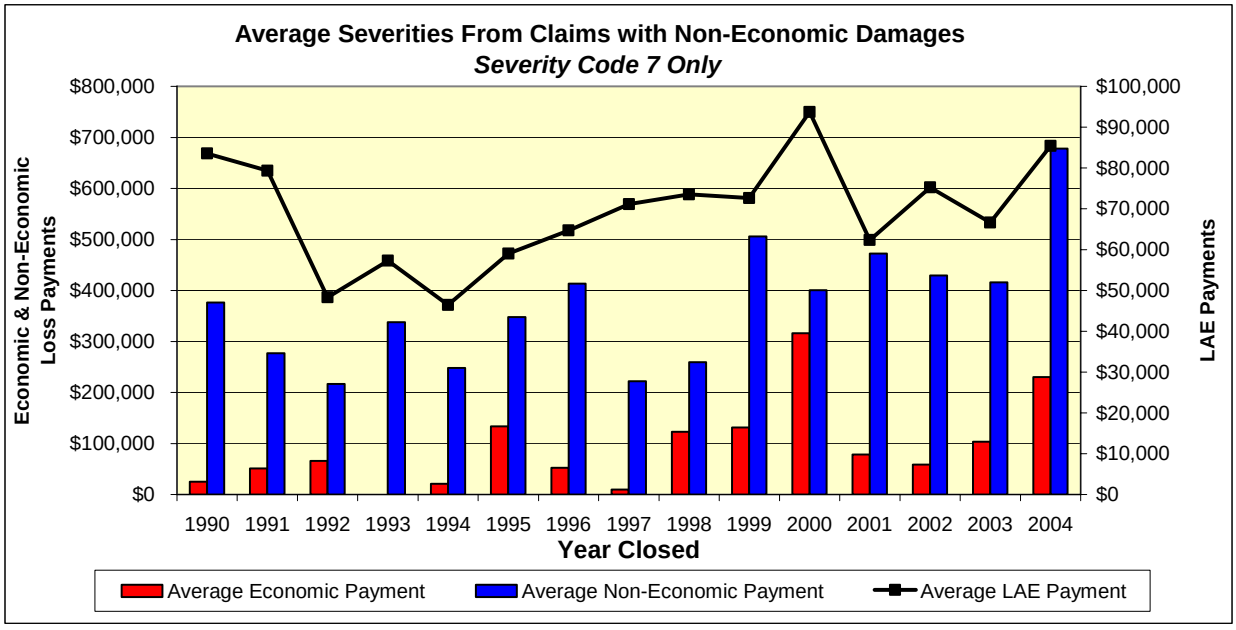


Chart 26

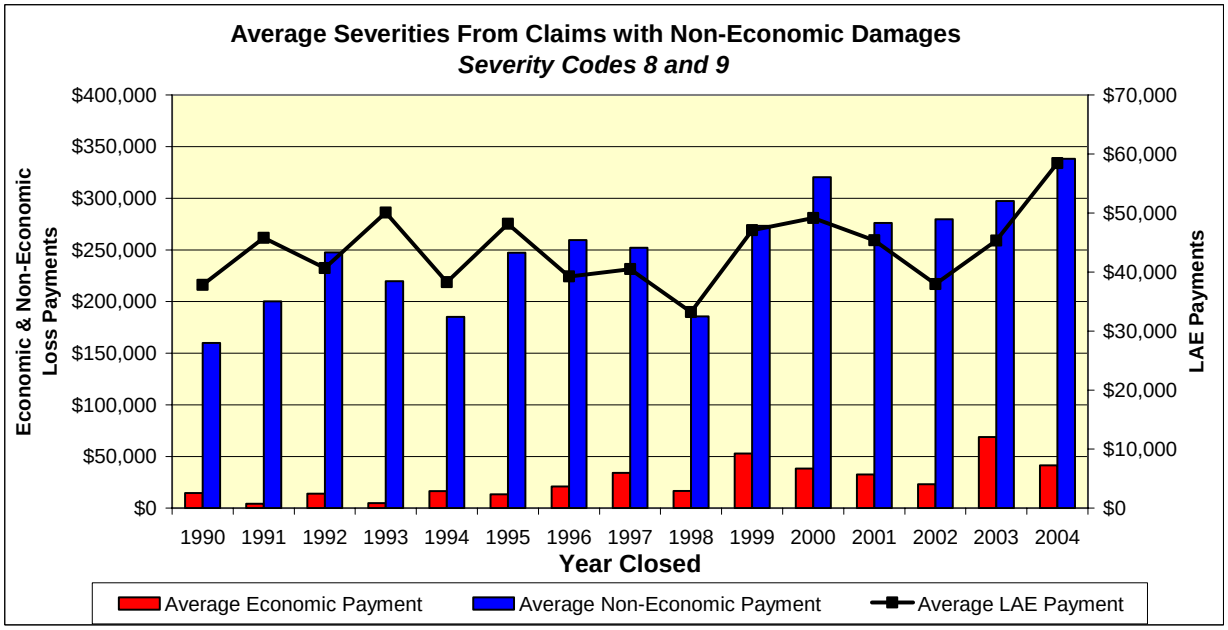


Chart 27

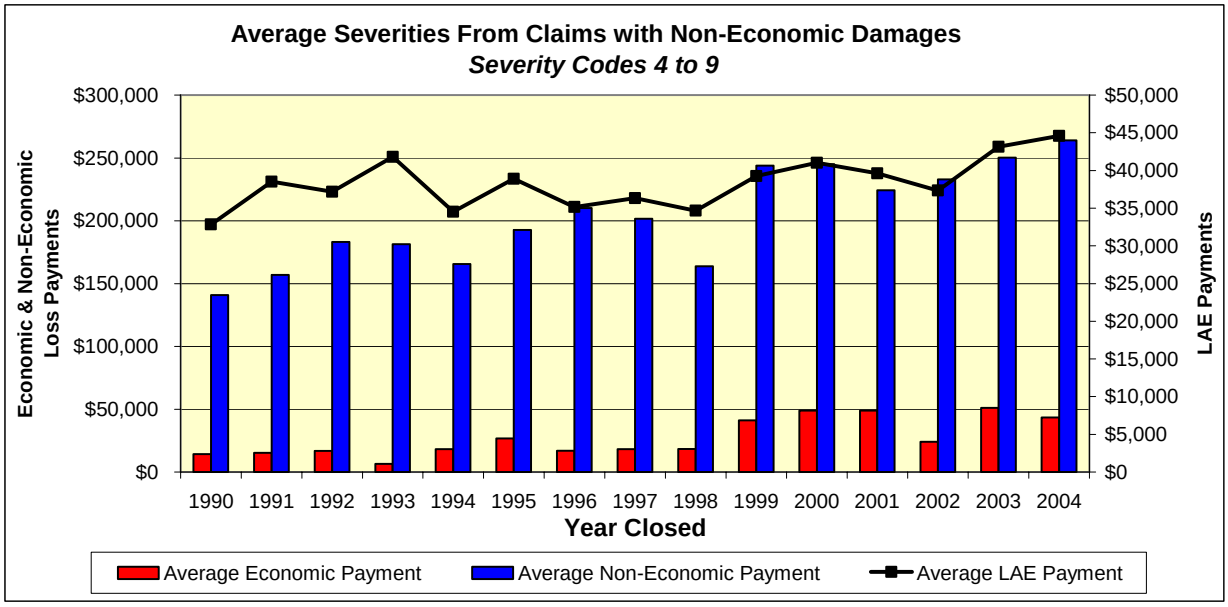
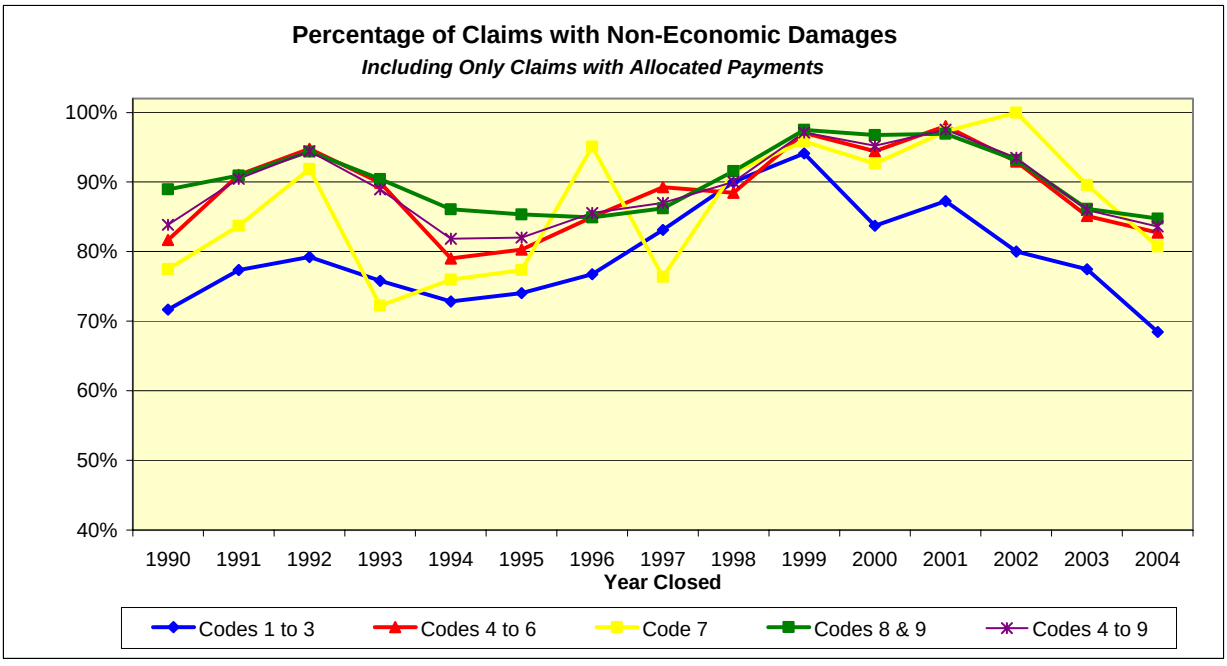


Chart 28 displays the percentage of claims, by severity group, that have non-economic damages. These indications are drawn from the subset of claims in the database that had an indemnity payment greater than zero and include itemized loss amounts.

Chart 28



TRENDS IN OTHER CHARATERISTICS

We have used the CCD to derive the following additional information regarding closed claims and to review possible trends in other closed claim characteristics.

Injury Location

Table 2 displays the percentage of closed claims by injury location. Locations include emergency room, patient's room, operating room, etc. Table 2 shows those percentages of claims closed in 2000 through 2004. Chart 29 displays the pattern of these percentages over time (excluding claims with no location shown).

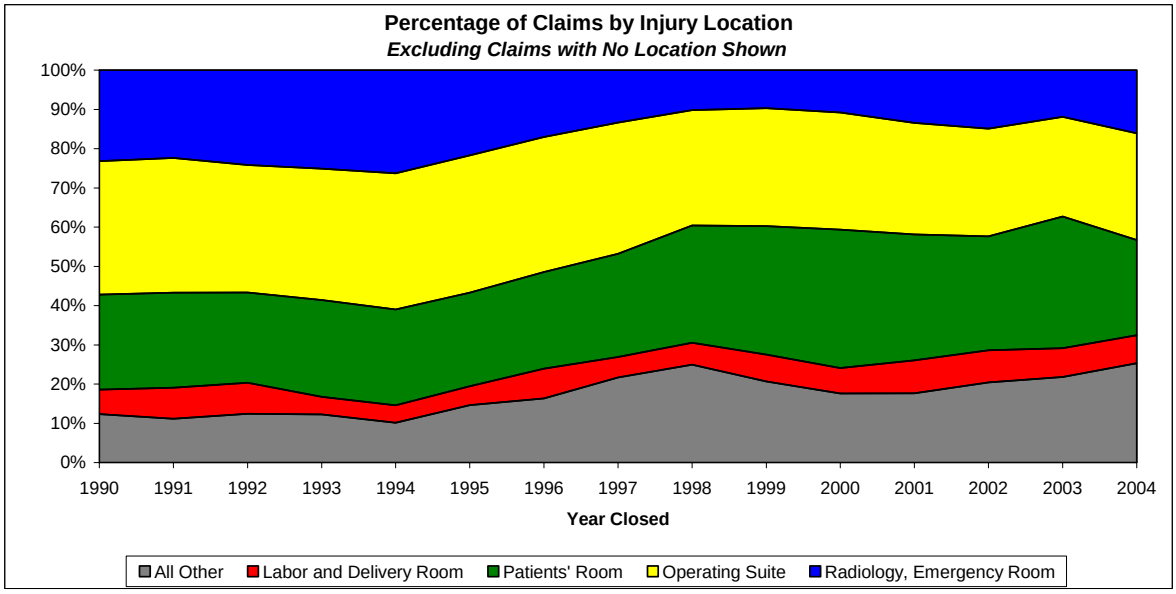
Table 2

Percentage of Claims Closed by Injury Location*

	Excluding Claims With No Location	Of All Claims
Radiology, Emergency Room	13.9%	9.4%
Labor and Delivery Room	7.4%	5.0%
Patients' Room	29.6%	20.0%
Operating Suite	27.4%	18.6%
All Other		
Special Procedure Room	4.4%	3.0%
Critical Care Unit	2.4%	1.7%
Nursery	0.4%	0.3%
Recovery Room	0.7%	0.5%
Physical Therapy	0.4%	0.3%
Other	13.3%	9.0%
No Location Shown	N/A	32.2%
	100.0%	100.0%

**Includes Years 2000 through 2004*

Chart 29



Stage of Settlement

Table 3 shows the percentage of closed claims by the stage in the settlement process in which they were closed, for claims closed in 2000 through 2004. Chart 29 displays the pattern of these percentages over time. In Chart 30, claims with no response have been excluded.

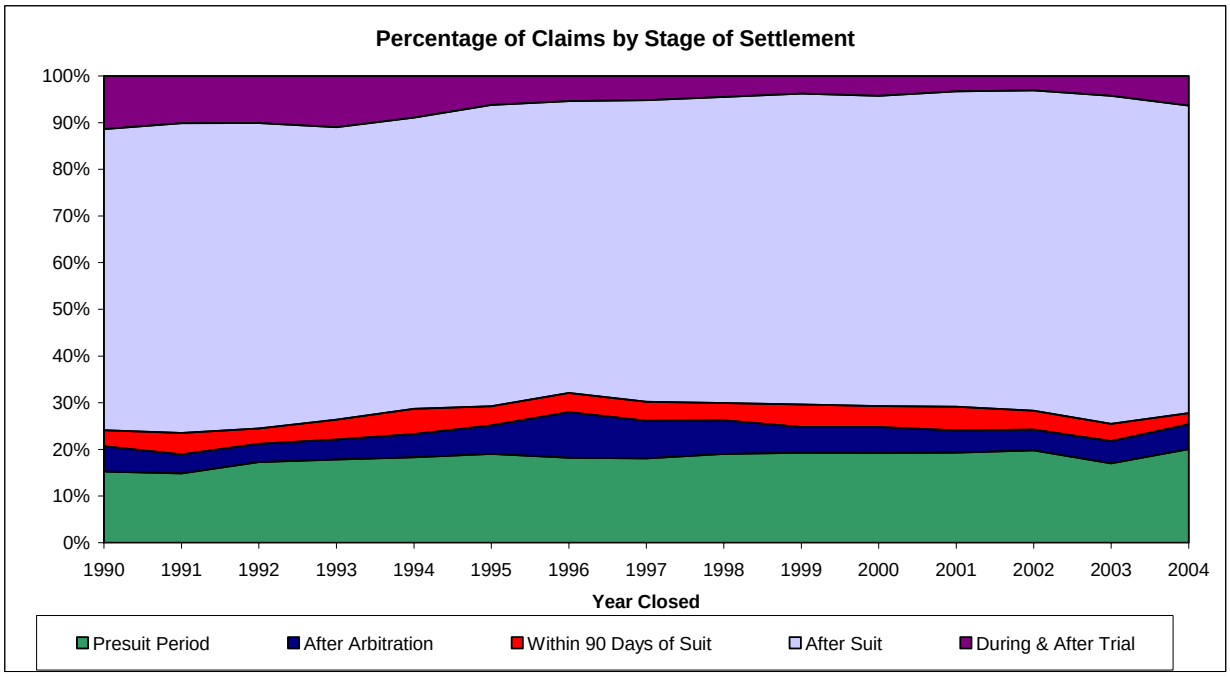
Table 3

Percentage of Claims By Stage of Settlement*

Presuit Period	18.9%
After Arbitration	4.9%
Within 90 Days of Suit	3.8%
After Suit	66.9%
During Trial, Before Verdict	2.1%
After Trial	2.2%
After Notice of Appeal	0.3%
During Appeal	0.3%
After Appeal	0.6%
Other/No Respones	0.0%
	100%

**Includes Years 2000 through 2004*
**Excludes Records with "Claim or Suit Abandoned"*

Chart 30


Percentage of Claims by Stage of Settlement
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
1990
1991
1992
1993
1994
1995
1996
1997
1998
1999
2000
2001
2002
2003
2004
Year Closed
Presuit Period
After Arbitration
Within 90 Days of Suit
After Suit
During & After Trial

III. APPENDIX A

ALL YEAR TRENDS IN DATA

This appendix contains 3 select charts that consider all of the years available for analysis in the CCD. In other words, instead of focusing on years 1990 through 2004, as is done in the main sections of this report, we have included claim data from as early as 1973. It is important to note that the data limitations of including data years prior to 1990 has been documented in this report as well as in Deloitte Consulting's October 1, 2004 report titled "Medical Malpractice Financial Information, Closed Claim Database and Rate Filings – Paragraph 627.912(6), Florida Statutes, as amended by Senate Bill 2-D (Ch. 2003-416)". Additionally, as stated in the Data Consideration sections of this report, we believe the fifteen-year period from 1990 to 2004 represents a reasonable period for reviewing and discussing trends in frequency, severity and other claim characteristics underlying Florida medical malpractice claims.

Chart 1 displays the percentage of total closed claim counts by severity group code, and the trend in that distribution over time. The early years shown on the chart are years in which the severity code indicator was not available.

Appendix A - Chart 1

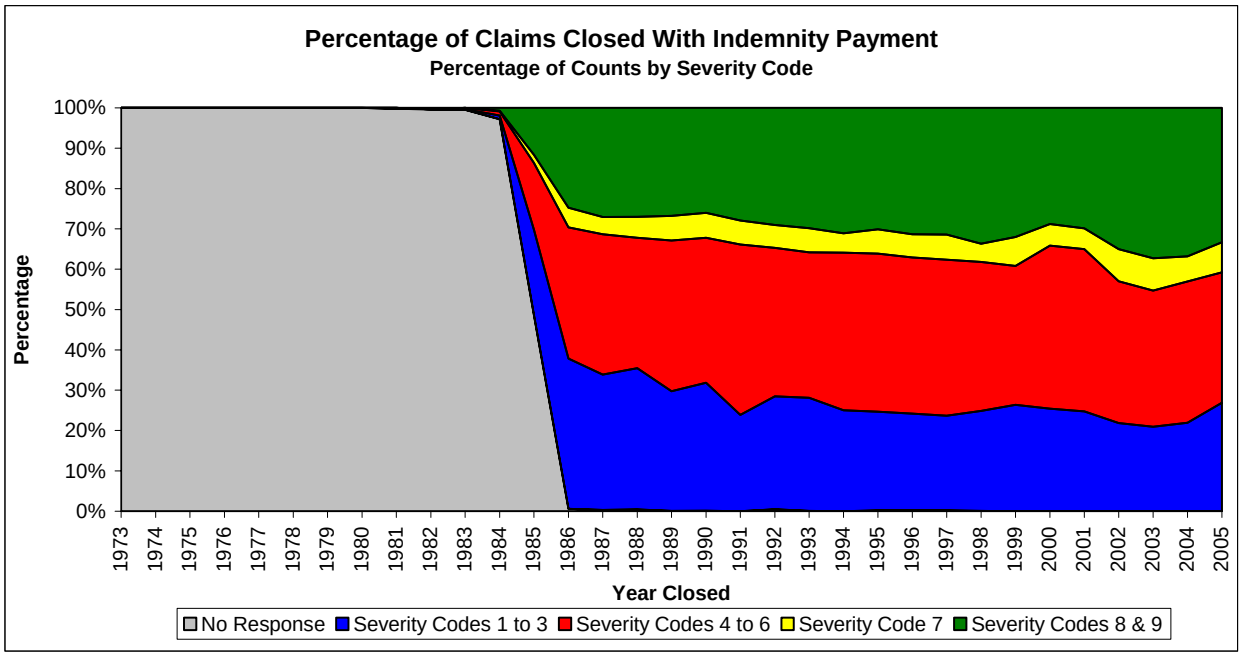
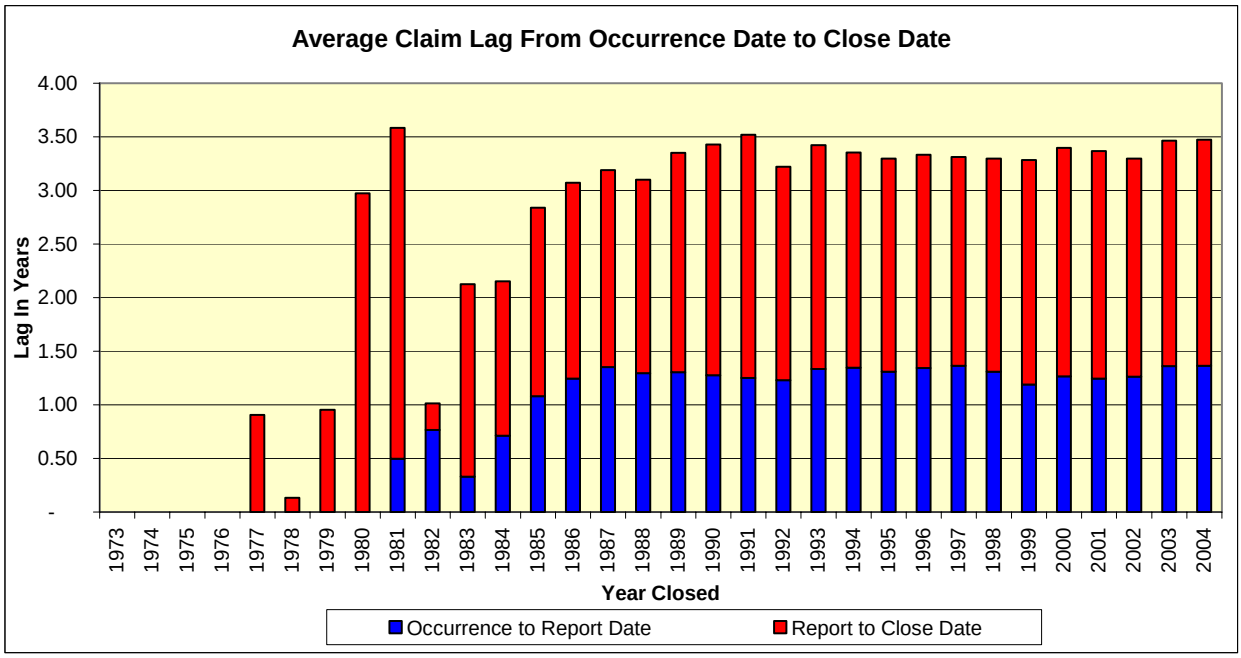


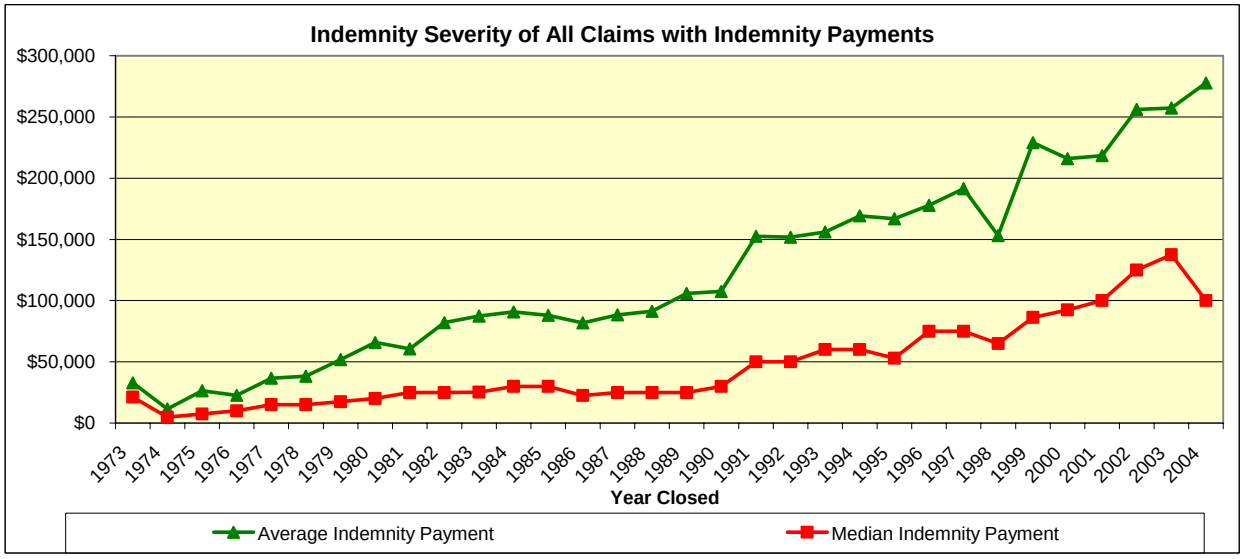
Chart 2 displays the average lag time from occurrence date to report date (blue bars) and report date to close date (red bars) for each year available in the database. It is important to note that claims with close date in the 1970's and early 1980's did not consistently include a separate occurrence date and report date.

Appendix A - Chart 2



We have also included Chart 3, which displays the average and median payments of closed with indemnity payments over the complete time period of 1973 through 2004. Chart 3 includes all severity codes.

Appendix A - Chart 3



IV. APPENDIX B

UNADJUSTED CCD STATISTICAL SUMMARY

This appendix contains 3 tables; an unadjusted statistical summary of the closed claim database (CCD) for all records from the Archive data file, an unadjusted statistical summary of the CCD records from the Current data file for all records (i.e., physicians, hospitals, etc.) and an unadjusted statistical summary of the CCD records from the Current data file for physicians records only.

Although this Appendix satisfies the intent of Paragraph 627.912(6)(a), F.S, Deloitte Consulting strongly believes that the raw data of the CCD must be prepared and processed to some degree before using it as a basis for analyzing trend indications or for other statistical purposes. For example, we found it necessary to purge duplicate entries, eliminate or limit the use of records with suspected input errors, etc. Please refer to Appendix C for details of our data processing efforts. As such, Deloitte Consulting's analysis and review of closed claim information as presented in the other sections of this report is based upon the raw data of the CCD after it has been processed and prepared accordingly.

Although each CCD record contains many unique data fields, the tables in this Appendix display unadjusted summaries of data drawn from those data fields which we considered to be the most useful and significant in the context of this report.

Appendix B - Table 1 - Statistical Summary of Archive Database (A)

YEAR OF REC_ DATE (B)	RECORD COUNT	SUM OF INDEM PD_INS	SUM OF LOSS ADJ_EXP	SUM OF OTH_LOSS ADJ_EXP	SUM OF ECONO MED_LOSS	SUM OF ECONO WAGE_LOSS	SUM OF ECONO OTH_EXP	SUM OF FUTURE MED_LOSS	SUM OF FUTURE WAGE_LOSS	SUM OF FUTURE OTH_EXP	SUM OF NON_ECONO LOSS
1975	969	9,633,881	2,248,693	11,194	-	-	-	-	-	-	-
1976	1,183	8,098,799	2,798,561	-	-	-	-	-	-	-	-
1977	1,347	11,840,345	3,685,528	-	-	-	-	-	-	-	-
1978	1,458	11,389,363	3,744,946	-	-	-	-	-	-	-	-
1979	1,475	11,430,026	3,542,469	-	-	-	-	-	-	-	-
1980	1,609	16,138,294	4,603,117	-	-	-	-	-	-	-	-
1981	2,030	26,116,238	6,499,496	388	-	-	-	-	-	-	-
1982	2,617	48,043,657	8,986,446	-	-	-	-	-	-	-	-
1983	2,504	50,033,269	9,930,809	-	-	-	-	-	-	-	-
1984	2,695	55,069,079	14,704,022	1,695	13,567	-	-	-	-	-	25,000
1985	1,943	74,766,524	15,713,725	754,662	481,145	263,589	6,398	51,300	120,000	200,000	6,927,881
1986	2,440	100,891,007	20,100,960	3,518,496	7,239,558	917,696	303,434	19,688,298	6,745,111	1,230,500	42,912,857
1987	4,848	173,890,389	33,844,773	10,611,798	23,154,395	1,953,496	1,399,563	10,984,713	8,275,975	479,250	76,111,683
1988	4,241	155,008,498	33,123,701	12,480,805	20,898,278	3,277,815	924,082	131,204,947	35,606,688	1,106,940	94,572,700
1989	4,000	194,608,312	41,782,301	13,696,718	24,924,135	5,308,386	1,025,287	23,260,774	32,551,588	5,997,500	117,460,998
1990	2,758	161,826,051	36,889,667	12,866,571	31,048,954	6,908,334	785,452	71,646,213	20,017,722	1,395,652	281,328,814
1991	2,505	216,222,321	48,286,410	14,996,671	28,485,242	5,369,547	964,658	137,007,578	49,165,360	8,092,921	123,284,589
1992	2,272	207,374,774	40,092,762	11,801,616	20,220,818	2,672,153	1,082,388	49,056,391	17,258,021	1,448,936	130,828,511
1993	2,156	194,156,884	42,860,501	13,753,976	27,429,294	3,154,995	481,105	148,198,244	24,367,384	846,436	109,303,477
1994	2,356	221,940,248	50,316,299	16,716,510	33,437,546	7,606,947	2,230,218	74,545,307	35,703,724	11,100,431	118,750,301
1995	2,394	269,563,127	57,275,579	19,851,220	52,389,098	13,253,358	2,084,249	46,188,650	45,061,191	29,386,890	147,473,762
1996	2,117	269,116,408	56,362,526	20,750,521	45,294,619	7,539,137	1,549,911	116,581,595	40,277,599	23,498,617	174,873,949
1997	1,253	161,618,139	45,068,319	15,781,088	28,160,887	6,389,990	6,184,214	83,508,805	39,474,463	11,906,624	112,705,408
1998	512	75,926,273	26,270,024	10,226,626	34,033,469	5,211,663	3,083,557	26,994,828	10,179,734	2,503,686	65,895,614
1998	91	21,460,872	6,131,227	2,063,374	2,634,100	1,632,600	1,400,000	6,061,000	6,314,897	-	11,661,127
Column Total	**53,773**	**2,746,162,778**	**614,862,861**	**179,883,929**	**379,845,105**	**71,459,706**	**23,504,516**	**944,978,643**	**371,119,457**	**99,194,383**	**1,614,116,671**

NOTES: (A) FOR DETAILED DEFINITIONS OF COLUMN HEADINGS PLEASE REFER TO CCD FIELD DESCRIPTION LISTING WHICH CAN BE OBTAINED FROM THE OFFICE OF INSURANCE REGULATION.
(B) YEAR CLAIM WAS RECEIVED BY THE OFFICE OF INSURANCE REGULATION.

Appendix B - Table 2 - Statistical Summary of Current Database For All Records (A)

YEAR FILED (B)	RECORD COUNT	SUM OF MPL_ INDEMNITY_ PAID	SUM OF MPL_ LOSS_ ADJUST	SUM OF MPL_ LOSS_ADJUST_ OTHER	SUM OF MPL_ IP_MEDICAL TO_DATE	SUM OF MPL_ IP_WAGE_ LOSS_TO_DATE	SUM OF MPL_IP OTHER_EXPENSE_ TO_DATE	SUM OF MPL_ IP_MEDICAL_ FUTURE	SUM OF MPL_ IP_WAGE_LOSS FUTURE	SUM OF MPL_ OTHER_EXPENSE_ FUTURE	SUM OF MPL_ IP_NON_ ECONOMIC_LOSS
Blank	2	-	-	-	-	-	66,825	-	-	11,000,000	-
1994	42	296,953	41,144	10,985	16,982	-	-	15,605	-	-	180,771
1995	315	24,695,164	763,273	463,700	2,918,881	2,628,872	26,460	3,326,564	2,327,823	500,140	14,444,008
1996	1,002	118,931,077	5,406,926	2,316,819	10,954,765	883,363	146,347	21,270,439	11,451,920	9,703,551	67,908,160
1997	1,746	193,247,655	18,098,634	6,902,057	29,086,361	7,690,423	12,816,200	23,581,021	43,336,063	14,263,235	132,804,512
1998	1,938	223,918,073	25,118,005	8,622,850	33,246,577	7,390,828	10,731,214	76,250,498	39,684,879	6,869,970	153,628,277
1999	1,874	425,115,101	63,173,743	21,847,231	71,513,629	17,981,407	3,204,467	111,833,813	61,474,734	60,836,321	286,108,213
2000	2,604	507,359,998	89,306,846	31,801,582	96,422,810	39,347,551	12,368,769	474,472,706	162,263,869	49,423,884	489,576,348
2001	2,724	639,432,120	85,136,164	24,121,291	87,840,991	74,136,368	32,203,688	196,960,324	140,684,799	13,924,143	441,255,657
2002	3,201	659,959,386	106,538,961	33,961,774	90,579,028	22,360,778	3,821,082	126,363,921	105,602,086	102,190,805	414,614,102
2003	3,404	976,856,065	155,079,959	50,278,681	581,068,620	44,613,994	14,093,837	465,540,217	167,984,933	2,259,376,371	508,037,341
2004	7,698	1,230,602,558	337,755,073	100,070,383	124,166,790	51,666,646	6,505,051	535,760,574	229,560,136	78,338,102	468,476,618
2005	1,649	232,476,172	65,242,762	21,784,996	50,107,638	3,989,968	1,472,201	230,737,012	45,420,659	3,313,165	95,142,946
Column Total	28,199	5,232,890,322	951,661,490	302,182,349	1,177,923,072	272,690,198	97,456,141	2,266,112,694	1,009,791,901	2,609,739,687	3,072,176,953

NOTES: (A) FOR DETAILED DEFINITIONS OF COLUMN HEADINGS PLEASE REFER TO CCD FIELD DESCRIPTION LISTING WHICH CAN BE OBTAINED FROM THE OFFICE OF INSURANCE REGULATION.
(B) YEAR RECORD WAS RECEIVED BY THE OFFICE OF INSURANCE REGULATION, AS DRAWN FROM THE MPL_DEPT_FILE_NUM DATA FIELD.

Appendix B - Table 3 - Statistical Summary of Current Database For Physician Records Only (i.e. Records with INSD_INSTYPE equal to "Individual")

YEAR FILED (B)	RECORD COUNT	SUM OF MPL_ INDEMNITY_ PAID	SUM OF MPL_ LOSS_ ADJUST	SUM OF MPL_ LOSS_ADJUST_ OTHER	SUM OF MPL_ IP_MEDICAL TO_DATE	SUM OF MPL_ IP_WAGE_ LOSS_TO_DATE	SUM OF MPL_IP OTHER_EXPENSE_ TO_DATE	SUM OF MPL_ IP_MEDICAL_ FUTURE	SUM OF MPL_ IP_WAGE_LOSS FUTURE	SUM OF MPL_ OTHER_EXPENSE_ FUTURE	SUM OF MPL_ IP_NON_ ECONOMIC_LOSS
Blank	-	-	-	-	-	-	-	-	-	-	-
1994	24	259,163	23,512	3,279	12,782	-	-	15,605	-	-	60,271
1995	172	17,362,904	424,691	382,693	2,335,719	2,581,049	20,300	936,849	2,165,323	220,400	11,487,681
1996	534	56,298,904	2,509,347	1,485,298	6,496,969	533,215	71,689	11,742,855	3,970,511	799,008	42,089,822
1997	1,008	100,179,514	9,371,539	4,558,573	18,035,511	6,417,642	12,031,428	12,108,367	5,276,424	11,083,258	77,565,173
1998	1,208	123,576,113	15,554,004	6,051,075	22,076,341	3,769,813	10,331,057	63,287,376	12,351,441	4,720,070	92,998,095
1999	1,134	240,384,754	36,572,782	14,531,465	46,092,088	16,750,992	1,417,676	55,646,806	45,376,927	28,302,155	171,342,033
2000	1,801	325,927,805	64,183,018	25,176,569	73,532,559	32,741,414	9,091,913	241,256,181	127,824,158	25,261,456	311,209,068
2001	1,836	447,872,790	58,580,854	16,148,319	68,076,479	16,624,056	31,180,009	129,551,374	117,143,635	10,153,393	292,331,037
2002	2,253	393,950,346	74,822,474	22,324,172	51,839,900	17,292,185	2,489,476	76,080,999	51,508,618	10,978,423	275,956,638
2003	2,163	430,154,792	87,684,077	34,591,413	464,403,089	27,233,729	9,109,666	170,430,942	111,302,344	1,934,274,621	240,492,714
2004	5,478	819,996,463	245,628,596	73,531,065	79,427,514	38,932,120	4,625,910	387,002,637	160,651,458	56,357,585	317,173,653
2005	1,227	130,105,302	46,325,178	16,306,114	28,005,213	3,294,676	806,927	201,575,012	38,441,568	2,476,862	50,501,381
Column Total	18,838	3,086,068,850	641,680,072	215,090,035	860,334,164	166,170,891	81,176,051	1,349,635,003	676,012,407	2,084,627,231	1,883,207,566

NOTES: (A) FOR DETAILED DEFINITIONS OF COLUMN HEADINGS PLEASE REFER TO CCD FIELD DESCRIPTION LISTING WHICH CAN BE OBTAINED FROM THE OFFICE OF INSURANCE REGULATION.
(B) YEAR RECORD WAS RECEIVED BY THE OFFICE OF INSURANCE REGULATION, AS DRAWN FROM THE MPL_DEPT_FILE_NUM DATA FIELD.

V. APPENDIX C

Florida Office of Insurance Regulation

Medical Professional Liability Closed Claim Database

I. DATA BACKGROUND AND LIMITATIONS

For purposes of this engagement, the State of Florida Department of Financial Services, Office of Insurance Regulation (OIR) provided Deloitte Consulting their historical Medical Professional Liability (MPL) closed claim database (CCD). Deloitte Consulting has made exclusive use of the closed claim data to determine any illustrative trends or observations in closed claim reports from recent years.

The database has been maintained by the OIR and consists of thousands of claim entries submitted primarily by Florida MPL insurers. Deloitte Consulting initially discussed with OIR management their concerns regarding potential limitations on the use of the closed claim data. These limitations are suspected by the OIR to have arisen primarily from known inconsistencies in both the collection and the reporting of the closed claim data.

More specifically, original entries to the OIR database were collected and entered manually until June 30, 1999, when revised forms and instructions became available and electronic submission of data first began. The paper collection system, which was used to collect data since inception of the CCD, was replaced with a diskette reporting system (a/k/a Insurer Closed Claim System/Department Closed Claim System) on July 1, 1999. The diskette reporting system was replaced with the internet reporting Professional Liability Claim Reporting system on July 1, 2004. Data has never been audited or checked for accuracy or completeness and OIR management suspects that errors and inconsistencies in the data submitted are likely.

The tables and charts in this report have been developed with the above considerations in mind. Furthermore, reliance upon the OIR database and the summarized information contain within this report by any third-party should be made with the above considerations in mind.

Additional details regarding the OIR closed claim database:

- The data comprising the CCD consists of two separate databases: the ICC or "Archive" file and PLCR or "Current" file. The Archive file contains claims with dates of occurrence through 1993 and the Current file contains claims with dates from 1994 to the present. The file layouts of each CCD file is different, and any attempt to combine the two databases must take this fact into consideration.

- Until June 30, 1999 closed claim data was manually keyed in as received (the "Archive" file). After June 30, 1999, forms and the data collection system were re-designed to allow for electronic collection, mainly by diskette. An outside vendor helped to create a revised file layout. On July 1, 2004, the data collection system was redesigned to allow for on-line submissions. The result was "Current" file, containing all claims submitted for the first time after mid-July 1999.

- The OIR has subsequently transferred a portion of the claims from the historical Archive file to the Current file. Currently, the Archive file contains claims with occurrence dates through 1993 and the Current file contains claims with occurrence dates in years 1994 and subsequent.

    - For the main sections of this report, Deloitte Consulting has chosen to use the only the most recent years in the Archive file in addition to the information used from the Current file. It is believed that the Current file is a more credible source of information.

    - The inclusion of claims from the Archive file and the expansion of the claims in the Current file by the OIR increases the number of claims which can be considered in our closed claims determinations in comparison to the claims used in our October 1, 2004 report, which focused on claims in the Current file only.

- The MPL database does not provide historical information on the number of claimants associated with each claim (e.g., spouse and three children versus spouse and no children).

- The MPL database does not track the actual dollars paid (i.e., comparative fault) by each defendant. Instead, the database requires the input of the total dollar award for each claimant, regardless of their share of the damages. Therefore, when multiple defendants have entered their claims into the MPL database, there will be duplicate dollars in the database.

- Until the passage of tort reform in 2003, only Florida authorized insurers were required to report closed claims to the OIR database. This would have excluded self-insurers and "unauthorized" insurers such as offshore and surplus lines insurers. Since tort reform, virtually all insurers and self-insureds are required to report claims to the OIR.

    - In September 2004, an Operational Audit of the Closed Claim Database was performed by State of Florida, Auditor General, William O. Monroe, CPA. Included in the audit findings, outlined in report number 2005-031, is a recommendation that the department develop and enforce more stringent rules regarding the reporting of closed claims. According to the report, there are indications that all closed claims may not have been reported by insurers. The reader is referred to the audit findings report for further details.

    - The CCD does not include a field that allows the user to easily identify the number of claims that have been reported by new reporting entities. We have attempted to quantify the impact of the new reporting entities by analyzing the number of entities that are reporting claims for the first time since the passage of tort reform. We have observed that less than 5% of the claims closed in years 2003 through 2005 have been made by new

entities. Although we consider this to be a reasonable estimate, it is difficult to tell by the above analysis if some of the claims are truly "new" to the CCD, or result from closed claims reported by new entities that would have been reported by authorized insurers in the past (e.g., physician who used to purchase insurance from an authorized insurer switches to purchasing insurance from a newly formed captive).

- The version of the closed claim database provided to us contained claims closed through March 2005.

II. DATA PREPARATION

In light of the information and limitations outlined above, Deloitte took the following steps to prepare the OIR closed claim database for use in this report:

- Removed duplicate entries flagged by capturing only those records unique across several key data fields, including but not limited to: department file number, accident date, report date, injured party date of birth, all loss fields, and injury severity code.
  - During this process, Deloitte Consulting also removed data fields captured by the CCD that were not considered to be relevant for the purposes of this report.
- Manually checked the MPL_INDEMNTIY_PAID field for negative entries, which would indicate a situation involving multiple defendants. In such instances, a single record with the total loss values was captured.
- Grouped the captured records according to accuracy of which the individual loss fields (economic versus non-economic) summed to the total indemnity paid as indicated in a separate field. A summary of these groups is outlined in the following table:

APPENDIX TABLE 1

Group	Portion of Total Counts	Criteria
A	62%	Total Indemnity Paid = the Sum of the Individual Parts
B	1%	Total Indemnity Paid = the Deductible + Sum of Parts OR Deductible +Total = Sum of Parts
C	18%	Total Indemnity Paid > $0, Sum of Parts = $0
D	3%	Sum of Parts is >$0, Total Indemnity Paid = $0
E	12%	Still Error after A-D and Sum of Parts is larger than Total
F	4%	Still Error after A-D and Total is larger than Sum of Parts

- Grouped records based on the injury severity code. Deloitte Consulting established 4 severity code groups, 1 to 3, 4 to 6, 7, and 8 to 9. The specific description of each severity code is outlined in the following table:

APPENDIX TABLE 2

Code	Description
1	Emotional Only - Fright, no physical damage
2	Temporary: Slight - Lacerations, contusions, minor scars, rash. No delay.
3	Temporary: Minor - Infections, misset fracture, fall in hospital. Recovery delayed.
4	Temporary: Major - Burns, surgical material left, drug side effect, brain damage. Recovery delayed.
5	Permanent: Minor - Loss of fingers, loss or damage to organs. Includes non-disabling injuries.
6	Permanent: Significant - Deafness, loss of limb, loss of eye, loss of one kidney or lung.
7	Permanent: Major - Paraplegia, blindness, loss of two limbs, brain damage.
8	Permanent: Grave - Quadraplegia, severe brain damage, lifelong care or fatal prognosis.
9	Permanent: Death.

VI. APPENDIX D

Title XXXVII - Insurance

Chapter 627 – Insurance Rates and Contracts

627.912 Professional liability claims and actions; reports by insurers and health care providers; annual report by office.--

(1)(a) Each self-insurer authorized under s. 627.357 and each commercial self-insurance fund authorized under s. 624.462, authorized insurer, surplus lines insurer, risk retention group, and joint underwriting association providing professional liability insurance to a practitioner of medicine licensed under chapter 458, to a practitioner of osteopathic medicine licensed under chapter 459, to a podiatric physician licensed under chapter 461, to a dentist licensed under chapter 466, to a hospital licensed under chapter 395, to a crisis stabilization unit licensed under part IV of chapter 394, to a health maintenance organization certificated under part I of chapter 641, to clinics included in chapter 390, or to an ambulatory surgical center as defined in s. 395.002, and each insurer providing professional liability insurance to a member of The Florida Bar shall report to the office any claim or action for damages for personal injuries claimed to have been caused by error, omission, or negligence in the performance of such insured's professional services or based on a claimed performance of professional services without consent, if the claim resulted in:

1. A final judgment in any amount.

2. A settlement in any amount.

3. A final disposition of a medical malpractice claim resulting in no indemnity payment on behalf of the insured.

(b) Each health care practitioner and health care facility listed in paragraph (a) must report any claim or action for damages as described in paragraph (a), if the claim is not otherwise required to be reported by an insurer or other insuring entity.

Reports under this subsection shall be filed with the office no later than 30 days following the occurrence of any event listed in paragraph (a).

(2) The reports required by subsection (1) shall contain:

(a) The name, address, health care provider professional license number, and specialty coverage of the insured.

(b) The insured's policy number.

(c) The date of the occurrence which created the claim.

(d) The date the claim was reported to the insurer or self-insurer.

(e) The name and address of the injured person. This information is confidential and exempt from the provisions of s. 119.07(1), and must not be disclosed by the office without the injured person's consent, except for disclosure by the office to the Department of Health. This information may be used by the office for purposes of identifying multiple or duplicate claims arising out of the same occurrence.

(f) The date of suit, if filed.

(g) The injured person's age and sex.

(h) The total number, names, and health care provider professional license numbers of all defendants involved in the claim.

(i) The date and amount of judgment or settlement, if any, including the itemization of the verdict.

(j) In the case of a settlement, such information as the office may require with regard to the injured person's incurred and anticipated medical expense, wage loss, and other expenses.

(k) The loss adjustment expense paid to defense counsel, and all other allocated loss adjustment expense paid.

(l) The date and reason for final disposition, if no judgment or settlement.

(m) A summary of the occurrence which created the claim, which shall include:

1. The name of the institution, if any, and the location within the institution at which the injury occurred.

2. The final diagnosis for which treatment was sought or rendered, including the patient's actual condition.

3. A description of the misdiagnosis made, if any, of the patient's actual condition.

4. The operation, diagnostic, or treatment procedure causing the injury.

5. A description of the principal injury giving rise to the claim.

6. The safety management steps that have been taken by the insured to make similar occurrences or injuries less likely in the future.

(n) Any other information required by the commission, by rule, to assist the office in its analysis and evaluation of the nature, causes, location, cost, and damages involved in professional liability cases.

(3) The office shall provide the Department of Health with electronic access to all information received under this section related to persons licensed under chapter 458, chapter 459, chapter

461, or chapter 466. The Department of Health shall review each report and determine whether any of the incidents that resulted in the claim potentially involved conduct by the licensee that is subject to disciplinary action, in which case the provisions of s. 456.073 shall apply.

(4) There shall be no liability on the part of, and no cause of action of any nature shall arise against, any person or entity reporting hereunder or its agents or employees or the office or its employees for any action taken by them under this section. The office shall impose a fine of $250 per day per case, but not to exceed a total of $10,000 per case, against an insurer, commercial self-insurance fund, medical malpractice self-insurance fund, or risk retention group that violates the requirements of this section, except that the office may impose a fine of $250 per day per case, not to exceed a total of $1,000 per case, against an insurer providing professional liability insurance to a member of The Florida Bar, which insurer violates the provisions of this section. If a health care practitioner or health care facility violates the requirements of this section, it shall be considered a violation of the chapter or act under which the practitioner or facility is licensed and shall be grounds for a fine or disciplinary action as such other violations of the chapter or act.

(5) Any self-insurance program established under s. 1004.24 shall report to the office any claim or action for damages for personal injuries claimed to have been caused by error, omission, or negligence in the performance of professional services provided by the state university board of trustees through an employee or agent of the state university board of trustees, including practitioners of medicine licensed under chapter 458, practitioners of osteopathic medicine licensed under chapter 459, podiatric physicians licensed under chapter 461, and dentists licensed under chapter 466, or based on a claimed performance of professional services without consent if the claim resulted in a final judgment in any amount, or a settlement in any amount. The reports required by this subsection shall contain the information required by subsection (3) and the name, address, and specialty of the employee or agent of the state university board of trustees whose performance or professional services is alleged in the claim or action to have caused personal injury.

(6)(a) The office shall prepare statistical summaries of the closed claims reports for medical malpractice filed pursuant to this section, for each year that such reports have been filed, and make such summaries and closed claim reports available on the Internet by July 1, 2005.

(b) The office shall prepare an annual report by October 1 of each year, beginning in 2004, which shall be available on the Internet, which summarizes and analyzes the closed claim reports for medical malpractice filed pursuant to this section and the annual financial reports filed by insurers writing medical malpractice insurance in this state. The report must include an analysis of closed claim reports of prior years, in order to show trends in the frequency and amount of claims payments, the itemization of economic and noneconomic damages, the nature of the errant conduct, and such other information as the office determines is illustrative of the trends in closed claims. The report must also analyze the state of the medical malpractice insurance market in Florida, including an analysis of the financial reports of those insurers with a combined market share of at least 80 percent of the net written premium in the state for medical malpractice for the prior calendar year, including a loss ratio analysis for medical malpractice

written in Florida and a profitability analysis of each such insurer. The report shall compare the ratios for medical malpractice in Florida compared to other states, based on financial reports filed with the National Association of Insurance Commissioners and such other information as the office deems relevant.

(c) The annual report shall also include a summary of the rate filings for medical malpractice which have been approved by the office for the prior calendar year, including an analysis of the trend of direct and incurred losses as compared to prior years.

(7) The commission may adopt rules requiring persons and entities required to report pursuant to this section to also report data related to the frequency and severity of open claims for the reporting period, amounts reserved for incurred claims, changes in reserves from the previous reporting period, and other information considered relevant to the ability of the office to monitor losses and claims development in the Florida medical malpractice insurance market.

History.--s. 1, ch. 74-219; s. 3, ch. 76-168; s. 1, ch. 77-174; s. 1, ch. 77-297; s. 1, ch. 77-457; ss. 2, 3, ch. 81-318; ss. 619, 625, 809(2nd), ch. 82-243; s. 79, ch. 82-386; s. 119, ch. 83-216; s. 7, ch. 85-175; s. 6, ch. 86-287; s. 43, ch. 88-1; s. 22, ch. 88-277; s. 89, ch. 92-289; s. 114, ch. 92-318; s. 8, ch. 93-289; s. 226, ch. 94-218; s. 84, ch. 95-211; s. 382, ch. 96-406; s. 147, ch. 97-237; s. 105, ch. 97-261; s. 23, ch. 97-273; ss. 159, 225, ch. 98-166; s. 34, ch. 98-191; s. 36, ch. 99-3; s. 220, ch. 2000-160; s. 1033, ch. 2002-387; s. 1226, ch. 2003-261; s. 45, ch. 2003-416.

Note.--Former ss. 624.431, 768.55, 624.432.