Florida
Department of Financial Services

REVIEW OF FLORIDA COMMITTEE SUBSTITUTE FOR SENATE BILL 2-D

Calculation of Section 40 "Presumed Factor"

Deloitte.

NOVEMBER 6, 2003

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November 6, 2003

Mr. J Steve Roddenberry
Deputy Director
Office of Insurance Regulation
J. Edwin Larson Building
200 East Gaines Street, Suite 121
Tallahassee, FL 32399-0326

Dear Mr. Roddenberry:

We are pleased to submit our actuarial review of Committee Substitute for Senate Bill 2-D and our calculation of Section 40's "Presumed Factor".

It was a pleasure working with you and we look forward to serving the Office of Insurance Regulation in the future. Please do not hesitate to call either Jan at (860) 543-7350, Kevin at (860) 543-7345 or Rich at (305) 789-9315 if we can be of any further assistance.

Sincerely,

Jan Lommele, FCAS, MAAA, FCA
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Senior Manager – Deloitte.

Richard Simring, Attorney at Law
Partner – Stroock

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I. EXECUTIVE SUMMARY

PURPOSE AND SCOPE

Deloitte & Touche LLP (Deloitte) has been retained by the Florida Department of Financial Services Office of Insurance Regulation (OIR) to evaluate the impact of recently passed Senate Bill 2-D (SB2D) on medical malpractice insurance rates in Florida.

Section 40 of the bill requires the OIR to calculate a presumed factor reflecting the impact that such reforms will have on rates for medical malpractice insurance and to publish such factor within 60 days of the effective date of the new law. The law further requires insurers to, within 60 days of publication of the presumed factor, make a rate filing reflecting the anticipated savings of the reforms.

In accordance with the contract signed on September 19, 2003, Deloitte has been asked by the OIR to analyze each Section of SB2D and provide a presumed factor impact, by Section, expressed in the form of a one decimal place percentage adjustment to base rates. Where a Section has no rate impact, Deloitte will disclose it.

BACKGROUND

Medical Malpractice 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.

DISTRIBUTION AND USE

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

RELIANCE AND LIMITATIONS

Estimates of the presumed factor by Section are based on background information, publicly available information, exposure data and loss data provided by the OIR. A specific audit of the data and background information is beyond the scope of this project. We have conducted such reasonableness tests of the data as we felt appropriate. In all other respects, we have relied without audit or verification on the data and background information provided. Any assumptions, adjustments or modifications made by Deloitte to the data will be documented in detail throughout the remainder of this report.

In our opinion, the estimates presented herein for the OIR produce presumed factors by Section based on accepted actuarial standards and principles.

In estimating the presumed factor by Section, we have assumed that historical trends, adjusted for the impact of SB2D, can be used to predict the future. The estimates make no provision for extraordinary future emergence of new types of losses or new cures not sufficiently represented in the historical information we reviewed or which are not yet quantifiable such as a major

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

advancement in medical technology or a cure for a disease like cancer or Alzheimers. We have applied what we feel are reasonable procedures in our analysis. However, due to the volatility of the loss exposures reviewed, the historical tracking of data by claim and not by claimant, and the limited amount of historical jury verdict data quantifying economic verses noneconomic damages, no assurance can be offered that actual savings will emerge according to the estimates contained in this report.

In addition, Deloitte's Section by Section quantification of the presumed factor relies upon aggregate Florida data. Therefore, to the extent that an individual insurer's book of business mix varies significantly from Florida's aggregate data, the presumed factor may need to be adjusted to reflect an individual company's actual exposure.

For example, a medical malpractice insurance company that writes a heavy concentration of low risk specialties (e.g., chiropractors, allergists, dermatologists – no surgery) would likely see a much lower savings than estimated by the presumed factor since low risk specialties typically have minimal exposure to large jury awards and bad faith judgments.

OVERALL PRESUMED FACTOR

In accordance with Section 40 of the bill, Deloitte has estimated the following overall presumed factor reflecting the impact SB2D will have on rates for medical malpractice insurance companies in the state of Florida:

Presumed Factor: 7.8%

II. PRESUMED FACTOR BY SECTION

The documentation for each Section is laid out as follows:

- Section number and title;
- Noteworthy additions;
- Noteworthy deletions;
- Commentary; and
- Selected impact.

Our additions, deletions and commentary have been focused specifically on areas of SB2D that we feel are important in the determination of the presumed factor. There are a number of other additions and deletions that we have not commented on in each Section. The purpose of this section of our report is not to reiterate every change in SB2D, but to focus the reader's attention on additions and deletions that we consider relevant to the work we have been asked to perform.

A complete copy of SB2D including deletetions, modifications and additions can be obtained from the web site www.myflorida.com under "find an agency" or by directly accessing the web site www.leg.state.fl.us.

The following Section by Section documentation assumes the reader has thoroughly read the 171 page SB2D Statutes with coding marking deletions and additions.

Section 1 – Findings

This Section documents the eighteen key findings identified by the Florida Legislature. The findings in this Section are consistent with findings identified in other states across the nation. Although the relative level of each crisis may vary by state, the following detail some of SB2D's findings:

- There is a medical malpractice insurance crisis in the State of Florida.
- The crisis impacts the quality and availability (e.g., physicians retiring early, not performing high-risk procedures) of health care.
- Florida is among the states with the highest medical malpractice insurance premiums in the nation.
- Premiums have increased dramatically during the past decade, above the national average.
- There are certain elements of damage presently recoverable that have no monetary value (i.e., noneconomic damages), except on a purely arbitrary basis, while other elements of damage (i.e., economic damages) are either easily measured on a monetary basis or reflect the ultimate monetary loss.
- The high cost of medical malpractice claims can be substantially alleviated by imposing a limitation on nonecomonic damages in medical malpractice actions.

SELECTED IMPACT: 0.0%

Section 2 – Litigation Notice Requirements

NOTEWORTHY ADDITIONS: NONE

NOTEWORTHY DELETIONS: NONE

COMMENTARY: NONE

SELECTED IMPACT: 0.0%

Section 3 – Staff Membership and Clinical Privileges

NOTEWORTHY ADDITIONS: NONE

NOTEWORTHY DELETIONS: NONE

COMMENTARY: NONE

SELECTED IMPACT: 0.0%

Section 4 – Internal Risk Management Program

NOTEWORTHY ADDITIONS:

"A system for informing a patient or an individual identified pursuant to s. 765.401(1) that the patient was the subject of an adverse incident, as defined in subsection (5). Such notice shall be given by an appropriately trained person designated by the licensed facility as soon as practicable to allow the patient an opportunity to minimize damage or injury."

"Each licensed facility shall annually report to the agency and the Department of Health the name and judgments entered against each health care practitioner for which it assumes liability. The agency and Department of Health, in their respective annual reports, shall include statistics that report the number of licensed care practitioners, by profession, for whom they assume liability."

NOTEWORTHY DELETIONS:

Removal of old notification requirements.

COMMENTARY:

See our comments on patient notification below.

In addition, we note that most large providers of medical services have already created sophisticated risk management and loss prevention programs. Even private practices have generally retained consulting support for risk management practices and procedures that include loss prevention.

It is important to note that these practices also include measures to be taken to limit or avoid liability. One phenomenon that we have noted elsewhere in this report is that physicians are purchasing lower policy limits. This trend is not simply the result of shrinking insurance capacity and skyrocketing rates; it reflects a belief that plaintiffs' attorneys will gravitate toward practitioners carrying higher limits. Not wanting to be a primary target of a plaintiff attorney by carrying higher policy limits (while others physicians suffer smaller claims because of lower policy limits), physicians have acted rationally by reducing their liability limits to avoid being targeted as the first among several in any multiple defendant action.

SELECTED IMPACT: 0.0%

Section 5 – Repeals 395.0198

NOTEWORTHY ADDITIONS: NONE

NOTEWORTHY DELETIONS: Repeal of 395.0198

COMMENTARY: NONE

SELECTED IMPACT: 0.0%

Section 6 – Patient Safety

NOTEWORTHY ADDITIONS:

"(2) Each licensed facility shall appoint a patient safety officer and a patient safety committee, which shall include at least one person who is neither employed by nor practicing in the facility, for the purpose of promoting the health and safety of patients, reviewing and evaluating the quality of patient safety measures used by the facility, and assisting in the implementation of the facility patient safety plan."

NOTEWORTHY DELETIONS: NONE

COMMENTARY:

The development of patient safety programs is a rapidly-emerging phenomenon among large healthcare provider systems. These are principally aimed at devising systems that examine past adverse events and even near-misses with a view toward avoiding preventable mistakes and engineering away the possibility of damage resulting from errors made by a single human being. Most large providers with whom we have worked have already implemented internal approaches to patient safety and are quite active in the field.

The Statute's provision (Section 10(2)) limiting the discoverability of patient safety data provides some incentive to continuing to develop these systems. The Statute will serve to build on progress that has been made thus far; few, if any, major healthcare providers will be only initiating patient safety programs strictly as a result of this Statute. Further, it is important to note that the law is drafted carefully to limit the discoverability of this data only insofar as it relates to the safety program. To the extent that the data becomes available in a way that is not strictly within the limits of the safety program, the data is discoverable. Also, there is little that prevents a person who has testified before a safety committee to essentially replicate that testimony in a different setting. The *testimony* cannot be used, but the witness *can* be recalled. The relevance of this passage will be limited for cases where it is hard to de-identify patient information as a result of specific case facts.

The larger impact of this aspect of the Statute will be its effect on smaller provider organizations. We expect that in order to comply with these provisions, most will be working with outside consultants to implement patient safety plans. At this time, we do not expect that these will represent a significant deviation from current risk management and patient safety practices, and are not likely to result either in significantly reduced malpractice events or consequent claims activity.

It is important to note that the intent of patient safety systems is to introduce a "no fault" aspect to the investigation of adverse incidents, with the goal of understanding the breakdown that led to the incident in order to design new patient care systems that engineer away potential errors. As medical errors are investigated in a "no fault" system, the patient safety system encourages practitioners to discuss errors in a safe environment without fear of retribution. Unfortunately, legislative changes with regard to practitioner discipline serve to undo the positive impact of this safe environment, simply reinforcing practitioners' belief that acting to avoid liability remains the best course of action.

In sum, as medical errors are acted upon with moral outrage and a need to punish, practitioners cannot be realistically expected to maximize the benefit of safety systems that rely on an open discussion of past mistakes.

SELECTED IMPACT: De Minimis Savings

Section 7 – Duty to Notify Patients (Facility)

NOTEWORTHY ADDITIONS:

"An appropriately trained person designated by each licensed facility shall inform each patient, or an individual identified pursuant to s. 765.401(1), in person about adverse incidents that result in serious harm to the patient. Notification of outcomes of care that result in harm to the patient under this Section shall not constitute an acknowledgement or admission of liability, nor can it be introduced as evidence."

NOTEWORTHY DELETIONS: NONE

COMMENTARY:

The Governor's Select Task Force on Healthcare Report cited a study that conducted a survey in which the practitioner informed the patient that an error had been made only about 31% of the time, and had apologized in only about 33% of the cases. There appears to be a theory that

direct, improved communication with patients will reduce the likelihood of adversarial lawsuits. Healthcare risk management professionals with whom we have worked in prior engagements have nearly all reported that high-quality patient communication is an important influence in reducing the severity of malpractice claims.

Currently, because of a fear that any admission of error can lead directly to liability, most physicians are counseled to avoid admission of any error. This frequently leads to a significant reduction in patient contact and communication during a critical time – when the practitioner can assure the patient of his or her concern for the patient's well-being.

The hope and expectation was that new notification requirements would stimulate behavior that has been observed in such other insurance lines as workers' compensation. In that line of business, large corporate employers have implemented "Total Disability Management" programs that have featured early and intense intervention by the employer aimed at expressing concern for the well-being of the employee/claimant. It has been widely successful in reducing lost work time and returning employees to work more rapidly.

However, there are some critical differences between medical malpractice liability and workers' compensation, the most important being that workers' compensation is a "no fault" coverage. Employers are working to *minimize* the impact of employee workplace injuries, not deny responsibility for them. Therefore, their behavior towards the employee/claimant, while still carefully controlled, is not enveloped in concerns about liability.

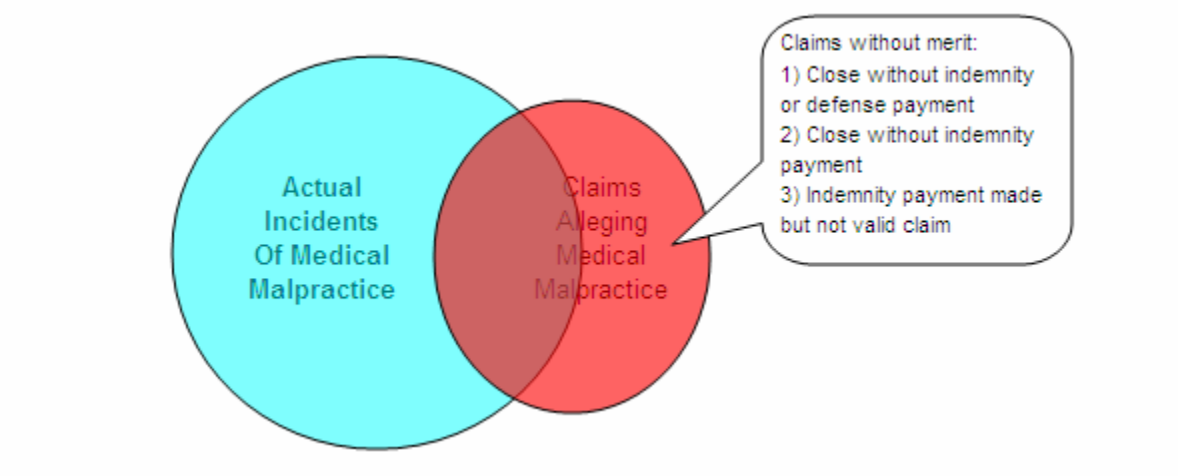
The new requirement to notify patients directly and in person is public knowledge. Regardless of any good will that is intended by practitioners in timely notifying patients of adverse incidents, patients will know that they are being informed of "adverse incidents" because practitioners are *required* to do so.

Furthermore, it is almost certain that the in-person notification will be a highly-scripted event; the practitioner or the facility representative delivering this notification will use language that is carefully crafted to emphasize non-admission of liability and strict compliance with the Statute. The improved patient communication that is hoped for in the Statute is likely to give way to pro forma "legalese" that may only serve to accelerate the claim process. In short, increased communication with patients is necessary, but not sufficient, in reducing the cost of claims; the quality and effectiveness of that communication at the human level is the critical factor.

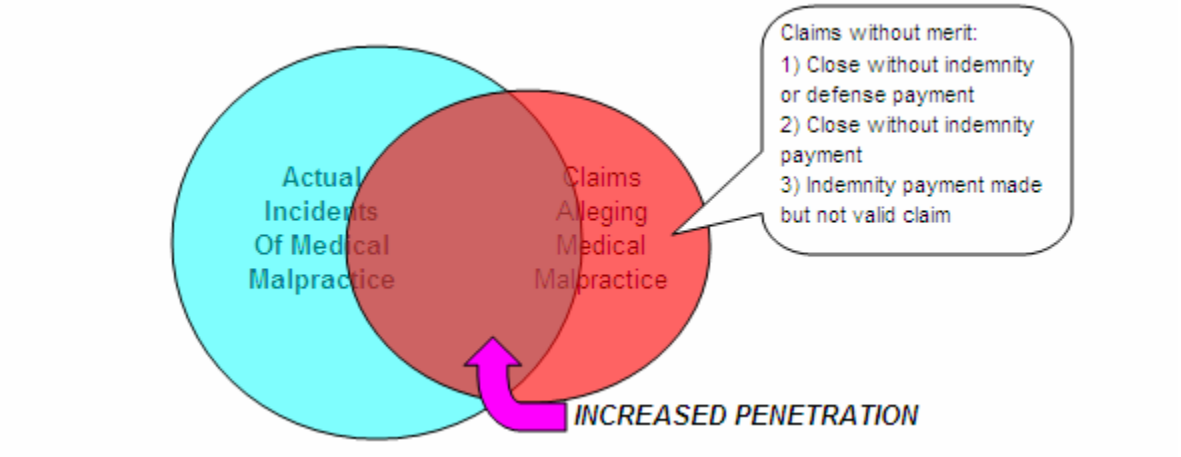
Healthcare practitioners who are already very wary of the plaintiffs' bar and its effects on their practices are not likely to change their communications style quickly, particularly when the new Statute is untested. This is particularly true given the Statute's new provisions regarding reporting and disciplining of healthcare practitioners.

Practitioners are already required to notify the agency of numerous types of adverse incidents; the new legislation has added three new types of occurrences that would trigger required notification to the agency. And, "serious harm" may be an expression that requires further definition.

Among the total set of claims alleging medical malpractice, only a subset are valid; similarly, only a subset of actual malpractice events result in claims.



Under the new Statute, patients will be made aware of situations and conditions of which they would *not* have been made aware under the previous Statute, both because of the duty to notify the patent directly, and the expanded definition of "adverse incident." Assuming that the notification requirement will not affect the number of actual malpractice events that occur, it is possible that notification will lead to higher claim frequency, and increased penetration of valid claims into the set of actual malpractice events.



Previously, adverse incidents reported only to the state could be investigated by the state, creating the likelihood that patients would first learn of the adverse incident from a third party. This set of

circumstances was likely to create an adversarial situation between patient/claimant and practitioner, leading to lengthy litigation. Now, due to the early direct patient communication necessitated by the Statute, it is possible that a higher proportion of these claims will be settled quickly.

It is worth noting that "adverse incident," as defined in Section 4 of the legislation, does not match exactly with the definition that appears in Section 22. And it is troubling that "serious harm" is not defined anywhere in the legislation. It is certainly possible and even likely that this could be interpreted by patients and their attorneys as including psychological harm. In any case, the expansion of the definition of "adverse incident," combined with the lack of definition of "serious harm," creates a strong likelihood that overall claims frequency will increase.

In summary, while increasing patient communications is intended to protect the interests of patients and decrease the level of suspicion with which the healthcare practitioners are viewed, it is not clear that the notification requirement will lead to lower loss costs. We believe that claims frequency will likely increase; we also believe, however, that timely notification and communication can lead to faster and less expensive settlements. The net outcome is uncertain, and we would project a neutral impact.

SELECTED IMPACT: De Minimis Cost

Section 8 – Duty to Notify Patients (Health Care Practitioner)

NOTEWORTHY ADDITIONS:

"Every licensed health care practitioner shall inform each patient, or an individual identified pursuant to s. 765.401(1), in person about the adverse incidents that result in serious harm to the patient. Notification of outcomes of care that result in harm to the patient under this Section shall not constitute an acknowledgment (or) admission of liability, nor can such notifications be introduced as evidence."

NOTEWORTHY DELETIONS: NONE

COMMENTARY: See above.

SELECTED IMPACT: De Minimis Cost

Section 9 – Civil Immunity for Members of or Consultants to Certain Boards, Committees, or Other Entities

NOTEWORTHY ADDITIONS: NONE

NOTEWORTHY DELETIONS: NONE

COMMENTARY: NONE

SELECTED IMPACT: 0.0%

Section 10 – Patient Safety Data Privilege

NOTEWORTHY ADDITIONS: NONE

NOTEWORTHY DELETIONS: NONE

COMMENTARY: NONE

SELECTED IMPACT: 0.0%

Section 11 – Department; General Licensing Provisions

NOTEWORTHY ADDITIONS: NONE

NOTEWORTHY DELETIONS: NONE

COMMENTARY: NONE

SELECTED IMPACT: 0.0%

Section 12 – Fees; Receipts; Disposition

NOTEWORTHY ADDITIONS: NONE

NOTEWORTHY DELETIONS: NONE

COMMENTARY: NONE

SELECTED IMPACT: 0.0%

Section 13 – Designated Health Care Professionals; Information Required for Licensure

NOTEWORTHY ADDITIONS: NONE

NOTEWORTHY DELETIONS: NONE

COMMENTARY: NONE

SELECTED IMPACT: 0.0%

Section 14 – Practitioner Profile; Creation

NOTEWORTHY ADDITIONS: NONE

NOTEWORTHY DELETIONS: NONE

COMMENTARY: NONE

SELECTED IMPACT: 0.0%

Section 15 – Practitioner Profile; Update

NOTEWORTHY ADDITIONS: NONE

NOTEWORTHY DELETIONS: NONE

COMMENTARY: NONE

SELECTED IMPACT: 0.0%

Section 16 – Health Care Practitioners; Reports on Professional Liability Claims and Actions

NOTEWORTHY ADDITIONS: NONE

NOTEWORTHY DELETIONS: NONE

COMMENTARY: NONE

SELECTED IMPACT: 0.0%

Section 17 – Reports of Professional Liability Actions; Bankruptcies; Department of Health's Responsibility to Provide

NOTEWORTHY ADDITIONS: NONE

NOTEWORTHY DELETIONS: NONE

COMMENTARY: NONE

SELECTED IMPACT: 0.0%

Section 18 – Ownership and Control of Patient Records; Report or Copies of Records to be Furnished

NOTEWORTHY ADDITIONS: NONE

NOTEWORTHY DELETIONS: NONE

COMMENTARY: NONE

SELECTED IMPACT: 0.0%

Section 19 – Grounds for Discipline; Penalties; Enforcement

NOTEWORTHY ADDITIONS: NONE

NOTEWORTHY DELETIONS: NONE

COMMENTARY: NONE

SELECTED IMPACT: 0.0%

Section 20 – Disciplinary Proceedings.

NOTEWORTHY ADDITIONS: NONE

NOTEWORTHY DELETIONS: NONE

COMMENTARY: NONE

SELECTED IMPACT: 0.0%

Section 21 – Authority to Issue Citations

NOTEWORTHY ADDITIONS: NONE

NOTEWORTHY DELETIONS: NONE

COMMENTARY: NONE

SELECTED IMPACT: 0.0%

Section 22 – Mediation

NOTEWORTHY ADDITIONS: NONE

NOTEWORTHY DELETIONS: NONE

COMMENTARY: NONE

SELECTED IMPACT: 0.0%

Section 23 – Financial Responsibility (Physician)

NOTEWORTHY ADDITIONS: NONE

NOTEWORTHY DELETIONS: NONE

COMMENTARY: NONE

SELECTED IMPACT: 0.0%

Section 24 – Financial Responsibility (Osteopathic Physician)

NOTEWORTHY ADDITIONS: NONE

NOTEWORTHY DELETIONS: NONE

COMMENTARY: NONE

SELECTED IMPACT: 0.0%

Section 25 – Grounds for Disciplinary Action; Action by the Board and Department (Physician)

NOTEWORTHY ADDITIONS: NONE

NOTEWORTHY DELETIONS: NONE

COMMENTARY: NONE

SELECTED IMPACT: 0.0%

Section 26 – Emergency Procedures for Disciplinary Action

NOTEWORTHY ADDITIONS:

"Notwithstanding any other provision of law to the contrary, no later than 30 days after a third report of a professional liability claim against a licensed physician has been submitted, within a 60-month period, as required by ss. 456.049 and 627.912, the Department of Health shall initiate an emergency investigation and the Board of Medicine shall conduct an emergency probable cause hearing to determine whether the physician should be disciplined for a violation of s 458.331(1)(t) or any other relevant provision of the law."

NOTEWORTHY DELETIONS: NONE

COMMENTARY: NONE

SELECTED IMPACT: 0.0%

Section 27 – Grounds for Disciplinary Action; Action by the Board and Department (Osteopathic)

NOTEWORTHY ADDITIONS: NONE

NOTEWORTHY DELETIONS: NONE

COMMENTARY: NONE

SELECTED IMPACT: 0.0%

Section 28 – Emergency Procedures for Disciplinary Action (Osteopathic)

NOTEWORTHY ADDITIONS: NONE

NOTEWORTHY DELETIONS: NONE

COMMENTARY: NONE

SELECTED IMPACT: 0.0%

Section 29 – Grounds for Disciplinary Action; Action by the Board; Investigations by Department (Podiatric)

NOTEWORTHY ADDITIONS: NONE

NOTEWORTHY DELETIONS: NONE

COMMENTARY: NONE

SELECTED IMPACT: 0.0%

Section 30 – Emergency Procedures for Disciplinary Action (Podiatric)

NOTEWORTHY ADDITIONS: NONE

NOTEWORTHY DELETIONS: NONE

COMMENTARY: NONE

SELECTED IMPACT: 0.0%

Section 31 – Grounds for Disciplinary Action; Action by the Board (Dental)

NOTEWORTHY ADDITIONS: NONE

NOTEWORTHY DELETIONS: NONE

COMMENTARY: NONE

SELECTED IMPACT: 0.0%

Section 32 – The Division of Administrative Hearings shall…

NOTEWORTHY ADDITIONS: NONE

NOTEWORTHY DELETIONS: NONE

COMMENTARY: NONE

SELECTED IMPACT: 0.0%

Section 33 – Patient Safety Instructional Requirements (Public School, College, and University)

NOTEWORTHY ADDITIONS:

"Each public school, college, and university that offers degrees in medicine, nursing, or allied health shall include in the curricula applicable to such degrees material on patient safety, including patient safety improvement. Materials shall include, but need not be limited to, effective communication and teamwork; epidemiology of patient injuries and medical errors; medical injuries; vigilance, attention, and fatigue; checklists and inspections; automation, technological, and computer support; psychological factors in human error; and reporting systems."

NOTEWORTHY DELETIONS: NONE

COMMENTARY: NONE

SELECTED IMPACT: 0.0%

Section 34 – Patient Safety Instructional Requirements (Private School, College, and University)

NOTEWORTHY ADDITIONS:

"Each private school, college, and university that offers degrees in medicine, nursing, and allied health shall include in the curricula applicable to such degrees material on patient safety, including patient safety improvement. Materials shall include, but need not be limited to, effective

communication and teamwork; epidemiology of patient injuries and medical errors; medical injuries; vigilance, attention, and fatigue; checklists and inspections; automation, technological, and computer support; psychological factors in human error; and reporting systems."

NOTEWORTHY DELETIONS: NONE
COMMENTARY: NONE
SELECTED IMPACT: 0.0%

Section 35 – The Agency for Health Care Administration Shall…

NOTEWORTHY ADDITIONS: NONE
NOTEWORTHY DELETIONS: NONE
COMMENTARY: NONE
SELECTED IMPACT: 0.0%

Section 36 – The Agency for Health Care Administration is directed…

NOTEWORTHY ADDITIONS: NONE
NOTEWORTHY DELETIONS: NONE
COMMENTARY: NONE
SELECTED IMPACT: 0.0%

Section 37 – Office of Program Policy Analysis and Government Accountability must…

NOTEWORTHY ADDITIONS: NONE

NOTEWORTHY DELETIONS: NONE

COMMENTARY: NONE

SELECTED IMPACT: 0.0%

Section 38 – The Department of Health Shall…

NOTEWORTHY ADDITIONS: NONE

NOTEWORTHY DELETIONS: NONE

COMMENTARY: NONE

SELECTED IMPACT: 0.0%

Section 39 – Commercial Self-Insurance Funds

NOTEWORTHY ADDITIONS: NONE

NOTEWORTHY DELETIONS: NONE

COMMENTARY: NONE

SELECTED IMPACT: 0.0%

Section 40 – Rate Standards

NOTEWORTHY ADDITIONS:

Section 40 establishes the requirement for calculating a presumed factor by Section. Observations regarding Section 40 can be found in Section IV.

NOTEWORTHY DELETIONS: NONE

COMMENTARY: NONE

SELECTED IMPACT: 0.0%

Section 41 – Office of Program Policy Analysis and Government Accountability Shall…

NOTEWORTHY ADDITIONS: NONE

NOTEWORTHY DELETIONS: NONE

COMMENTARY: NONE

SELECTED IMPACT: 0.0%

Section 42 – Medical Malpractice Self-Insurance

NOTEWORTHY ADDITIONS:

"remains solvent and"

NOTEWORTHY DELETIONS: NONE

COMMENTARY: NONE

SELECTED IMPACT: 0.0%

Section 43 – Medical Malpractice Insurance Contracts

NOTEWORTHY ADDITIONS: NONE

NOTEWORTHY DELETIONS: NONE

COMMENTARY: NONE

SELECTED IMPACT: 0.0%

Section 44 – Public Notice of Medical Malpractice Rate Filings

NOTEWORTHY ADDITIONS: NONE

NOTEWORTHY DELETIONS: NONE

COMMENTARY: NONE

SELECTED IMPACT: 0.0%

Section 45 – Professional Liability Claims and Actions; Reports by Insurers and Health Care Providers; Annual Report

NOTEWORTHY ADDITIONS: NONE

NOTEWORTHY DELETIONS: NONE

COMMENTARY: NONE

SELECTED IMPACT: 0.0%

Section 46 – Definitions (HMO)

NOTEWORTHY ADDITIONS: NONE

NOTEWORTHY DELETIONS: NONE

COMMENTARY: NONE

SELECTED IMPACT: 0.0%

Section 47 – Quality Assurance Program; Second Medical Opinion Requirement

NOTEWORTHY ADDITIONS: NONE

NOTEWORTHY DELETIONS: NONE

COMMENTARY: NONE

SELECTED IMPACT: 0.0%

Section 48 – Medical Negligence; Standards of Recovery; Expert Witness

NOTEWORTHY ADDITIONS:

"(5) A person may not give expert testimony concerning the prevailing professional standard of care unless that person is a licensed health care provider and meets the following criteria:

(a) If the health care provider against whom or on whose behalf the testimony is offered is a specialist, the expert witness must:

1. Specialize in the same specialty as the health care provider against whom or on whose behalf the testimony is offered; or specialize in a similar specialty that includes the evaluation, diagnosis, or treatment of the medical condition that is the subject of the claim and have prior experience treating similar patients; and

2. Have devoted professional time during the 3 years immediately preceding the date of the occurrence that is the basis for the action to:

a. The active clinical practice of, or consulting with respect to, the same or similar specialty that includes the evaluation, diagnosis, or treatment of the medical condition that is the subject of the claim and have prior experience treating similar patients;

b. Instruction of students in an accredited health professional school or accredited residency or clinical research program in the same or similar specialty; or

c. A clinical research program that is affiliated with an accredited health professional school or accredited residency or clinical research program in the same or similar specialty.

(b) If the health care provider against whom or on whose behalf the testimony is offered is a general practitioner, the …"

"(10) In any action alleging medical negligence, an expert witness may not testify on a contingency fee basis."

"(11) Any attorney who proffers a person as an expert witness pursuant to this Section must certify that such person has not been found guilty of fraud or perjury in any jurisdiction."

NOTEWORTHY DELETIONS:
Removal of old expert witness criteria.

COMMENTARY:
Section 48 defines expert witness testimony and when a person may give expert testimony concerning the prevailing professional standard of care. Although the change in expert witness qualifications will likely increase costs for plaintiff attorneys and reduce the likelihood of the use of so called "general" experts, it is our belief that these savings will be offset by the increased costs associated with insurance companies having to use expert witnesses in defending cases and in other Sections of the bill.

SELECTED IMPACT: De Minimis Cost

Section 49 – Notice Before Filing Action for Medical Negligence; Presuit Screening Period; Offers for Admission of Liability and for Arbitration; Informal Discovery; Review

NOTEWORTHY ADDITIONS:

"Notice to each prospective defendant must include, if available, a list of all known health care providers seen by the claimant for the injuries complained of subsequent to the alleged act of negligence, all known health care providers during the 2-year period prior to the alleged act of negligence who treated or evaluated the claimant, and copies of all of the medical records relied upon by the expert in signing the affidavit. The requirement of providing the list of known health care providers may not serve as grounds for imposing sanctions for failure to provide presuit discovery."

"Upon receipt by a prospective defendant of a notice of claim, the parties shall make discoverable information available without formal discovery. Failure to do so is grounds for the dismissal of claims or defenses ultimately asserted."

"Written questions"
"Medical information release"
"Sanctions"

NOTEWORTHY DELETIONS:

Removal of old arbitration wording.

COMMENTARY: NONE

SELECTED IMPACT: 0.0%

Section 50 – Mandatory Mediation and Mandatory Settlement Conference in Medical Negligence Actions

NOTEWORTHY ADDITIONS:

"Mandatory mediation and"

"(1) Within 120 days after the suit is filed, unless such period is extended by mutual agreement of all parties, all parties shall attend in-person mandatory mediation in accordance with s. 44.102 if binding arbitration under s. 766.207 has not been agreed to by the parties. The Florida Rules of Civil Procedure shall apply to mediation held pursuant to this Section."

NOTEWORTHY DELETIONS: NONE

COMMENTARY: NONE

SELECTED IMPACT: 0.0%

Section 51 – Health Care Providers; Creation of Agency Relationship with Governmental Contractors

NOTEWORTHY ADDITIONS: NONE

NOTEWORTHY DELETIONS: NONE

COMMENTARY: NONE

SELECTED IMPACT: 0.0%

Section 52 – Comparative Fault

NOTEWORTHY ADDITIONS: NONE

NOTEWORTHY DELETIONS: NONE

COMMENTARY: NONE

SELECTED IMPACT: 0.0%

Section 53 – Settlement Agreements; Prohibition on Restricting Disclosure to Division of Medical Quality Assurance

NOTEWORTHY ADDITIONS:

"(1) Each final settlement agreement relating to medical negligence shall include the following statement: "The decision to settle a case may reflect the economic practicalities pertaining to the cost of litigation and is not, alone, an admission that the insured failed to meet the required standard of care applicable to the patient's treatment. The decision to settle a case may be made by the insurance company without consulting its client for input, unless otherwise provided by the insurance policy."

NOTEWORTHY DELETIONS: NONE

COMMENTARY: NONE

SELECTED IMPACT: 0.0%

Section 54 – Determination of Noneconomic Damages

NOTEWORTHY ADDITIONS:

"(1) Definitions."

"(2) Limitation on noneconomic damages for negligence of practitioners."

"(3) Limitation on noneconomic damages for negligence of nonpractitioner defendants."

"(4) Limitation on noneconomic damages for negligence of practitioners providing emergency services and care."

"(5) Limitation on noneconomic damages for negligence of nonpractitioner defendants providing emergency services and care."

"(6) Setoff."

"(7) Actions governed by Sovereign Immunity Law."

NOTEWORTHY DELETIONS: NONE

COMMENTARY:

Section 54 describes the cap on noneconomic damages for practitioners, nonpractitioners, non emergency room, emergency room, and situations when the cap is pierced. In order to develop the foundation for calculating the presumed factor for Section 54, the following items need to be addressed:

- Simplified Cap Flow Chart;
- Constitutional Issues;
- Policy Limits;
- Claimants;
- Inclusion of Minor Severity Types;
- ALAE Adjustment Assumptions;
- SB2D Phase in Assumptions; and
- Calculation of Presumed Factor.

Simplified Cap Flow Chart

The following flow chart illustrates the impact of Section 54 in an easy-to-follow format.

SECTION 54
766.118 DETERMINATION OF NONECONOMIC DAMAGES

☐ Practitioner

- **Non emergency room**
  - $500,000 per claimant (2)(a)
  - $500,000 per practitioner (2)(a)

"Pierced Cap"

Death or permanent vegetative state	$1,000,000 aggregate practitioner cap (2)(b) regardless of the number of claimants
Manifest injustice plus catastrophic injury	$1,000,000 aggregate cap recoverable by injured patient

- **Emergency room**
  - $150,000 per claimant (4)(a)
  - $300,000 aggregate practitioner cap (4)(b)

☐ Nonpractitioner

- **Non emergency room**
  - $750,000 per claimant (3)(a)
  - $750,000 per nonpractitioner (3)(a)

"Pierced Cap"

Death or permanent vegetative state	$1,500,000 aggregate nonpractitioner cap (3)(b) regardless of the number of claimants
Manifest injustice plus catastrophic injury	$1,500,000 aggregate cap recoverable by injured patient

- **Emergency room**
  - $750,000 per claimant (5)(a)
  - $1,500,000 aggregate non practitioner cap (5)(b)
  - Nonpractitioner defendants may receive a full setoff for payments made by practitioner defendants (5)(c)

Definitions

Claimant means any person who has a cause of action for damages based on personal injury or wrongful death arising from medical negligence.

Health care practitioner means any person licensed under chapter 457 (acupuncture); chapter 458 (medical practice); chapter 459 (osteopathic medicine); chapter 460 (chiropractic medicine); chapter 461 (podiatric medicine); chapter 462 (naturopathy); chapter 463 (optometry); chapter 464 (nursing); chapter 465 (pharmacy); chapter 466 (dentistry); chapter 467 (midwifery); part I (speech-language pathology and audiology), part II (nursing home administration), part III (occupational therapy), part V (respiratory therapy), part X (dietetics and nutrition practice), part XIII (athletic trainers), or part XIV (orthotics, prosthetics, and pedorthics) of chapter 468; chapter 478 (electrolysis); chapter 480 (massage practice); part III (clinical laboratory personnel) or part IV (medical physicists) of chapter 483; chapter 484 (dispensing of optical devices and hearing aids); chapter 486 (physical therapy practice); chapter 490 (psychological services); or chapter 491 (clinical, counseling and psychotherapy services).

Non practitioner means hospitals, health maintenance organizations (HMOs), hospice providers, and other non-physician entities.

Constitutional Issues

Section 54 of the new legislation creates Section 766.118, Florida Statutes, which imposes caps on the amount of noneconomic damages recoverable in all medical malpractice actions, including those involving wrongful death.

The specific cap amounts are discussed earlier in this report.

Section 54 likely will be challenged by the plaintiffs' bar alleging that the caps are unconstitutional under the following provisions of the Florida Constitution:

1. Right of access to the courts;
2. Equal protection;
3. Due process; and
4. "Taking" without just compensation.

The principal challenge will likely be brought under the access to courts provisions. There is no corresponding provision in the federal Constitution.

Article I, Section 21 of the Florida Constitution provides: "The courts shall be open to every person for redress of any injury, and justice shall be administered without sale, denial, or delay."

The Florida Supreme Court has adopted a two-part alternative test for weighing whether particular legislation unconstitutionally infringes on the access to courts provision. The Legislature must show that it either has established a "reasonable alternative" to the right that is being abolished (also known as the "commensurate benefit" requirement) or the legislature must show (i) an "overpowering public necessity" for the legislation and (ii) that there is no alternative method for satisfying the public necessity. Kluger v. White, 281 So. 2d 1, 4 (Fla. 1973).

The Florida Supreme Court previously addressed the constitutionality of damages caps in medical malpractice actions in University of Miami v. Echarte, 618 So. 2d 189 (Fla. 1993), which is the only Florida case directly on point.

Echarte addressed the $250,000 noneconomic damages cap that was enacted by the 1988 Florida Legislature as part of the voluntary arbitration provision that was added to the medical malpractice Statute. The Court concluded that the cap was constitutional and did not violate the access to courts provision.

The decision was essentially a 4-3 vote, with the politically liberal members of the court dissenting. Although Justice Kogan was recused from the decision, most commentators familiar with his jurisprudence would agree that he likely would have voted with the dissent.

It is important to note that **none** of the current justices of the Florida Supreme Court were sitting when Echarte was decided in 1993. However, at least two current members of the Court (Justices Anstead and Quince) have expressed doubt about the "soundness" of the access to courts analysis in Echarte. See St. Mary's Hospital, Inc. v. Phillipe, 769 So. 2d 961, 974 (Fla. 2000).

The legislation at issue in Echarte allowed either the plaintiff or the defendant voluntarily to demand binding arbitration. If the plaintiff demanded arbitration and the defendant refused, then the plaintiff could proceed to trial by jury without any damages cap plus the opportunity to recover reasonable attorneys' fees up to 25% of the award. If a defendant demanded arbitration and the plaintiff refused, then the plaintiff's noneconomic damages were capped at $350,000 at trial. If the parties agreed to arbitrate, then the Statute capped the plaintiff's recoverable noneconomic damages at $250,000. In return for arbitrating, however, the plaintiff gained, among others, the following benefits: prompt payment upon issuance of an arbitration award, limited appeals by the defendants, and recovery of reasonable attorneys' fees up to 15% of the award.

The Florida Supreme Court held that the cap was constitutional because it satisfied the "commensurate benefit" test under Kluger v. White. Specifically, the Court found that the arbitration provision provided a reasonable alternative (i.e., commensurate benefit) to plaintiffs because of the various benefits that plaintiffs received from agreeing to arbitrate, including speedy resolution, prompt payment of claims, lower attorneys' fees, and limited appellate review.

The Court also held, in what is typically referred to as an "even if" argument, that the cap was constitutional "even if" the Statute did not provide a commensurate benefit to plaintiffs because the Legislature had satisfied the second test under Kluger v. White: an "overpowering public necessity" without any available alternative.

It is important to distinguish the Statute at issue in Echarte from SB2D. In Echarte, the cap only applied if one of the parties demanded arbitration. The cap had no applicability in the event that the parties both agreed to proceed in court. Here, the caps enacted by the 2003 Florida Legislature apply to all court cases involving injury or death due to medical negligence.

The Court's conclusion regarding the second prong of Kluger v. White is particularly relevant here because it is doubtful that the new "blanket" cap on noneconomic damages can satisfy the "commensurate benefit" test. Relevant to this conclusion is Smith v. Department of Insurance, 507 So. 2d 1080 (Fla. 1987), where the Florida Supreme Court struck down the $450,000 cap on noneconomic damages that the Legislature enacted as part of the "Tort Reform and Insurance Act of 1986." The cap enacted as part of that Statute applied to all tort actions, not just medical negligence actions.

The Legislature did not argue in Smith that there was an "overpowering public necessity" for the cap. Thus, the Court only analyzed whether the cap provided a "commensurate benefit" to plaintiffs under Kluger v. White. The Court held that it did not. The Court specifically addressed and rejected the argument that the damages cap has not completely abolished any particular cause of action and therefore had not denied "access" to the courts.

> This reasoning focuses on the title to Article I, Section 21, "Access to court," and overlooks the contents which must be read in conjunction with Section 22, "Trial by jury." Access to courts is granted for the purpose of redressing injuries. A plaintiff who receives a jury verdict for, e.g., $1,000,000, has not received a constitutional redress of injuries if the legislature statutorily, and arbitrarily, caps the recovery at $450,000. Nor, we add, because the jury verdict is being arbitrarily capped, is the plaintiff receiving the constitutional benefit of a jury trial as we have heretofore understood that right. **Further, if the legislature may constitutionally cap recovery at $450,000, there is no discernible reason why it could not cap the recovery at some other figure, perhaps $50,000, or $1,000, or even $1. None of these caps, under the reasoning of appellees, would "totally" abolish the right of access to the courts. At least one of the appellees candidly argues that there is no constitutional bar to completely abolishing noneconomic damages by requiring potential injured victims to buy insurance protecting themselves against economic loss due to injury as an alternative remedy. That particular issue is not before us but we note that if it were permissible to restrict the constitutional right by legislative action, without meeting the conditions set forth in Kluger, the constitutional right of access to the courts for redress of injuries would be subordinated to, and a creature of, legislative grace or, as Mr. Smith puts it, "majoritarian whim."** There are political systems where constitutional rights are subordinated to the power of the executive or legislative branches, but ours is not such a system.

Smith, 507 So. 2d 1088-89 (Emphasis added).

Thus, it would appear that, in order for the 2003 legislation to pass muster under the "access to courts" provision, the Legislature must meet the second Kluger test: "overpowering public necessity" plus no alternative method for meeting that necessity.

This legal reasoning was not lost on the Governor's Task Force, which obviously was acutely aware of the holding in Echarte and its analysis of the "overpowering public necessity" test. Indeed, the January 29, 2003 letter enclosing the Task Force report to the Governor specially says, "The task force has taken great care to conform its recommendations to the requirements of the Florida Constitution and the case law[.]"

In finding that the cap on noneconomic damages in the arbitration Statute satisfied the second Kluger test, the Echarte Court relied very heavily (almost exclusively) on the report and recommendations issued by the "Academic Task Force for Review of the Insurance and Tort Systems." The report made the following significant findings, among others: (i) the dramatic increase in the size or amounts of paid claims was the major cause of the increase in total claims payments; the frequency of claims against physicians had increased only slightly; (ii) strengthening the discipline and oversight of doctors was a supplement but not an alternative to tort reform.

The report in Echarte was the result of an "extensive" study, including seven public meetings and hearings, eight research projects studying data from, among others, the Insurance Services Office, a survey of 1,500 doctors and 1,500 medical malpractice lawyers, an analysis of insurance company data, and an analysis of civil litigation rates in Florida.

The heavy reliance on the task force report in Echarte will likely result in a comparison of that report to the report of the Governor's Select Task Force on Healthcare Professional Liability Insurance that is cited by the Legislature in its findings related to the Statute at issue here.

We have reviewed the Task Force report here in detail. The report, and the investigations, meetings, and analyses that were conducted by the Task Force prior to writing the report, were clearly designed to satisfy the holding in Echarte. Simply put, the Task Force has "dotted every 'i' and crossed every 't'". In particular, like the report in Echarte, this report concludes that (i) the severity of claim payments significantly increased between 1998 and 2000 and (ii) a cap on noneconomic damages is the "only" way to accomplish the Legislature's goal of reducing

healthcare costs. Task Force Report, page xi ("Without the inclusion of a cap on potential awards of noneconomic damages in a legislative package, no legislative reform plan can be successful in achieving the goal of controlling increases in healthcare costs.")

Nobody can predict how the Florida Supreme Court will rule when (not if, but when) the constitutionality of the new law is brought before it. Accordingly, we will not attempt to do so here, other than to observe, as we have above, that at least Justices Anstead and Quince appear to question even the limited holding in Echarte and are likely to take a critical view of the new caps.

Additionally, we would observe that the Task Force relies on the success of caps in California to support its recommendation for caps in Florida, and notes that California upheld the constitutionality of the caps. It is worth noting that California, unlike Florida, does not have a specific "access to courts" provision in its constitution.

In terms of timing, the Florida Supreme Court likely will not rule on the constitutionality of the new law until, at the earliest, the Fall of 2006. This is because it will take approximately 18 to 24 months for a jury verdict to be rendered in excess of the cap, after which an appeal will have to be taken to the intermediate appellate court in Florida. That appeal likely will take approximately one year to complete, after which the parties will be able to seek review in the Florida Supreme Court. It will take approximately another full year for the Florida Supreme Court to issue a decision.

In the event that the Florida Supreme Court declares the law unconstitutional, and if the basis of the court's decision falls under the Florida Constitution, then it would be necessary to pass an amendment to the Florida Constitution to validate the caps. (If the decision is based on the United States Constitution, either the due process clause, the equal protection clause, or the right to jury clause, then an amendment to the United States Constitution would be required.)

PRESUMED FACTOR

There are three basic methods to propose amendments to the Florida constitution: a three-fifths vote of each house of the Legislature; a petition drive reflecting the appropriate number of required signatures (about 8% of the voters); or a constitutional convention. Article XI, Fla. Const. Regardless of the method chosen to propose an amendment, the amendment must be approved by the electorate "at the next general election held more than ninety days after the joint resolution, initiative petition or . . . constitutional convention." Article XI, Section 5(a). "If the proposed amendment or revision is approved by vote of the electors, it shall be effective as an amendment to or revision of the constitution of the state on the first Tuesday after the first Monday in January following the election, or on such other date as may be specified in the amendment or revision." Article XI, Section 5(c). Thus, any proposed amendment would be required to be voted upon at the next general election after the amendment is validly proposed, which likely would be the year 2008 if the amendment is not proposed until after a ruling by the Florida Supreme Court on the constitutionality of the current legislation.

Section 40 – Rate Standards notes: "(c) If any provision of medical malpractice legislation enacted during the 2003 Special Session D of the Florida Legislature is held invalid by a court of competent jurisdiction, the office shall permit an adjustment of all medical malpractice rates filed under this section to reflect the impact of such holding on such rates so as to ensure that the rates are not excessive, inadequate, or unfairly discriminatory."

For purposes of our analysis, we will calculate the presumed factor as if Section 54 is not held invalid by a court of competent jurisdiction. If Section 54 is found invalid, the Office of Insurance Regulation will adjust the overall presumed factor calculated in this report by subtracting the Section 54 presumed factor from the overall presumed factor.

Policy Limits

The Governor's Select Task Force on Healthcare Professional Liability (GSTF) report documents the drastic reduction in insurance companies providing coverage in Florida, rising medical malpractice premiums and the impact on the affordability of policy limits in excess of $250,000 for insurance consumers.

In order to estimate the impact of the cap on noneconomic damages, it is important to understand the mix of policy limits offered by insurance companies. The GSTF report, newspaper articles and industry publications document the current trend in Florida: healthcare providers are purchasing lower and lower policy limits (e.g., $250,000 per occurrence/ $750,000 in the aggregate) or are choosing not to purchase coverage at all. The following table is from the GSTF report, prepared by the RCH Healthcare survey of South Florida physicians:

Changes in Coverage Limitations

Percentage Buying:	Last Year	This Year
$1,000,000/$3,000,000	35.0%	30.7%
$500,000/$1,500,000	12.5%	11.4%
$250,000/$750,000	47.1%	51.5%
No Malpractice Coverage	5.4%	16.4%
Total	100.0%	100.0%

This survey, completed in November of 2002, illustrates the dramatic shift towards lower limits (or no coverage at all). Given the size of rate increases filed in 2003, the continuing after-effects of major insurance companies that have exited the Florida market, and the reduction in capacity offered by Florida's remaining insurers, we expect this trend to continue.

As a part of our presumed factor analysis, we reviewed a number of medical malpractice filings made by Florida's largest insurers based on 2002 direct written premium. The medical malpractice ratemaking files we reviewed represented approximately 72% of the $829 million of 2002 direct premium written in the State of Florida (NAIC database provided in Appendix E). The following table illustrates the distribution of policies identified in one of the rate filings we reviewed:

DISTRIBUTION BY POLICY LIMIT

Limits of Liability	Company B Physicians	Company B Surgeons
$100,000/$300,000	0.5%	0.0%
$250,000/$750,000	32.0%	43.7%
$500,000/$500,000	0.1%	0.0%
$500,000/$1,500,000	17.7%	16.7%
$1,000,000/$1,000,000	1.8%	1.7%
$1,000,000/$3,000,000	42.1%	36.9%
$1,500,000/$3,000,000	1.8%	0.6%
$2,000,000/$4,000,000	4.1%	0.4%
	100.0%	100.0%

The following table illustrates our estimation of the distribution of policies using the Florida closed claim database for disposition years 1983 through 2003:

FLORIDA CLOSED CLAIM DATABASE
DISTRIBUTION BY LIMIT

Policy Limits[1]	Practitioner	Nonpractitioner
100,000	6%	7%
250,000	23%	10%
500,000	15%	4%
1,000,000	37%	18%
2,000,000	6%	12%
5,000,000	2%	3%
10,000,000	3%	4%
> 10,000,000 [2]	1%	28%
< 10,000,000 [3]	7%	14%
TOTAL	100%	100%

Note: 1) Records with policy limit documented
2) Policy limits over $10,000,000
3) Policy limits under $10,000,000 not shown seperately above

A review of more recent years confirms the shift towards lower policy limits as medical malpractice premiums started to rise. Given that we are in the middle stages of Florida's hard market, it is likely that the current database does not reflect the actual shift towards lower policy limits because of the following:

1. The database only displays closed claims which will tend to reflect an older mix of policy limits; and
2. The database does not include more recent policy renewals that would reflect some of the more staggering rate increases that have forced healthcare providers to forgo higher limit protection for stability in medical malpractice premiums.

The next table displays the increased limit factors (ILFs) that are used to convert basic limit manual rates of $250,000/$750,000 to a higher policy limits.

INCREASED LIMIT FACTORS

Limits of Liability	Company A Physicians & Dentists	Company A ER Med, OB/GYN, Radiologists	Company B Physicians	Company B Surgeons	Company C Physicians & Surgeons
$100,000/$300,000	0.750	0.750	0.736	0.736	0.725
$250,000/$750,000	1.000	1.000	1.000	1.000	1.000
$500,000/$1,500,000	1.350	1.400	1.279	1.313	1.275
$1,000,000/$3,000,000	1.900	2.040	1.624	1.674	1.558

Limits of Liability	Company D Surgeons	Company E Physicians	Company F Physicians Excluding Chiropractors	Company F Chiropractors	Company I Surgeons
$100,000/$300,000	0.864	0.754			
$250,000/$750,000	1.000	1.000	1.000	1.000	1.000
$500,000/$1,500,000	1.455		1.404	1.142	1.161
$1,000,000/$3,000,000	2.091	1.639	1.733	1.357	1.671

As one can see from above table, physicians and surgeons who want to purchase policy limits of $1,000,000/$3,000,000 must pay approximately 60% to 100% more than it would cost to purchase policy limits of $250,000/$750,000.

When one considers the fact that rates have increased in excess of 100% over the last couple of years for some physicians and surgeons, it is easy to see why they would be tempted to purchase lower limits of coverage in order to help offset the cost of rising medical malpractice premiums. **As more physicians and surgeons shift to lower policy limits, the less impact the caps on noneconomic damages will have.** For example, if a physician purchases an insurance policy with limits of $250,000/$750,000, a $500,000 cap on noneconomic damages adds little (if any) value to the insurance company in terms of savings when bad faith is not an issue. In certain situations where bad faith is an issue and noneconomic damages are capped, insurance companies could achieve savings when payments in excess of policy limits are reduced because of the cap (see Section 56).

In order to get a better understanding of the policy limits currently being written by medical malpractice insurers in the State of Florida, the OIR assisted us in gathering policy limit information from some of the top insurers. The following table displays the policy limit distribution provided by each insurer, a weighted average of the insurers and our selected policy limit assumptions for use in calculating the presumed factor:

POLICY LIMIT DISTRIBUTION

■ Practitioner

Policy Limit	Company 1	Company 2	Company 3	Company Volume Weighted	Closed Claim Database (All Years)	Selected Distribution
$100,000	0.0%	0.0%	0.1%	0.0%	6.6%	**2.0%**
$250,000	4.6%	40.6%	25.7%	25.1%	25.2%	**25.0%**
$500,000	12.1%	18.6%	15.9%	15.8%	16.1%	**16.0%**
$1,000,000	62.2%	40.8%	54.9%	51.6%	39.4%	**47.5%**
$2,000,000	17.3%	0.0%	3.1%	6.3%	6.3%	**7.5%**
$5,000,000	0.0%	0.0%	0.2%	0.0%	2.3%	**0.5%**
OTHER	3.8%	0.0%	0.0%	1.2%	4.1%	**1.5%**
TOTAL	100.0%	100.0%	100.0%	100.0%	100.0%	**100.0%**

■ Nonpractitioner

Policy Limit	Company 1	Company 2	Company Volume Weighted	Closed Claim Database (All Years)	Selected Distribution
$100,000	0.0%	0.0%	0.0%	8.2%	**2.5%**
$250,000	1.8%	31.2%	19.1%	11.4%	**17.5%**
$500,000	10.4%	12.1%	11.4%	4.6%	**10.0%**
$1,000,000	64.6%	56.7%	60.0%	20.3%	**50.0%**
$2,000,000	15.8%	0.0%	6.5%	14.3%	**7.5%**
$5,000,000	0.0%	0.0%	0.0%	3.9%	**2.5%**
OTHER	7.4%	0.0%	3.1%	37.3%	**10.0%**
TOTAL	100.0%	100.0%	100.0%	100.0%	**100.0%**

Claimants

The word "claimant" as used in the chapter of the Florida Statutes relating to medical malpractice was defined as "any person who has a cause of action arising from medical negligence." § 766.202(1), Fla. Stat.

Section 58 of the new law revised the definition to read as follows: "any person who has a cause of action for damages based on personal injury or wrongful death arising from medical negligence."

This revision was likely intended to make clear that the definition of "claimant" (and thus the cap on noneconomic damages and other revisions to the medical malpractice law) applied to both regular actions based on medical negligence and actions involving wrongful death arising from medical negligence.

Neither this revision or any other revision in the new law appears to change or alter which categories of persons can assert claims for noneconomic damages based on medical negligence. Those categories are as follows:

A. Non-Death

Persons who can typically recover noneconomic damages for medical negligence that does not result in the death of the injured person are as follows:

1. Injured person.
2. Spouse of injured person.
3. Children of injured person, regardless of the age of the "child," but only if the "child" is unmarried and financially dependent on the injured person and the injury resulted in a permanent total disability. (Note: Typically, minor children and non-dependent adult children do not have significant claims for noneconomic damages due to injury to a parent)
4. Parents, but only if the injured person is under 18 at the time of the injury.

B. Death

The Florida wrongful death act, Section 768.21, Florida Statutes, enumerates which "survivors" of a deceased person can recover noneconomic damages for medical malpractice as follows:

1. Spouse.
2. All children under 25 years of age.
3. Parents, but only if the injured person is a child under 25 years of age.

For purposes of analyzing the caps, we have assumed the following distribution for the number of claimants and/or defendants:

Number of Claimants and/or Defendants			
1/1	2/2	3/3	4/4
25%	50%	20%	5%

In selecting the above distribution of claimants and/or defendants, we were comfortable with the general assumption that, on average, the closed claim database would average approximately two claimants (e.g., husband and wife, wife and child, etc.) over the entire sample of records. In order to reflect the possible variation in savings as the number of claimants and/or defendants vary, we decided to allocate 50% to the other categories as displayed above. We believe these assumptions are reasonable given the limitations of the closed claim database discussed below and our expectations regarding the number of claimants and defendants.

A discussion of our assumptions regarding the comparative fault of each defendant has been provided in the Observation Section of the report.

Inclusion of Minor Severity Types

Based upon a review of the "current" closed claim database file, we found that the average severity for injuries types 1 through 3 (i.e., those expected to have the least impact on the presumed factor calculation) were almost 4 times smaller than the average severity for injury types 4 through 9.

To improve efficiency, we decided to eliminate entries associated with the lowest severity injury types. The excluded severity injury types were;

1. Emotional Only – Fright, no physical damage.
2. Temporary Slight – Lacerations, contusions, minor scars, rash. No delay.
3. Temporary Minor – Infections, misset fracture, fall in hospital. Recovery Delayed.

The following severity injury types were not excluded:

4. Temporary: Major - Burns, surgical material left, drug side effect, brain damage. Recovery delayed.
5. Permanent: Minor - Loss of fingers, loss or damage to organs. Includes non-disabling injuries.
6. Permanent: Significant - Deafness, loss of limb, loss of eye, loss of one kidney or lung.
7. Permanent: Major - Paraplegia, blindness, loss of two limbs, brain damage.
8. Permanent: Grave - Quadriplegia, severe brain damage, lifelong care or fatal prognosis
9. Permanent: Death.

A review of the "current" closed claim database indicated that the lowest severity injury types represent over 25% of the claim counts, but only 8% of the indemnity payments.

Therefore, at the end of the savings calculations, we have selected a savings factor of 2.5% for the 8% portion of the indemnity payments we excluded. This 2.5% factor was selected based upon the relative average severity of these claims to the more severe claims and the low probability of the cap on noneconomic damages impacting these smaller dollar claims.

ALAE Adjustment Assumptions

A review of A.M. Best's Financial Databases for P&C Companies indicate the following countrywide ratios of allocated loss adjustment expense (ALAE) to indemnity payments:

Medical Malpractice – Occurrence	30%
Medical Malpractice – Claims Made	36%

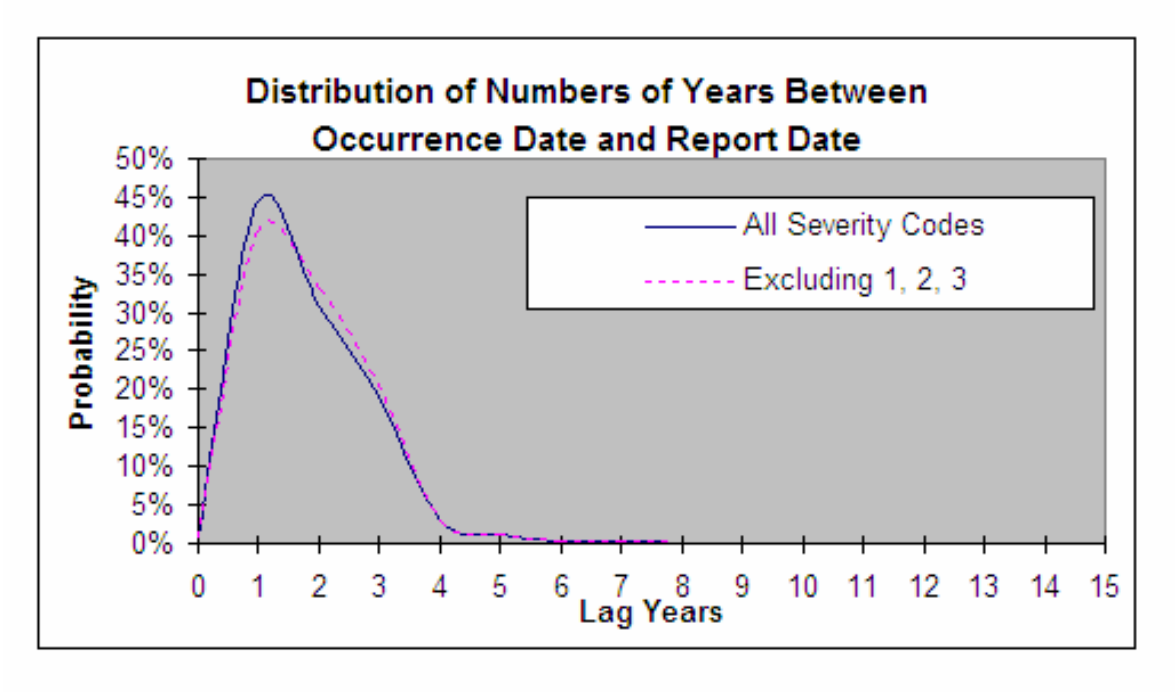
A review of the Florida rate filings indicated a ratio of ALAE to indemnity payments in the 40% to 55% range by year. We believe the higher than countrywide ratio is driven by Florida's heavy distribution of lower policy limits. A lower average policy limit magnifies the impact of dollars spent defending a claim since the indemnity payments will be capped at a lower dollar level than similar cases settled throughout the rest of the country.

For purposes of calculating the presumed factor, we have assumed that ALAE costs equal roughly 45% of the indemnity payments made in Florida.

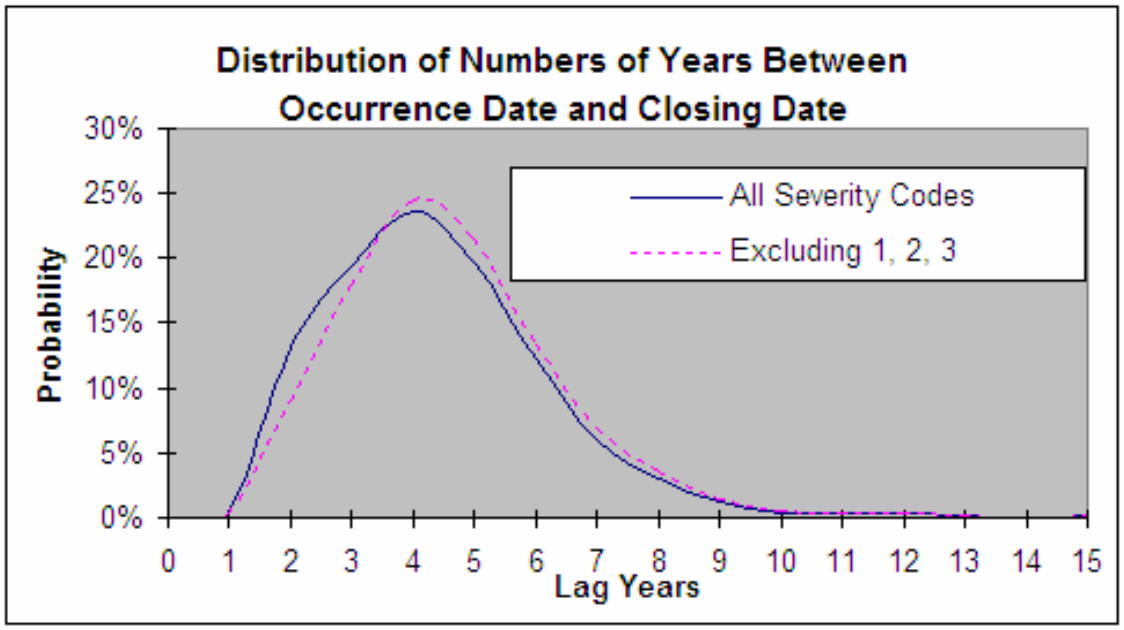
This assumption is important because the savings calculated in Section 54 only apply to indemnity payments. Medical malpractice policy limits do not apply to ALAE payments, only indemnity payments such as economic and noneconomic damages. Therefore, ALAE payments **should not** be adjusted to reflect the indemnity savings calculated in this Section using the closed claim database.

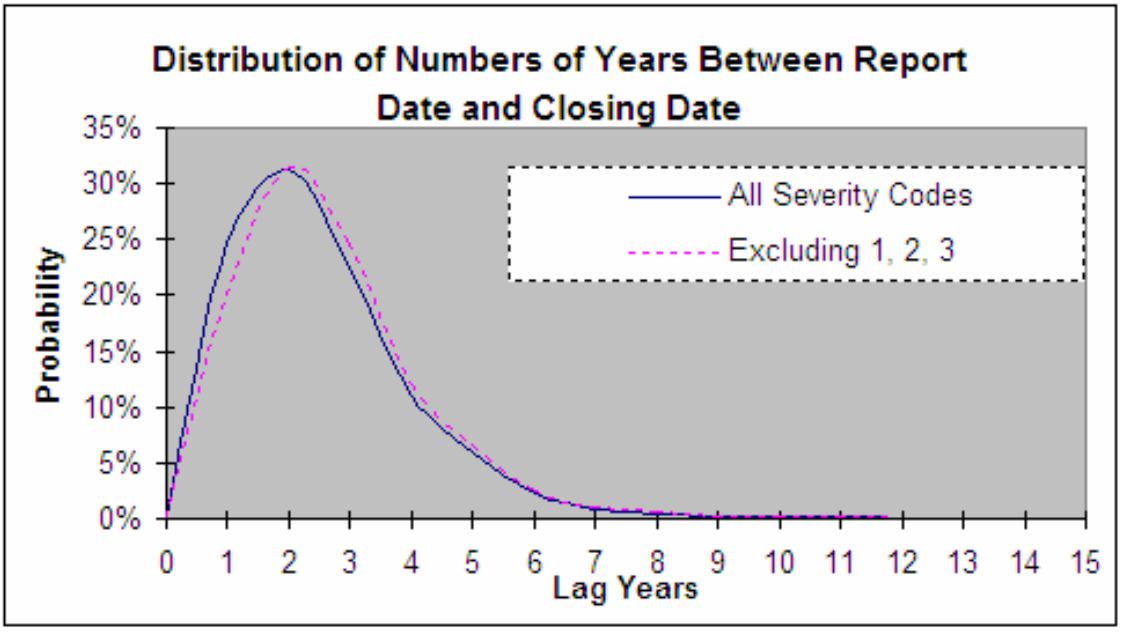
SB2D Phase in Assumptions

As is noted below in Section 86, the cap on noneconomic damages will likely not apply to injuries or misdiagnoses or other types of medical negligence that caused injury before September 15, 2003, even if presuit notice was initiated after September 15, 2003. Therefore, the impact of the law will take time to phase in. The following graphs illustrate our research on various lag times which we compiled from the closed claim database:



Deloitte.


Distribution of Numbers of Years Between Occurrence Date and Closing Date
Probability
30%
25%
20%
15%
10%
5%
0%
0 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15
Lag Years
All Severity Codes
Excluding 1, 2, 3


Distribution of Numbers of Years Between Report Date and Closing Date
Probability
35%
30%
25%
20%
15%
10%
5%
0%
0 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15
Lag Years
All Severity Codes
Excluding 1, 2, 3

CLOSED CLAIM DATABASE LAG SUMMARY

Lag Years	Distribution of Numbers of Years Between Occurrence Date and Report Date	Occurrence Date and Closing Date	Report Date and Closing Date
0	0.9%	0.0%	0.1%
1	40.5%	0.3%	20.2%
2	33.1%	9.0%	31.6%
3	20.7%	18.0%	24.6%
4	3.0%	24.6%	12.0%
5	1.2%	21.5%	6.7%
6	0.3%	13.4%	2.5%
7	0.2%	6.8%	1.0%
8	0.0%	3.5%	0.6%
9	0.0%	1.3%	0.3%
10	0.0%	0.5%	0.2%
11	0.0%	0.4%	0.2%
12	0.0%	0.3%	0.1%
13	0.0%	0.2%	0.1%
14	0.0%	0.1%	0.0%
15	0.0%	0.1%	0.1%
	100.0%	100.0%	100.0%

The mean lag is displayed below:

CLOSED CLAIM DATABASE LAG SUMMARY

Lag Years	Distribution of Numbers of Years Between Occurrence Date and Report Date	Occurrence Date and Closing Date	Report Date and Closing Date
Mean	1.91	4.64	2.74

Based upon the above information, the average delay from the reporting of a claim to the closing of a claim will result in a phased in effect of the savings observed from the cap on noneconomic damages. Pre-SB2D claims with no savings will take time to be cleared out of the system. In addition, post-SB2D claims reflecting savings from the cap on noneconomic damages will take time to enter the system based upon the above lag distributions.

Therefore, we have selected a factor of 0.85 based upon a review of the lag factors above in order to reflect the fact that savings will be phased in over time. Using an analogy, the selected phase in

factor is similar to a present value factor that one would apply to a stream of future payments to convert them into today's current dollar value.

Calculation of Presumed Factor

For the interested reader, Appendix A, Summary Sheet B2 displays a flow chart of the presumed factor savings flow for Section 54. A visual may be helpful before reading on.

The following table displays the savings estimated by policy limit and the number of claimants and/or defendants:

Matrix of Indemnity Savings

■ **Practitioner**

Policy Limits	Selected Distribution	Number of Claimants and/or Defendants 1/1	2/2	3/3	4/4
$100,000	2.0%	0.0%	0.0%	0.0%	0.7%
$250,000	25.0%	1.5%	1.3%	2.4%	3.0%
$500,000	16.0%	3.5%	3.0%	6.2%	8.6%
$1,000,000	47.5%	16.9%	10.8%	12.6%	13.5%
$2,000,000	7.5%	26.5%	16.0%	16.1%	16.1%
$5,000,000	2.0%	31.8%	19.0%	17.9%	17.5%
	100.0%	13.9%	8.4%	9.8%	10.6%

■ **Nonpractitioner**

Policy Limits	Selected Distribution	Number of Claimants and/or Defendants 1/1	2/2	3/3	4/4
$100,000	2.5%	0.0%	0.0%	0.0%	0.0%
$250,000	17.5%	0.0%	0.0%	0.0%	0.0%
$500,000	10.0%	0.0%	0.0%	0.0%	1.5%
$1,000,000	50.0%	2.3%	1.8%	5.5%	8.6%
$2,000,000	7.5%	11.8%	9.9%	14.2%	16.4%
$5,000,000	2.5%	24.0%	19.4%	19.1%	18.6%
$100,000,000	10.0%	30.2%	19.9%	19.1%	18.6%
	100.0%	8.3%	5.3%	7.2%	8.9%

■ **Total**

Policy Limits	Number of Claimants and/or Defendants 1/1	2/2	3/3	4/4
$100,000	0.0%	0.0%	0.0%	0.6%
$250,000	1.3%	1.2%	2.1%	2.6%
$500,000	3.1%	2.6%	5.4%	7.7%
$1,000,000	15.1%	9.7%	11.7%	12.8%
$2,000,000	24.6%	15.2%	15.8%	16.1%
$5,000,000	30.7%	19.1%	18.1%	17.6%
$100,000,000	30.2%	19.9%	19.1%	18.6%
	13.1%	**8.0%**	**9.4%**	**10.4%**

For a better understanding of the above matrix, Please refer to Appendix B, Examples A, B, and C for detailed illustrations

PRESUMED FACTOR

In order to calculate the presumed factor, we have to make the following adjustments:

1. Apply policy limit distribution assumptions (already completed above);
2. Apply claimant/defendant assumptions;
3. Adjust savings for severity injury types 1 through 3;
4. Apply ALAE assumption; and
5. Apply "phase in" assumption.

STEP 2:

	Number of Claimants and/or Defendants			
	1/1	2/2	3/3	4/4
Indemnity Savings:	13.1%	8.0%	9.4%	10.4%
Selected Allocation:	25%	50%	20%	5%

Indemnity Savings (2): **9.7%**

STEP 3:

Severity Injury Code:	4 through 9	1 through 3
Indemnity Savings (2):	9.7%	2.5%
Selected Allocation:	92.0%	8.0%

Indemnity Savings (3): **9.1%**

STEP 4:

Payment Type:	Indemnity	ALAE	
Indemnity Savings (3):	9.1%	0.0%	
Selected Allocation:	69.0%	31.0%	*= .45 / (1 + .45)*

Indemnity Savings (4): **6.3%**

STEP 5:

Indemnity Savings (4):	6.3%
Phase in adjustment:	0.85

Presumed Factor: **5.3%**

SELECTED IMPACT: 5.3%

Section 55 – The Legislature Finds and Declares …

NOTEWORTHY ADDITIONS: NONE

NOTEWORTHY DELETIONS: NONE

COMMENTARY: NONE

SELECTED IMPACT: 0.0%

Section 56 – Bad Faith

NOTEWORTHY ADDITIONS:

"In all actions for bad faith against a medical malpractice insurer relating to professional liability insurance coverages for medical negligence, and in determining whether the insurer could and should have settled the claim within policy limits had it acted fairly and honestly towards its insureds with due regard for his or her interest, whether under **Statute or common law**:

(1)(a) An insurer shall not be held in bad faith for failure to pay its policy limits if it tenders its policy limits and meets other reasonable conditions of settlement by the earlier of either:

1. The 210th day after service of the complaint in the medical negligence action upon the insured. The time period specified in this subparagraph shall be extended by an additional 60 days if the court in the bad-faith action finds that, at any time during such period and after the 150th day after the service of the complaint, the claimant provided new information previously unavailable to the insurer relating to the identity or testimony of any material witness or the identity of any additional claimants or defendants, if such disclosure materially alters the risk to the insured of an excess judgment; or

2. The 60th day after the conclusion of all of the following:

a. Deposition of all claimants named in the complaint or amended complaint.

b. Deposition of all defendants named in the complaint or amended complaint, including, in the case of a corporate defendant, deposition of a designated representative.

c. Deposition of all the claimants' expert witnesses.

d. The initial disclosure of witnesses and production of documents.

e. Mediation as provided in s. 766.108."

"(1)(d) The fact that the insurer did not tender policy limits during the time periods specified in this paragraph **is not** presumptive evidence that the insurer acted in bad faith."

NOTEWORTHY DELETIONS: NONE

COMMENTARY:

Section 56 describes the changes in the bad faith (a/k/a contractual obligations) law. In order to develop the foundation for calculating the presumed factor for Section 56, the following items need to be addressed:

- Bad Faith Example – Before SB2D
- Legal;
- Settlement Rate Statistics;
- Speed up in Loss Payout Example;
- Bad Faith and Medical Malpractice Rates;
- Calculation of Presumed Factor.

Bad Faith Example – Before SB2D

The following example walks through a sample claim resulting in bad faith using a $5,250,000 jury verdict and a policy limit of $250,000:

1. Insurer investigates and reviews the available claim information
2. Insurer decides not to tender policy limits because of its perception of the merits of the case
3. Case goes to trial and jury awards verdict
4. Insurer pays policy limit of $250,000 and is then subject to a separate law suit in excess of the policy limits
5. Insurance company found liable for bad faith for refusing to tender the policy limits
6. Insurance company pays the excess verdict, or $5,000,000

In summary, bad faith claims converts medical malpractice insurance contracts from limited to unlimited policies.

Legal

Section 56 creates an entirely new statutory provision that governs bad faith action in medical negligence situations.

A finding of "bad faith" renders an insurance company liable for the full amount of a judgment against its insured even if the amount of the judgment exceeds the policy limits.

Existing law allowed for two types of bad faith claims in Florida: first party bad faith claims (i.e., claims brought by the insured) and third-party bad faith claims (i.e., claims brought by the party injured by the insured).

First party bad faith claims are governed entirely by Section 624.155, Florida Statutes, which provides that an insurance company is liable for bad faith for failing to attempt "[i]n good faith to settle claims when, under all circumstances, it could and should have done so, had it acted fairly and honestly toward its insured and with due regards for his interest." § 624.155(1)(b)(1), Fla. Stat. That Statute specifically provides that "[n]o action shall lie" if an insurance company pays the policy limits within 60 days of a written request.

Third-party bad faith claims are actionable under the same Statute as well as under common law. The common law standard is essentially the same as the statutory standard: the insurer is required to settle cases where a reasonably prudent person facing the prospect of paying the entire judgment would do so.

Thus, there are two separate actions that can be brought for third party bad faith in Florida. This is significant because, although the Statute provides for a 60-day period in which an insurer can pay the requested damages and avoid liability for bad faith, **there is no defined period under the common law.** Thus, depending on the circumstances, a plaintiff can give an insurance company only 10 or 20 days to respond to a demand for payment of damages (even if no underlying

complaint for damages against the tortfeasor has been filed) and, if the demand is not paid, a potential bad faith action may be asserted.

The new law makes a number of changes that affect bad faith claims in connection with medical negligence.

First, the new law indicates that it applies to both statutory and common law claims for bad faith.

Second, the new law provides that an insurer shall not be held in bad faith for failure to pay its policy limits if it tenders those limits (and meets other reasonable conditions of settlement) by the earlier of (i) the 210th day after service of the complaint or (ii) the 60th day after the conclusion of all party and expert depositions plus mediation. There are also provisions to extend these periods under certain circumstances.

Third, if the insurer does not tender its policy limits by the deadlines, then the Statute sets forth 10 criteria for a jury to follow in finding bad faith, such as the insurer's willingness to negotiate, whether the insurer timely notified the insured of an offer to settle, and whether the plaintiff provided relevant information to the insured on a timely basis.

The law did not eliminate third party bad faith actions as recommended by the Task Force. Nevertheless, the extended time period to investigate claims should allow insurers more time to make informed decisions about the strengths and weaknesses of a plaintiff's case and therefore arguably reduce instances of uninformed settlements that result in erroneous decisions to pay the full policy limits. In other words, the new extended time frames arguably will give insurers a better opportunity to avoid paying policy limits as a "knee jerk" reaction to a threat of bad faith, especially in cases that do not warrant payment of the full policy limits, such as where injuries are not as severe as they may first seem or where the injuries are the result of preexisting conditions that were not uncovered by the insurer's investigation given the short time frame for responding to a "bad faith" demand under common law.

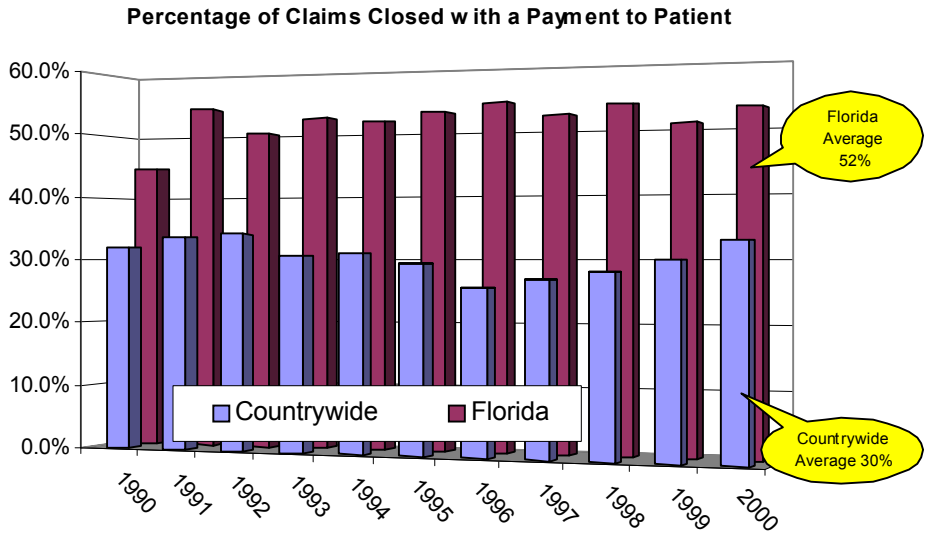
We are cognizant of the view that the new time periods may not provide any added benefit because, as a practical matter, most insurers had between seven and nine months to investigate claims before being required to make a decision to tender the policy limits. Although this may have been true in some situations, there is strong anecdotal evidence of situations where plaintiffs serve a demand for payment of the policy limits in the first two or three months after an injury occurs, even before a lawsuit is commenced, and it is the problem of weighing the merits of paying the policy limits in those types of cases that is solved by the new time frames imposed by the new law.

Settlement Rate Statistics

On August 14, 2003, A.M. BestWire published a story titled *Insurers Say Florida's New Med-Mal Legislation Falls Short on 'Bad Faith'*. In the article, Mr. Sam Miller of the Florida Insurance Council noted:

> *"In Florida, we are so concerned about being successfully sued for bad faith, even though we don't think we did anything wrong, that companies settle 50% of the cases that come in the door even when we know they are not meritorious, as opposed to 33% in the rest of the country…"*

In order to analyze the impact of Section 56, we thought it was critical to obtain the detailed backup support for the settlement rates quoted by Mr. Miller. After receiving our written request, Mr. Miller provided the following support via email:



Mr. Miller noted:

> *"The graph above compares the percentage of cases closed for Florida to national data submitted to the Physicians Insurers Association of America from January 1, 1991 to December 31, 2000. The Florida data is derived from reports to the Office of Insurance Regulation through December 31, 1997 and First Professional Insurance Company's data using the universally accepted definition of a claim."*

We have accepted the above support as a reasonable estimate of the current difference between Florida's settlement rate and the countrywide settlement rate.

Speed up in Loss Payout Example

The following table illustrates how a 25% and 50% shift in the payout pattern of losses can result in an increased rate indication as a result of lost investment income:

SPEED UP IN MEDICAL MALPRACTICE LOSS PAYOUT PATTERNS

Payout Year	Composite Rate Filing Incremental Payout	25% Shift In Loss Payout	50% Shift In Loss Payout	3.58% After Tax Discount Factor	Composite Discounted Incremental Payout	25% Discounted Incremental Payout	50% Discounted Incremental Payout
1	5.6%	9.5%	17.9%	0.983	5.5%	9.4%	17.6%
2	24.6%	25.5%	26.3%	0.949	23.3%	24.2%	24.9%
3	27.9%	26.7%	24.1%	0.916	25.6%	24.5%	22.1%
4	20.3%	18.4%	15.0%	0.884	17.9%	16.2%	13.2%
5	9.6%	9.0%	7.7%	0.854	8.2%	7.7%	6.6%
6	5.8%	5.3%	4.5%	0.824	4.8%	4.4%	3.7%
7	3.2%	2.9%	2.4%	0.796	2.5%	2.3%	1.9%
8	1.6%	1.4%	1.0%	0.768	1.2%	1.1%	0.8%
9	0.5%	0.5%	0.4%	0.742	0.4%	0.4%	0.3%
10	0.3%	0.3%	0.3%	0.716	0.2%	0.2%	0.2%
11	0.3%	0.2%	0.3%	0.692	0.2%	0.1%	0.2%
12	0.3%	0.2%	0.2%	0.668	0.2%	0.2%	0.1%
13	0.0%	0.0%	0.0%	0.645	0.0%	0.0%	0.0%
	100.0%	100.0%	100.0%		90.1%	90.6%	91.6%
				IMPACT ON RATES:		**0.6%**	**1.7%**

The speed up in loss payout increases costs for insurance companies. Dollars that were held as reserves earning investment income must now be paid out earlier, reducing the amount of investment income that can be used to reduce future medical malpractice rates.

Bad Faith and Medical Malpractice Rates

Based upon our review of Florida rate filings, medical malpractice insurers in the State of Florida have made bad faith payments for physicians and surgeons ranging from 3% to 17% of total losses payments limited to $250,000 for the 1993 to 2002 years. For illustrative purposes, assuming annual loss payments of $200 million dollars, this would equate to a range of $6 million to $34 million dollars of bad faith payments in a given year.

Although we believe SB2D tightens up the common law loophole as discussed above and will reduce the dollar amount of awards in excess of policy limits because of the caps on noneconomic damages (See Section 54), it is important to note that any benefit from savings on bad faith payments **will not** impact the presumed factor in Section 56, even if medical malpractice insurers saved the full 17% going forward. This is because medical malpractice insurance companies are not allowed to include bad faith payments in the development of their indicated manual rate changes. Stated another way, premiums that healthcare providers pay annually already exclude the impact of bad faith payments.

Our review of the rate filings also included research on the handling of reinsurance costs in the calculation of the insurer's indicated manual rate change. We wanted to make sure that bad faith payments, which are excluded from the ratemaking data, were not being included indirectly through the purchase of reinsurance coverage that covers extra contractual obligations. Essentially, we were checking to see if the variable expense calculations (used to derive the expected loss ratio) included a loading for bad faith payments. We observed the following handling by insurers:

1. Explicit loading for extra contractual obligations reinsurance costs; and
2. No reference to reinsurance costs in the variable expense calculations.

In situations where there was an explicit loading identified by the medical malpractice insurer, correspondence with the State Insurance Department and later modifications at the request of the Department illustrated that these costs had to be removed from the calculation of the final indicated manual rate. Therefore, explicit loadings for reinsurance premiums related to bad faith are not included in premiums healthcare providers pay and **will not** impact the presumed factor

In situations where no reference to reinsurance costs were made in the calculation of the variable expense factor, we believe some companies may be including extra contractual obligation reinsurance in their expense assumptions. In situations like these, one could argue that the

tightening up of the common law loophole discussed above could result in reduced reinsurance costs. Unfortunately, given the state of the medical malpractice market, reduced reinsurance capacity and the significant medical malpractice reserve strengthening reinsurers have taken over the past three years; it seems highly unlikely that reinsurers will lower their rates in reaction to SB2D. If anything, we would expect reinsurance rates to continue to rise over the next few years, regardless of the impact of SB2D. Furthermore, it seems unlikely that primary reinsurers will be able to leverage SB2D to negotiate lower reinsurance attachment appoints or better coverage terms. For the foreseeable future, we believe reinsurers will continue forcing primary insurers to retain more risk as reinsurers continue to move further away from the "working layer" loss level.

Calculation of Presumed Factor:

For the interested reader, Appendix A, Summary Sheet A displays a flow chart of the presumed factor savings flow for Section 56. A visual may be helpful before reading on.

We identified three potential areas of savings that would impact **insurance company** savings on Sheet A:

1. Savings and leverage gained from changes in bad faith strategies, driven by:
    a. Settlement rates vs. countrywide rates
    b. Change in settlement costs
    c. Speed up in claim payments
    d. Defense cost mitigation strategies.
2. Reduction in insurance company payments in excess of policy limits.
3. Reduction in reinsurance premium to reflect lower bad faith payments.

We identified one potential area of savings that would impact the **presumed factor** on Sheet A:

1. Savings and leverage gained from changes in bad faith strategies, driven by:
    a. Settlement rates vs. countrywide rates
    b. Change in settlement costs
    c. Speed up in claim payments

d. Defense cost mitigation strategies.

As noted above, item 2 and item 3 have no real impact on the presumed factor. Therefore, the following discussion will focus mainly on the impact of item 1 on the presumed factor. Even though item 2 does not directly impact the presumed factor, we believe that a reduced threat from paying certain sizeable bad faith awards will indirectly affect the savings of medical malpractice insurers and their strategy for settling claims. By tightening up the common law loophole, providing time frames for tendering policy limits, and setting forth 10 criteria for the jury to follow in finding bad faith, we believe their will be a reduction in the number of "knee jerk" settlements and a reduction in the incentive for plaintiff attorneys to maximize the "hanging fruit" of possible large dollar bad faith awards.

With this said, Section 56 presents a formidable challenge in determining the presumed factor. We note the following:

- Florida's settlement rate of 52% is significantly higher than the countrywide settlement rate of 30%. Although we think Section 56 will reduce the current percentage of claims closed with payment to a patient, we are skeptical that the ratio will move significantly closer to the countrywide average settlement rate. This is largely driven by the fact that Florida insurers write considerably lower policy limits than the rest of the country. This fact makes the consideration of defense cost mitigation strategies more important in Florida (see Section 54 for a Florida versus countrywide comparison of the ratio of ALAE payments to indemnity). When deciding to settle a claim, the insurer must consider the potential for bad faith payments **and** the cost/benefit of spending defense dollars on a claim that could be cheaper to settle. If an insurer can settle a claim for a percentage of the anticipated defense costs (e.g., 50%, 100%), or settle a claim for policy limits (e.g., $250,000 in Florida versus $1,000,000 or higher in the rest of the country), and avoid the risk of a catastrophic bad faith award, the choice to settle becomes a much easier decision in Florida.

We also noted above that most insurers already had between seven and nine months to investigate claims before being required to make a decision to tender the policy limits. In addition, some experts in the industry have even quoted time frames in excess of 12 months before being required to make a decision to tender the policy limits. For these claims, the new bad faith law does not really change the amount of time insurers have to investigate and avoid bad faith payments. Therefore, one would expect little or no change in the average settlement cost or timing of claim payments for these claims.

- We have noted above that any speed up in claim payment would reduce the investment income insurers can earn on reserves supporting the future payout of medical malpractice losses. This cost will partially offset some of the savings one would achieve by paying claims below policy limits earlier in the claim settlement process.

- By reducing the likelihood of bad faith awards in certain situations (e.g., when a plaintiff serves a demand for payment of the policy limits in the first two or three months after an injury occurs), we believe insurers will gain some leverage in avoiding some of the truly low value/high bad faith potential cases that shouldn't have been brought to trial in the first place. Although most of the savings here will not impact the presumed factor, the leverage created by the new law in certain situations will contribute to a decrease in the number of colorable claims for bad faith.

Given the above comments, we have selected a presumed factor of 2.5% for Section 56. This factor was determined by reviewing a number of different combinations of settlement rate reductions (e.g., 2.5%, 5%, 7.5% and 10%), allocation of claim count reductions to severity types, and average claim severities. The 2.5% factor was determined by reducing a 3.5% selected savings by 1% to reflect the cost impact on insurers for the speed up of claim payments.

SELECTED IMPACT: 2.5%

Section 57 – Legislative Findings and Intent

NOTEWORTHY ADDITIONS: NONE

NOTEWORTHY DELETIONS: NONE

COMMENTARY: NONE

SELECTED IMPACT: 0.0%

Section 58 – Definitions

NOTEWORTHY ADDITIONS:

Change of claimant definition to include "for damages based on personal injury or wrongful death".

Change of economic damages to include "to the extent the claimant is entitled to recover such damages under general law, including the Wrongful Death Act."

New definition of health care provider.

Change of noneconomic damages to include "to the extent the claimant is entitled to recover such damages under general law, including the Wrongful Death Act."

NOTEWORTHY DELETIONS: NONE

COMMENTARY: NONE

SELECTED IMPACT: 0.0%

Section 59 – Limitations on Damages …

NOTEWORTHY ADDITIONS: NONE

NOTEWORTHY DELETIONS: NONE

COMMENTARY: NONE

SELECTED IMPACT: 0.0%

Section 60 – Presuit Investigation

NOTEWORTHY ADDITIONS: NONE

NOTEWORTHY DELETIONS: NONE

COMMENTARY: NONE

SELECTED IMPACT: 0.0%

Section 61 – Presuit Investigation of Medical Negligence Claims and Defenses by Court

NOTEWORTHY ADDITIONS: NONE

Claimant investigation addition of "including a review of the claim and a verified written medical expert opinion by an expert witness as defined in s. 766.202".

Defendant investigation addition of "including a review of the claim and a verified written medical expert opinion by an expert witness as defined in s. 766.202".

NOTEWORTHY DELETIONS: NONE

COMMENTARY: NONE

SELECTED IMPACT: De Minimis Cost

Section 62 – Voluntary Binding Arbitration

NOTEWORTHY ADDITIONS: NONE

NOTEWORTHY DELETIONS: NONE

COMMENTARY: NONE

SELECTED IMPACT: 0.0%

Section 63 – Effects of Failure to Offer or Accept

NOTEWORTHY ADDITIONS:

Adds "damages subject to the limitations in s. 766.118"

NOTEWORTHY DELETIONS:

Removes "without limitation on damages"

COMMENTARY: NONE

SELECTED IMPACT: 0.0%

Section 64 – Limitation on Actions Against Insurers…

NOTEWORTHY ADDITIONS:

Section added.

NOTEWORTHY DELETIONS: NONE

COMMENTARY: NONE

SELECTED IMPACT: 0.0%

Section 65 – Good Samaritan Act; Immunity from Civil Liability

NOTEWORTHY ADDITIONS:

Clarification of "reckless disregard". New wording "created an unreasonable risk of injury so as to affect the life or health of another, and such risk was substantially greater than that which is necessary to make the conduct negligent."

NOTEWORTHY DELETIONS:

Clarification of "reckless disregard". Removed wording "would be likely to result in injury so as to affect the life or health of another, taking into account the following to the extent they may be present;

a. The extent or serious nature of the circumstances prevailing.
b. The lack of time or ability to obtain appropriate consultation.
c. The lack of prior patient physician relationship.
d. The inability to obtain an appropriate medical history of the patient.
e. The time constraints imposed by coexisting emergencies."

COMMENTARY:

Section 65 amends the Good Samaritan Act, Section 763.13, Florida Statutes, to provide more stringent standards for finding doctors and hospitals liable for treatment provided in emergency situations.

The Good Samaritan Act, as amended by the new law, covers three distinct circumstances: (i) where a practitioner renders emergency medical care outside of a hospital or doctor's office; (ii) where a hospital or health care provider is rendering emergency medical services inside an emergency room or trauma center; and (iii) where a practitioner is unexpectedly called upon to render emergency medical services in a hospital to a person who is not his or her patient.

A. Services Provided Outside of a Hospital During An Emergency.

The new law does not amend the rule for emergency services provided outside of a hospital.

B. Regular Emergency Room Care.

Under the old law, emergency room staff were given immunity unless treatment was provided (or not provided) under "circumstances demonstrating a reckless disregard for the consequences."

The old law defined "reckless disregard" as conduct "which a health care provider knew or should have known, at the time such services were rendered, would be likely to result in injury so as to affect the life or health of another," taking into account five factors: (i) the seriousness of the circumstances; (ii) lack of time to consult; (iii) lack of prior patient relationship; (iv) inability to obtain patient's medical history; and (v) the time constraints imposed by other emergencies. § 768.13(2)(b)(3), Fla. Stat.

The old law also defined two circumstances that were excluded from the "reckless disregard" standard: (i) where the treatment at issue occurred after the patient was stabilized, unless follow-up surgery was required as a result of the emergency treatment; and (ii) where the treatment was unrelated to the original emergency. § 768.13(2)(b)(2), Fla. Stat. Thus, if either of these two exclusions were met, the standard reverted back to the regular negligence standard applicable in non-emergency medical care.

Section 65 amends the definition of "reckless disregard" and also amends the two excluded circumstances.

First, the definition of "reckless disregard" has been modified to create a higher threshold for finding emergency room practitioners liable for emergency room treatment. The new standard provides for immunity unless the services "**created an unreasonable risk of injury so as to affect the life or health of another, and such risk was substantially greater than that which is necessary to make the conduct negligent.**" The modification also deleted the five

enumerated factors from consideration. It is worth nothing that this modification was enacted even though the Task Force found that the existing definition was sufficient. Only subsequent judicial interpretations and jury decisions will shed light on whether this new standard actually provides heightened immunity as compared to the old standard.

Second, the new law also modified the two existing exclusions but it is unclear whether the amendments will provide additional immunity.

With respect to the first exclusion, the old law excluded from heightened protection treatment that occurred after the patient was stabilized. According to the Governor's Task Force Report, this exclusion resulted in additional litigation over whether the patient was stabilized before treatment was rendered (and thus whether the regular negligence standard should apply). The Task Force recommended that the exclusion for stabilization be removed. In lieu of removing it, however, the legislature amended the exclusion. The new law now provides that the "reckless disregard" standard applies to treatment (including diagnosis, which is a change from the old law) that occurs "prior to the time" the patient is stabilized. By implication, the law still appears to allow the same argument by plaintiffs, namely, that treatment was provided after stabilization and therefore the immunity is inapplicable.

Similarly, the amendment to the second exclusion (treatment unrelated to the original emergency) seems to be "form over substance," now "including" treatment that is "related" to the original emergency. Again, by implication, the same exclusion seems applicable: treatment not related to the original medical emergency is not given immunity.

C. Non-Emergency Room Practitioners Treating Emergency Victims.

The new law carves out a special exception for practitioners who provide voluntary emergency care to a person who is not their patient while the practitioner is at the hospital making rounds or for reasons unrelated to patient care.

In that circumstance, the practitioner is not liable unless the treatment amounted to conduct "that is willful and wanton and would likely result in injury so as to affect the life or health of another." § 768(2)(c)(1), Fla. Stat.

This standard appears to provide an even greater degree of protection than the "reckless disregard" standard applicable to regular emergency room staff.

SELECTED IMPACT: De Minimis Savings

Section 66 – Damages

NOTEWORTHY ADDITIONS: NONE

NOTEWORTHY DELETIONS: NONE

COMMENTARY: NONE

SELECTED IMPACT: 0.0%

Section 67 – Sovereign Immunity

NOTEWORTHY ADDITIONS:

Healthcare practitioner language regarding acting as an agent of a state university board of trustees.

NOTEWORTHY DELETIONS: NONE

COMMENTARY: NONE

SELECTED IMPACT: 0.0%

Section 68 – Itemized Verdict

NOTEWORTHY ADDITIONS: NONE

NOTEWORTHY DELETIONS: NONE

COMMENTARY: NONE

SELECTED IMPACT: 0.0%

Section 69 – Sovereign Immunity

NOTEWORTHY ADDITIONS: NONE

NOTEWORTHY DELETIONS: NONE

COMMENTARY: NONE

SELECTED IMPACT: 0.0%

Section 70 – Athletics in Public K-12 Schools

NOTEWORTHY ADDITIONS: NONE

NOTEWORTHY DELETIONS: NONE

COMMENTARY: NONE

SELECTED IMPACT: 0.0%

Section 71 through Section 87

NOTEWORTHY ADDITIONS: NONE

NOTEWORTHY DELETIONS: NONE

COMMENTARY:

Section 86 expresses the Legislature's intent that the law should apply retroactively, i.e., to incidents of medical negligence that occurred before the effective date of the law, with the provision that the changes to Chapter 766 should be applied only to cases of medical negligence for which a notice of intent to initiate litigation was mailed on or after the effective date of the new law (September 15, 2003).

Thus, under this provision, the Legislature has indicated its intent that the amendments created by Sections 1 through 47 and 70 through 87 of the new law apply immediately, but the amendments created by Section 48 through 69 only apply to newly filed cases.

Section 86 recognizes, however, the retroactive application of new laws raises constitutional concerns (in particular, it raises due process concerns), and thus the Legislature indicated that its intent applies only if retroactive application "is not prohibited by the State Constitution or Federal Constitution."

The primary issue that is raised by Section 86 is whether the amendments to Chapter 766 can be applied to cases in which the medical negligence (i.e., the injury or misdiagnosis) occurred before September 15, 2003.

The answer, as discussed below, is that the amendments affecting "substantive rights," such as the cap on damages, likely **cannot** be applied to cases involving pre-September 15 incidents of medical negligence (even if the presuit notice is filed after September 15), but that amendments affecting "procedural rights," such as the presuit notice requirements of informal discovery and providing a list of treating physicians, may be applied retroactively. Obvious gray areas, such as whether the amendments to the bad faith laws are procedural or substantive, will likely have to be resolved by the Florida Supreme Court.

The Florida Supreme Court has adopted a two-part test for determining whether it is permissible to apply an amended Statute retroactively. Metro. Dade County v. Chase Fed. Hous. Corp., 737 So. 2d 494, 499 (Fla.1999).

The first test is whether the Legislature intended the amendment to apply retroactively. In this case, the answer is obviously "yes."

The second test is whether retroactive application is constitutionally permissible. Id. (citing State Farm Mut. Auto. Ins. v. Laforet, 658 So .2d 55, 61 (Fla.1995)).

Courts will not permit retroactive application of a Statute if the Statute "impairs vested rights," even when the Legislature expressly states that the Statute is to have retroactive application.

In short, procedural amendments may be applied retroactively; amendments affecting substantive rights may not.

"Substantive law prescribes duties and rights and procedural law concerns the means and methods to apply and enforce those duties and rights."

A substantive, vested right is "an immediate right of present enjoyment, or a present, fixed right of future enjoyment." Sanford v. McClelland, 163 So. 513, 514-15 (1935). A vested right is thus a "fixed" right that cannot be abrogated or taken away without violation of the possessor's right to due process. Chase Fed., 737 So. 2d at 503 ("Thus, retroactive abolition of substantive vested rights is prohibited by constitutional due process considerations.") .

Here, because previous reforms to the medical malpractice Statute have been compared to the limitations on rights set forth in the workers' compensation system, see, e.g., University of Miami v. Echarte, 618 So. 2d 189 (Fla. 1993), cases construing the workers' compensation Statutes are applicable by analogy for guidance.

The general rule in workers' compensation cases is that the substantive rights of the parties are fixed by the law in effect **on the date of the injury**, but that no party has a vested right in any particular procedure. See, e.g., McCarthy v. Bay Area Signs, 639 So. 2d 1114, 1115-16 (Fla. 1st DCA 1994).

Accordingly, because the "date of the injury" has typically been viewed as the operative date for determining an injured party's vested rights, it is likely that none of the substantive amendments to Chapter 766, such as the cap on damages, will apply to injuries or misdiagnoses or other types of medical negligence that caused injury before September 15, 2003 even if presuit notice was initiated after September 15, 2003. By contrast, changes to the presuit notice and discovery requirements are likely to be deemed procedural and therefore applicable to all cases in which presuit notice was initiated on or after September 15, 2003.

SELECTED IMPACT: 0.0%

III. PRESUMED FACTOR SUMMARY MATRIX

COMMITTEE SUBSTITUTE FOR SENATE BILL 2-D
Presumed Factor Summary Matrix

Section	Title	Subject	Type of Reform	Selected Presumed Factor
1	Findings	18 Legislature findings	Other	0.0%
2	creates 395.0056	Litigation notice requirement	Hospital	0.0%
3	amends 395.0191	Staff membership and clinical privileges	Hospital	0.0%
4	amends 395.0197	Internal risk management program	Hospital	0.0%
5	repeals 395.0198	Repeal of section	Hospital	0.0%
6	creates 395.1012	Patient safety	Hospital	0.0%
7	creates 395.1051	Duty to notify patients - licensed facility	Hospital	0.0%
8	creates 456.0575	Duty to notify patients - health care practitioner	Physician	0.0%
9	Civil immunity for boards etc	Civil immunity	Tort	0.0%
10	Patient Safety Data Privilege	Patient safety and data privilege	Tort	0.0%
11	amends 456.013	Department; general licensing provisions	Physician	0.0%
12	amends 456.025	Fees; receipts; disposition	Physician	0.0%
13	amends 456.039	Designated HCP; information required for licensure	Physician	0.0%
14	amends 456.041	Practitioner profile; creation	Physician	0.0%
15	amends 456.042	Practitioner profile; update	Physician	0.0%
16	amends 456.049	HCP; reports on professional liability claims and actions	Physician	0.0%
17	amends 456.051	Reports on professional liability actions; bankruptcies; DOH responsibility to provide	Physician	0.0%
18	amends 456.057	Ownership and control of patient records; report or copies of records to be furnished	Physician	0.0%
19	amends 456.072	Grounds for discipline; penalties; enforcement	Physician	0.0%
20	amends 456.073	Disciplinary proceedings	Physician	0.0%
21	amends 456.077	Authority to issue citations	Physician	0.0%
22	amends 456.078	Mediation	Physician	0.0%
23	amends 456.320	Financial responsibility - physician	Physician	0.0%
24	amends 459.0085	Financial responsibility - osteopathic physician	Physician	0.0%
25	amends 458.331	Grounds for disciplinary action; action by the board and department	Physician	0.0%
26	creates 458.3311	Emergency procedures for disciplinary action	Physician	0.0%
27	amends 459.015	Grounds for disciplinary action; action by the board and department (osteopathic)	Physician	0.0%
28	creates 459.0151	Emergency procedures for disciplinary action (osteopathic)	Physician	0.0%
29	amends 461.013	Grounds for disciplinary action; action by the board; investigations by department (podiatric)	Physician	0.0%
30	creates 461.0131	Emergency procedures for disciplinary action (podiatric)	Physician	0.0%

COMMITTEE SUBSTITUTE FOR SENATE BILL 2-D
Presumed Factor Summary Matrix

Section	Title	Subject	Type of Reform	Selected Presumed Factor
31	amends 466.028	Grounds for disciplinary action; action by the board (dental)	Physician	0.0%
32	DoAH shall …		Administrative	0.0%
33	creates 1004.08	Patient safety instructional requirements (public school, college, university)	Other	0.0%
34	creates 1005.07	Patient safety instructional requirements (private school, college, university)	Other	0.0%
35	AHCA shall …	Quality of care study based on NY and TX hospital quality reports	Physician	0.0%
36	AHCA … is directed …	Comprehensive study and report on the establishment of a Patient Safety Authority	Physician	0.0%
37	OPPAGA and … must	Audit of DOH's health care practitioner disciplinary process and closed claims	Physician	0.0%
38	DOH shall …	Workgroup to study the healthcare practitioner disciplinary process	Physician	0.0%
39	amends 624.462	Commercial self-insured funds	Insurance	0.0%
40	amends 627.062	Rate standards - ratemaking and insurer's base rate, "Presumed Factor"	Insurance	0.0%
41	OPPAGA must …	merits of Public Counsel to examine insurance company rate filings	Other	0.0%
42	amends 627.357	Medical malpractice self-insurance	Insurance	0.0%
43	amends 627.4147	Medical malpractice insurance contracts	Insurance	0.0%
44	creates 627.41495	Public notice of medical malpractice rate filings	Insurance	0.0%
45	amends 627.912	Professional liability claims and actions; reports by insurers and HCP; annual report by office	Insurance	0.0%
46	amends 641.19	Definitions (HMO)	Insurance	0.0%
47	amends 641.51	HMO quality assurance program; second medical option required	Insurance	0.0%
48	amends 766.102	Medical negligence; standards of recovery; expert witness	Tort	0.0%
49	amends 766.106	Notice before filing for medical negligence; pre-suit screening; offers for admission of liability and for	Tort	0.0%
50	amends 766.108	Mediation	Tort	0.0%
51	amends 766.1115	Health Care Providers; Creation of Agency Relationship with Governmental Contractors	Tort	0.0%
52	amends 766.112	Comparative fault	Tort	0.0%
53	amends 766.113	Settlement agreements	Tort	0.0%
54	creates 766.118	Noneconomic damages	Tort	5.3%
55	the legislature finds … ems	Emergency medical services	Tort	0.0%
56	creates 766.1185	Bad faith	Tort	2.5%
57	amends 766.201	Legislative findings and intent	Tort	0.0%
58	amends 766.202	Definitions	Tort	0.0%
59	creates 766.2021	Limitations on damages…	Tort	0.0%
60	amends 766.203	Presuit investigation	Tort	0.0%

COMMITTEE SUBSTITUTE FOR SENATE BILL 2-D
Presumed Factor Summary Matrix

Section	Title	Subject	Type of Reform	Selected Presumed Factor
61	amends 766.206	Presuit medical expert opinion	Tort	0.0%
62	amends 766.207	Voluntary binding arbitration of medical negligence claims	Tort	0.0%
63	amends 766.209	Effects of failure to offer or accept voluntary binding arbitration	Tort	0.0%
64	creates 768.0981	limitations on actions against	Tort	0.0%
65	amends 768.13	Good Samaritan Act; immunity from civil liability - clarification of "reckless disregard"	Tort	0.0%
66	amends 768.21	damages	Tort	0.0%
67	amends 768.28	Sovereign immunity	Tort	0.0%
68	amends 768.77	itemized verdict	Tort	0.0%
69	Nothing in this act constitutes a waiver of	Sovereign immunity	Tort	0.0%
70	amends 1006.20	Athletics in public k-12 schools	Tort	0.0%
71	DOH shall study and report	Inclusion of medical review panels in pre-suit process	Other	0.0%
72	amends 391.025	Applicability and scope	Other	0.0%
73	amends 391.029	Program eligibility	Other	0.0%
74	amends 766.303	Florida Birth-Related Neurological Injury Compensation Plan; exclusiveness of remedy	Other	0.0%
75	amends 766.304	Administrative law judge to determine claims	Administrative	0.0%
76	amends 766.305	Filing of claims and responses; medical disciplinary review	Other	0.0%
77	adds to 766.309	Determination of claims; presumption; findings of administrative law judge binding on participants.	Administrative	0.0%
78	amends 766.310	Administrative law judge awards for birth-related neurological injuries; notice of award	Administrative	0.0%
79	amends 766.314	Assesments; plan of operations	Other	0.0%
80	OPPAGA shall complete a study	Florida birth-related neurological injury compensation association	Other	0.0%
81	DOH and AHCA staff funding	Appropriations of $687,786 and $1,629,994, respectively	Other	0.0%
82	OIR funding for implementing Act	Appropriations of $1,450,000	Other	0.0%
83	Patient safety initiative funding	Appropriations of $850,000	Other	0.0%
84	If any law that is amended by this act	Procedural	Other	0.0%
85	If any provisions of this act or its applications …	Procedural	Other	0.0%
86	It is the intent of the legislature to apply …		Other	0.0%
87	Effective date of act	September 15, 2003	Other	0.0%

COMMITTEE SUBSTITUTE FOR SENATE BILL 2-D
Presumed Factor Summary Matrix

Section	Title	Subject	Type of Reform	Selected Presumed Factor
ALL	**Total Presumed Factor**		**All**	**7.8%**

NOTE: AHCA - Agency for Health Care Administration
DoAH - Division of Administrative Hearings
DOH - Department of Health
HCP - Health care professional
OIR - Office of Insurance Regulation
OPPAGA - Office of Program Policy Analysis and Government Accountability

Chapter	Title (Name - not to be confused with an aggregation of Chapters)
395	Hospital Licensing and Regulation
456	Health Professions and Occupations: General Provisions
458	Medical Practice
459	Osteopathic Medicine
461	Podiatric Medicine
466	Dentistry, Dental Hygiene, and Dental Laboratories
624	Insurance Code: Administration and General Provisions
627	Insurance Rates and Contracts
641	Health Care Service Programs
766	Medical Malpractice and Related Matters
768	Negligence
1004	Support for Learning

IV. OBSERVATIONS

Observations

This section of the report addresses issues that may span multiple Sections of SB2D or require a more detailed discussion than presented above.

- **"Presumed Factor" (Section 40)**

  Section 40 requires a rate freeze and mandatory medical malpractice rate filing to reflect the savings of SB2D. Rates approved on or before July 1, 2003 for medical malpractice insurance remain in effect until the effective date of the filing required by SB2D. Insurers must make that rate filing effective no later than January 1, 2004, to reflect the savings of SB2D, using the presumed factor established by the Office of Insurance Regulation.

  If, however, the medical malpractice insurer contends that the presumed factor results in a rate that is excessive, inadequate, or unfairly discriminatory, the insurer may use a different factor subject to the prior approval of the Office of Insurance Regulation. Section 40 states:

  > *"(b) Any insurer or rating organization that contends that the rate provided for in paragraph (a) is excessive, inadequate, or unfairly discriminatory shall separately state in its filing the rate it contends is appropriate and shall state with specificity the factors or data that it contends should be considered in order to produce such appropriate rate. The insurer or rating organization shall be permitted to use all of the generally accepted actuarial techniques provided in this Section in making any filing pursuant to this subsection. The office shall review each such exception and approve or disapprove it prior to use. It shall be the insurer's burden to actuarially justify any deviations from the rates required to be filed under paragraph (a)."*

  Deloitte's Section-by-Section quantification of the presumed factor relies upon aggregate Florida data. Therefore, to the extent that an individual insurer's book of business mix varies

significantly from Florida's aggregate data, the presumed factor may need to be adjusted to reflect an individual company's actual exposure.

For example, a medical malpractice insurance company that writes a heavy concentration of low risk specialties (e.g., chiropractors, allergists, dermatologists – no surgery) would likely see a much lower savings than estimated by the presumed factor since low risk specialties typically have minimal exposure to large jury awards and bad faith judgments.

On the other hand, a medical malpractice insurance company that writes a heavy concentration of high risk specialties (e.g., Neurologists, Gynecologists with significant annual deliveries, Obstetricians) might see a higher savings than estimated by the presumed factor when compared to aggregate Florida data which also includes lower risk specialties.

It is up to each medical malpractice insurer with direct written premium in the State of Florida to determine if the presumed factor presented in this report produces rates that are excessive, inadequate, or unfairly discriminatory to the company based upon their own independent analysis and review of their own book of business.

- **Modification to the "Presumed Factor" in Section 54**

  In the calculation of the presumed factor for the cap on noneconomic damages, we have provided a matrix of indemnity savings shown by policy limit and for practitioner versus non-practitioner. It is conceivable that some medical malpractice insurers with a dramatically different distribution of policy limits or practitioner versus non-practitioner split may attempt to use the matrix to calculate their own presumed factor.

  If a company were to calculate their own Section 54 presumed factor, we note the following considerations for the OIR's consideration:

  1. The medical malpractice insurer must walk through the five steps in order to complete the calculation of the presumed factor.

2. If the practitioner versus non-practitioner split assumption is changed from our current reliance on the closed claim database mix, the medical malpractice insurer must add an additional step. This step would illustrate their assumed split assumption. The five steps should then be followed.
3. It may be in the OIR's best interest to request additional information in future rate filings documenting the distribution of policy limits split out by practitioner versus non-practitioner. Although we don't like to burden insurers with additional data requests, the information would reduce the likelihood of someone making the argument to the OIR that some insurers may be gaming the system by accepting the presumed factor when they should actually be reflecting higher savings.
4. Even with the above adjustments, the claims in the closed claim database may not be representative of the claims (e.g., average severity, severity type, and split of damages) an individual medical malpractice carrier may observe. The low risk specialty insurer discussed above is a great example. Changing the assumptions may be of little value if the insurer's book of business focuses only on low risk exposures.

- **"Presumed Factor" and the Current Rate Indication**

  It is important to note that the presumed factor determined in this analysis must be considered in combination with the medical malpractice insurance company's current indicated manual rate change adjusted for the benefits of SB2D. As is noted in the Contingencies article *The Million-Dollar Challenge: Measuring the Impact of Medical Liability Tort Reform*[2]:

  "If an insurance company's indicated premium rate change is +40.0 percent, and the estimated premium savings from tort reform 37.5 percent, insurance consumers in the above example would NOT see a 37.5 percent premium savings but a net premium increase of 2.5 percent (e.g., 40.0 percent - 37.5 percent). This fact is often misunderstood and lost in the communication of tort reform's final impact."

[2] September/October 2003 Contingencies Magazine The Million-Dollar Challenge: Measuring the Impact of Medical Liability Tort Reform, Kevin Bingham.

If a medical malpractice insurance company has rates that are excessive, inadequate, or unfairly discriminatory, Section 40 allows the company (see first bullet) to file alternative rates. Using the +40.0 percent manual rate indication quoted in the above article, the insurance company would file a +40.0 percent increase minus the presumed factor, not the presumed factor.

It is important to stress this fact when the public and most legislators are expecting to see rates drop by the impact of the presumed factor, not increase by the manual rate indication less the presumed factor. This was a challenging issue to communicate in our recent work in Texas and will likely present similar challenges in Florida when doctors are expecting a rate decrease, **not a reduced increase**.

- **Noneconomic Damages – Freeze of Rates**

  Section 40 requires a freeze of all rates approved on or before July 1, 2003, with the freeze remaining in effect until the effective date of the filing required by SB2D. For those medical malpractice insurers whose proposed rates were not approved before July 1, 2003, they have to wait until SB2D allows new rates to be filed. These insurers will likely see their rate inadequacy build during the "freeze" period. This building rate inadequacy will likely increase the probability that insurers in this category will need to file a reduced increase, and not an overall decrease. Given the current state of Florida's medical malpractice marketplace, we would expect the majority of insurers to fall into this category (i.e., we don't believe there are many insurers that were waiting to file rate decreases before the freeze).

- **Noneconomic Damages – Phase In of Law**

  As is noted above in Section 86, the cap on noneconomic damages will likely not apply to injuries or misdiagnoses or other types of medical negligence that caused injury before September 15, 2003, even if presuit notice was initiated after September 15, 2003. Therefore, the full impact of the savings from the cap on noneconomic damages will take time to phase in. Based upon our review of the rate filings, it is not uncommon for only 25% to 35% of

claims to be reported in the first year of a claims made policy's effective date. Stated another way, 65% to 75% of claims are reported in the second and subsequent year after the policy is issued. We have adjusted our presumed factor in Section 54 using lag statistics from the closed claim database to reflect the impact of the phase in. We are comfortable that our presumed factor falls within a reasonable range of potential savings.

- **Noneconomic Damages – Spreading vs. Telescoping Comparative Fault**

  Florida law does not allow a defendant to be jointly liable for a plaintiff's noneconomic damages. With the caps on noneconomic damages that have been created in Section 54, it is important to understand their impact on potential plaintiff attorney strategies when it comes to arguing the comparative fault of defendants. A simple example may help illustrate the issue now facing Florida plaintiff attorneys and their clients:

Jury verdict: $2,400,000

	Scenario 1 - "Spread"			Scenario 2 - "Telescope"		
Defendant	Comparative Fault	Award Before Cap	Capped Award	Comparative Fault	Award Before Cap	Capped Award
Physician 1	25.0%	$600,000	$500,000	92.5%	$2,220,000	$500,000
Physician 2	25.0%	$600,000	$500,000	2.5%	$60,000	$60,000
Physician 3	25.0%	$600,000	$500,000	2.5%	$60,000	$60,000
Physician 4	25.0%	$600,000	$500,000	2.5%	$60,000	$60,000
		$2,400,000	**$2,000,000**		$2,400,000	**$680,000**
					Difference:	**$1,320,000**

As you can see from the above example, it is in the plaintiff attorney's best interest to argue for the "spreading" of comparative fault between defendants when the ratio of noneconomic damages to economic damages is high. This strategy optimizes the benefit of the caps by spreading the maximum possible damages to each defendant. On the contrary, "telescoping" comparative fault to one defendant quickly forces damages above the statutory caps.

As the ratio of noneconomic damages to total damages decreases, the above strategy for optimizing the benefit of the cap becomes less important. In situations with big pocket

defendants (e.g., hospital), the issues of "telescoping" vs. "spreading" becomes less important. Instead, it is more important to capitalize on the joint and several liability for economic damages (see s. 768.81(3)) if there is a belief that the other small pocket defendants will be unable to pay their fair share of the economic damages.

- **Noneconomic Damages – Claimant Assumptions**

  The current closed claim database does not include information regarding the number of claimants. One could argue (and reasonably should) that a jury would react differently to a case with one claimant (e.g., wife) versus a case with multiple claimants (e.g., wife and five kids). For purposes of our analysis, we have assumed that the historical distribution of claims in the closed claim database represent a reasonable mix of potential multi-claimant law suits. Therefore, we believe our approach to estimating the presumed factor discussed in Section 54 and Appendix B is reasonable given the limitations on the historical data.

- **Cap on Noneconomic Damages – Clarification of Savings**

  In order to understand the true savings medical malpractice insurance companies receive from the implementation of a cap on noneconomic damages, it is important to walk through a simplified example of how individuals might communicate the savings from SB2D:

JURY VERDICT EXAMPLE - $500,000 POLICY LIMIT

	Economic Damages	Noneconomic Damages	Total Damages	Policy Limits Payable
Before Senate Bill 2-D	$1,500,000	$3,500,000	$5,000,000	$500,000
	Economic Damages	Noneconomic Damages	Total Damages	Policy Limits Payable
After Senate Bill 2-D	$1,500,000	500,000	$2,000,000	$500,000
	Economic Damages	Noneconomic Damages	Total Damages	Policy Limits Payable
Change	$0	$3,000,000	$3,000,000	$0
% Change	0.0%	85.7%	60.0%	0.0%

As one can see from the above example, the $5,000,000 jury verdict against a single practitioner defendant can be communicated in three different ways:

1. Noneconomic damages are reduced by approximately 86%.
2. Total damages are reduced by 60%.
3. Insurance company payments are reduced by 0%.

The drastic difference in perceived effect of the cap is driven by the point of view of the individual receiving or paying the damages. In the first two communications, the percentage reduction is from the point of view of the plaintiff. In the third communication, the percentage savings is from the point of view of the insurance company.

In this example, even though the noneconomic damages are reduced by 86%, the insurance company doesn't lower its loss payments at all. This is an extremely important point given the significant reduction in policy limits being purchased by healthcare providers in the State of Florida over the past few years. As policy limits drop, the savings insurance companies can pass on to insurance consumers decreases. For policy limits purchased under $500,000, there is little or no benefit to pass on to insurance consumers at all.

The only potential savings for the insurance company in the above example would be if the insurer would have been found in bad faith before the passage of SB2D and not in bad faith after the passage of SB2D. The insurance company's payment of $2,000,000 (i.e., $500,000 policy limit + $1,500,000 bad faith payment) would drop by the $1,500,000 bad faith payment or 75%. Although this reduction in payments is significant, medical malpractice insurance companies currently do not include bad faith payments in their ratemaking data. Therefore, there is no impact on the presumed factor (See Section 56 for full discussion).

- **High Policy Limits "Catch 22"**

  Healthcare providers in the State of Florida who purchase higher policy limits (e.g., greater than $1,000,000) are often put in an increasingly difficult situation as their healthcare provider

peers continue to purchase lower limits (if any). In situations where multiple physicians are named as defendants, it is common knowledge that physicians with the higher policy limits represent the most attractive target for plaintiff attorneys. Therefore, it becomes easier to understand the counterintuitive argument that healthcare providers should purchase the lowest possible limits in order to reduce likelihood of being sued for bigger awards than other defendants.

- **ALAE**

  During our analysis of SB2D, we have been careful to consider the impact of the bill on the insurer's cost of defending claims. It is our belief that what the law "gives with one hand, it takes away with the other." For example, Section 48 defines expert witness testimony and when a person may give expert testimony concerning the prevailing professional standard of care. Although the change in expert witness qualifications will likely increase costs for plaintiff attorneys and reduce the likelihood of the use of so called "general" experts, it is our belief that these savings will be offset by the increased costs associated with insurance companies having to use expert witnesses in defending cases and in other Sections of the bill.

- **SB2D Impact on Policy Limit Purchasing Trends**

  After medical malpractice insurers incorporate the presumed factor into their rates, one could try and argue that the incentive to purchase lower policy limits would be alleviated by the savings resulting from SB2D. Unfortunately, the overall presumed factor calculated in this report will likely have little or no impact on the current trend of doctors purchasing lower policy limits. Therefore, we do not believe that their will be a rush of healthcare providers deciding to purchase higher policy limits which would alter our current assumptions regarding the distribution of policy limits that we used in our calculation of the presumed factor in Section 54.

- **Bad Faith – Offset to Speed up of Payout Patterns**

  We noted above that Section 56 would likely result in the speed up of claim payments in medical malpractice claims and a reduction in investment income achievable by insurers. We also believe that for a small number of claims of questionable merit, SB2D will increase the likelihood that insurers will see the case through to a jury trial. For these specific claims, switching from a settlement before SB2D to a jury verdict after SB2D would actually slow down the payout pattern. In the aggregate, we believe the current law will result in a speed up in the payout of losses as discussed in Section 56.

- **Bad Faith – Common Law Example**

  One of the perceived practical benefits of the new law is demonstrated by the following real life example which has been modified for confidentiality. An insurance company received a pre-suit request to settle a potential medical malpractice matter for the policy limits of $1 million. The plaintiff had been rendered a quadriplegic due to the alleged negligence of the doctor and his staff. The offer letter, which was sent approximately 60 days after the procedure that resulted in the injury, gave a 20-day deadline for the insurer to respond. The insurer missed the deadline due to simple inadvertence by one of its personnel. The plaintiff thereafter rejected the $1 million tender and filed suit. Ultimately, to avoid a trial and to avoid a potential bad faith claim, the insurer settled for **6 times** the policy limits.

  The new 210 day deadline will make it much less likely that such "administrative" inadvertence will result in potential bad faith claims because plaintiffs will no longer be able to impose artificially short response deadlines under common law. In addition, insurers will have more time to investigate claims and make more informed decisions about settlement.

- **Disciplinary Challenge**

  Medical malpractice is often times communicated in the news as “bad doctors routinely doing bad things.” Stories like that of a Doctor in Hawaii who was recently sued for at least the eighth time are not standard drivers of claims. Although stories like his often dominate the

news headlines (i.e., he hack sawed and inserted a screwdriver into a patient's back instead of the titanium rod which he misplaced before the operation), one mustn't extrapolate this type of gross negligence onto the entire physician population.

The fact of the matter is that medical malpractice is essentially "good doctors doing unfortunate things" in the vast majority of the claims. Most clear cut malpractice claims (e.g., wrong blood type, amputation of the wrong leg) represent a small fraction (e.g., less than 4%) of the total medical malpractice claims that are reported every year. Of these claims, there is often no clear cut repeat offender that a regulatory body can identify and remove from practice. When there is an individual who appears to have more claims relative to other doctors, it may be because he or she practices in a high risk specialty (e.g., surgeons and OB/GYNs versus chiropractors and dermatologists) or a more difficult territory in the state (e.g., high risk Dade County or Broward County versus lower risk Saint Johns County or Martin County). Therefore, one could theoretically discipline 4% of the doctors every year and still not reduce the likelihood of future adverse events.

All people, especially healthcare practitioners feel horrible when a mistake is made and a patient is injured under their care. If a physician could reverse an adverse event; there isn't a doctor in the world that wouldn't turn back the clock. Unfortunately, medical malpractice events cannot be fixed or reversed as easy as other professionals such as the revising of an actuarial analysis or restatement of previously incorrect "audited" financial statements. When a doctor is sued, it is very traumatic event. In most cases, disciplinary proceedings add further salt to the wounds without creating a real solution. As the Institute of Medicine's[3] study *To Err is Human* stated:

> *"The focus must shift from blaming individuals for past errors to a focus on preventing future errors by designing safety into the system. This does not mean that*

[3] 2000 Institute of Medicine study To Err Is Human – Building a Safer Health System

individuals can be careless. People must still be vigilant and held responsible for their actions. But when an error occurs, blaming an individual does little to make the system safer and prevent someone else from committing the same error."

Without question, Doctors like the Hawaii doctor mentioned above should be disciplined. Excluding Florida's own Hawaii like examples, it is important to reiterate that the current Sections dealing with practitioner discipline will not help to dramatically reduce or eliminate medical malpractice costs in Florida.

- **Closed Claim Database – Publicly Documented Caveats**

  Our analysis of the cap on noneconomic damages relies upon Florida's Closed Claim Database (CCD). A number of individuals and organizations have commented on the integrity of the data contained in the CCD. We believe the Select Committee on Medical Liability Insurance Report (SCMLI)[4] and the GSTF Report clearly illustrate some of the issues. The SCMLI Report states:

  "Questions have been raised concerning the integrity of the Closed Claim Database, and there are additional factors which should be considered when this data is used as a barometer of the current medical malpractice market. The database reflects claims that have been closed as of any one point in time. The injuries occurred many years prior to the claims' closures. So, when one looks for changes in severity or for frequency trends, looking at the number and size of claims that have recently been closed evidences an incomplete picture. Better data would be the inclusion of the number of claims, and the associated reserves established thereon, that are currently being realized by insurers. Rate filings include data that reflect claims paid in prior years and the reserves that have been set relative to claims filed in those years, but not yet paid or closed.

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

It is the number and severity of claims currently being incurred that seem to be the most concern to the insurance industry. The industry is seeing two things happen that are not reflected in the Closed Claim Database. They are seeing an increasing number of claims being filed. Likewise, some are finding the need to set higher reserves for those claims in response to recent experience in either litigating the claims or settling them prior to litigation. It may not matter whether or not this perception is ultimately deemed accurate. If such perception results in the legitimate establishment of increased reserves; reported losses (for income purposes) effectively rise; and rate increases naturally follow – or insurers reduce their willingness to provide the coverage – or the insurers even leave the State altogether."

"The Closed Claim Database is being increasingly relied upon to draw conclusions about the current state of the medical malpractice market. The OIR has contended that while the information in the Database is not without value, the contents do not reflect a current, comprehensive picture of the medical malpractice market. They note that the data is not validated. Conclusions drawn from the Database should recognize this fact. Not all entities providing medical malpractice in Florida are required to report closed claims to the Office. Moreover, it cannot be assured that all of the insurance entities required to report to the Database have consistently done so. Finally, not all licensed physicians have insurance. The OIR argues that, accordingly, analyses that presume a comprehensive Database may be fundamentally flawed.

There are a couple of additional concerns raised by the OIR with the Database. For more than 20 years, the information was submitted to OIR by insurers on paper. The paper information was then key-punched into the database by P.R.I.D.E. The OIR was not able to supervise this data entry, nor was there any formal OIR-administered audit program in place during these years. For the years this data was entered into the system via the Florida's prison system, the OIR can not attest that all of the submitted data was entered, or that it was entered correctly."

The GSTF Report states:

> *"The FLDOI database is available on CD and comes with the following disclaimer.*
>
> *"Neither the Department of Insurance nor the State of Florida accepts legal liability or responsibility for the accuracy, completeness or usefulness of this information on closed claim reports filed by insurers. This information is unaudited."*
>
> *The FLDOI database consists of two databases. "Archive" contains years 1975 up to mid-July 1999 and "Current" contains data from mid-July 1999 to present. The Department of Insurance provides very specific information regarding duplicate records and steps that need to be taken to successfully work with the data.*
>
> *Concerns have been raised by some stakeholders at Task Force meetings that this database is incomplete due to underreporting of claims. Steve Roddenberry, Deputy Director of the Division of Insurer Services at the Florida Department of Insurance, confirms that some insurers may not report to the FLDOI as required. In addition, self-insurers, off-shore captives, risk retention groups, and surplus line companies do not report to the closed claim database "*

The GSTF Report also has comments from consulting firms that had to modify the data when using it for analysis purposes.

Although we recognize the questions that have been raised concerning the integrity of the CCD, we have taken what we believe are reasonable and prudent steps to cleanse the data into a useable format. In addition, we believe the following items help to mitigate the concerns regarding the credibility of the closed claim data and adjustments we have made to clean up the database:

1. Similar to other studies mentioned in the GSTF Report, we have eliminated duplicate claim records. (see Appendix B for details)
2. Noneconomic damages are capped in our study.
    a. Adjustments that we have made to gross up the noneconomic portion of the settlements capped at policy limits are mitigated by the application of the cap. As is shown in Appendix B, a majority of the claims did not need to be adjusted.
    b. Assumptions that we have applied to trend the historical settlements to current dollar levels are mitigated by the application of the cap.
3. Total damages are capped at policy limits in our study.
    a. Healthcare practitioners have been purchasing significantly lower policy limits than the claims that are included in the CCD. While the higher limits in the current database help to make the data more credible (i.e., higher limits provide a better estimate of the economic versus noneconomic split since policy limits are less likely to cap settlements), the lower policy limits significantly mitigate the impact of settlement and trend assumptions.
    b. Policy limits cap noneconomic damages and economic damages. By overlaying the policy limits on top of the noneconomic damage caps mentioned above, the impact of the settlement and trend assumptions are further mitigated (see Appendix B for three different claim example illustrations).

Given the mitigating impact of the caps and policy limits, we feel the presumed factor calculated in Section 54 falls within a reasonable range of results. Furthermore, the impact compares reasonably with findings of the GSTF Report which quantified savings of 21% for a $250,000 hard cap, 9% for a $500,000 hard cap, and 2% for a $1,000,000 hard cap.

- **Recoverable Damages in Medical Malpractice Actions**

  One of the changes implemented by the new law concerns the categories of damages that are recoverable in medical negligence arbitrations.

  In essence, the legislature "overturned" a portion of the Florida Supreme Court's decision in St. Mary's Hospital, Inc. v. Phillipe, 769 So. 2d 961, 972-73 (Fla. 2000), which held that, with respect to the voluntary arbitration mechanism in the medical malpractice Statute, the categories of damages recoverable in a medical negligence case involving wrongful death were governed by the medical malpractice Statute and not by the Wrongful Death Statute. Thus, under St. Mary's, the court allowed a claimant who had elected voluntary arbitration in a wrongful death case involving medical negligence to recover damages for the lost earning capacity of the decedent, even though that type of economic damages would not have been recoverable in a wrongful death action outside of arbitration (i.e., in court). The basis for the court's ruling was that the Legislature had not specified which act controlled the applicable damages in the event of a voluntary arbitration.

  In the new law, the Legislature has answered the call by amending the definitions of both "economic" and "noneconomic" damages in Section 766.202 to include the following language: "to the extent the claimant is entitled to recover such damages under general law, including the Wrongful Death Act."

  The Legislature also amended the arbitration Section of the medical malpractice Statute to reflect that "damages shall be awarded as provided by general law, including the Wrongful Death act." See Section 62 of the new law.

  These amendments clarify that, in the event of a medical negligence action involving wrongful death, the damages recoverable, in both court and in arbitrations, are proscribed by the Wrongful Death Statute. Thus, if this new amendment had been in effect at the time of the St.

Mary's decision, the claimant in that case would not have been permitted to recover economic damages for loss of future earning capacity of the decedent.

- **Complexity of Report**

  We have done our best to document our findings and observations using examples and terminology with the least amount of actuarial and legal terminology. Although we have attempted to do this, certain sections of this report will still require additional attention for those readers unfamiliar with the field of actuarial science or interpretation of Statutes. We have included a ratemaking primer section in the appendices as well as numerous illustrations throughout the report to provide additional color to our written comments.

  Given the short time frame we had to deliver the final report, we are hopeful that readers will appreciate the thoroughness of the report. Our team enjoyed working on this engagement.

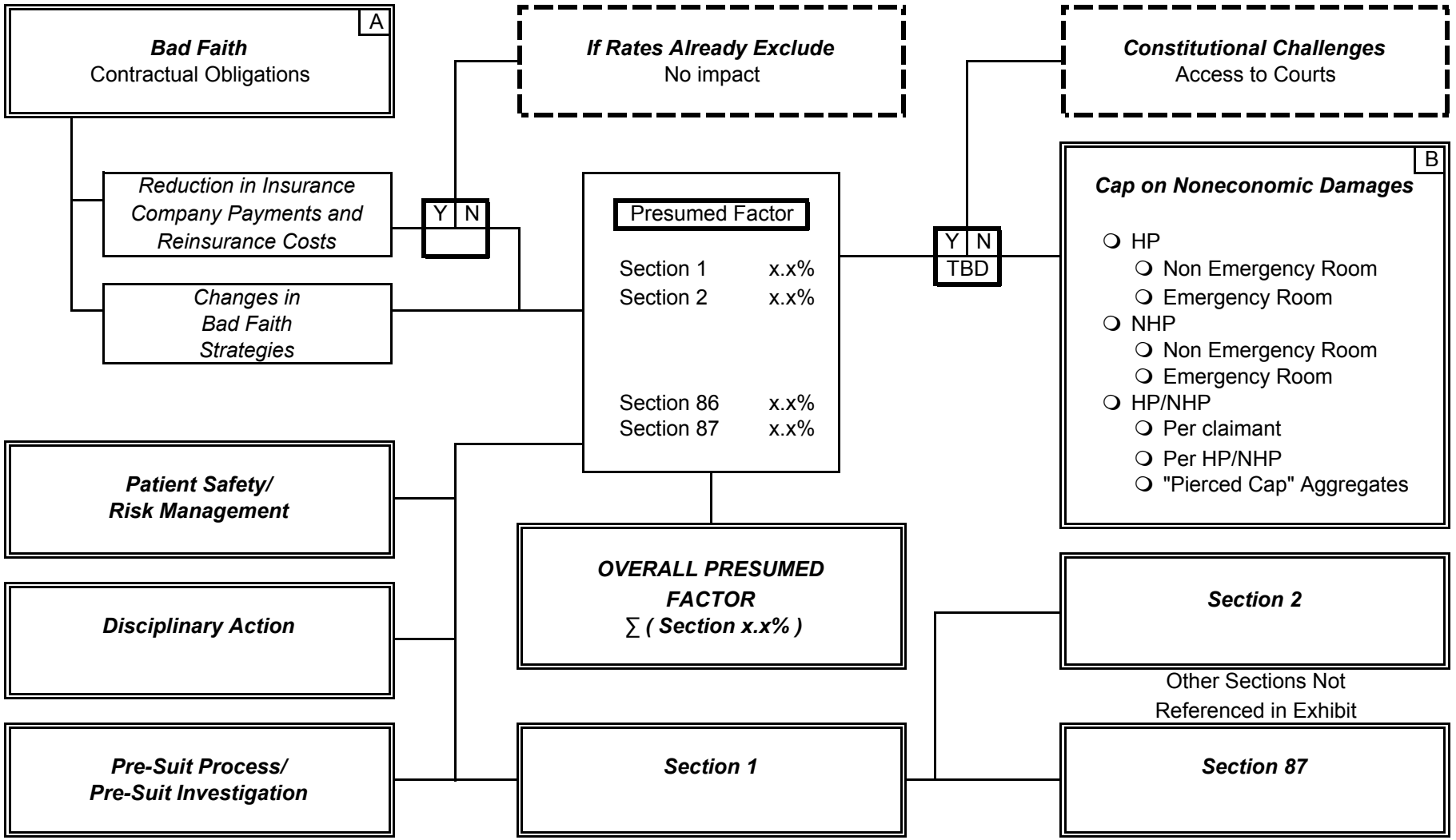
V. APPENDIX

APPENDIX A

SB2D Savings Flow Chart

SECTION 40
"PRESUMED FACTOR (PF)" - SAVINGS FLOW

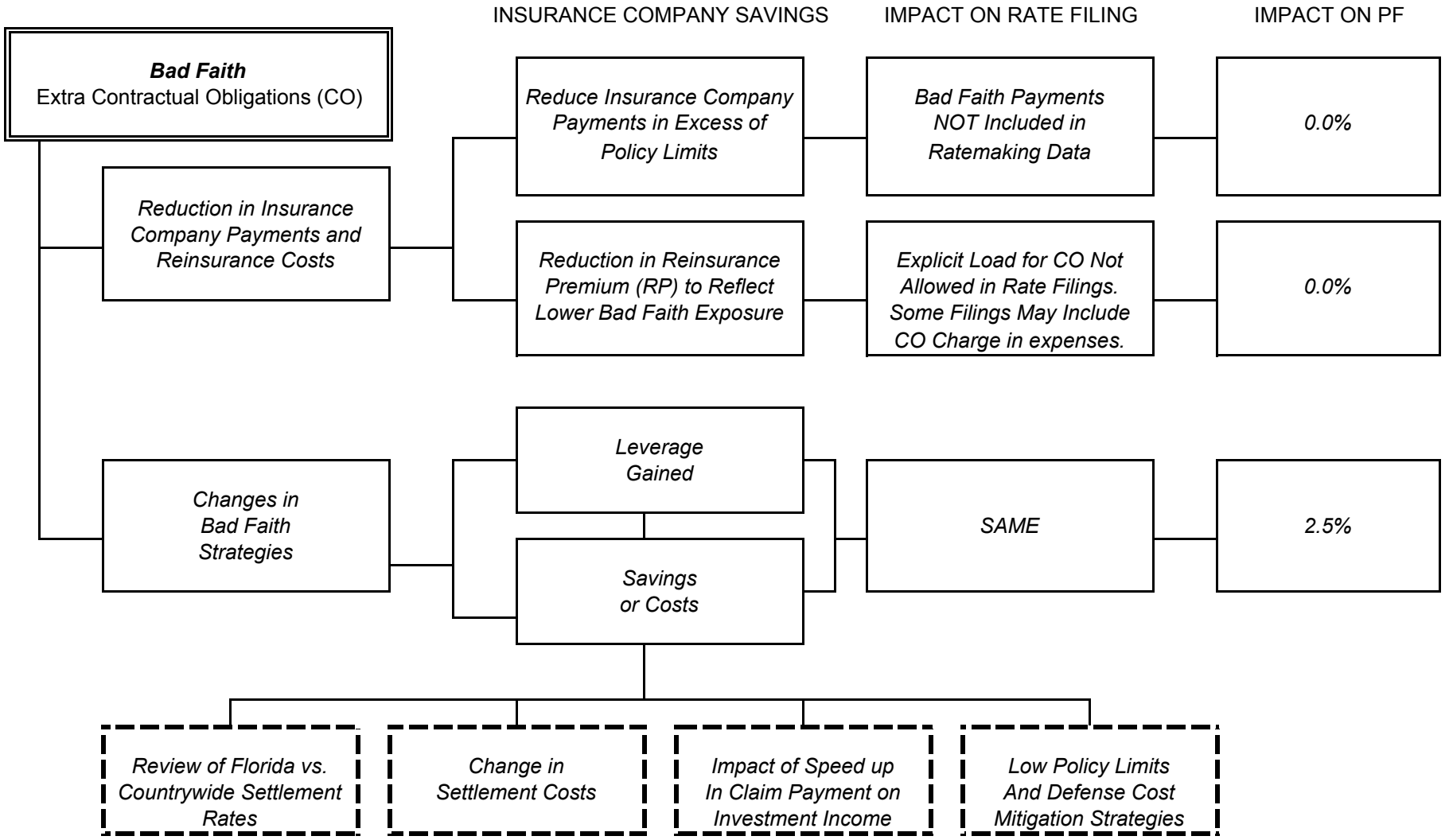
SUMMARY



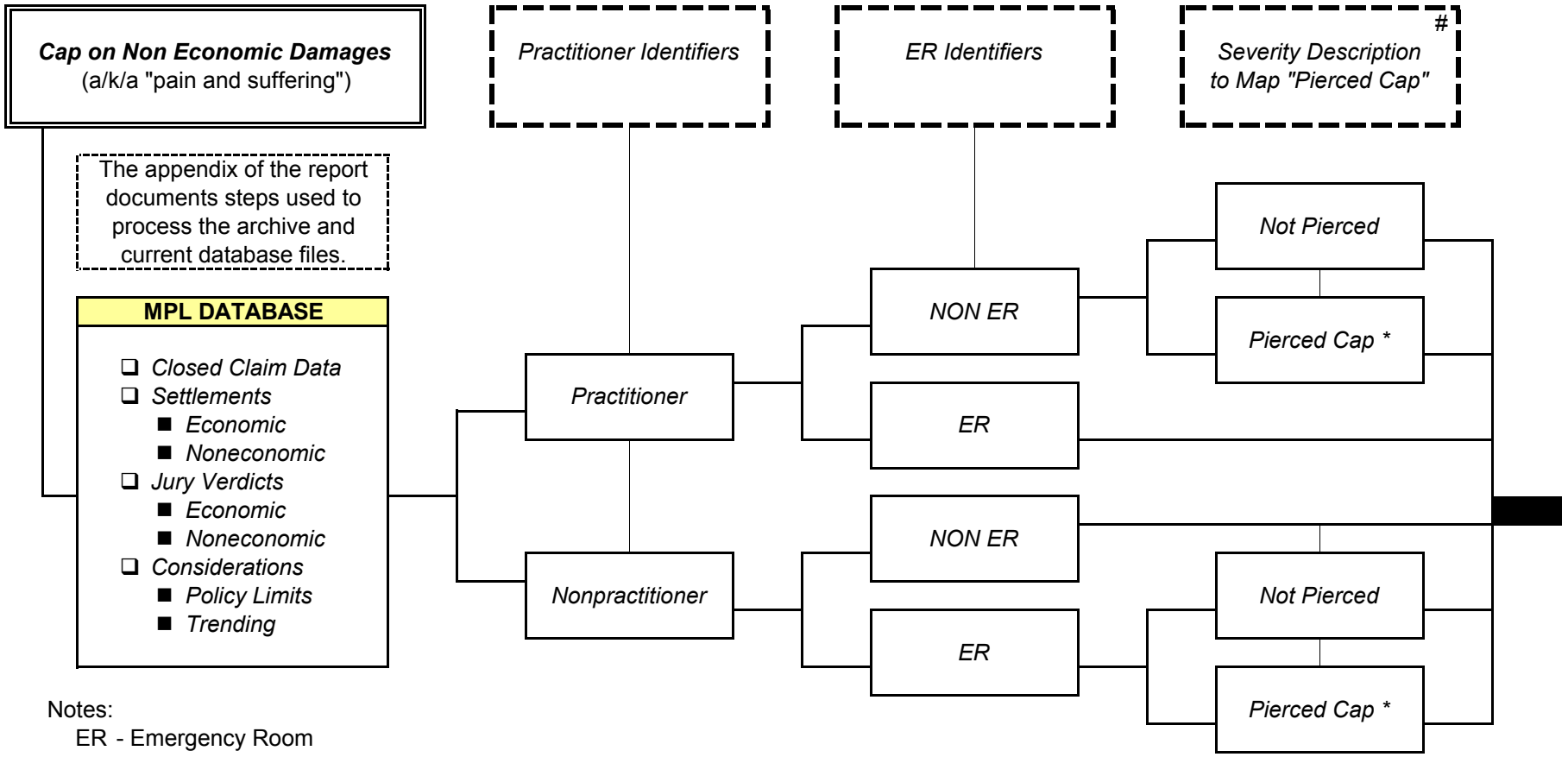
SECTION 40
"PRESUMED FACTOR (PF)" - SAVINGS FLOW
BAD FAITH

SUMMARY

SHEET A



SECTION 40
"PRESUMED FACTOR (PF)" - SAVINGS FLOW
CAP ON NONECONOMIC DAMAGES

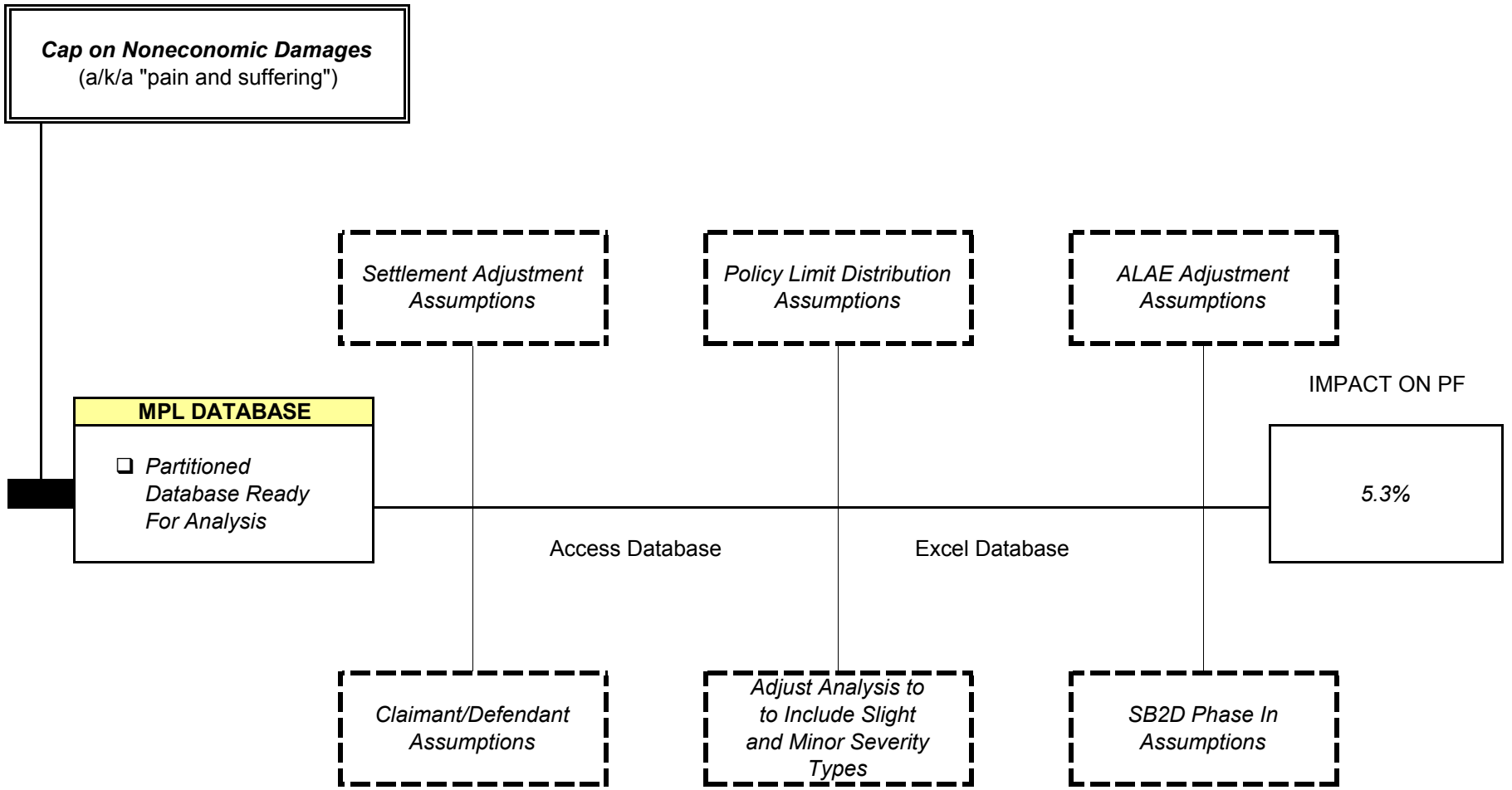


Notes:
ER - Emergency Room
* - Pierced Cap
1) Death or permanent vegetative state
2) Manifest injustice plus catastrophic injury
\# - Codes 1 (emotional only - fright, no physical damage) through 9 (death), Analysis excludes 1 through 3 (Slight and Minor).

SECTION 40
"PRESUMED FACTOR (PF)" - SAVINGS FLOW
CAP ON NONECONOMIC DAMAGES

SUMMARY

SHEET B.2



SECTION 54
766.118 DETERMINATION OF NONECONOMIC DAMAGES

☐ Practitioner

- **Non emergency room**
  - $500,000 per claimant (2)(a)
  - $500,000 per practitioner (2)(a)

"Pierced Cap"

	Death or permanent vegetative state
	$1,000,000 aggregate practitioner cap (2)(b) regardless of the number of claimants
	Manifest injustice plus catastrophic injury
	$1,000,000 aggregate cap recoverable by injured patient

- **Emergency room**
  - $150,000 per claimant (4)(a)
  - $300,000 aggregate practitioner cap (4)(b)

☐ Nonpractitioner

- **Non emergency room**
  - $750,000 per claimant (3)(a)
  - $750,000 per nonpractitioner (3)(a)

"Pierced Cap"

	Death or permanent vegetative state
	$1,500,000 aggregate nonpractitioner cap (3)(b) regardless of the number of claimants
	Manifest injustice plus catastrophic injury
	$1,500,000 aggregate cap recoverable by injured patient

- **Emergency room**
  - $750,000 per claimant (5)(a)
  - $1,500,000 aggregate non practitioner cap (5)(b)
  - Nonpractitioner defendants may receive a full setoff for payments made by practitioner defendants (5)(c)

Definitions

Claimant means any person who has a cause of action for damages based on personal injury or wrongful death arising from medical negligence.

Health care practitioner means any person licensed under chapter 457 (acupuncture); chapter 458 (medical practice); chapter 459 (osteopathic medicine); chapter 460 (chiropractic medicine); chapter 461 (podiatric medicine); chapter 462 (naturopathy); chapter 463 (optometry); chapter 464 (nursing); chapter 465 (pharmacy); chapter 466 (dentistry); chapter 467 (midwifery); part I (speech-language pathology and audiology), part II (nursing home administration), part III (occupational therapy), part V (respiratory therapy), part X (dietetics and nutrition practice), part XIII (athletic trainers), or part XIV (orthotics, prosthetics, and pedorthics) of chapter 468; chapter 478 (electrolysis); chapter 480 (massage practice); part III (clinical laboratory personnel) or part IV (medical physicists) of chapter 483; chapter 484 (dispensing of optical devices and hearing aids); chapter 486 (physical therapy practice); chapter 490 (psychological services); or chapter 491 (clinical, counseling and psychotherapy services).

Non practitioner means hospitals, health maintenance organizations (HMOs), hospice providers, and other non-physician entities.

Catastrophic Injury

1. Spinal cord injury involving severe paralysis of an arm, a leg, or the trunk
2. Amputation of an arm, a hand, a foot, or a leg involving the effective loss of use of that appendage
3. Severe brain or closed-head injury
4. Second-degree or third-degree burns of 25 percent or more of the total body surface or third-degree burns of 5 % or more to the face and hands
5. Blindness, as defined as a complete and total loss of vision
6. Loss of reproductive organs which results in an inability to procreate

APPENDIX B

Section 54 Detailed Appendix

Florida Office of Insurance Regulation
Medical Professional Liability Closed Claim Database

I. DATA BACKGROUND AND LIMITATIONS

For purposes of this engagement, the State of Florida Department of Financial Services, Office of Insurance Regulation (OIR) made available to Deloitte their historical Medical Professional Liability (MPL) closed claim database. We have made use of the closed claim database to assist us in deriving an estimate of the Senate Bill 2-D (SB2D) "presumed factor". Specifically, the MPL database has been used extensively in the calculation of the presumed factor in Section 54.

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

More specifically, original entries to the OIR database were collected and entered manually until mid-July 1999 when revised forms and instructions became available and electronic submission of data first began. Data has never been audited or checked for accuracy or completeness and OIR management suspects that errors and inconsistencies in the data submitted are likely.

Reliance upon the use of the OIR database is made with the above considerations in mind.

Additional details regarding the OIR closed claim database:

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

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

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

- Only Florida authorized insurers are required to report closed claims to the OIR database. This excludes self-insurers and "unauthorized" insurers such as offshore and surplus lines insurers.

- The actual occurrence dates of individual MPL incidents are often several years prior to the date of closure. As a result, OIR closed claim data cannot be expected to be representative of current MPL trends and conditions without some adjustment or other consideration. We note that the database has claims closed as recently as summer 2003 and the instructions for the database mandate that claims be reported to the department within 30 days of closing.

- The version of the closed claim database provided to us contained claims closed through June of 2003.

II. DATA PREPARATION

In light of the information and limitations outlined above, Deloitte took the following steps to prepare the OIR closed claim database for use in the presumed factor analysis.

PHASE I:

As outlined below, Phase I involved our initial data preparation efforts. Initial background information and guidance was first provided by OIR management. We began with a detailed review and testing of the raw data in order to become familiar with the nature and characteristics of the database. Claim entry forms and instructions were made available and were reviewed in order to become familiar with the intended content of several key data fields.

Several key tasks where performed during Phase I:

- We condensed multiple defendant record entries to a single record.
- To improve efficiency, we eliminated entries associated with the lowest severity injury types (i.e., those expected to have the least impact on the presumed factor calculation). The excluded severity injury types were;
    1. Emotional Only – Fright, no physical damage.
    2. Temporary Slight – Lacerations, contusions, minor scars, rash. No delay.
    3. Temporary Minor – Infections, misset fracture, fall in hospital. Recovery Delayed.
- We created a set of key captured loss fields which we populated from the entries made in the Archive and Current database segments. This allowed us to combine the Archive and Current database segments into one database with common key data fields.
- We subtotaled and cross checked loss dollar entries against posted totals and eliminated entries which could not be reconciled, subject to certain conditions.

The following outlines the procedures involved in our Phase I data preparation efforts in greater detail:

	Description of Phase I Procedure	**Approximate Lines Beginning**	
Step 1.	Original databases supplied by OIR. Closed claims only. "Archive" contained all claims with disposition dates prior to July 1999, also those initially logged prior to July 1999. "Current" contained claims newly logged on or after July 1999.	Archive	Current
		59,000	11,000

	Description of Phase I Procedure	**Approximate Lines Remaining**	
Step 2.	"Current" entries only: Using the "MPL_DEPT_FILE_NUM" field, a unique file identifier in the "Current" database, lines with multiple defendants were collapsed to a single line per claim. Duplicates also eliminated in this process.	Archive	Current
		59,000	6,300

	Description of Phase I Procedure	**Approximate Lines Remaining**	
Step 3.	Eliminated records with severity codes ("SEVERITY_CODE" (Archive) and "MPL_SEV_OF_INJURY_PI" (Current)), left blank and those with entries of either 1-"emotional only", 2-"temporary slight" or 3-"temporary minor". Remaining entries are for 4-"temporary major" up through 9-"permanent-death" claims.	Archive	Current
		27,400	4,700

Description of Phase I Procedure		Approximate Lines Remaining	
Step 4.	"Archive" entries only. Attempted to remove claims with multiple defendants. A unique field identifier is not available in this file (the "DEPTNO_MPL_OTH" field does not appear to be unique). Sorted and searched on several fields, including occurrence date, severity code, (and injured party's age) and removed duplicates by inspecting for exact matches by hand.	Archive	Current
		26,900	4,700

Description of Phase I Procedure		Approximate Lines Remaining
Step 5.	"Archive" and "Current" databases combined. The following fields created. Refer to our *"Key Captured Loss Fields*" outline below: "Expense Paid", "Total Loss Cost", "Total Paid By Insurer", "Total Medical Cost", "Total Economic Loss", "Total Noneconomic Loss" and "Dollars Not Allocated".	Combined Data
		31,607

Description of Phase I Procedure		Approximate Lines Remaining	
Step 6.	A line by line comparison was made of two quantities: B = ["Total Loss Cost"] versus C+d = ["Total Paid By Insurer" plus deductible ("MPL_DEDUCT" or "DEDUCT_PAID_DEFEND")] Comparison resulted in 20,330 lines with (i) C+d = B matching, (ii) 4,961 lines with C+d > B and B = $0, (iii) 1,589 lines with C+d > B and B>$0 and (iv) 4,727 lines with C+d < B. ("Dollars Not Allocated" now generated for (ii). Total usable files, items (i) and (ii).	Combined Data	
		(i) C+d = B	20,330
		(ii) C+d > B (B=$0)	4,961
		(iii) C+d > B (B>$0)	1,589
		(iv) C+d < B	4,727
		(v) Total used (i)+(ii)	**25,291**

The following table displays the key captured loss fields used in connection with Steps 5 and 6 of our Phase I data preparation as described above:

TABLE OF KEY CAPTURED LOSS FIELDS

	OIR Database Source – Current		OIR Database Source – Archive	
	Field Name	**Description**	**Field Name**	**Description**
(A) Expense Paid				
	MPL_LOSS_ADJUST	Loss Adjustment expense paid to Defense Counsel	LOSS_ADJ_EXP	Loss adjustment expense paid to defense counsel
	MPL_LOSS_ADJUST_OTHER	All other loss adjustment expense paid	OTHER_LOSS_ADJ_EXP	All other loss adjustment expense paid
(B) Total Loss Cost				
	MPL_IP_MEDICAL_TO_DATE	Injured party's economic medical loss incurred to date	ECONO_MED_LOSS	Injured party's economic medical loss incurred to date
	MPL_IP_WAGE_TO_DATE	Injured party's economic wage loss incurred to date	ECONO_WAGE_LOSS	Injured party's economic wage loss incurred to date
	MPL_IP_OTHER_EXPENSE_TO_DATE	Injured party's economic other loss incurred to date	ECONO_OTH_EXP	Injured party's economic other loss incurred to date
	MPL_IP_MEDICAL FUTURE	Injured party's estimated future medical loss	FUTURE_MED_LOSS	Injured party's estimated future medical loss
	MPL_IP_WAGE_FUTURE	Injured party's estimated future wage loss	FUTURE_WAGE_LOSS	Injured party's estimated future wage loss
	MPL_IP_OTHER_EXPENSE_FUTURE	Injured party's estimated future other loss	FUTURE_OTH_EXP	Injured party's estimated future other loss
	MPL_DEDUCT	Deductible	DEDUCT_PD_DEFEND	An amount of deductible paid by the defendant (insured)
	MPL_NON_ECONOMIC_LOSS	Amount paid for injured party's non-economic loss	NON_ECONO_LOSS	Amount paid for injured party's non-economic loss
			TOT_EXPECT_PAY	Total expected payment to plaintiff if a structured settlement or periodic payments
(C) Total Paid By Insurer				
	MPL_INDEMNITY_PAID	Amount paid to plaintiff by primary insurer	INDEM_PD_INS	An amount of money paid to the plaintiff by the primary insurer
			INDEM_PD_EXEC	An amount of money paid to the plaintiff by the excess insurer
			COST_OF_PAY	Cost to the insurer of the payments if a structured settlement or periodic payments
(D) Total Medical Cost				
	MPL_IP_MEDICAL_TO_DATE	Injured party's economic medical loss incurred to date	ECONO_MED_LOSS	Injured party's economic medical loss incurred to date
	MPL_IP_MEDICAL_ FUTURE	Injured party's estimated future medical loss	FUTURE_MED_LOSS	Injured party's estimated future medical loss
(E) Total Other Economic Loss				
	MPL_IP_WAGE_TO_DATE	Injured party's economic wage loss incurred to date	ECONO_WAGE_LOSS	Injured party's economic wage loss incurred to date
	MPL_IP_OTHER_EXPENSE_TO_DATE	Injured party's economic other loss incurred to date	ECONO_OTH_EXP	Injured party's economic other loss incurred to date
	MPL_IP_WAGE_FUTURE	Injured party's estimated future wage loss	FUTURE_WAGE_LOSS	Injured party's estimated future wage loss
	MPL_IP_OTHER_EXPENSE_FUTURE	Injured party's estimated future other loss	FUTURE_OTH_EXP	Injured party's estimated future other loss
	MPL_DEDUCT	Deductible	DEDUCT_PD_DEFEND	An amount of deductible paid by the defendant (insured)
(F) Total Noneconomic Loss				
	MPL_NON_ECONOMIC_LOSS	Amount paid for injured party's non-economic loss	NON_ECONO_LOSS	Amount paid for injured party's non-economic loss
(G) Dollars Not Allocated				
	If (C) + (Deductible) > (B), Difference is here.		*If (C) + (Deductible) > (B), Difference is here.*	

PHASE II:

The first step of Phase II involved the adjustment of the data selected from our Phase I efforts to their full unlimited values. In certain cases, this involved the "grossing up" of existing noneconomic loss components to levels reflecting an industry benchmark ratio of noneconomic losses to total losses of 70%. This benchmark ratio was selected based on a review of the closed claim database and publicly available information contained in the Government's Select Task Force Report. In certain other cases, when individual loss components where absent from a claim, the 70% ratio was applied to the total loss amount to derive the noneconomic loss component of the claim. In the majority of cases, no adjustments were required.

The following table displays the specific conditions under which noneconomic loss adjustments have been made and the numbers of claims falling into each of our seven Phase II adjustment categories We have designed these categories to reflect the relationships between each claim's policy limit and the total damage amount as well as the absence (or presence) of individual loss allocation data (i.e., components such as noneconomic loss, medical, wage loss, etc.). In some cases, the presence of noneconomic loss entries allowed us to examine an individual claim's ratio of noneconomic loss to total losses as an additional criterion for consideration. This consideration was called into play when an individual claim's total damages met the stated policy limit. In these cases, no adjustment to the noneconomic loss value was made when the ratio was greater than our industry benchmark assumption of 70% (i.e., code C below). When the ratio was less than 70% we kept the economic loss values unchanged while increasing the noneconomic loss to a level reflective of the 70% assumption (i.e., code B below). In addition, as shown below, we chose not to make adjustments to claims settled in court.:

Base Criteria For Adjustment of Noneconomic Vs. Economic Loss Components

Code	SITUATION	PHASE II ACTION	Claim Count	Claim Count Settled in Court (A)
A	Policy Limit > Total Damages, Losses Allocated	No change to noneconomic loss amounts.	18,783	2,287
B	Policy Limit = Total Damages, Ratio < Assumption	Grossed up total loss amount to keep economic loss the same and allow noneconomic loss to be the assumed percentage of total.	94	2
C	Policy Limit = Total Damages, Ratio > Assumption	No change to noneconomic loss amount.	802	13
D	Policy Limit > Total Damages, Not Allocated	Allocated economic and non economic loss based on assumed percentage.	3,766	100
E	Policy Limit = Total Damages, Not Allocated	Allocated economic and non economic loss based on assumed percentage.	340	10
F	Policy Limit < Total Damages, Allocated	No change to noneconomic loss amount.	651	143
G	Policy Limit < Total Damages, Not Allocated	Allocated economic and non economic loss based on assumed percentage.	855	38
	Total All Claims		25,291	2,593

Note: (A) If a claim was settled in court, the loss amounts were not adjusted, except for trend.

The next step in our Phase II data preparation efforts was to trend the claim values to current levels based on the disposition date of the claim. An annual trend of 6% was selected for the

economic component of loss. An annual trend of 6% was selected for the noneconomic loss component through 1993 with a 10% annual trend selected for the 1994 through 2003 years. The higher trend selection for noneconomic loss during the 1994 through 2003 years is intended to be reflective of the faster rate at which noneconomic loss has been increasing in recent years. As is often noted in the media, there has been an increase in the "lottery mentality" of jury awards in recent years. We believe the 4% adjustment helps to reflect this fact.

At this stage of Phase II all claims have been adjusted to an unlimited basis and also to a 2003 loss cost level.

The final step of Phase II was to enter the refined and adjusted data into the factor matrix model. The claims were first sorted and grouped by (i) emergency room versus non-emergency room, (ii) practitioner versus non-practitioner and (iii) non-pierced cap verses pierced cap. Further, pierced claim claims were separated between a) death or permanent vegetative state and b) manifest injustice plus catastrophic injury (see Appendix A, Summary Sheet B1).

In the factor matrix model, the loss from each claim was derived at numerous possible policy limits within each group, before and after the application of the appropriate cap on noneconomic damages and reflecting the impact of multiple claimants and/or defendants combinations.

Example A represents how a claim with $700,000 of economic loss and $1.4 million of noneconomic loss and limited by the non-pierced practitioner non-emergency room cap (i.e., $500,000 for the first claimant/defendant, $1,000,000 for the second claimants/defendants, $1,500,000 for the third claimants/defendants, $2,000,000 for the fourth claimants/defendants) would be entered into the practitioner non-emergency room group matrix. Note the column headings 1/1, 2/2, etc. which are intended to represent 1 claimant/defendant, 2 claimants/defendants, etc.:

EXAMPLE A — SHEET 1

PRE-SB2D

Damages	Value Without Policy Limits 1/1	2/2	3/3	4/4
Economic	$ 700,000	$ 700,000	$ 700,000	$ 700,000
Noneconomic	$ 1,400,000	$ 1,400,000	$ 1,400,000	$ 1,400,000
Total	$ 2,100,000	$ 2,100,000	$ 2,100,000	$ 2,100,000

Representative Policy Limit	Maximum Policy Limits Available 1/1	2/2	3/3	4/4
$100,000	$ 100,000	$ 200,000	$ 300,000	$ 400,000
$250,000	$ 250,000	$ 500,000	$ 750,000	$ 1,000,000
$500,000	$ 500,000	$ 1,000,000	$ 1,500,000	$ 2,000,000
$1,000,000	$ 1,000,000	$ 2,000,000	$ 3,000,000	$ 4,000,000
$2,000,000	$ 2,000,000	$ 4,000,000	$ 6,000,000	$ 8,000,000
$5,000,000	$ 5,000,000	$ 10,000,000	$ 15,000,000	$ 20,000,000

Representative Policy Limit	Value At Policy Limits 1/1	2/2	3/3	4/4
$100,000	$ 100,000	$ 200,000	$ 300,000	$ 400,000
$250,000	$ 250,000	$ 500,000	$ 750,000	$ 1,000,000
$500,000	$ 500,000	$ 1,000,000	$ 1,500,000	$ 2,000,000
$1,000,000	$ 1,000,000	$ 2,000,000	$ 2,100,000	$ 2,100,000
$2,000,000	$ 2,000,000	$ 2,100,000	$ 2,100,000	$ 2,100,000
$5,000,000	$ 2,100,000	$ 2,100,000	$ 2,100,000	$ 2,100,000

POST-SB2D

Damages	Value Without Policy Limits 1/1	2/2	3/3	4/4
Economic	$ 700,000	$ 700,000	$ 700,000	$ 700,000
Noneconomic	**$ 500,000**	**$ 1,000,000**	**$ 1,400,000**	**$ 1,400,000**
Total	$ 1,200,000	$ 1,700,000	$ 2,100,000	$ 2,100,000

Representative Policy Limit	Maximum Policy Limits Available 1/1	2/2	3/3	4/4
$100,000	$ 100,000	$ 200,000	$ 300,000	$ 400,000
$250,000	$ 250,000	$ 500,000	$ 750,000	$ 1,000,000
$500,000	$ 500,000	$ 1,000,000	$ 1,500,000	$ 2,000,000
$1,000,000	$ 1,000,000	$ 2,000,000	$ 3,000,000	$ 4,000,000
$2,000,000	$ 2,000,000	$ 4,000,000	$ 6,000,000	$ 8,000,000
$5,000,000	$ 5,000,000	$ 10,000,000	$ 15,000,000	$ 20,000,000

Representative Policy Limit	Value At Policy Limits 1/1	2/2	3/3	4/4
$100,000	$ 100,000	$ 200,000	$ 300,000	$ 400,000
$250,000	$ 250,000	$ 500,000	$ 750,000	$ 1,000,000
$500,000	$ 500,000	$ 1,000,000	$ 1,500,000	$ 2,000,000
$1,000,000	$ 1,000,000	$ 1,700,000	$ 2,100,000	$ 2,100,000
$2,000,000	$ 1,200,000	$ 1,700,000	$ 2,100,000	$ 2,100,000
$5,000,000	$ 1,200,000	$ 1,700,000	$ 2,100,000	$ 2,100,000

Representative Policy Limit	Savings 1/1	2/2	3/3	4/4
$100,000	0.0%	0.0%	0.0%	0.0%
$250,000	0.0%	0.0%	0.0%	0.0%
$500,000	0.0%	0.0%	0.0%	0.0%
$1,000,000	0.0%	15.0%	0.0%	0.0%
$2,000,000	40.0%	19.0%	0.0%	0.0%
$5,000,000	42.9%	19.0%	0.0%	0.0%

EXAMPLE A - CALCULATIONS

SHEET 2

PRE-SB2D

Damages	Value Without Policy Limits 1/1	2/2	3/3	4/4
Economic		$ 700,000		
Noneconomic		$ 1,400,000		
Total		$ 2,100,000	= Economic + Noneconomic	

Representative Policy Limit	Maximum Policy Limits Available (B) 1/1	2/2	3/3	4/4
$100,000		$ 200,000		
$250,000		$ 500,000	= Policy Limit x # Def/Clmts	
$500,000		$ 1,000,000		
$1,000,000		$ 2,000,000	= Policy Limit x # Def/Clmts	
$2,000,000		$ 4,000,000		
$5,000,000		$ 10,000,000	= Policy Limit x # Def/Clmts	

Representative Policy Limit	Value At Policy Limits (C) 1/1	2/2	3/3	4/4
$100,000		$ 200,000		
$250,000		$ 500,000	= MIN [Economic + Noneconomic ,	
$500,000		$ 1,000,000	Max Policy Limits Available]	
$1,000,000		$ 2,000,000		
$2,000,000		$ 2,100,000		
$5,000,000		$ 2,100,000		

POST-SB2D

Damages	Value Without Policy Limits 1/1	2/2	3/3	4/4
Economic		$ 700,000		
Noneconomic	(A)	$ 1,000,000	= $1.4M capped at $1.0M	
Total		$ 1,700,000	= $0.7M + $1.0M	

Representative Policy Limit	Maximum Policy Limits Available (B) 1/1	2/2	3/3	4/4
$100,000		$ 200,000		
$250,000		$ 500,000	= $250,000 x 2	
$500,000		$ 1,000,000		
$1,000,000		$ 2,000,000	= $1,000,000 x 2	
$2,000,000		$ 4,000,000		
$5,000,000		$ 10,000,000	= $5,000,000 x 2	

Representative Policy Limit	Value At Policy Limits (C) 1/1	2/2	3/3	4/4
$100,000		$ 200,000		
$250,000		$ 500,000	= MIN [$1.7M, $0.5M]	
$500,000		$ 1,000,000		
$1,000,000		$ 1,700,000	= MIN [$1.7M, $2.0M]	
$2,000,000		$ 1,700,000		
$5,000,000		$ 1,700,000	= MIN [$1.7M, $10.0M]	

Representative Policy Limit	Savings 1/1	2/2	3/3	4/4
$100,000		0.0%		
$250,000	1.0 - [$0.5M / $0.5M] =	0.0%		
$500,000		0.0%		
$1,000,000	1.0 - [$1.7M / $2.0M] =	15.0%		
$2,000,000		19.0%		
$5,000,000	1.0 - [$1.7M / $2.1M] =	19.0%		

NOTE: (A) Caps apply to noneconomic damages.
(B) Policy limits apply to noneconomic **and** economic damages.
(C) Maximum policy limits available assume "spreading" of comparative fault (see Observation Section).

To determine the presumed factor for this group, each Phase I adjusted claim is passed into the above matrix and the values are totaled for each claim to produce a single matrix of the same format that covers all claims for the group. The values "at policy limits after cap" are divided by the values "at policy limits before cap" to yield a matrix of presumed factor ratios for each possible policy limit and claimant/defendant combination. A single presumed factor is determined by averaging the matrix ratios using selected distributions of weighting current policy limit levels written by Florida insurers (down the columns) as well as the selected distribution of likely defendant/claimant numbers (across the rows). Our selections have been documented in Section 54.

As a final step, the overall presumed factor is adjusted to reflect several additional considerations including the "phase-in" effect of the law, the impact of including low severity injury types (i.e. 1-emotional only, 2-temporary: slight and 3-temporary: minor) and the impact of including allocated loss adjustment expenses.

We have provided two additional examples in order to demonstrate the importance of changing the magnitude of economic damages (and therefore the ratio of noneconomic damages to total damages):

- Example B displays a claim with $10,000,000 of economic loss and $10,000,000 of noneconomic loss, limited by the non-pierced practitioner non-emergency room cap.
- Example C displays a claim with $100,000 of economic loss and $10,000,000 of noneconomic loss, limited by the non-pierced practitioner non-emergency room cap.

For any of the other cap on noneconomic damage groups (e.g., practitioner emergency room, non-practitioner non-emergency room, etc.), the examples presented below would be similar. The only difference by group would be to reflect the appropriate cap.

EXAMPLE B

PRE-SB2D

Damages	Value Without Policy Limits 1/1	2/2	3/3	4/4
Economic	$ 10,000,000	$ 10,000,000	$ 10,000,000	$ 10,000,000
Noneconomic	$ 10,000,000	$ 10,000,000	$ 10,000,000	$ 10,000,000
Total	$ 20,000,000	$ 20,000,000	$ 20,000,000	$ 20,000,000

Representative Policy Limit	Maximum Policy Limits Available 1/1	2/2	3/3	4/4
$100,000	$ 100,000	$ 200,000	$ 300,000	$ 400,000
$250,000	$ 250,000	$ 500,000	$ 750,000	$ 1,000,000
$500,000	$ 500,000	$ 1,000,000	$ 1,500,000	$ 2,000,000
$1,000,000	$ 1,000,000	$ 2,000,000	$ 3,000,000	$ 4,000,000
$2,000,000	$ 2,000,000	$ 4,000,000	$ 6,000,000	$ 8,000,000
$5,000,000	$ 5,000,000	$ 10,000,000	$ 15,000,000	$ 20,000,000

Representative Policy Limit	Value At Policy Limits 1/1	2/2	3/3	4/4
$100,000	$ 100,000	$ 200,000	$ 300,000	$ 400,000
$250,000	$ 250,000	$ 500,000	$ 750,000	$ 1,000,000
$500,000	$ 500,000	$ 1,000,000	$ 1,500,000	$ 2,000,000
$1,000,000	$ 1,000,000	$ 2,000,000	$ 3,000,000	$ 4,000,000
$2,000,000	$ 2,000,000	$ 4,000,000	$ 6,000,000	$ 8,000,000
$5,000,000	$ 5,000,000	$ 10,000,000	$ 15,000,000	$ 20,000,000

POST-SB2D

Damages	Value Without Policy Limits 1/1	2/2	3/3	4/4
Economic	$ 10,000,000	$ 10,000,000	$ 10,000,000	$ 10,000,000
Noneconomic	**$ 500,000**	**$ 1,000,000**	**$ 1,500,000**	**$ 2,000,000**
Total	$ 10,500,000	$ 11,000,000	$ 11,500,000	$ 12,000,000

Representative Policy Limit	Maximum Policy Limits Available 1/1	2/2	3/3	4/4
$100,000	$ 100,000	$ 200,000	$ 300,000	$ 400,000
$250,000	$ 250,000	$ 500,000	$ 750,000	$ 1,000,000
$500,000	$ 500,000	$ 1,000,000	$ 1,500,000	$ 2,000,000
$1,000,000	$ 1,000,000	$ 2,000,000	$ 3,000,000	$ 4,000,000
$2,000,000	$ 2,000,000	$ 4,000,000	$ 6,000,000	$ 8,000,000
$5,000,000	$ 5,000,000	$ 10,000,000	$ 15,000,000	$ 20,000,000

Representative Policy Limit	Value At Policy Limits 1/1	2/2	3/3	4/4
$100,000	$ 100,000	$ 200,000	$ 300,000	$ 400,000
$250,000	$ 250,000	$ 500,000	$ 750,000	$ 1,000,000
$500,000	$ 500,000	$ 1,000,000	$ 1,500,000	$ 2,000,000
$1,000,000	$ 1,000,000	$ 2,000,000	$ 3,000,000	$ 4,000,000
$2,000,000	$ 2,000,000	$ 4,000,000	$ 6,000,000	$ 8,000,000
$5,000,000	$ 5,000,000	$ 10,000,000	$ 11,500,000	$ 12,000,000

Representative Policy Limit	Savings 1/1	2/2	3/3	4/4
$100,000	0.0%	0.0%	0.0%	0.0%
$250,000	0.0%	0.0%	0.0%	0.0%
$500,000	0.0%	0.0%	0.0%	0.0%
$1,000,000	0.0%	0.0%	0.0%	0.0%
$2,000,000	0.0%	0.0%	0.0%	0.0%
$5,000,000	0.0%	0.0%	23.3%	40.0%

EXAMPLE C

PRE-SB2D

Damages	Value Without Policy Limits 1/1	2/2	3/3	4/4
Economic	$ 100,000	$ 100,000	$ 100,000	$ 100,000
Noneconomic	$ 10,000,000	$ 10,000,000	$ 10,000,000	$ 10,000,000
Total	$ 10,100,000	$ 10,100,000	$ 10,100,000	$ 10,100,000

Representative Policy Limit	Maximum Policy Limits Available 1/1	2/2	3/3	4/4
$100,000	$ 100,000	$ 200,000	$ 300,000	$ 400,000
$250,000	$ 250,000	$ 500,000	$ 750,000	$ 1,000,000
$500,000	$ 500,000	$ 1,000,000	$ 1,500,000	$ 2,000,000
$1,000,000	$ 1,000,000	$ 2,000,000	$ 3,000,000	$ 4,000,000
$2,000,000	$ 2,000,000	$ 4,000,000	$ 6,000,000	$ 8,000,000
$5,000,000	$ 5,000,000	$ 10,000,000	$ 15,000,000	$ 20,000,000

Representative Policy Limit	Value At Policy Limits 1/1	2/2	3/3	4/4
$100,000	$ 100,000	$ 200,000	$ 300,000	$ 400,000
$250,000	$ 250,000	$ 500,000	$ 750,000	$ 1,000,000
$500,000	$ 500,000	$ 1,000,000	$ 1,500,000	$ 2,000,000
$1,000,000	$ 1,000,000	$ 2,000,000	$ 3,000,000	$ 4,000,000
$2,000,000	$ 2,000,000	$ 4,000,000	$ 6,000,000	$ 8,000,000
$5,000,000	$ 5,000,000	$ 10,000,000	$ 10,100,000	$ 10,100,000

POST-SB2D

Damages	Value Without Policy Limits 1/1	2/2	3/3	4/4
Economic	$ 100,000	$ 100,000	$ 100,000	$ 100,000
Noneconomic	**$ 500,000**	**$ 1,000,000**	**$ 1,500,000**	**$ 2,000,000**
Total	$ 600,000	$ 1,100,000	$ 1,600,000	$ 2,100,000

Representative Policy Limit	Maximum Policy Limits Available 1/1	2/2	3/3	4/4
$100,000	$ 100,000	$ 200,000	$ 300,000	$ 400,000
$250,000	$ 250,000	$ 500,000	$ 750,000	$ 1,000,000
$500,000	$ 500,000	$ 1,000,000	$ 1,500,000	$ 2,000,000
$1,000,000	$ 1,000,000	$ 2,000,000	$ 3,000,000	$ 4,000,000
$2,000,000	$ 2,000,000	$ 4,000,000	$ 6,000,000	$ 8,000,000
$5,000,000	$ 5,000,000	$ 10,000,000	$ 15,000,000	$ 20,000,000

Representative Policy Limit	Value At Policy Limits 1/1	2/2	3/3	4/4
$100,000	$ 100,000	$ 200,000	$ 300,000	$ 400,000
$250,000	$ 250,000	$ 500,000	$ 750,000	$ 1,000,000
$500,000	$ 500,000	$ 1,000,000	$ 1,500,000	$ 2,000,000
$1,000,000	$ 600,000	$ 1,100,000	$ 1,600,000	$ 2,100,000
$2,000,000	$ 600,000	$ 1,100,000	$ 1,600,000	$ 2,100,000
$5,000,000	$ 600,000	$ 1,100,000	$ 1,600,000	$ 2,100,000

Representative Policy Limit	Savings 1/1	2/2	3/3	4/4
$100,000	0.0%	0.0%	0.0%	0.0%
$250,000	0.0%	0.0%	0.0%	0.0%
$500,000	0.0%	0.0%	0.0%	0.0%
$1,000,000	40.0%	45.0%	46.7%	47.5%
$2,000,000	70.0%	72.5%	73.3%	73.8%
$5,000,000	88.0%	89.0%	84.2%	79.2%

APPENDIX C

Ratemaking Primer

On March 13, 2003, Mr. James Hurley presented testimony to the Unitized States Senate titled *"Causes of the Medical Liability Insurance Crisis"*[5]. We have included "The Ratemaking Process" section of the written testimony prepared by the Medical Malpractice Subcommittee of the American Academy of Actuaries (Mr. Bingham is a member of the subcommittee):

> *"Ratemaking is the term used to describe the process by which companies determine what premium is indicated for a coverage. In the insurance transaction, the company assumes the financial risk associated with a future, contingent event in exchange for a fixed premium before it knows what the true cost of the event is, if any. The company must estimate those costs, determine a price for it and be willing to assume the risk that the costs may differ, perhaps substantially, from those estimates. A general principle of ratemaking is that the rate charged reflects the costs resulting from the policy and the income resulting from the anticipated policy covered losses, not what is actually paid or is going to be paid on past policies. It does not reflect money lost on old investments. In short, a rate is a reflection of future costs.*
>
> *In general, the actuarial process used in making these estimations for medical malpractice insurance starts with historical loss experience for the specific coverage and, usually, for a specific jurisdiction. Rates are determined for this coverage, jurisdiction, and a fixed time period. To the appropriately projected loss experience, a company must incorporate consideration of all expenses, the time value of money and an appropriate provision for risk and profit associated with the insurance transaction.*

[5] United States Senate Committee on Appropriations Subcommittee on Labor, Health and Human Services, Education, and Related Agencies - Hearing on "Causes of the Medical Liability Insurance Crisis", Statement of James Hurley, ACAS, MAAA, Chairperson, Medical Malpractice Subcommittee, American Academy of Actuaries

For a company already writing a credible volume of the coverage in a state, the indications of the adjusted ultimate loss experience can be compared to its current premiums to determine a change. For a company entering the line or state for the first time, obtaining credible data to determine a proper premium is often difficult and, sometimes, not possible. In the latter situation, the risk of being wrong is increased significantly.

Additionally, some lines of insurance coverage are more predictable than other lines. The unpredictability of coverage reflects its inherent risk characteristics. Most companies would agree that costs and, therefore, rates for automobile physical damage coverage, for example, are more predictable than for medical malpractice insurance because automobile insurance is relatively high frequency/low severity coverage compared to medical malpractice insurance. In the case of auto physical damage, one has a large number of similar claims for relatively small amounts that fall in a fairly narrow range. In medical malpractice insurance, one has a small number of unique claims that have a much higher average value and a significantly wider range of possible outcomes. There also is significantly longer delay for medical malpractice insurance between the occurrence of an event giving rise to a claim, the reporting of the claim, and the final disposition of the claim. This longer delay adds to the uncertainty inherent in projecting the ultimate value of losses, and consequently premiums.

The following guidelines explain the ratemaking process:

1. *Historical loss experience is collected in coverage year detail for the last several years. This usually will include paid and outstanding losses and counts. The data is reviewed for reasonableness and consistency, and estimates of the ultimate value of the coverage-year loss are developed using actuarial techniques.*
2. *Ultimate losses are adjusted to the prospective level (i.e., the period for which rates are being made). This involves an appropriate adjustment for changes in*

average costs and claim frequencies (called trend). Adjustments also would be made for any changes in circumstances that may affect costs (e.g., if a coverage provision has been altered).

3. *Adjusted ultimate losses are compared to premium (or doctor counts) to determine a loss ratio (or loss cost per doctor) for the prospective period.*
4. *Expenses associated with the business must be included. These are underwriting and general expenses (review of application, policy issuance, accounting, agent commission, premium tax, etc.) Other items to consider are the profit and contingency provision, reinsurance impact, and federal income tax.*
5. *A final major component of the ratemaking process is consideration of investment income. Typically for medical malpractice insurance, a payment pattern and anticipated prospective rate of return are used to estimate a credit against the otherwise indicated rate.*

These five steps, applied in a detailed manner and supplemented by experienced judgment, are the standard roadmap followed in developing indicated rates. There are a number of other issues to address in establishing the final rates to charge. These include recognizing differences among territories within a state, limits of coverage, physician specialty, and others. The final rates will reflect supplemental studies of these various other aspects of the rate structure.

Many states have laws and regulations that govern how premium rates can be set and what elements can or must be included. The state regulators usually have the authority to regulate that insurance premium rates are not excessive, inadequate, or unfairly discriminatory. It is not uncommon for state insurance regulators to review the justification for premium rates in great detail and, if deemed necessary, to hold public hearings with expert testimony to examine the basis for the premium rates. In many states, the insurance regulator has some authority to restrict the premium rates that insurance companies can charge."

The following glossary of terms may be a useful reference guide to the reader:

Accident Year	An annual time period used in the statistical collection of claims data. Data for an accident year consists of all claims arising from events occurring during the particular period (e.g., 1/1/XX through 12/31/XX+1), regardless of time lags in the reporting or payment of claims.
Report Year	An annual time period used in the statistical collection of claims data. Data for a report year consists of all claims arising from events reported during the particular period (e.g., 1/1/XX through 12/31/XX+1), regardless of the occurrence date of the claim.
Paid Losses	The cumulative loss amount paid for a claim as of a particular point in time.
Reserves	An estimate of the unpaid amount of a report/accident year's loss experience as of a particular point in time. It includes all individual claim estimates as provided by the claim adjuster. It also includes any expected future change in those estimates as estimated by an actuary, which is referred to as incurred but not reported or IBNR.
Incurred Losses	The cumulative loss amount paid for a claim as of a particular point in time, plus outstanding unpaid amounts as estimated by a claims adjuster.
Ultimate Losses	Total losses for a particular report year or accident year. This equals the sum of all payments, case reserves and IBNR.
Reported Counts	The cumulative number of claims reported as of a particular point in time.
Loss Components	
Indemnity-	The portion of a claim relating to compensation for a claimant's economic and noneconomic damages.
ALAE-	The portion of a claim relating to the cost of settlement. This includes defense costs, court costs, medical reports, investigative reports, etc.

PRESUMED FACTOR

Loss Ratio	Ratio of losses (paid, incurred, or ultimate) to net earned premium as a percentage.
Claims Frequency	Ultimate number of claims divided by an exposure base (e.g., occupied beds, net earned premium).
Claims Severity	Ultimate losses divided by ultimate number of claims.
Development Factor	A multiplicative factor applied to either paid losses, incurred losses, reported counts or average severities in order to estimate ultimate losses, ultimate claims or ultimate severities.
Manual Rate Indication	Sample Calculation: (1) Ultimate Loss and ALAE Ratio (2) Death, Disability and Retirement Load (DDRL) (3) Expected Loss Ratio (4) Average Policy Discount Indication = [(1) x (2)] / [(3) x { 1.0 – (4) }] - 1.0 Note: a) Format of the formula varies by rate filing. b) Changes to other assumptions (e.g., territorial and class relativities) would also need to be included in order to determine the final base rate change.

APPENDIX D

SB2D Definitions

Claimant means any person who has a cause of action for damages based on personal injury or wrongful death arising from medical negligence.

Health care practitioner means any person licensed under Chapter 457 (acupuncture); Chapter 458 (medical practice); Chapter 459 (osteopathic medicine); Chapter 460 (chiropractic medicine); Chapter 461 (podiatric medicine); Chapter 462 (naturopathy); Chapter 463 (optometry); Chapter 464 (nursing); Chapter 465 (pharmacy); Chapter 466 (dentistry); Chapter 467 (midwifery); part I (speech-language pathology and audiology), part II (nursing home administration), part III (occupational therapy), part V (respiratory therapy), part X (dietetics and nutrition practice), part XIII (athletic trainers), or part XIV (orthotics, prosthetics, and pedorthics) of Chapter 468; Chapter 478 (electrolysis); Chapter 480 (massage practice); part III (clinical laboratory personnel) or part IV (medical physicists) of Chapter 483; Chapter 484 (dispensing of optical devices and hearing aids); Chapter 486 (physical therapy practice); Chapter 490 (psychological services); or Chapter 491 (clinical, counseling and psychotherapy services).

Non practitioner means hospitals, health maintenance organizations (HMOs), hospice providers, and other non-physician entities

Health care provider means any hospital, ambulatory surgical center, or mobile surgical facility as defined and licensed under Chapter 395; a birth center licensed under Chapter 383; any person licensed under Chapter 458, Chapter 459, Chapter 460, Chapter 461, Chapter 462, Chapter 463, part I of Chapter 464, Chapter 466, Chapter 467 or Chapter 486; a clinical lab licensed under Chapter 483; a health maintenance organization certificated under part I of Chapter 641; a blood bank; a plasma center; an industrial clinic; a renal dialysis facility; or a professional association

partnership, corporation, joint venture, or other association for professional activity by health care providers.

Economic damages means financial losses that would not have occurred but for the injury giving rise to the cause of action, including, but not limited to, past and future medical expenses and 80 percent of wage loss and loss of earning capacity to the extent the claimant is entitled to recover such damages under general law, including the Wrongful Death Act.

Noneconomic damages (a/k/a "pain and suffering') means non financial losses that would not have occurred but for the injury giving rise to the cause of action, including pain and suffering, inconvenience, physical impairment, mental anguish, disfigurement, loss of capacity for enjoyment of life, and other non financial losses to the extent the claimant is entitled to recover such damages under general law, including the Wrongful Death Act.

Contractual obligations (a/k/a "bad faith") means any matter regarding an insurance claim by an insured that is wrongfully denied by the insurer (e.g., unreasonable delay of payment, unreasonable denial of benefits, failure to thoroughly investigate a claim, etc.).

Helpful abbreviations

AHCA or Agency	Agency for Health Care Administration
DoAH	Division of Administrative Hearings
DOH	Department of Health
HCP	Health Care Professional
OIR	Office of Insurance Regulation
OPPAGA	Office of Program Policy Analysis and Government Accountability

APPENDIX E

Medical Malpractice Statistics by Company

Florida
Line of Business: Medical Malpractice

Company Name	2002 Med Mal Dir Prem Written	2002 Med Mal Dir Pre Earned	2002 Med Mal Dir Losses Incurred	2002 Med Mal Loss Ratio	2001 Med Mal Dir Prem Written	2001 Med Mal Dir Pre Earned	2001 Med Mal Dir Losses Incurred	2001 Med Mal Loss Ratio
First Professionals Ins Co	169,558,079	152,449,954	94,069,722	61.7%	109,672,505	89,044,736	60,151,888	67.6%
Health Care Ind Inc	106,482,154	106,482,154	86,394,037	81.1%	88,970,154	88,970,154	95,305,166	107.1%
Pronational Ins Co	69,113,034	60,347,429	23,617,524	39.1%	55,259,931	57,149,827	51,412,895	90.0%
MAG Mut Ins Co	52,976,737	40,956,626	42,365,508	103.4%	26,525,321	19,808,077	22,262,490	112.4%
Truck Ins Exch	50,996,746	53,497,755	70,389,982	131.6%	35,245,611	28,668,519	15,102,796	52.7%
Lexington Ins Co	49,142,955	31,925,627	20,492,933	64.2%	5,823,049	2,144,367	2,264,126	105.6%
Medical Protective Co	44,917,670	39,591,739	36,076,008	91.1%	31,096,627	30,731,371	33,677,746	109.6%
Doctors Co An Interins Exchn	38,848,939	28,511,037	22,888,656	80.3%	23,223,681	20,422,981	10,707,616	52.4%
Evanston Ins Co	36,189,511	25,487,045	16,799,194	65.9%	11,353,089	10,808,815	8,493,880	78.6%
TIG Ins Co	25,457,473	20,856,846	44,323,115	212.5%	21,469,578	21,880,706	15,938,329	72.8%
American Physicians Assur Corp	23,636,756	28,912,506	24,599,692	85.1%	26,690,239	21,451,709	25,789,305	120.2%
Anesthesiologists Pro Assur Co	16,770,204	14,284,978	8,775,981	61.4%	11,835,465	10,699,479	3,539,170	33.1%
American Healthcare Ind Co	13,737,893	21,007,412	33,518,266	159.6%	20,235,101	16,151,733	25,445,948	157.5%
Continental Cas Co	13,226,566	11,082,742	5,975,794	53.9%	23,542,376	22,609,659	5,398,082	23.9%
Chicago Ins Co	11,071,903	13,739,888	17,218,267	125.3%	12,461,372	10,546,455	12,555,545	119.0%
Steadfast Ins Co	8,620,597	9,069,825	26,849,699	296.0%	9,652,435	6,883,427	29,555,580	429.4%
St Paul Fire & Marine Ins Co	8,356,995	19,905,115	85,550,588	429.8%	24,422,097	21,024,763	35,808,730	170.3%
Everest Ind Ins Co	7,632,064	3,044,230	1,691,239	55.6%				-
Clarendon Natl Ins Co	6,256,410	14,029,875	14,386,074	102.5%	21,456,110	24,438,787	39,960,548	163.5%
American Cas Co Of Reading PA	4,801,070	4,478,692	1,749,589	39.1%	4,828,738	5,460,507	15,265,523	279.6%
Podiatry Ins Co Of Amer RRG Mut Co	4,635,090	4,345,723	3,018,546	69.5%				-
TIG Specialty Ins Corp	4,278,706	2,370,710	2,756,901	116.3%	959,352	1,158,689	3,504,102	302.4%
Columbia Cas Co	4,072,818	3,837,090	(1,451,828)	-37.8%	3,303,851	704,450	503,552	71.5%
NCMIC Ins Co	3,785,004	3,582,036	919,862	25.7%	3,221,697	2,926,417	(108,985)	-3.7%
Ophthalmic Mut Ins Co RRG	3,783,880	3,110,442	871,198	28.0%				-
National Union Fire Ins Co Of Pitts	3,647,949	1,816,833	18,432,302	1014.5%	186,737	223,577	8,033,243	3593.1%
Firemans Fund Ins Co	3,630,948	4,279,217	6,114,734	142.9%	4,306,718	3,719,127	2,147,009	57.7%
Oms Natl Ins Co Rrg	3,427,473	3,178,252	1,738,511	54.7%				-
Interstate Fire & Cas Co	3,197,895	5,991,773	7,956,257	132.8%	8,104,787	6,424,907	5,832,255	90.8%
Professional Undrwtrs Liab Ins Co	2,543,404	2,510,358	940,481	37.5%	1,860,976	1,237,392	164,292	13.3%
Preferred Physicians Medical RRG	2,413,908	2,437,822	3,319,759	136.2%				-
Admiral Ins Co	2,275,775	1,269,574	3,230,162	254.4%	1,005,997	933,471	12,183,302	1305.2%
Medical Assur Co Inc	2,253,024	2,003,409	4,384,834	218.9%	4,748,067	6,923,930	2,917,199	42.1%
Physicians Professional Liabilty RRG	2,252,284	729,187	184,709	25.3%				-
Royal Surplus Lines Ins Co	2,234,001	1,275,886	5,649,364	442.8%	1,030,460	961,311	15,582,880	1621.0%
Zurich American Ins Co	2,068,583	2,491,708	18,285,728	733.9%	7,617,101	12,588,915	25,236,100	200.5%
General Star Ind Co	1,907,952	755,287	134,000	17.7%	23,480	21,620	4,000	18.5%
American Healthcare Specialty	1,647,573	1,887,631	870,450	46.1%	898,483	832,417	1,277,304	153.4%
Ace American Ins Co	1,585,945	1,667,509	1,076,271	64.5%	1,695,846	1,501,882	1,119,254	74.5%
Illinois Union Ins Co	1,209,000	421,562	274,741	65.2%	13,500	114,958	(2,664)	-2.3%
Arch Speciality Ins Co	1,160,997	278,232	145,145	52.2%				-
Western World Ins Co	1,093,224	842,395	4,094,652	486.1%	647,907	1,110,930	4,381,564	394.4%
Fortress Ins Co	981,225	366,838	(3,759)	-1.0%				-
Cincinnati Ins Co	946,531	885,766	738,880	83.4%	1,068,916	895,455	(198,771)	-22.2%
Campmed Cas & Ind Co Inc MD	940,215	283,299	163,523	57.7%				-
Granite State Ins Co	922,729	558,393	1,160,220	207.8%	366,510	355,814	1,162,430	326.7%
Executive Risk Speciality Ins Co	850,531	980,954	(205,112)	-20.9%	417,580	432,624	1,854,285	428.6%
Preferred Professional Ins Co	800,874	559,689	232,813	41.6%				-
Traders & Pacific Ins Co	750,000	125,342	83,603	66.7%				-
Connecticut Ind Co	729,670	565,045	250,219	44.3%	368,422	342,100	76,530	22.4%
PACO Assur Co Inc	706,870	622,779	115,883	18.6%	493,747	189,124	-	0.0%
First Specialty Ins Corp	624,189	1,222,173	(215,039)	-17.6%	823,171	705,869	240,259	34.0%
Gulf Ins Co	518,797	970,358	(232,212)	-23.9%	1,536,909	1,659,953	2,243,578	135.2%
Westport Ins Corp	499,526	431,692	133,964	31.0%	464,552	420,165	555,596	132.2%
Essex Ins Co	403,678	380,082	638,785	168.1%	269,513	184,231	143,977	78.2%
American Assoc Of Othodontists RRG	298,791	286,344	162,310	56.7%				-
Executive Risk Ind Inc	282,865	254,077	3,106,645	1222.7%	843,225	1,109,823	2,863,729	258.0%
American Equity Ins Co	231,332	293,378	13,682,749	4663.9%	1,327,855	3,474,024	7,999,171	230.3%
Kemper Ind Ins Co	231,174	623,282	2,427,326	389.4%	906,833	358,093	742,384	207.3%
Community Blood Cntr Exch RRG	184,045	172,358	(5,467)	-3.2%				-
Clarendon Amer Ins Co	177,743	1,723,151	(5,080,154)	-294.8%	8,479,338	7,280,227	6,469,627	88.9%
St Paul Mercury Ins Co	168,624	272,316	(1,018,494)	-374.0%	445,701	947,995	(45,410)	-4.8%
Lumbermens Mut Cas Co	133,845	55,789	52,188	93.5%				-
Genesis Ind Ins Co	129,500	165,020	520,500	315.4%	141,543	132,916	228,000	171.5%
Church Mut Ins Co	115,412	54,291	40,537	74.7%	43,062	30,669	51,106	166.6%
General Ins Co Of Amer	110,349	127,297	153,667	120.7%	135,311	104,883	36,276	34.6%
American Ins Co	94,904	25,758	12,000	46.6%				-
Scottsdale Ins Co	76,232	87,972	1,115,451	1268.0%	73,114	1,378,133	6,503,906	471.9%
Athena Assur Co	71,818	173,797	3,058,024	1759.5%	350,252	440,000	908,730	206.5%
TIG Ind Co	56,190	77,933	(177,010)	-227.1%	152,070	220,934	624,110	282.5%
Lion Ins Co	50,619	60,925	366,618	601.8%	435,418	556,913	3,211,788	576.7%
Lawrenceville Prop & Cas Co	34,226	35,791	231,887	647.9%	34,226	32,493	25,011	77.0%
St Paul Guardian Ins Co	31,576	138,811	2,464,271	1775.3%	427,533	571,934	4,387,539	767.1%
Colony Ins Co	28,495	17,932	-	0.0%				-
Westchester Surplus Lines Ins Co	21,596	21,596	3,682	17.0%				-
National Surety Corp	11,374	11,412	-	0.0%	5,143	3,392	-	0.0%
Colony National Ins Co	3,463	4,753	(35,654)	-750.1%	1,875	2,454	(105,377)	-4294.1%
Nationwide Mut Fire Ins Co	1,338	1,532	(1,396)	-91.1%	1,787	1,787	(391)	-21.9%
Kemper Cas Ins Co	1,226	2,098	-	0.0%	1,443	544	-	0.0%
Nationwide Mut Ins Co	647	507	(5,347)	-1054.6%	512	918	100	10.9%
Insurance Co Of The State Of PA	586	772	2,648	343.0%	1,987	3,076	(7,543)	-245.2%
Travelers Ind Co Of IL	176	176	3,485,237	1980248.3%				-
Liberty Mut Ins Co	150	44	-	0.0%				-
Western Ind Ins Co	55	55	(575,131)	-1045692.7%	6,295	215,317	242,617	112.7%
TOTAL	829,122,375	763,385,688	787,527,502	103.2%	623,012,281	572,331,925	631,623,027	110.4%

Prepared by: Lee Roddenberry
11/6/2003

Source: NAIC Database

Florida
Line of Business: Medical Malpractice

Company Name	2000 Med Mal Dir Prem Written	2000 Med Mal Dir Pre Earned	2000 Med Mal Dir Losses Incurred	2000 Med Mal Loss Ratio	1999 Med Mal Dir Prem Written	1999 Med Mal Dir Pre Earned	1999 Med Mal Dir Losses Incurred	1999 Med Mal Loss Ratio
First Professionals Ins Co	69,981,763	65,649,122	36,456,829	55.5%	70,073,897	70,853,737	30,410,053	42.9%
Health Care Ind Inc	79,146,087	79,146,087	55,599,597	70.2%	74,707,458	74,707,458	61,986,675	83.0%
Pronational Ins Co	57,609,425	56,801,083	82,177,140	144.7%	57,114,420	56,442,471	10,419,812	18.5%
MAG Mut Ins Co	11,788,918	9,493,590	7,392,550	77.9%	6,612,025	8,121,409	10,123,100	124.6%
Truck Ins Exch	23,585,973	23,381,222	40,439,254	173.0%	12,885,174	15,432,591	31,141,555	201.8%
Lexington Ins Co	2,898,843	659,425	(1,179,232)	-178.8%	621,519	550,823	(4,803,736)	-872.1%
Medical Protective Co	25,368,190	21,618,073	39,506,544	182.7%	23,368,640	19,921,593	11,901,815	59.7%
Doctors Co An Interins Exchn	15,855,742	12,617,508	5,576,532	44.2%	8,450,127	5,158,899	3,545,474	68.7%
Evanston Ins Co	8,979,143	7,545,228	11,517,766	152.6%	6,915,784	7,589,328	6,004,911	79.1%
TIG Ins Co	18,604,025	16,545,926	11,658,616	70.5%	15,081,057	14,017,435	7,830,855	55.9%
American Physicians Assur Corp	20,181,528	17,094,630	15,834,126	92.6%	13,857,344	9,682,763	6,029,043	62.3%
Anesthesiologists Pro Assur Co	8,812,061	8,332,314	5,091,966	61.1%	7,465,806	7,122,492	3,628,839	50.9%
American Healthcare Ind Co	18,275,286	13,121,060	11,561,639	88.1%	12,743,355	11,824,723	8,940,951	75.6%
Continental Cas Co	7,661,250	6,689,494	(1,261,220)	-18.9%	4,970,235	6,933,732	5,719,685	82.5%
Chicago Ins Co	7,850,374	6,719,822	5,161,593	76.8%	5,052,089	4,586,244	3,402,503	74.2%
Steadfast Ins Co	5,114,016	3,660,416	14,575,503	398.2%	2,692,469	4,378,961	10,482,096	239.4%
St Paul Fire & Marine Ins Co	12,744,190	12,941,477	29,444,458	227.5%	21,372,913	25,902,809	32,443,850	125.3%
Everest Ind Ins Co				-				-
Clarendon Natl Ins Co	20,192,134	16,650,086	16,648,711	100.0%	17,981,931	16,871,289	11,309,121	67.0%
American Cas Co Of Reading PA	6,091,375	6,753,200	83,204	1.2%	6,561,361	6,814,985	14,179,758	208.1%
Podiatry Ins Co Of Amer RRG Mut Co	3,903,720	3,923,689	2,730,470	69.6%	803,156	737,438	1,936,144	262.6%
TIG Specialty Ins Corp	1,046,030	821,996	440,792	53.6%	1,236,721	1,418,410	1,626,573	114.7%
Columbia Cas Co	294,466	263,283	(894,338)	-339.7%	99,078	(854,735)	1,995,353	-233.4%
NCMIC Ins Co	2,739,235	2,745,040	900,126	32.8%	2,710,058	2,840,440	619,627	21.8%
Ophthalmic Mut Ins Co RRG	1,764,786	1,811,854	305,830	16.9%	1,914,576	1,883,545	(152,500)	-8.1%
National Union Fire Ins Co Of Pitts	374,626	1,269,119	8,536,785	672.7%	2,468,114	3,461,738	8,639,937	249.6%
Firemans Fund Ins Co	1,261,151	1,053,226	776,676	73.7%	1,501	1,501	167,281	11144.6%
Oms Natl Ins Co Rrg	2,748,089	2,677,961	(62,975)	-2.4%	2,768,817	2,748,045	1,204,791	43.8%
Interstate Fire & Cas Co	3,404,584	2,297,118	2,687,702	117.0%	1,194,324	1,115,686	528,303	47.4%
Professional Undrwtrs Liab Ins Co	734,979	380,479	224,450	59.0%	60,885	64,801	31,752	49.0%
Preferred Physicians Medical RRG	1,735,201	1,757,328	5,037,901	286.7%	2,389,745	2,383,368	2,541,252	106.6%
Admiral Ins Co	1,075,019	2,008,168	14,709,644	732.5%	3,126,313	3,024,685	5,980,200	197.7%
Medical Assur Co Inc	7,414,448	6,410,726	1,865,946	29.1%	3,993,603	5,022,572	2,783,222	55.4%
Physicians Professional Liabilty RRG				-				-
Royal Surplus Lines Ins Co	770,609	1,165,875	11,880,020	1019.0%	3,166,721	3,241,053	3,809,518	117.5%
Zurich American Ins Co	14,358,978	11,176,269	28,761,206	257.3%	13,125,285	12,149,144	16,125,585	132.7%
General Star Ind Co	16,194	7,607	-	0.0%	3,696	4,081	1,000	24.5%
American Healthcare Specialty	384,918	401,611	76,142	19.0%	221,380	30,695	15,371	50.1%
Ace American Ins Co	1,058,425	637,922	(37,321)	-5.9%	264,246	215,039	66,904	31.1%
Illinois Union Ins Co	313,984	210,199	56,594	26.9%	10,307	13,797	2,730	19.8%
Arch Speciality Ins Co				-				-
Western World Ins Co	1,476,766	879,643	2,626,141	298.5%	448,113	516,082	689,162	133.5%
Fortress Ins Co				-				-
Cincinnati Ins Co	741,307	746,353	298,481	40.0%	735,195	737,913	665,290	90.2%
Campmed Cas & Ind Co Inc MD				-				-
Granite State Ins Co	344,304	322,409	196,636	61.0%	280,273	132,617	1,278,693	964.2%
Executive Risk Speciality Ins Co	604,297	666,203	1,357,399	203.8%	593,122	683,791	364,324	53.3%
Preferred Professional Ins Co				-				-
Traders & Pacific Ins Co				-				-
Connecticut Ind Co	338,905	257,483	40,791	15.8%	108,731	33,133	-	0.0%
PACO Assur Co Inc				-				-
First Specialty Ins Corp	675,000	140,625	135,816	96.6%				-
Gulf Ins Co	1,783,470	1,750,743	600,716	34.3%	1,824,791	1,693,975	2,055,132	121.3%
Westport Ins Corp	183,838	175,049	24,939	14.2%	139,392	131,796	(401)	-0.3%
Essex Ins Co	19,659	7,345	401	5.5%	5,000	3,839	2,475	64.5%
American Assoc Of Othodontists RRG	249,526	247,973	58,493	23.6%	242,611	227,574	51,905	22.8%
Executive Risk Ind Inc	1,946,504	1,721,801	3,082,116	179.0%	1,243,690	1,091,131	581,355	53.3%
American Equity Ins Co	4,829,525	3,205,388	4,942,278	154.2%	1,674,479	1,246,039	759,183	60.9%
Kemper Ind Ins Co	19,104	9,631	4,007	41.6%				-
Community Blood Cntr Exch RRG	139,025	95,250	(18,584)	-19.5%	77,749	74,886	1,932	2.6%
Clarendon Amer Ins Co	612,100	109,187	81,890	75.0%				-
St Paul Mercury Ins Co	991,794	701,423	7,810,017	1113.5%	688,296	715,412	10,304,841	1440.4%
Lumbermens Mut Cas Co				-				-
Genesis Ind Ins Co	116,425	100,677	58,000	57.6%	50,039	38,607	18,000	46.6%
Church Mut Ins Co	23,950	23,880	152,658	639.3%	24,475	24,313	65,902	271.1%
General Ins Co Of Amer	47,605	32,478	(10,538)	-32.4%	7,246	5,120	13,332	260.4%
American Ins Co				-				-
Scottsdale Ins Co	4,328,873	4,544,468	7,552,126	166.2%	4,625,252	4,154,476	3,289,104	79.2%
Athena Assur Co	945,801	1,596,217	3,593,057	225.1%	2,163,918	2,297,639	1,825,485	79.5%
TIG Ind Co	261,085	245,785	308,179	125.4%	185,387	104,399	73,821	70.7%
Lion Ins Co	550,608	566,952	1,445,236	254.9%	884,975	303,292	215,000	70.9%
Lawrenceville Prop & Cas Co	26,182	24,801	16,232	65.4%				-
St Paul Guardian Ins Co	1,560,427	2,543,116	10,851,298	426.7%	1,498,684	3,437,219	4,531,489	131.8%
Colony Ins Co				-				-
Westchester Surplus Lines Ins Co				-				-
National Surety Corp	2,160	630	-	0.0%				-
Colony National Ins Co	2,042	75,148	98,400	130.9%	219,817	302,389	(30,952)	-10.2%
Nationwide Mut Fire Ins Co	1,774	2,048	207	10.1%	2,061	2,237	(169)	-7.6%
Kemper Cas Ins Co				-				-
Nationwide Mut Ins Co	918	1,443	(656)	-45.5%	2,295	2,283	267	11.7%
Insurance Co Of The State Of PA	4,385	5,117	(7,446)	-145.5%	9,457	15,177	(11,935)	-78.6%
Travelers Ind Co Of IL	231,102	231,102	1,565,948	677.6%	141,914	998,579	314,138	31.5%
Liberty Mut Ins Co				-				-
Western Ind Ins Co	832,613	1,779,175	2,491,429	140.0%	2,882,642	2,340,385	5,962,396	254.8%
TOTAL	490,030,839	449,248,776	513,636,893	114.3%	428,845,734	427,729,348	345,639,172	80.8%

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Source: NAIC Database