

# Florida Office of Insurance Regulation



## **Medical Malpractice Financial Information, Closed Claim Database and Rate Filings**

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**Section 627.912(6), Florida  
Statutes, as amended by  
Senate Bill 2-D,  
(Ch. 2003-416)**

**Deloitte.**

**OCTOBER 1, 2004**



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October 1, 2004

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Dear Ms. Miller:

Deloitte Consulting is pleased to submit our report completing Section 45(6)(b) and (c) of CS for SB 2-D, 1st Engrossed.

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

Sincerely,

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Principal – Deloitte.

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Member of  
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## **I. EXECUTIVE SUMMARY**

### **PURPOSE AND SCOPE**

Deloitte Consulting LLP (Deloitte Consulting) has been retained by the Florida Department of Financial Services Office of Insurance Regulation (OIR) to complete the requirements of Section 627.912(6), Florida Statutes, as amended by Senate Bill 2-D, (Ch. 2003-416), which states:

*“(b) OIR shall prepare an annual report by October 1 of each year, beginning in 2004, which shall be available on the Internet, which summarizes and analyzes the closed claim reports and the annual financial reports filed by insurers writing medical malpractice insurance in Florida. The report must include: (1) an analysis of closed claim reports of prior years in order to show trends in the frequency and amount of claims payments; (2) the itemization of economic and noneconomic damages; (3) the nature of the errant conduct; and (4) such other information that OIR determines is illustrative of the trends in closed claims. The report must also analyze the state of the medical malpractice insurance market in Florida including: (1) an analysis of the financial reports of those insurers with a combined market share of at least 80 percent of the net written premium in the state for medical malpractice for the prior calendar year; (2) loss ratio analysis for medical malpractice written in Florida; and (3) a profitability analysis of each such insurer. The report shall compare the ratios for medical malpractice in Florida compared to other states, based on financial reports filed with the National Association of Insurance Commissioners and such other information that OIR deems relevant.*

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

### **BACKGROUND**

#### ***Medical Malpractice Synopsis<sup>1</sup>***

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

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<sup>1</sup> 2003 University of Central Florida Governor’s Select Task Force on Healthcare Professional Liability Insurance, Chapter 2

claim for damages due to the death, injury, or monetary loss to any person arising out of any medical, dental, or surgical diagnosis, treatment, or care by any provider of healthcare.

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

### **DISTRIBUTION AND USE**

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

### **RELIANCE AND LIMITATIONS**

Deloitte Consulting's analysis of Section 45(6)(b) and (c) is based on background information, publicly available information, rate filings, responses to the market leader data request, and financial data provided by the OIR. A specific audit of the data and background information is beyond the scope of this project. Deloitte Consulting has conducted such reasonableness tests of the data as we felt appropriate. In all other respects, Deloitte Consulting has relied without audit or verification on the data and background information provided. Any assumptions, adjustments or modifications made by Deloitte Consulting to the data will be documented in detail throughout the remainder of this report.

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

**The following report assumes the reader has thoroughly read all SB2D Statutes.**

## **OVERALL CONCLUSIONS**

- It is too early to evaluate and establish the ultimate impact of SB2D based upon our review of individual company financial reports, responses to our market leader data request, rate filing review, analysis of the Closed Claim Database and status of the Berges case.
- It is not possible at this time to estimate when the trial court in the Berges case will rule on the issue of whether the cap is constitutional. The defendants may argue that the issue is not "ripe" for determination unless and until a jury verdict is rendered in excess of the cap. The trial court therefore may postpone a decision on constitutionality until after the case goes to trial, which may take one or two years. Whenever the trial court does rule, however, there is a possibility that the parties will request a "fast track" appeal to the Florida Supreme Court, bypassing the intermediate appellate court. If that occurs (it is within the discretion of the intermediate appellate court to decide), then the appeal time in our original report could be expedited by approximately one year. Accordingly, a final decision on constitutionality from the Florida Supreme Court could occur within 12 to 18 months of a ruling by the trial court.
- We believe it is reasonable to focus on medical malpractice insurance company financial results over a time period roughly equal to the average historical medical malpractice cycle

when analyzing profitability. Analysis of profit and ratemaking decisions made based upon a few quarters' profits without considering the cumulative results over the average cycle would not portray the economic realities of the medical malpractice business.

- We believe that from a Florida perspective, the average return on surplus for the years reviewed in this study continue to be in the low single digits and well below levels which would indicate excessive profits.
- We believe the favorable first quarter 2004 operating ratios may indicate that Florida's companies will continue to be profitable through year-end 2004, helping to stabilize the need for future rate changes in the State of Florida.
- We believe rate increases should moderate over the next few years, driven by the favorable trend in report year/accident year loss ratios flowing into the ratemaking calculations.
- We believe that company leverage ratios and RBC ratios will likely improve as a result of rising surplus levels and a renewed focus on underwriting (i.e., targeting a combined ratio under 100%).
- Deloitte Consulting believes the OIR did a thorough job of reviewing the assumptions in the rate filings and asking for additional support.
- The trend towards lower policy limits and "going bare" will likely continue into the future.
- If the cap is declared unconstitutional, medical malpractice rates that reflected the PF will be inadequate by the amount of PF reflected in the rate filings (e.g., 5.3% PF for cap on non-economic damages), then Florida's insurers would need to file higher rates, re-visiting ratemaking assumptions and eliminating the effect of the presumed factor.

For a detailed listing of Deloitte Consulting's findings, please refer to **Section IV. Observations and Conclusions**.

## **II. SECTION 45(6)(b)**

### **MEDICAL MALPRACTICE INDUSTRY OVERVIEW**

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

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

Using insurance industry medical malpractice information from A.M. Best’s 2004 edition of *Best’s Aggregates & Averages - Property/Casualty Edition*<sup>3</sup>, we will walk the reader through a number of key metrics illustrating the performance of the medical malpractice industry through December 31, 2003. These statistics will help lay the groundwork for Deloitte Consulting’s detailed drill down into the performance of Florida’s medical malpractice writers with a combined market share of at least 80 percent of the net written premium in the state for the 2003 calendar year.

**Our analysis of Florida’s top writers begins on page 30 of this report.**

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<sup>2</sup> July/August 2004 Contingencies Magazine ([www.contingencies.org](http://www.contingencies.org)), *The Medical Malpractice Market: From National Dominance to Regional Focus*, Kevin Bingham.

<sup>3</sup> A.M. Best Company ([www.ambest.com](http://www.ambest.com)), *Best’s Aggregates & Averages - Property/Casualty 2004 Edition*.

**LEADING WRITERS AND INDUSTRY RESULTS**

Table 1 displays the top ten medical malpractice insurance groups ranked by 2003 net written premium.

<b>TABLE 1</b>			
<b>GROUP</b>	<b>NET WRITTEN PREMIUM (000s)</b>		
	<b>2001</b>	<b>2002</b>	<b>2003</b>
MLMIC GROUP	671,866	921,924	843,474
AIG	235,272	486,587	785,346
GE GLOBAL INSURANCE	358,486	547,050	712,545
PROASSURANCE	265,418	367,911	476,523
HEALTH CARE IND	260,338	318,622	376,973
DOCTORS COMPANY	280,398	402,255	347,620
ISMIE MUTUAL	174,427	216,273	276,791
PHYSICIANS RECIP INS	125,403	150,757	273,010
NORCAL GROUP	227,543	223,631	257,347
CNA INSURANCE	116,700	181,930	243,761
<b>INDUSTRY</b>	<b>6,074,675</b>	<b>7,080,968</b>	<b>8,279,450</b>

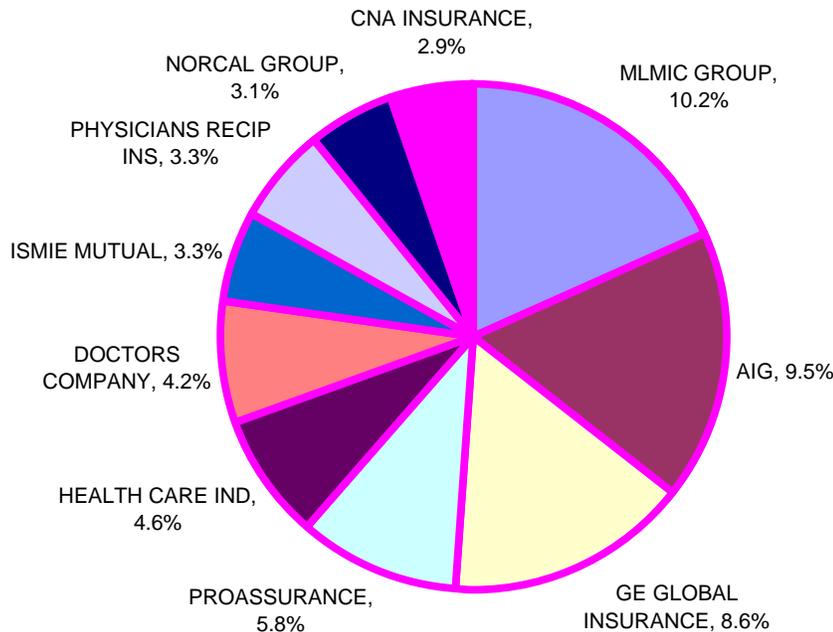
Table 2 displays the percentage change in net written premium for the insurance groups.

<b>TABLE 2</b>			
<b>GROUP</b>	<b>% CHANGE IN NET WRITTEN PREMIUM</b>		
	<b>2001</b>	<b>2002</b>	<b>2003</b>
MLMIC GROUP	-33.0%	37.2%	-8.5%
AIG	100.0%	106.8%	61.4%
GE GLOBAL INSURANCE	27.8%	52.6%	30.3%
PROASSURANCE	2.3%	38.6%	29.5%
HEALTH CARE IND	32.1%	22.4%	18.3%
DOCTORS COMPANY	33.5%	43.5%	-13.6%
ISMIE MUTUAL	25.8%	24.0%	28.0%
PHYSICIANS RECIP INS	173.5%	20.2%	81.1%
NORCAL GROUP	15.6%	-1.7%	15.1%
CNA INSURANCE	-31.0%	55.9%	34.0%
<b>INDUSTRY</b>	<b>8.7%</b>	<b>16.6%</b>	<b>16.9%</b>

For most of the groups<sup>4</sup>, the growth in net written premiums over the past few years can largely be explained by significant rate increases filed in their core states of business where medical malpractice trends indicated the need for large rate increases.

Table 3 displays the 2003 market share of the top ten insurance groups.

**TABLE 3**



GE Global Insurance includes the following major medical malpractice writing company:

- **Medical Protective Company – Top 80% Florida Writer (benchmark established by SB2D for this study)**

AIG includes the following major medical malpractice writing company:

- **Lexington Insurance Company – Top 80% Florida Writer (benchmark established by SB2D for this study)**

<sup>4</sup> Insurance groups can own multiple insurance companies. Schedule Y – “Information Concerning Activities of Insurer Members of a Holding Company Group” of the NAIC Annual Statement displays the ownership structure of a typical insurance group. For example, FPIC Insurance Group, Inc. owns 100% of First Professionals Insurance Co., Inc. and 100% of Anesthesiologists Professional Assurance Co. The industry statistics displayed in this report are for insurance groups. The Florida company statistics shown in this report are for individual insurance companies.

Doctors Company includes the following major medical malpractice writing companies:

- **Doctors Co an Interinsurance Exchange – Top 80% Florida Writer (benchmark established by SB2D for this study)**
- Professional Underwriters Liability Insurance Company

Health Care Ind. includes the following major medical malpractice writing company:

- **Health Care Indemnity Inc. – Top 80% Florida Writer (benchmark established by SB2D for this study)**

ProAssurance includes the following major medical malpractice writing companies:

- Medical Assurance Company Inc.
- **Pronational Insurance Company – Top 80% Florida Writer (benchmark established by SB2D for this study)**

Table 4 displays the calendar year net<sup>5</sup> incurred loss ratios (IL) for the top ten insurance groups. Incurred losses, as used in the *Best Aggregates and Averages* report, means the cumulative amounts paid (e.g., economic damage, non-economic damage) for all claims as of a particular point in time, plus outstanding unpaid amounts as estimated by claim adjusters, plus an estimate for the actuarially determined incurred but not reported (IBNR)<sup>6,7</sup>. The net incurred loss ratio equals the net incurred losses divided by net earned premium. The IL ratio measures how much of a premium dollar is dedicated to paying the insurance claims of the company in a calendar year, excluding loss adjustment expense (i.e., defense costs, court costs, medical reports, investigative reports, etc.). An IL ratio of 80% implies the company pays 80 cents for every dollar of premium earned to indemnify its insureds.

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<sup>5</sup> Net implies after the impact of reinsurance.

<sup>6</sup> Actuarially determined IBNR can include the following items: 1) "Pure" incurred but not reported (IBNR) - claims not yet known and not recorded in the loss system; 2) "Pipeline" IBNR - claims known but not yet recorded in the loss system; 3) Case development - future development on known, recorded claims; and 4) Reopened claims - future reopened claims which are coded to the year in which the original claim occurred. All 4 items are considered for occurrence policies (i.e. accident year data). Item 1) is not included for claims-made policies (i.e., report year data).

<sup>7</sup> The title "incurred losses" or "incurred losses and LAE" shown in Schedule P of the Annual Statement and used in the *Best Aggregates and Averages* includes a provision for IBNR. Using standard industry terminology, the inclusion of IBNR in the calculation of incurred losses or incurred loss and LAE is often referred to as "ultimate losses" or "ultimate losses and ALAE". Unless otherwise noted, each section will clarify the definition of incurred losses used by Deloitte Consulting.

**TABLE 4**

GROUP	NET INCURRED LOSS (IL) RATIO		
	2001	2002	2003
MLMIC GROUP	104.8%	149.6%	102.7%
AIG	141.7%	112.0%	102.4%
GE GLOBAL INSURANCE	50.9%	80.7%	65.4%
PROASSURANCE	61.7%	52.4%	47.7%
HEALTH CARE IND	97.2%	88.1%	89.1%
DOCTORS COMPANY	65.1%	63.3%	68.1%
ISMIE MUTUAL	72.3%	99.5%	73.2%
PHYSICIANS RECIP INS	70.1%	14.9%	96.1%
NORCAL GROUP	71.5%	57.5%	52.3%
CNA INSURANCE	211.9%	74.3%	82.0%
INDUSTRY	98.6%	86.2%	82.7%

Table 5 displays the calendar year net incurred loss and loss adjustment expense (LAE) ratios for the top ten insurance groups. LAE means the cumulative payments made for defense and cost containment (i.e., defense costs, court costs, medical reports, investigative reports, etc.) and adjusting and other (i.e., fees/salaries for appraisers, expenses of adjusters and settling agents, etc.) for all claims as of a particular point in time, plus outstanding unpaid amounts as estimated by claim adjusters, plus an estimate for IBNR<sup>8</sup>. The net incurred loss and LAE ratio equals the net incurred losses and LAE divided by net earned premium. The IL and LAE ratio measures how much of a premium dollar is dedicated to paying the insurance claims and LAE costs of the company in a calendar year. An IL and LAE ratio of 120% implies the company pays 120 cents for every dollar of premium earned to defend and indemnify its insureds.

<sup>8</sup> Loss adjustment expenses include defense and cost containment (DCC ) and adjusting and other (AO). DCC represents expenses such as surveillance expenses, fixed amounts for medical cost containment, litigation management expenses, attorney fees incurred owing to a duty to defend, and fees/salaries for appraisers, investigators, rehab nurse, working on the defense of a claim. AO represent expenses such as fees and expenses of adjusters and settling agents, fees/salaries for appraisers, investigators, if working in the capacity of an adjuster, and attorney fees incurred in the determination of coverage, including litigation between an insurer and the policyholder. The insurance industry changed it's terminology in the late 90s from allocated loss adjustment expense (ALAE) to DCC and unallocated loss adjustment expense (ULAE) to AO, noting that the relationship was not one-to-one.

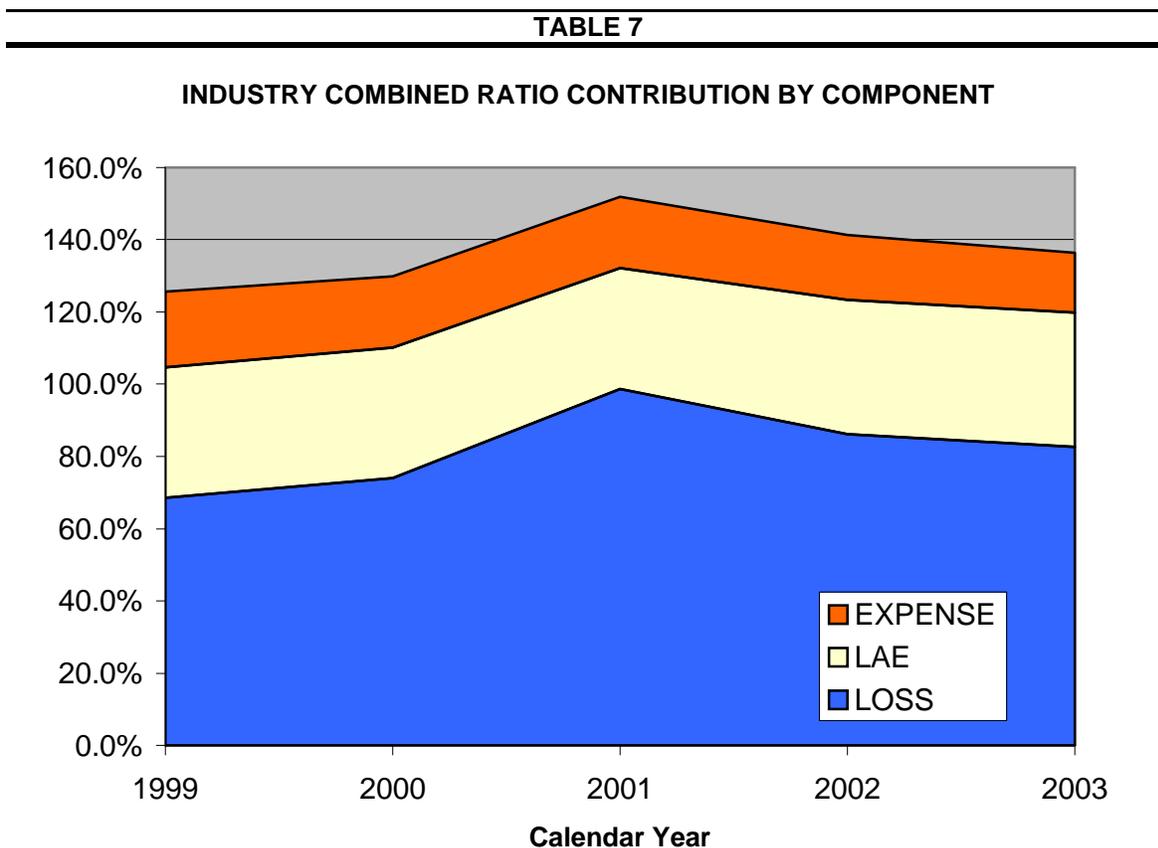
<b>TABLE 5</b>			
<b>GROUP</b>	<b>2003 RATIOS TO NET EARNED PREMIUM</b>		
	<b>INCURRED LOSSES</b>	<b>LOSS ADJUSTMENT EXPENSE (LAE)</b>	<b>NET IL AND LAE RATIO</b>
MLMIC GROUP	102.7%	47.3%	150.0%
AIG	102.4%	21.2%	123.6%
GE GLOBAL INSURANCE	65.4%	26.7%	92.1%
PROASSURANCE	47.7%	49.1%	96.8%
HEALTH CARE IND	89.1%	22.1%	111.2%
DOCTORS COMPANY	68.1%	40.7%	108.8%
ISMIE MUTUAL	73.2%	31.6%	104.8%
PHYSICIANS RECIP INS	96.1%	40.1%	136.2%
NORCAL GROUP	52.3%	48.3%	100.6%
CNA INSURANCE	82.0%	41.1%	123.1%
INDUSTRY	82.7%	37.1%	119.8%

Table 6 displays the combined ratios (CR) for the top ten insurance groups and industry.

<b>TABLE 6</b>			
<b>GROUP</b>	<b>2003 RATIOS</b>		
	<b>NET IL AND LAE RATIO</b>	<b>EXPENSE RATIO</b>	<b>COMBINED RATIO</b>
MLMIC GROUP	150.0%	11.0%	161.0%
AIG	123.6%	12.5%	136.1%
GE GLOBAL INSURANCE	92.1%	15.5%	107.6%
PROASSURANCE	96.8%	13.3%	110.1%
HEALTH CARE IND	111.2%	1.4%	112.6%
DOCTORS COMPANY	108.8%	11.4%	120.2%
ISMIE MUTUAL	104.8%	13.7%	118.5%
PHYSICIANS RECIP INS	136.2%	16.8%	153.0%
NORCAL GROUP	100.6%	16.4%	117.0%
CNA INSURANCE	123.1%	19.9%	143.0%
INDUSTRY	119.8%	16.5%	136.3%
DIVIDEND RATIO:			0.5%
INCLUDING DIVIDEND RATIO:			136.8%

The CR equals the net IL and LAE ratio plus the expense ratio. The expense ratio equals the ratio of commission, brokerage, field supervision, collection expense, taxes, licenses, fees, and general expenses to net written premium. The CR measures how much of a premium dollar is dedicated to paying insurance costs of the company in a calendar year. A CR of 135% implies the company lost 35 cents for every dollar of premium earned before considering investment income.

Table 7 displays the combined ratio (CR) contribution by component excluding the impact of dividends for the industry.

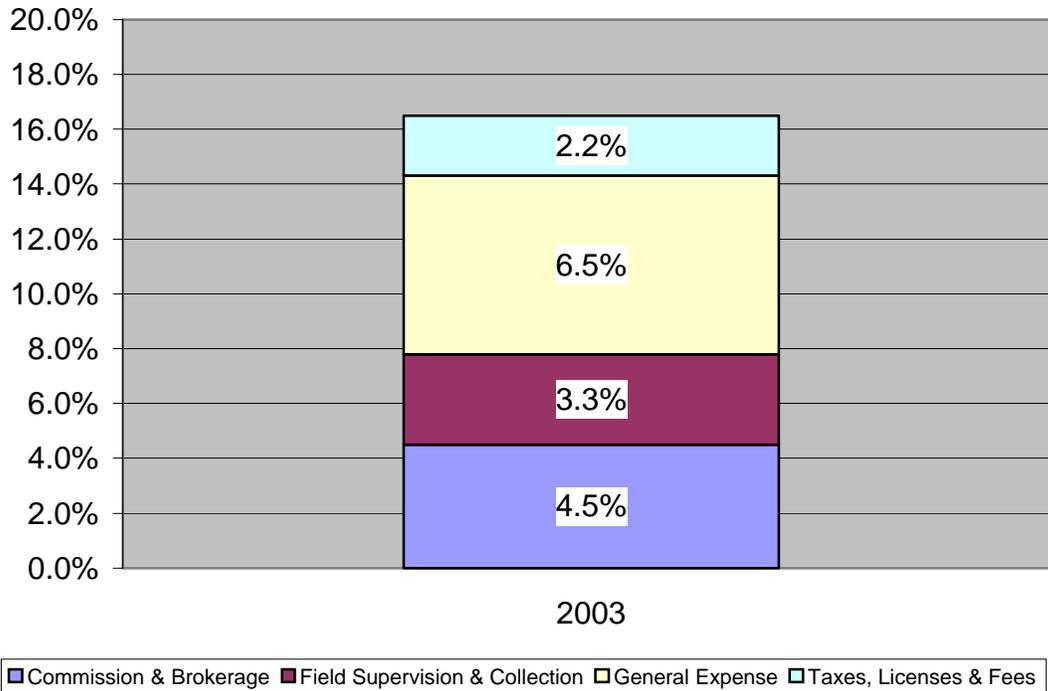


The impact of the current hard market can be seen on the declining combined ratio since 2001.

Table 8 displays the components of the incurred expense ratio<sup>9</sup> that underlie the industry combined ratio displayed above.

TABLE 8

INDUSTRY EXPENSE RATIO BY COMPONENT



<sup>9</sup> A.M. Best Company ([www.ambest.com](http://www.ambest.com)), Best's Aggregates & Averages - Property/Casualty 2004 Edition, "By Line Underwriting Experience" displays the above expense categories as a ratio to net written premium. For ratemaking purposes, general expenses and other acquisition, field supervision and collection expenses are often expressed as a percentage of earned premium.

Table 9 displays the before-tax operating ratios (OR) for the top ten insurance groups and industry. The OR equals the CR minus the net investment income and other income ratio to earned premium (NII). The OR measures how much of a premium dollar is left after considering the impact of investment income earned on the CR. An OR of 120% implies the industry lost 20 cents for every dollar of premium earned after the consideration of investment income.

<b>TABLE 9</b>			
GROUP	2003 RATIOS		
	COMBINED RATIO	NII AND OTHER INC. (TO NEP)	NET OPERATING RATIO
MLMIC GROUP	161.0%	19.6%	141.4%
AIG	136.1%	8.3%	127.8%
GE GLOBAL INSURANCE	107.6%	10.2%	97.4%
PROASSURANCE	110.1%	11.0%	99.1%
HEALTH CARE IND	112.6%	10.0%	102.6%
DOCTORS COMPANY	120.2%	6.0%	114.2%
ISMIE MUTUAL	118.5%	22.1%	96.4%
PHYSICIANS RECIP INS	153.0%	47.1%	105.9%
NORCAL GROUP	117.0%	13.3%	103.7%
CNA INSURANCE	143.0%	16.0%	127.0%
INDUSTRY	136.3%	15.6%	120.7%
DIVIDEND RATIO:			0.5%
INCLUDING DIVIDEND RATIO:			121.2%

Table 10 displays the net liability<sup>10</sup> to surplus ratio (NLSR) and net written premium to surplus ratio (NPSR) for 54 organizations<sup>11</sup>. The NLSR equals the net loss and LAE reserves divided by surplus. The NLSR provides a measure of underwriting leverage, and thus risk. Surplus serves as a financial buffer to guard against adverse events and changes in financial condition, such as

<sup>10</sup> Net liability is defined as net loss and LAE reserves only (i.e., excludes other liabilities shown on Page 3 of the Annual Statement).

<sup>11</sup> A.M. Best Company ([www.ambest.com](http://www.ambest.com)), Best's Aggregates & Averages - Property/Casualty 2004 Edition. The 54 organizations (a/k/a, medical malpractice composite) represent groups and unaffiliated single companies for which more than 50% of their business is in medical malpractice. The medical malpractice net written premium of the 54 organizations represents over two thirds of the medical malpractice industry's total net written premium. The inclusion of organizations where medical malpractice is not a core focus of the company would reduce the informational value of the composite figures (e.g., company focuses mainly on personal lines, company with minimal medical malpractice business significantly increases asbestos or D&O reserves, etc.).

can result when reserve strengthening is required. A lower ratio signifies greater financial strength and a greater capacity to absorb adverse development in reserves. In lines of insurance such as medical malpractice that have significant potential for this to occur, it is important that the NLSR be relatively low, especially for companies that are not diversified insurance writers. The NPSR equals the net written premium divided by surplus. The NPSR measures the insurer's capacity to write additional business.

**TABLE 10**

**LEVERAGE RATIOS - 54 ORGANIZATIONS**

	2003	2002	2001	2000	1999
NLSR	2.867	2.951	2.213	1.941	1.826
NPSR	0.911	0.956	0.679	0.588	0.475
L&LAE RES (\$M)	17,437	16,323	14,847	14,019	13,682
% CHANGE	6.8%	9.9%	5.9%	2.5%	0.6%
NWP (\$M)	5,544	5,288	4,553	4,245	3,555
% CHANGE	4.8%	16.1%	7.3%	19.4%	2.0%
SURPLUS (\$M)	6,083	5,532	6,709	7,223	7,492
% CHANGE	10.0%	-17.5%	-7.1%	-3.6%	8.4%

As one can see from above, both the NLSR and NPSR have risen since their 1999 levels. The NLSR increase has been driven by the adverse development observed by companies over the past few years, in combination with declining surplus through 12/31/2002. The NPSR increase in recent years is driven by the cumulative impact of rate increases taken since early 2000, in combination with declining surplus through 12/31/2002.

Table 11 displays the after tax net income for the 2003 calendar year and the ratio to earned premium<sup>12</sup>.

<b>TABLE 11</b>		
<b>2003 PROFITABILITY - 54 ORGANIZATIONS</b>		
INCOME STATEMENT ITEM	(000s)	% OF EP
PREMIUMS EARNED	5,413,857	100.0%
LOSSES INCURRED	4,017,374	74.2%
LAE INCURRED	2,085,632	38.5%
U/W EXPENSE INCURRED	835,264	15.4%
OTHER DEDUCTIONS	18,916	0.3%
DIVIDENDS TO POLICYHOLDERS	<u>20,426</u>	0.4%
NET U/W INCOME	(1,563,755)	-28.9%
NET INVESTMENT INCOME	924,221	17.1%
OTHER INCOME/(EXPENSE)	<u>98,517</u>	1.8%
PRETAX OPERATING INCOME	(541,017)	-10.0%
REALIZED CAPITAL GAINS (CG)	132,241	2.4%
INCOME TAXES INCURRED (TAX)	<u>30,240</u>	0.6%
NET INCOME	(439,016)	-8.1%
L&LAE RATIO		112.7%
EXPENSE RATIO		15.8%
<u>DIVIDEND RATIO</u>		<u>0.4%</u>
COMBINED RATIO		128.9%
<u>NII AN OTHER INCOME RATIO</u>		<u>18.9%</u>
OPERATING RATIO (BEFORE TAX & CG)		110.0%
<u>TAX &amp; CG RATIO</u>		<u>-1.9%</u>
OPERATING RATIO (AFTER TAX & CG)		108.1%

The 54 organizations, representing over two-thirds of the 2003 industry net written premium, lost \$439 million in 2003, after reflecting the impact of items such as rate increases (impacts the premiums earned), reserve strengthening (impacts the losses and LAE incurred), changes in policyholder dividend strategies (impacts dividends to policyholders), and changes in investment strategy (impacts net investment income earned on bonds and realized capital gains on stocks sold throughout the year).

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<sup>12</sup> Other areas of the report display the ratio of underwriting expenses to written premiums.

The above exhibit also displays the income statement items in the ratio format discussed earlier in the report. The net income ratio to earned premium of -8.1% equals 100% minus the 108.1% operating ratio. Stated another way, the industry lost 8.1 cents on every dollar of premium earned after considering investment income, realized capital gains and income taxes (i.e., after-tax earnings generated from operations and realized capital gains).

Table 12 displays the after tax net income and return on average surplus (ROS) for the past five years.

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**TABLE 12**

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**PROFITABILITY - 54 ORGANIZATIONS**

	2003	2002	2001	2000	1999
NET INCOME (\$M)	(439)	(903)	(328)	487	661
SURPLUS (\$M)	6,083	5,532	6,709	7,223	7,492
ROS	-7.6%	-14.8%	-4.7%	6.6%	9.2%

In the past three years, the 54 organizations have lost \$1.67 billion. In the past five years, the organizations have lost \$522 million. As the recently filed rate increases continue to flow into earned premiums, we would expect the net income of the 54 organizations and the industry to continue its favorable trend towards break-even in 2004. If development on prior accident/report year reserves continues to stabilize, net income could potentially result in a positive 2004 return on surplus (i.e., net income > 0) for the first time since 2000.

**INDUSTRY SCHEDULE P CLAIMS-MADE RESULTS**

Table 13 and Table 14 display total industry medical malpractice loss and premium information from Schedule P, Part 1F, Section 2 (claims-made).

<b>TABLE 13</b>				
CLAIMS-MADE				
REPORT YEAR	INCURRED LOSS AND LAE			% CHANGE IN NET
	DIRECT AND ASSUMED	CEDED	NET	
1994	3,714,696	833,724	2,880,972	
1995	4,493,594	1,226,495	3,267,099	13.4%
1996	4,830,076	1,428,749	3,401,327	4.1%
1997	5,362,052	1,506,247	3,855,805	13.4%
1998	5,908,567	1,602,015	4,306,552	11.7%
1999	6,070,505	1,734,468	4,336,037	0.7%
2000	6,557,360	1,935,740	4,621,620	6.6%
2001	6,794,741	1,759,923	5,034,818	8.9%
2002	6,883,076	1,779,995	5,103,081	1.4%
2003	7,237,393	2,141,333	5,096,060	-0.1%

<b>TABLE 14</b>				
CLAIMS-MADE				
REPORT YEAR	EARNED PREMIUM			% CHANGE IN NET
	DIRECT AND ASSUMED	CEDED	NET	
1994	4,108,461	1,081,378	3,027,083	
1995	4,296,211	1,239,623	3,056,588	1.0%
1996	4,222,431	1,083,902	3,138,529	2.7%
1997	4,493,025	1,188,259	3,304,766	5.3%
1998	4,427,296	1,051,196	3,376,100	2.2%
1999	4,458,248	1,009,761	3,448,487	2.1%
2000	4,565,525	1,217,578	3,347,947	-2.9%
2001	5,148,838	1,316,602	3,832,236	14.5%
2002	6,833,731	2,187,336	4,646,395	21.2%
2003	8,297,408	2,839,632	5,457,776	17.5%

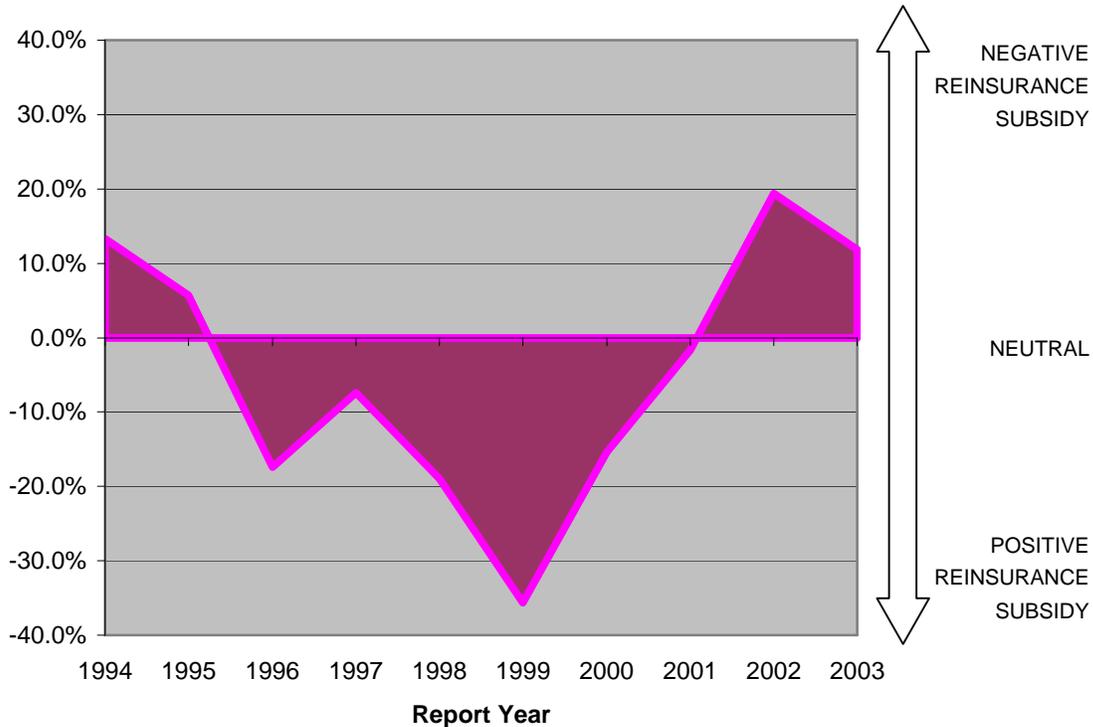
Table 15 and Table 16 display industry medical malpractice loss ratios and the amount of reinsurance subsidy.

<b>TABLE 15</b>				
CLAIMS-MADE				
REPORT YEAR	EARNED PREMIUM			D&A/ CEDED DIFF.
	DIRECT AND ASSUMED	CEDED	NET	
1994	90.4%	77.1%	95.2%	13.3%
1995	104.6%	98.9%	106.9%	5.7%
1996	114.4%	131.8%	108.4%	-17.4%
1997	119.3%	126.8%	116.7%	-7.4%
1998	133.5%	152.4%	127.6%	-18.9%
1999	136.2%	171.8%	125.7%	-35.6%
2000	143.6%	159.0%	138.0%	-15.4%
2001	132.0%	133.7%	131.4%	-1.7%
2002	100.7%	81.4%	109.8%	19.3%
2003	87.2%	75.4%	93.4%	11.8%

The reinsurance subsidy equals the direct and assumed loss ratio minus the ceded loss ratio. The subsidy level, combined with the level of reinsurance used by the industry, ultimately drives the final difference between direct and assumed loss ratios and net loss ratios that are recorded by the industry.

TABLE 16

CLAIMS-MADE REINSURER SUBSIDY LEVEL



As one can see from Table 16, the claims-made ceded incurred loss and expense ratios for report years 1996 through 2000 significantly exceeded the direct and assumed ratios, representing a positive reinsurance subsidy. Subsequent to 2001, the claims-made subsidy has switched from heavily positive to heavily negative. The change in subsidy level is driven by higher reinsurance rates (i.e., hard reinsurance market), stricter reinsurance terms & conditions, and the increase in primary company risk retention levels (e.g., doubling of most self-insured retention levels since year-end) forcing primary companies to retain more risk.

Table 17 displays industry medical malpractice incurred loss and defense cost containment (DCC) development on prior report years from Schedule P, Part 2F, Section 2 (claims-made).

**TABLE 17**

CLAIMS-MADE

DEVELOPMENT ON PRIOR YEARS - ADVERSE/(FAVORABLE)

REPORT YEAR	ONE YEAR	TWO YEAR	THREE YEAR	FOUR YEAR
PRIOR	(39,766)	(93,638)	(260,589)	(392,486)
1994	(9,981)	(38,945)	(50,581)	(108,583)
1995	858	(16,026)	(30,994)	(75,895)
1996	30,510	47,864	65,391	(37,552)
1997	9,473	44,607	113,664	111,786
1998	70,262	183,144	348,035	472,184
1999	96,684	155,644	445,157	1,660,222
2000	290,439	594,769	919,071	
2001	405,132	685,754		
2002	217,947			
	1,071,558	1,563,173	1,549,154	1,629,676

*NOTE: LOSS & DCC*

Report year 2002 and prior reserves developed adversely by \$1.07 billion in calendar year 2003. The majority of the adverse development was driven by report years 2000, 2001 and 2002. Over a four year period, one can see how report years 1998 and 1999 have increased significantly from their original report year estimates. This represents quite a change from report years 1996 and prior when reserves developed favorably over a four year period.

Table 18 displays a ten-year graph of the prior report year development in the current calendar year. Through calendar year 1999, medical malpractice insurers were able to use favorable development on prior report year reserves to help prop up the results of the current calendar year. Subsequent to 2000, development on prior report year reserves turned unfavorable (i.e., estimates were higher than originally thought), resulting in a negative impact on the current calendar year financials.

**TABLE 18**

CLAIMS-MADE

HISTORICAL PRIOR YEAR DEVELOPMENT - ADVERSE/(FAVORABLE)

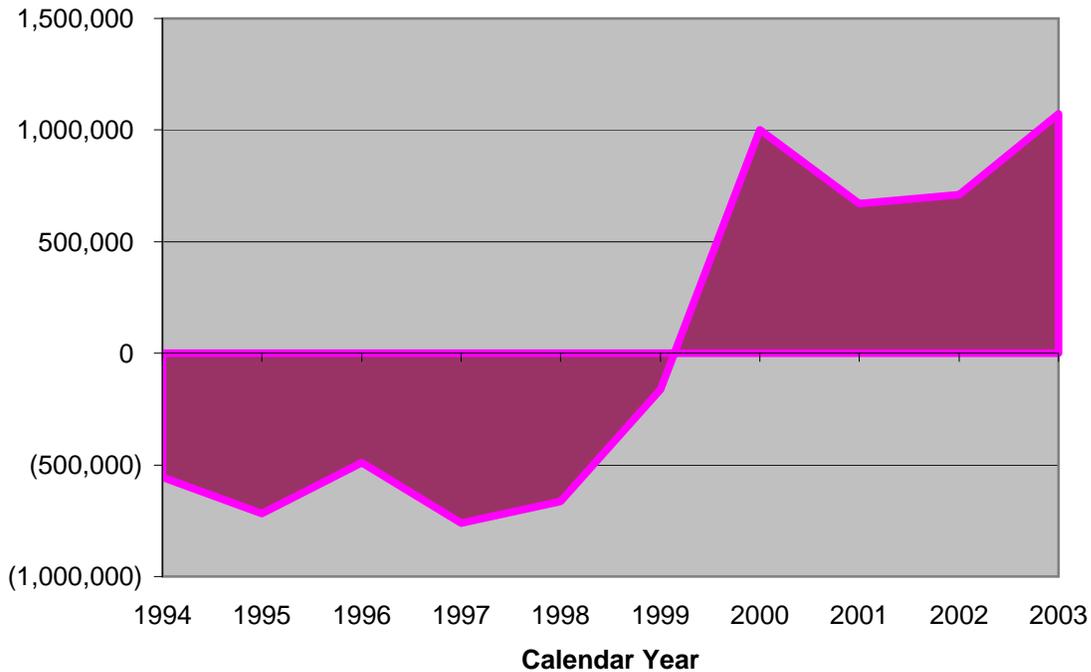
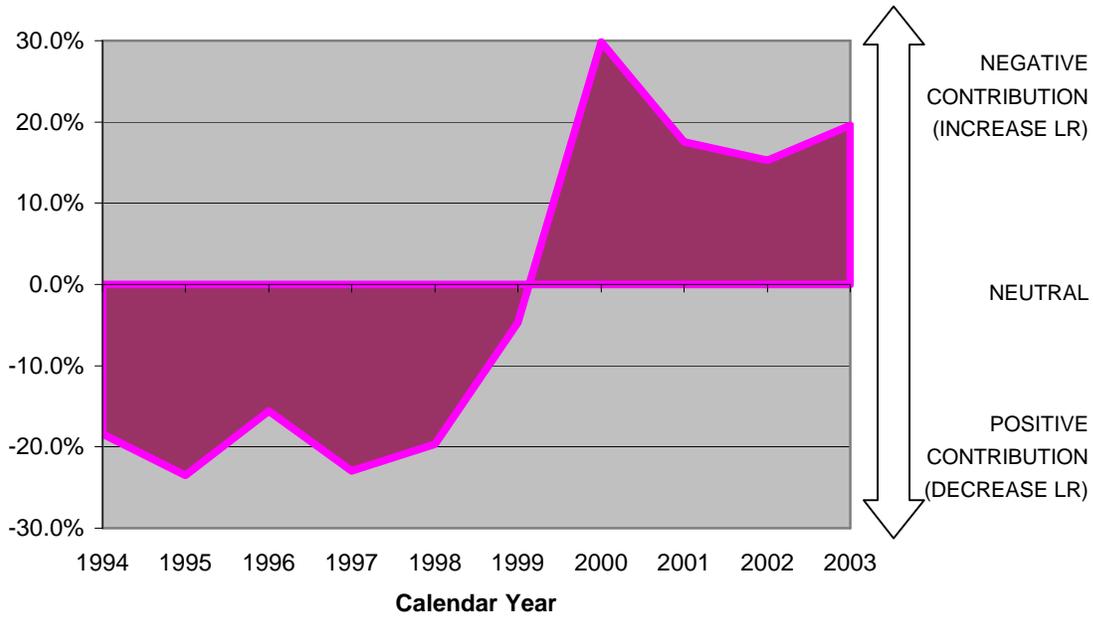


Table 19 displays the net calendar year contribution ratio (i.e., the ratio of the development on prior report year reserves to the net earned premium). Table 20 displays the difference between the report year and calendar year loss & DCC ratios. When the contribution ratio is favorable, the calendar year loss ratio is lower than the report year loss ratio. When the contribution ratio is unfavorable, the calendar year loss ratio is higher than the report year loss ratio.

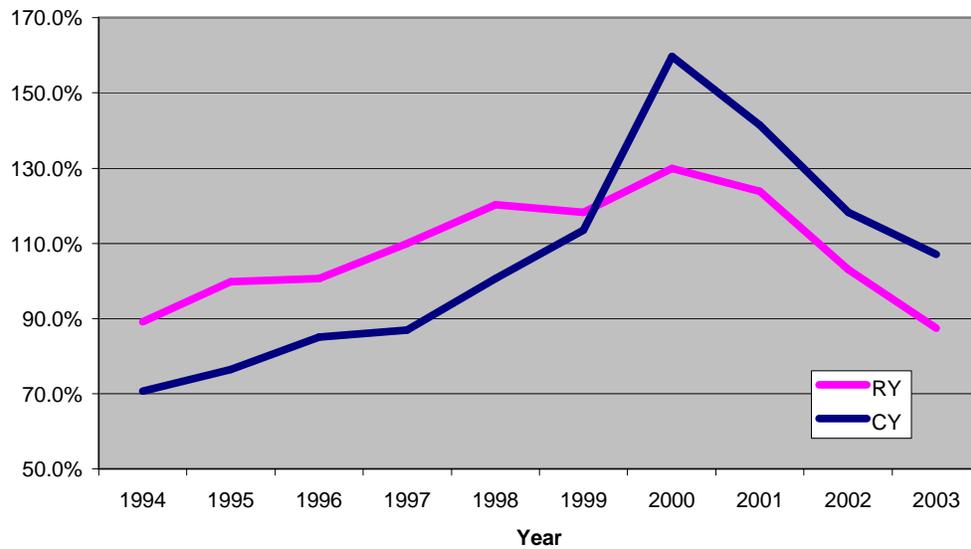
**TABLE 19**

CLAIMS-MADE  
NET CALENDAR YEAR CONTRIBUTION RATIO



**TABLE 20**

CLAIMS-MADE  
REPORT YEAR VERSUS CALENDAR YEAR LOSS & DCC RATIO



**INDUSTRY SCHEDULE P OCCURRENCE RESULTS**

Table 21 and Table 22 display total industry medical malpractice loss and premium information from Schedule P, Part 1F, Section 1 (occurrence).

<b>TABLE 21</b>				
OCCURRENCE				
ACCIDENT YEAR	INCURRED LOSS AND LAE			% CHANGE IN NET
	DIRECT AND ASSUMED	CEDED	NET	
1994	1,729,211	224,357	1,504,854	
1995	2,081,308	322,630	1,758,678	16.9%
1996	2,225,473	455,996	1,769,477	0.6%
1997	2,455,826	589,008	1,866,818	5.5%
1998	2,709,772	637,968	2,071,804	11.0%
1999	3,049,961	800,606	2,249,355	8.6%
2000	2,754,199	580,720	2,173,479	-3.4%
2001	2,760,488	528,561	2,231,927	2.7%
2002	2,778,507	409,228	2,369,279	6.2%
2003	3,009,995	503,205	2,506,790	5.8%

<b>TABLE 22</b>				
OCCURRENCE				
ACCIDENT YEAR	EARNED PREMIUM			% CHANGE IN NET
	DIRECT AND ASSUMED	CEDED	NET	
1994	1,619,845	286,573	1,333,272	
1995	1,770,961	350,076	1,420,885	6.6%
1996	1,756,672	381,255	1,375,417	-3.2%
1997	1,728,957	365,615	1,363,342	-0.9%
1998	1,748,676	350,219	1,398,457	2.6%
1999	1,862,050	417,062	1,444,988	3.3%
2000	2,254,380	422,354	1,832,026	26.8%
2001	2,259,943	553,742	1,706,201	-6.9%
2002	2,646,092	583,932	2,062,160	20.9%
2003	3,067,830	662,746	2,405,084	16.6%

Table 23 and Table 24 display total industry medical malpractice loss ratios and the amount of reinsurance subsidy.

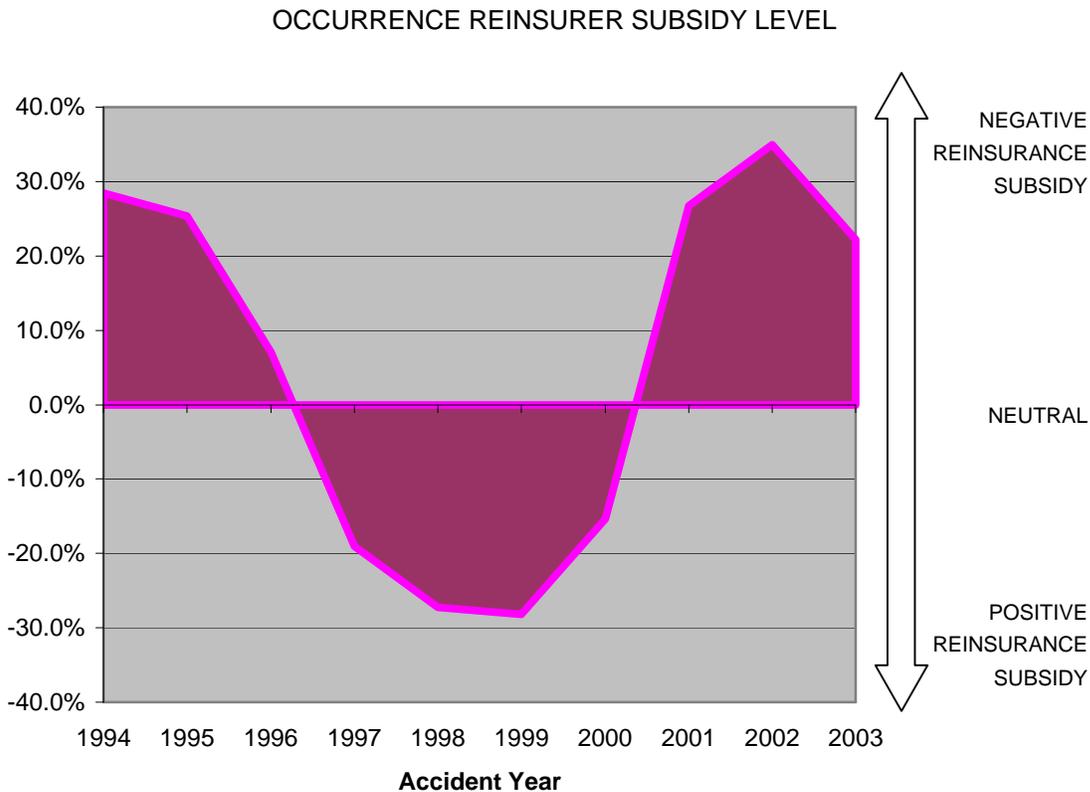
**TABLE 23**

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ACCIDENT YEAR	EARNED PREMIUM			D&A/ CEDED DIFF.
	DIRECT AND ASSUMED	CEDED	NET	
1994	106.8%	78.3%	112.9%	28.5%
1995	117.5%	92.2%	123.8%	25.4%
1996	126.7%	119.6%	128.7%	7.1%
1997	142.0%	161.1%	136.9%	-19.1%
1998	155.0%	182.2%	148.1%	-27.2%
1999	163.8%	192.0%	155.7%	-28.2%
2000	122.2%	137.5%	118.6%	-15.3%
2001	122.1%	95.5%	130.8%	26.7%
2002	105.0%	70.1%	114.9%	34.9%
2003	98.1%	75.9%	104.2%	22.2%

The reinsurance subsidy equals the direct and assumed loss ratio minus the ceded loss ratio. The subsidy level, combined with the level of reinsurance used by the industry, ultimately drives the final difference between direct and assumed loss ratios and net loss ratios that are recorded by the industry.

TABLE 24



As one can see from Table 24, the occurrence ceded incurred loss and expense ratios for accident years 1997 through 2000 significantly exceeded the direct and assumed ratios, representing a positive reinsurance subsidy. Subsequent to 2000, the occurrence subsidy has switched from heavily positive to heavily negative. The change in subsidy level is driven by higher reinsurance rates (i.e., hard reinsurance market), stricter reinsurance terms & conditions, and the increase in primary company risk retention levels (e.g., doubling of most self-insured retention levels since year-end) forcing primary companies to retain more risk.

Table 25 displays industry medical malpractice incurred loss and defense cost containment development on prior accident years from Schedule P, Part 2F, Section 1 (occurrence).

**TABLE 25**

OCCURRENCE

DEVELOPMENT ON PRIOR YEARS - ADVERSE/(FAVORABLE)

ACCIDENT YEAR	ONE YEAR	TWO YEAR	THREE YEAR	FOUR YEAR
PRIOR	3,562	(23,427)	11,510	(85,928)
1994	5,898	1,089	(15,494)	(49,368)
1995	13,688	7,653	(9,084)	(32,215)
1996	13,130	(24,257)	(45,975)	(4,085)
1997	(1,259)	(23,632)	(9,686)	89,710
1998	75,509	78,570	219,789	336,419
1999	157,697	239,099	416,636	467,417
2000	127,070	348,576	442,017	
2001	209,251	281,272		
2002	68,448			
	672,994	884,943	1,009,713	721,950

*NOTE: LOSS & DCC*

Accident year 2002 and prior reserves developed adversely by \$673 million in calendar year 2003. The majority of the adverse development was driven by accident years 1999, 2000 and 2001. Over a four year period, one can see how accident years 1998 and 1999 have increased significantly from their original accident year estimates. This represents quite a change from accident years 1996 and prior when reserves developed favorably over a four year period.

Table 26 displays a ten-year graph of the prior accident year development in the current calendar year. Through calendar year 1999, medical malpractice insurers were able to use favorable development on prior accident year reserves to help prop up the results of the current calendar year. Subsequent to 1999, development on prior accident year reserves turned unfavorable (i.e., estimates were higher than originally thought), resulting in a negative impact on the current calendar year financials.

TABLE 26

OCCURRENCE

HISTORICAL PRIOR YEAR DEVELOPMENT - ADVERSE/(FAVORABLE)

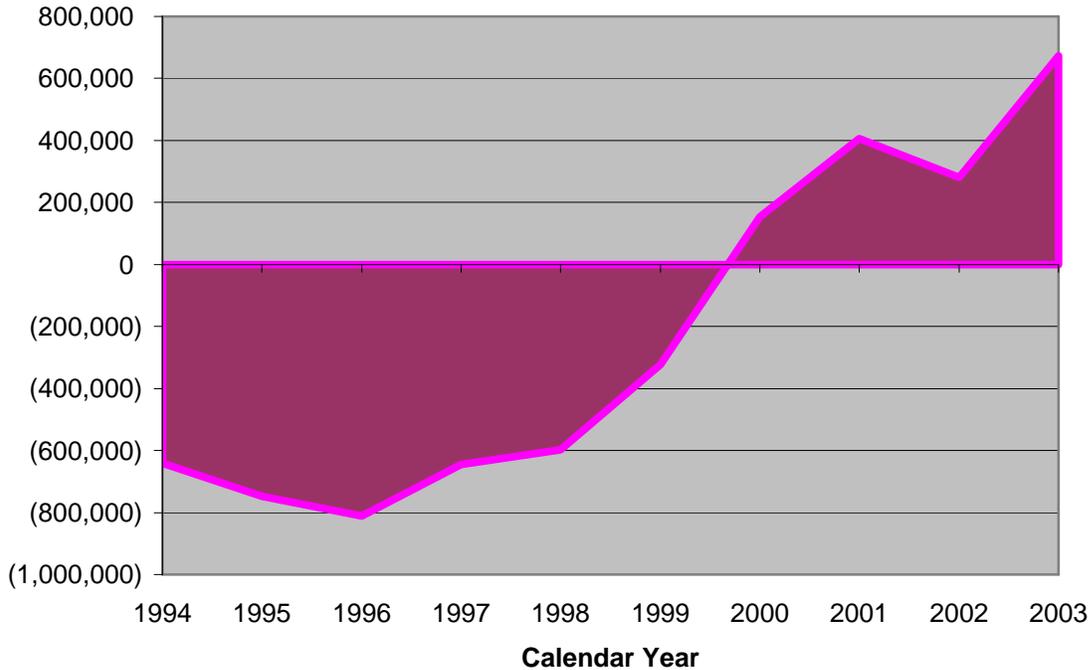


Table 27 displays the net calendar year contribution ratio (i.e., the ratio of the development on prior accident year reserves to the accident year net earned premium). Table 28 displays the difference between the accident year and calendar year loss & DCC ratios. When the contribution ratio is favorable, the calendar year loss ratio is lower than the accident year loss ratio. When the contribution ratio is unfavorable, the calendar year loss ratio is higher than the accident year loss ratio.

TABLE 27

OCCURRENCE  
NET CALENDAR YEAR CONTRIBUTION RATIO

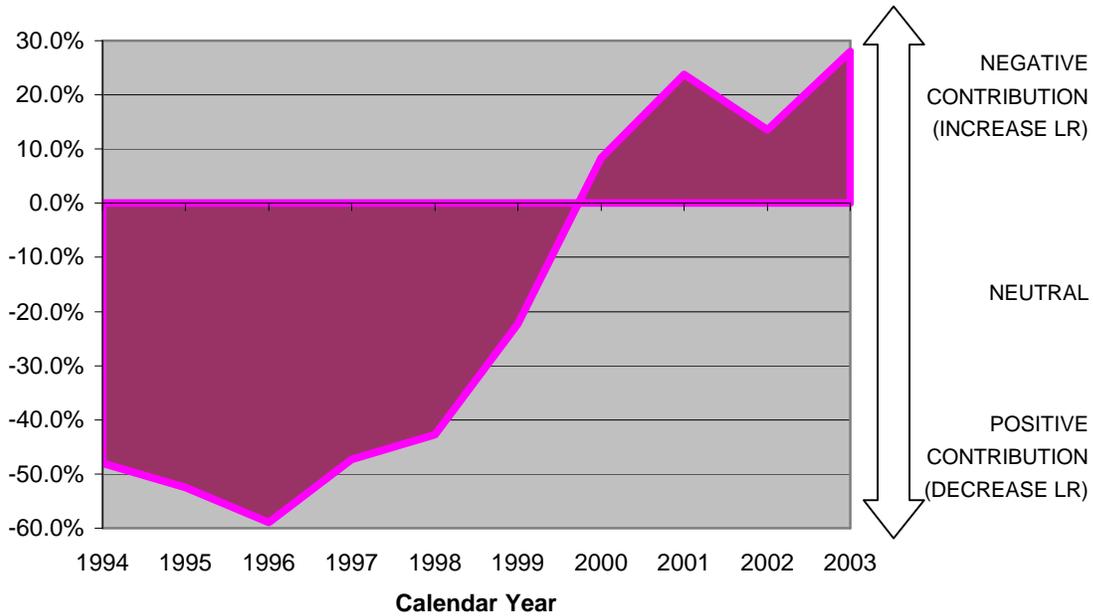
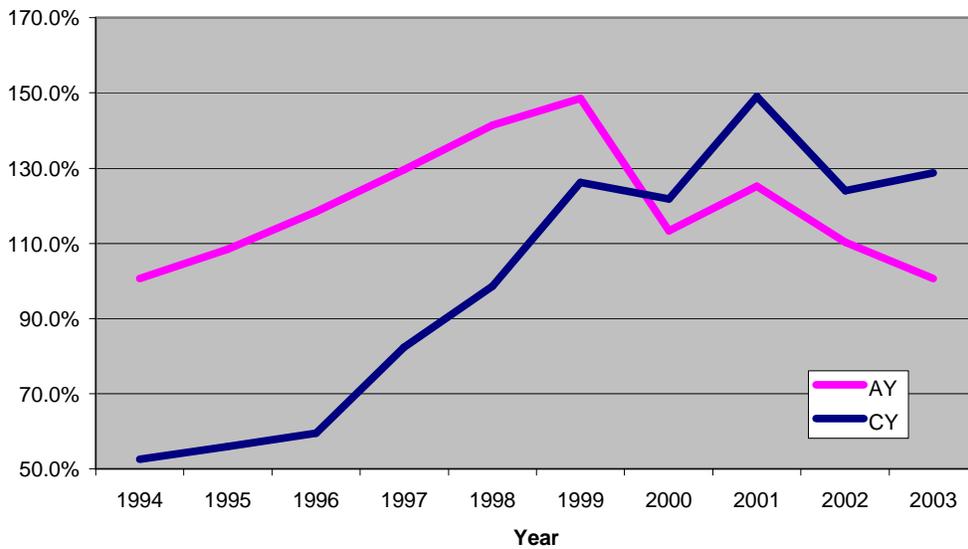


TABLE 28

OCCURRENCE  
ACCIDENT YEAR VERSUS CALENDAR YEAR LOSS & DCC RATIO



## **STATE OF THE MEDICAL MALPRACTICE MARKET IN FLORIDA**

For insurers representing over 80% of Florida's 2003 market share, using information from their December 31, 2003 Annual Statement filed with the Florida OIR, we will walk the reader through a number of key metrics illustrating the performance of these insurers through December 31, 2003. In addition, we will also discuss the performance of these insurers based upon their Statutory Accounting<sup>13</sup> results through first quarter 2004.

### **Analysis of Financial Reports**

Table F1 displays the market share of the eleven Florida writing companies we will analyze throughout the remainder of this report. The below companies represent over 80% of Florida's 2003 direct written premium and net written premium.

<b>TABLE F1</b>				
<b>FLORIDA MEDICAL MALPRACTICE</b>				
<b>Writing Company Name</b>	<b>Deloitte Abbreviation</b>	<b>Direct Written Premium</b>	<b>% of Florida</b>	<b>Cumulative %</b>
First Professionals Ins Co	FPIC	188,312,565	21.1%	21.1%
Health Care Ind Inc	HCII	115,509,472	13.0%	34.1%
Pronational Ins Co	PIC	77,102,502	8.7%	42.8%
Medical Protective Co	MPC	73,513,367	8.3%	51.0%
MAG Mut Ins Co	MMIC	70,481,160	7.9%	58.9%
Lexington Ins Co	LIC	63,560,018	7.1%	66.0%
Evanston Ins Co	EIC	37,956,032	4.3%	70.3%
Doctors Co An Interins Exchn	DCIE	29,992,132	3.4%	73.7%
Continental Cas Co	CCC	24,832,697	2.8%	76.5%
TIG Ins Co	TIC	20,134,711	2.3%	78.7%
Anesthesiologists Pro Assur Co	APAC	19,782,689	2.2%	80.9%
All Other Writing Companies		169,785,621	19.1%	100.0%
<b>Total</b>		<b>890,962,966</b>	<b>100.0%</b>	

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<sup>13</sup> Statutory accounting requirements are based on criteria established by the National Association of Insurance Commissioners in regard to the preparation of an insurer's financial statements required to be filed with a state insurance department. We note that our report does not include any discussion or metrics based on Generally Accepted Accounting Principles (GAAP), a widely accepted set of rules, standards, conventions and procedures for reporting financial information on public companies, as established by the Financial Accounting Standards Board.

Each company in Table F1 has its own unique strategy in writing medical malpractice business in the State of Florida. The following items illustrate the differences that may underlie the direct written premiums figures shown above:

### **Specialty Underwritten**

Although the majority of written premium in the State of Florida covers physicians and surgeons, it is important to note that each company may target different types of specialties (e.g., chiropractors, emergency room, OB/GYN, neurosurgeon, etc.) or focus on the non-practitioner market (e.g., hospitals). For example, APAC focuses exclusively on insuring anesthesiologists. HCII<sup>14</sup> focuses almost exclusively on insuring hospitals (i.e., does not target individual practitioners). Depending on each company's focus, the actual premium charged per policy will vary dramatically based upon the risk of the specialties targeted (e.g., chiropractor versus neurosurgeon), policy limits offered (e.g., \$250,000/\$750,000, \$1,000,000/\$3,000,000, etc.) and other discounts offered by the company (e.g., loss free credit, schedule credits/debits).

### **County Underwritten**

The cost of insuring policyholders in some Florida counties is significantly higher than the cost in other counties. Depending on the area of the state where each company sells policies, the actual premium charged per policy will be directly impacted by the historical costs implied by the county (i.e., relative cost to other counties in the state).

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<sup>14</sup> HCII is a captive insurance company domiciled in the state of Colorado that provides professional liability insurance services for hospitals, ambulatory care centers and employed physicians that are affiliated with its ultimate parent, HCA Inc., and for hospitals affiliated with LifePoint Hospitals, Inc. and Triad Hospitals, Inc.

### **Policy Type Underwritten**

Insurance policies may be issued on either an occurrence basis or a claims-made basis. A claims-made policy covers claims reported to the insurer during the contract period.<sup>15</sup> An occurrence-basis policy provides coverage for insured events occurring during the contract period, regardless of the length of time that passes before the insurance company is notified of the claim. Physicians who purchase a first year, second year or even third year claims-made policy often pay significantly less premium than what it would cost to purchase an occurrence policy or a mature claims-made policy.

Although the majority of the written premium displayed in Table F1 is from claims made policies, we note that HCII writes primarily occurrence policies in the state of Florida.

### **Expenses**

The cost of insuring policyholders varies by company depending upon its structure and how it approaches the insurance market (e.g., direct writer versus the use of agents). Commissions and brokerage, other acquisition expense and general expense can vary significantly by company. An illustration of the wide range of expense ratios underlying Florida rate filings will be discussed later in the **Rate Filing Trend Analysis** section of the report.

### **Admitted Company**

An admitted company is an insurer granted permission (i.e., authorized) by Florida to sell specific lines of insurance within the state. While the procedure may vary from state to state, approval is usually granted when an insurer presents financial information demonstrating its financial stability. An admitted insurance company must make rate

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<sup>15</sup> Claims-made insurance policies contain “extended reporting” clauses or endorsements that provide for coverage, in specified circumstances (e.g., 5 years of coverage with the insurer before retirement), of claims occurring during the contract period but reported after the expiration of the policy. This coverage is often referred to as “free tail” or death, disability or retirement (DDR).

filings in accordance with Florida laws. All of the Table F1 companies are admitted insurers except for LIC and EIC.

### **Surplus Lines Company**

According to Chapter 626, PART VIII (Surplus Lines Law) of the Florida Statutes, an "Eligible surplus lines insurer" means an unauthorized insurer which has been made eligible by the department to issue insurance coverage under the Surplus Lines Law. The Florida Surplus Lines Service Office defines Surplus Lines Insurance as:

*“A risk or a part of a risk for which there is no market available through the original or producing agent in the standard or "admitted" market. Therefore, it is placed with non-admitted insurers, who are made eligible by the Florida Department of Financial Services to offer coverage in the State of Florida, in accordance with the surplus lines provisions of the state law<sup>16</sup>.”*

A surplus lines company is not required to make rate filings in the State of Florida. LIC and EIC are surplus lines insurers.

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<sup>16</sup> Please refer to the Florida Surplus Lines Service Office ([www.fslso.com](http://www.fslso.com)) for further information on Florida's surplus lines carriers and surplus lines Laws.

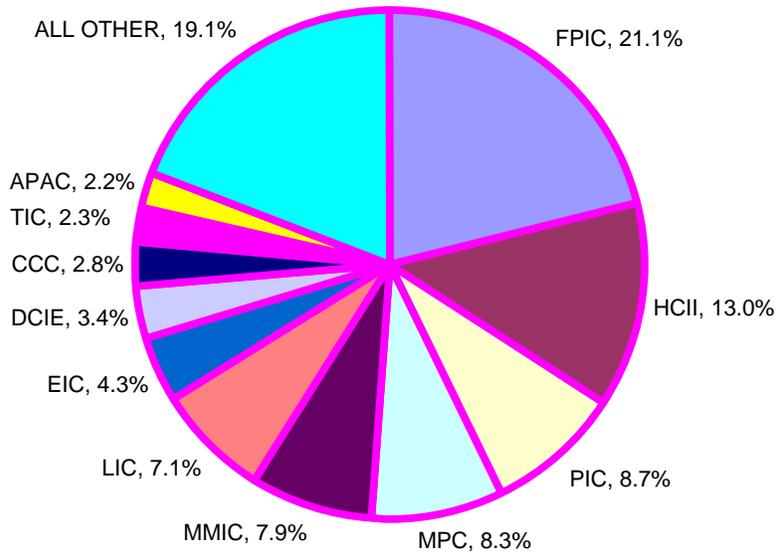
Table F2 graphically displays the 2003 market share of the top eleven writing companies<sup>17</sup>.

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**TABLE F2**

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2003 FLORIDA DIRECT WRITTEN PREMIUM



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<sup>17</sup> The Florida information comes from the Annual Statements and “Page 14” data provided by the insurance companies in response to our MLDR. In addition, when available, we pulled information from Sheshunoff Information Services ([www.sheshunoff.com](http://www.sheshunoff.com)), Insurance Analyst: Property & Casualty Online Company Profiler Application.

Tables F3 and F4 display the 2003 direct written premium by line of business for all states.

<b>TABLE F3</b>				
DIRECT WRITTEN PREMIUM (000's)				
ALL LINES OF BUSINESS (LOB)				
Companies	<i>Medical Malpractice (MM)</i>		Workers	All Other
	Claims-Made	Occurrence	Compensation	
FPIC	217,787	14,986	-	452
MPC	518,017	326,186	-	5,138
CCC	163,114	9,925	359,166	4,347,750
TIC	90,815	2,955	(3,292)	200,127
DCIE	325,046	49,672	-	3,937
HCII	2,332	377,439	-	27
APAC	32,589	1,599	30,852	-
PIC	151,416	25,388	-	8,605
MMIC	270,432	11,664	2,809	4,740
LIC	777,322	11,623	7,052	3,755,452
EIC	182,426	-	-	694,975

<b>TABLE F4</b>				
DISTRIBUTION OF DIRECT WRITTEN PREMIUM (000's)				
ALL LINES OF BUSINESS (LOB)				
Companies	<i>Medical Malpractice (MM)</i>		Workers	All Other
	Claims-Made	Occurrence	Compensation	
FPIC	93%	6%	0%	0%
MPC	61%	38%	0%	1%
CCC	3%	0%	7%	89%
TIC	31%	1%	-1%	69%
DCIE	86%	13%	0%	1%
HCII	1%	99%	0%	0%
APAC	50%	2%	47%	0%
PIC	82%	14%	0%	5%
MMIC	93%	4%	1%	2%
LIC	17%	0%	0%	83%
EIC	21%	0%	0%	79%

Table F5 displays the direct written premium for the top five states including all lines of business.

TABLE F5

DIRECT WRITTEN PREMIUM - TOP 5 STATES (000's)  
ALL LINES OF BUSINESS (LOB)

Companies	State 1	State 2	State 3	State 4	State 5	All Other
FPIC	<b>188,580</b>	17,685	10,888	7,632	5,003	3,437
MPC	143,052	107,248	74,856	<b>73,513</b>	35,126	415,546
CCC	477,192	386,089	<b>337,352</b>	287,015	210,403	3,181,905
TIC	55,228	32,753	<b>32,401</b>	22,130	16,874	131,218
DCIE	124,175	<b>30,354</b>	29,617	25,114	22,770	146,624
HCII	131,110	<b>115,509</b>	12,209	11,567	11,150	98,253
APAC	25,791	<b>21,553</b>	8,048	4,412	2,161	3,075
PIC	<b>77,103</b>	54,440	21,892	8,443	8,354	15,178
MMIC	150,627	<b>72,823</b>	45,079	8,991	8,968	3,158
LIC	715,637	439,090	<b>381,189</b>	334,334	230,861	2,450,339
EIC	208,469	79,594	<b>78,625</b>	48,636	41,318	420,761

Companies	Florida All LOBs	Florida MM	Florida MM %
FPIC	188,580	188,313	99.9%
MPC	73,513	73,513	100.0%
CCC	337,352	24,833	7.4%
TIC	32,401	20,135	62.1%
DCIE	30,354	29,992	98.8%
HCII	115,509	115,509	100.0%
APAC	21,553	19,783	91.8%
PIC	77,103	77,103	100.0%
MMIC	72,823	70,481	96.8%
LIC	381,189	63,560	16.7%
EIC	78,625	37,956	48.3%

As illustrated by the boxed figures, Florida falls in the top 4 market share for all eleven companies. At the bottom of the chart, one can see that the medical malpractice line of business represents a significant portion of the direct written premium for a majority of the companies except for Continental Casualty Company (i.e., CNA) and Lexington Insurance Company (i.e., AIG). These two companies are large national multiline carriers who do not focus exclusively on the medical malpractice line of business.

Table F6 displays the percentage of direct written premium for the top five states including all lines of business and the percentage of Florida medical malpractice premium to the company's total direct written premium.

**TABLE F6**  
DIRECT WRITTEN PREMIUM - TOP 5 STATES  
ALL LINES OF BUSINESS

Companies	State 1	State 2	State 3	State 4	State 5	All Other
FPIC	<b>81%</b>	8%	5%	3%	2%	1%
MPC	17%	13%	9%	<b>9%</b>	4%	49%
CCC	10%	8%	<b>7%</b>	6%	4%	65%
TIC	19%	11%	<b>11%</b>	8%	6%	45%
DCIE	33%	<b>8%</b>	8%	7%	6%	39%
HCII	35%	<b>30%</b>	3%	3%	3%	26%
APAC	40%	<b>33%</b>	12%	7%	3%	5%
PIC	<b>42%</b>	29%	12%	5%	5%	8%
MMIC	52%	<b>25%</b>	16%	3%	3%	1%
LIC	16%	10%	<b>8%</b>	7%	5%	54%
EIC	24%	9%	<b>9%</b>	6%	5%	48%

Companies	Florida All LOBs	Florida MM %	MM % of DWP
FPIC	81%	81%	100%
MPC	9%	9%	100%
CCC	7%	1%	7%
TIC	11%	7%	62%
DCIE	8%	8%	99%
HCII	30%	30%	100%
APAC	33%	30%	92%
PIC	42%	42%	100%
MMIC	25%	24%	97%
LIC	8%	1%	17%
EIC	9%	4%	48%

As one can see from the bottom of the chart, FPIC is the most heavily focused Florida writer with 81% of its medical malpractice business being written in the state of Florida. Pronational Insurance Company is second with 42% of its medical malpractice business being written in the state of Florida.

Although we will provide financial information on CNA and AIG throughout the remainder of this report, we will focus most of our discussion on those insurers whose emphasis is more heavily weighted toward medical malpractice.

Table F7 displays the direct, assumed and ceded written premiums by insurance company. The following definitions apply in the table:

- Direct written premium (DWP) – The dollar amount charged when a policyholder contracts for insurance coverage before reinsurance has been ceded and/or assumed (e.g., OB/GYN purchases a claims made policy from a Florida insurance company).
- Assumed written premium (AWP) - Premiums accepted by an insurance company in exchange for accepting all or part of insurance on a risk or exposure (e.g., Florida insurance company insures another Florida insurance company)
- Gross written premium (GWP) = DWP + AWP
- Ceded written premium (CWP) - Premiums paid to an assuming company in exchange for that company accepting all or part of insurance on a risk or exposure (i.e., Florida insurance company purchases reinsurance).
- Net written premium (NWP) = GWP – CWP = DWP + AWP - CWP
- % Ceded = CWP / GWP

**TABLE F7**

2003 NET WRITTEN PREMIUM MEDICAL MALPRACTICE, ALL STATES						
Companies	Occurrence					
	Direct	Assumed	Gross	Ceded	Net	% Ceded
FPIC	14,986	12,728	27,713	15,343	12,370	55.4%
MPC	326,186	-	326,186	45,111	281,075	13.8%
CCC	9,925	95,444	105,369	46,213	59,156	43.9%
TIC	2,955	250	3,205	768	2,436	24.0%
DCIE	49,672	-	49,672	9,515	40,157	19.2%
HCII	377,439	442	377,880	9,497	368,384	2.5%
APAC	1,599	2,245	3,844	1,404	2,440	36.5%
PIC	25,388	77	25,465	353	25,112	1.4%
MMIC	11,664	-	11,664	1,677	9,987	14.4%
LIC	11,623	-	11,623	2,445	9,179	21.0%
EIC	-	-	-	-	-	-
<b>TOTAL</b>	<b>831,437</b>	<b>111,185</b>	<b>942,622</b>	<b>132,327</b>	<b>810,295</b>	<b>14.0%</b>

Companies	Claims-Made					
	Direct	Assumed	Gross	Ceded	Net	% Ceded
FPIC	217,787	41,086	258,873	168,108	90,765	64.9%
MPC	518,017	-	518,017	89,148	428,869	17.2%
CCC	163,114	159,729	322,843	136,880	185,964	42.4%
TIC	90,815	35,683	126,498	105,920	20,578	83.7%
DCIE	325,046	51,839	376,886	89,282	287,603	23.7%
HCII	2,332	6,257	8,589	-	8,589	0.0%
APAC	32,589	16,473	49,062	32,784	16,278	66.8%
PIC	151,416	18,086	169,502	7,332	162,170	4.3%
MMIC	270,432	-	270,432	126,258	144,174	46.7%
LIC	777,322	15,498	792,820	359,276	433,544	45.3%
EIC	182,426	21,790	204,216	66,927	137,289	32.8%
<b>TOTAL</b>	<b>2,731,296</b>	<b>366,442</b>	<b>3,097,738</b>	<b>1,181,914</b>	<b>1,915,824</b>	<b>38.2%</b>
<b>TOTAL MM</b>	<b>3,562,732</b>	<b>477,627</b>	<b>4,040,359</b>	<b>1,314,241</b>	<b>2,726,119</b>	<b>32.5%</b>

The percentage ceded by writing company varies dramatically, ranging from the low single digits to as high as almost 84%. The percentage ceded would vary by company depending upon the reinsurance attachment point selected, the type of protection purchased (e.g., per claimant excess of loss, catastrophic per incident excess of loss, quota share), company leverage ratios, risk based capital considerations, and the historical penetration of losses into the reinsurance layers.

We note that for many of Florida's insurers falling outside the top 80%, it is likely that the percentage ceded would be higher than the 32.5% average displayed above. This would be driven

by the lower surplus levels of smaller companies and their inability to absorb individual shock losses or heavier than expected attritional losses.

Table F8 displays the net liability to surplus ratio for each company.

<b>TABLE F8</b>					
<b>BALANCE SHEET</b>					
<b>NET LIABILITY TO SURPLUS RATIO</b>					
<b>Companies</b>	<b>Q1 04</b>	<b>2003</b>	<b>2002</b>	<b>2001</b>	<b>2000</b>
FPIC	1.56	1.78	1.71	1.90	1.89
MPC	2.71	2.77	2.35	1.82	1.96
CCC	2.52	2.69	2.38	2.14	1.78
TIC	1.38	1.60	1.38	1.36	1.22
DCIE	2.07	2.04	1.82	1.36	1.27
HCII	2.24	2.23	2.61	2.00	2.08
APAC	2.56	2.56	2.37	1.77	1.29
PIC	2.97	3.10	2.59	2.72	1.72
MMIC	1.68	1.69	2.04	1.59	1.55
LIC	1.41	1.37	0.91	0.59	0.55
EIC	1.83	1.88	2.02	2.06	2.32

The above statistics, which include all lines of business, compare to a medical malpractice composite industry NLSR of approximately 2.9 (see Table 10).

Based on the distribution of direct written premium displayed in Table 4, the companies that focus almost exclusively on medical malpractice (i.e., FPIC, MPC, DCIE, HCII, APAC, PIC and MMIC) appear to be well below the industry composite. Only PIC is slightly above the industry composite.

**TABLE F9**

BALANCE SHEET  
NWP TO SURPLUS RATIO

Companies	2003	2002	2001	2000
FPIC	0.87	0.85	1.08	1.39
MPC	1.61	1.34	0.85	0.72
CCC	1.22	1.38	0.73	0.76
TIC	0.18	0.64	1.04	0.92
DCIE	0.96	1.16	0.74	0.57
HCII	0.60	0.66	0.45	0.36
APAC	1.25	1.37	1.30	1.43
PIC	1.03	0.76	0.75	0.44
MMIC	0.90	1.01	0.72	0.56
LIC	1.33	1.05	0.55	0.33
EIC	1.53	1.81	1.58	1.57

The above statistics, which include all lines of business, compare to a medical malpractice composite industry NPSR of approximately 0.9 (see Table 10).

Based on the distribution of direct written premium displayed in Table 4, the companies that focus almost exclusively on medical malpractice (i.e., FPIC, MPC, DCIE, HCII, APAC, PIC and MMIC) appear to be consistent with the industry composite. Only MPC's NPSR significantly exceeds the industry ratio. MPC's high ratio is largely driven by the size of the rate increases MPC has filed across the country over the past few years. APAC has a higher leverage ratio of 1.25, likely driven by the 47% share of direct written premium from workers compensation and primary focus on anesthesiologists.

CCC, TIC, LIC and EIC NLSR and NPSR ratios are impacted by the fact that 69% or more of their business is written in non-medical malpractice lines of business (e.g., workers compensation, personal lines, general liability, etc.).

## **Profitability Analysis**

Table F10 displays each Company's after tax net income for the 2003 calendar year, first quarter 2004, and the ratio to earned premium<sup>18</sup>. Through first quarter 2004, the companies appear to be on track for operating ratios less than 100%<sup>19</sup> after reflecting the impact of items such as rate increases (impacts the premiums earned), reserve strengthening (impacts the losses and LAE incurred), changes in policyholder dividend strategies (impacts dividends to policyholders), and changes in investment strategy (impacts net investment income earned on bonds and realized capital gains on stocks sold throughout the year).

Focusing on companies with a heavy percentage of Florida medical malpractice exposure (e.g., FPIC, PIC and HCII), the operating ratios are all under 100%. The favorable first quarter 2004 operating ratios may indicate that these Florida companies will continue to be profitable through year-end 2004, helping to stabilize the need for future rate changes in the State of Florida. In a perfect world (i.e., medical malpractice rates are currently set at adequate levels and prior year reserve estimates are perfect), companies would only have to keep up with loss severity trends, frequency trends, changing expenses associated with running the company, and changing investment returns<sup>20</sup> in future rate filings.

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<sup>18</sup> Other areas of the report display the ratio of underwriting expenses to written premiums.

<sup>19</sup> Excluding CCC which was impacted by significant reserve strengthening not related to the medical malpractice line of business.

<sup>20</sup> For example, rising interest rates would produce higher investment income as the average portfolio yield increases over time. A rising portfolio yield would allow insurers to reflect higher investment income credit in the ratemaking process, resulting in lower rate indications.

Deloitte Consulting regularly attends the quarterly and year-end earnings calls of the major publicly traded medical malpractice insurers listed on the New York Stock and NASDAQ Exchanges. During recent earnings calls, the management of most companies publicly stated that their companies are actively targeting a combined ratio of 100% or less. Assuming net investment income and other income equal roughly 10% to 15% of earned premium, this would imply a target operating ratio ranging from 85% to 90% before taxes (assuming no adverse prior year reserve development). If a combined ratio of 95% is assumed, this would imply a target operating ratio ranging from 80 to 85%.

**Section 627.912(6), Florida Statutes, as amended by Senate Bill 2-D, (Ch. 2003-416)**

**TABLE F10**

INCOME STATEMENT  
2003 PROFITABILITY (000s)

INCOME STATEMENT ITEM	FPIC	MPC	CCC	TIC	DCIE	HCII	APAC	PIC	MMIC	LIC	EIC
PREMIUMS EARNED	95,142	701,752	5,929,490	315,425	331,287	374,738	17,267	178,973	131,483	2,385,046	651,794
LOSSES INCURRED	53,115	441,910	4,965,060	211,183	229,974	334,028	10,538	90,979	81,324	1,661,428	325,752
LAE INCURRED	34,587	182,395	1,979,394	202,273	133,062	82,840	5,052	93,724	49,103	296,240	90,687
U/W EXPENSE INCURRED	15,797	110,221	2,132,375	124,359	56,088	4,948	3,201	28,725	26,760	266,800	192,052
OTHER DEDUCTIONS	0	0	128,411	0	0	0	0	0	0	0	0
DIVIDENDS TO POLICYHOLDERS	0	0	68,342	19	0	0	0	0	0	0	0
NET U/W INCOME	(8,357)	(32,774)	(3,344,091)	(222,409)	(87,836)	(47,078)	(1,525)	(34,455)	(25,705)	160,579	43,304
NET INVESTMENT INCOME	8,883	62,878	1,526,515	51,777	32,913	54,643	1,695	28,351	20,350	289,563	51,560
OTHER INCOME/(EXPENSE)	127	4,175	(415,508)	13,575	3	487	8	433	1,803	(817)	3
PRETAX OPERATING INCOME	652	34,279	(2,233,084)	(157,057)	(54,920)	8,052	179	(5,670)	(3,552)	449,324	94,866
REALIZED CAPITAL GAINS (CG)	4,693	29,555	(8,931)	143,810	(4,168)	(2,058)	1,234	828	4,575	61,179	20,358
INCOME TAXES INCURRED (TAX)	2,821	17,824	(678,863)	374	(9,022)	(5,549)	381	4,128	1,003	209,735	45,589
NET INCOME	2,524	46,010	(1,563,151)	(13,621)	(50,066)	11,543	1,032	(8,971)	21	300,768	69,635
L&LAE RATIO	92.2%	89.0%	117.1%	131.1%	109.6%	111.2%	90.3%	103.2%	99.2%	82.1%	63.9%
EXPENSE RATIO	16.6%	15.7%	38.1%	39.4%	16.9%	1.3%	18.5%	16.0%	20.4%	11.2%	29.5%
DIVIDEND RATIO	0.0%	0.0%	1.2%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
COMBINED RATIO	108.8%	104.7%	156.4%	170.5%	126.5%	112.6%	108.8%	119.3%	119.5%	93.3%	93.4%
<u>NII AN OTHER INCOME RATIO</u>	<u>9.5%</u>	<u>9.6%</u>	<u>18.7%</u>	<u>20.7%</u>	<u>9.9%</u>	<u>14.7%</u>	<u>9.9%</u>	<u>16.1%</u>	<u>16.8%</u>	<u>12.1%</u>	<u>7.9%</u>
OPERATING RATIO (BEFORE TAX & CG)	99.3%	95.1%	137.7%	149.8%	116.6%	97.9%	99.0%	103.2%	102.7%	81.2%	85.4%
<u>TAX &amp; CG RATIO</u>	<u>-2.0%</u>	<u>-1.7%</u>	<u>-11.3%</u>	<u>-45.5%</u>	<u>-1.5%</u>	<u>-0.9%</u>	<u>-4.9%</u>	<u>1.8%</u>	<u>-2.7%</u>	<u>6.2%</u>	<u>3.9%</u>
OPERATING RATIO (AFTER TAX & CG)	97.3%	93.4%	126.4%	104.3%	115.1%	96.9%	94.0%	105.0%	100.0%	87.4%	89.3%
<b><u>FIRST QUARTER 2004</u></b>											
PREMIUMS EARNED	27,024	147,396	1,682,056	31,602	109,953	92,512	4,395	44,724	35,539	750,381	174,928
NET INCOME	3,923	23,432	123,463	(146,999)	6,932	10,292	(231)	741	816	98,026	26,398
OPERATING RATIO (AFTER TAX & CG)	85.5%	84.1%	92.7%	565.2%	93.7%	88.9%	105.3%	98.3%	97.7%	86.9%	84.9%

**Section 627.912(6), Florida Statutes, as amended by Senate Bill 2-D, (Ch. 2003-416)**

Table F11 displays each Company's after tax net income and ROS for the past four years.

**TABLE F11**

INCOME STATEMENT  
PROFITABILITY (000s)

Company	2003			2002			2001			2000		
	Net Income	Surplus	ROS	Net Income	Surplus	ROS	Net Income	Surplus	ROS	Net Income	Surplus	ROS
FPIC	2,524	118,873	1.1%	10,961	110,858	5.4%	(6,623)	91,682	-3.6%	(6,792)	91,594	-3.6%
MPC	46,010	442,881	5.4%	(13,747)	401,726	-1.7%	73,650	408,215	9.4%	80,921	372,771	11.1%
CCC	(1,563,151)	6,045,822	-14.0%	1,667,491	5,115,932	17.0%	(881,513)	4,700,064	-8.0%	972,566	6,342,320	7.5%
TIC	(13,621)	695,928	-0.8%	(114,832)	1,095,258	-4.8%	(113,424)	1,303,811	-4.8%	(184,103)	1,060,242	-9.4%
DCIE	(50,066)	350,190	-7.2%	(56,662)	341,412	-7.8%	2,268	383,965	0.3%	25,073	381,085	3.2%
HCII	11,543	626,526	1.0%	(107,613)	482,536	-10.1%	72,004	583,763	6.4%	123,648	542,885	11.7%
APAC	1,032	15,009	3.5%	569	14,612	1.9%	(1,131)	15,405	-3.6%	(1,088)	15,923	-3.2%
PIC	(8,971)	187,937	-2.3%	9,915	196,955	2.7%	(17,032)	175,874	-4.0%	(11,472)	253,545	-2.4%
MMIC	21	177,177	0.0%	(10,046)	142,978	-3.3%	6,628	158,558	2.1%	7,026	150,074	2.3%
LIC	300,768	2,116,406	7.8%	115,903	1,763,654	3.3%	116,604	1,746,113	3.4%	141,051	1,639,415	4.4%
EIC	69,635	457,608	9.0%	20,689	313,850	3.8%	14,766	230,889	3.7%	25,676	163,448	8.5%
ALL COS	(1,204,275)	11,234,356	-5.7%	1,522,628	9,979,772	7.7%	(733,802)	9,798,338	-3.5%	1,172,506	11,013,302	5.3%
MM FOCUS	2,094	1,918,592	0.1%	(166,623)	1,691,077	-4.7%	129,765	1,817,462	3.6%	217,316	1,807,876	6.1%
<b>Adverse/(Favorable) Reserve Development (ARD)</b>												
ALL COS	2,610,616			285,974			1,499,980			156,369		
MM FOCUS	127,282			191,308			(71,640)			(194,712)		
<b>Restated Net Income (i.e., adding back 65% of ARD to NI)</b>												
ALL COS	492,625	11,234,356	2.3%	1,708,511	9,979,772	8.6%	241,185	9,798,338	1.2%	1,274,146	11,013,302	5.8%
MM FOCUS	84,827	1,918,592	2.3%	(42,273)	1,691,077	-1.2%	83,199	1,817,462	2.3%	90,753	1,807,876	2.5%

Profitability can be extremely volatile from year to year as observed in Table 11. FPIC, which writes 81% of its medical malpractice book of business in Florida, had negative net income in 2000 and 2001. In 2002 and 2003, FPIC produced positive net income large enough to just offset the negative net income from the 2000 and 2001 years. Through first quarter 2004, FPIC continues to produce positive net income (see Table F10). HCII's negative net income in 2002 was driven by \$122 million of net investment losses partially offset by favorable development of \$22 million on prior accident years. DCIE's negative net income in 2003 was largely driven by adverse development on prior accident years of \$78 million.

The 2003 return on average surplus varies from a low of -14.0% to a high of 9.0%. The 2002 ROS varies from a low of -10.1% to a high of 17.0%. In all calendar years, the impact of items such as gains/(losses) on investment income and adverse development on prior accident years can significantly impact the ROS.

The ROS for the medical malpractice focused companies was 0.1% in 2003, -4.7% in 2002, 3.6% in 2001 and 6.1% in 2000 (see Table F11). These single digit returns hardly represent figures that would be indicative of excess profits in an industry where a target ROS of 15% is required to attract investor capital. Adjusting the net income and ROS figures to remove the impact of adverse/(favorable) reserve development on prior accident years<sup>21</sup>, the medical malpractice focused companies produced an adjusted ROS of 2.3% in 2003, -1.2% in 2002, 2.3% in 2001 and 2.5% in 2000. Even with the benefit of removing the adverse development in the 2003 and 2002 years, the ROS continues to be in the low single digits and well below the levels necessary to indicate excess profit levels.

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<sup>21</sup> In order to reduce the volatility in the actual net income and ROS figures, we have restated the ROS to remove the impact of the adverse/(favorable) prior year reserve development. Net income is restated by adding 65% of the adverse/(favorable) development back into net income. The 65% adjustment equals 100% minus an assumed 35% tax rate. We have not attempted to restate surplus in this simplistic example.

Table F12 displays the adverse/(favorable) development<sup>22</sup> by year and by company:

<b>TABLE F12</b>					
ADVERSE/(FAVORABLE) RESERVE DEVELOPMENT (000's)					
ALL LINES OF BUSINESS					
	2003	2002	2001	2000	1999
FPIC	1,948	1,404	10,191	4,717	(16,387)
MPC	43,272	95,720	(45,978)	(77,899)	(41,636)
CCC	2,331,312	(167,170)	1,420,178	92,078	423,187
TIC	(345)	97,359	97,219	266,089	181,340
DCIE	78,109	105,014	1,762	(47,531)	(17,359)
HCII	(10,241)	(22,247)	(44,044)	(63,461)	(58,816)
APAC	68	605	243	(1,085)	(3,600)
PIC	65	(10,118)	25,318	(161)	(21,086)
MMIC	14,061	20,930	(19,132)	(9,292)	(1,627)
LIC	148,347	159,140	64,265	24,754	(6,208)
EIC	4,020	5,337	(10,042)	(31,840)	(18,450)
ALL COS	2,610,616	285,974	1,499,980	156,369	419,358
MM FOCUS	127,282	191,308	(71,640)	(194,712)	(160,511)

As one can see above, the medical malpractice focused companies (i.e., FPIC, MPC, DCIE, HCII, APAC, PIC and MMIC) all experienced favorable development through 2001, positively impacting the net income and ROS figures. The favorable development lasted one year longer than the industry results displayed in Table 18 and Table 26 which turned unfavorable in 2000. In 2002, development on prior accident years turned adverse, negatively impacting the calendar year net income and ROS figures.

In discussing profitability, it is important to remember that the medical malpractice line of business has a very long “tail”. As will be discussed in the **Analysis of Closed Claim Database** section of this report, Florida medical malpractice claims take approximately three and a half years on average from the date of occurrence to the date of closing. In addition, approximately 1.4% of the claims in the Closed Claim Database take 9 or more years from the date of occurrence to the

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<sup>22</sup> Adverse development implies prior year estimates have increased. Favorable development implies prior year estimates have decreased.

date of closing. Given Florida’s medical malpractice “tail” and the challenges associated with correctly determining premium rates companies must to charge today for claims where the ultimate cost may not be known for 9 or more years, it is important for readers of financial statements to focus on insurance company results over a multi-year period. Table F13 displays the composite profitability over the full four year period (i.e., 2000 through 2003).

<b>TABLE F13</b>					
<b>COMPOSITE PROFITABILITY (000s)</b>					
<b>ALL LINES OF BUSINESS</b>					
	<b>NET</b>		<b>ADV/(FAV)</b>	<b>ADJ.</b>	<b>ADJ.</b>
	<b>INCOME</b>	<b>ROS</b>	<b>DEV.</b>	<b>NI</b>	<b>ROS</b>
FPIC	70	0.0%	18,260	11,939	2.9%
MPC	186,834	11.5%	15,115	196,659	12.1%
CCC	195,393	0.9%	3,676,398	2,585,052	11.6%
TIC	(425,980)	-10.3%	460,322	(126,771)	-3.1%
DCIE	(79,386)	-5.4%	137,354	9,894	0.7%
HCII	99,582	4.5%	(139,993)	8,587	0.4%
APAC	(618)	-1.0%	(169)	(728)	-1.2%
PIC	(27,560)	-3.4%	15,104	(17,742)	-2.2%
MMIC	3,628	0.6%	6,567	7,897	1.3%
LIC	674,326	9.3%	396,506	932,055	12.8%
EIC	130,766	11.2%	(32,525)	109,624	9.4%
ALL COS	757,056	1.8%	4,552,939	3,716,467	8.8%
MM FOCUS	182,551	2.5%	52,238	216,506	3.0%

Over the four year period, the medical malpractice focused companies produced an average ROS of 2.5%, or an adjusted ROS of 3.0% after removing the impact of the \$52.2 million in cumulative adverse development. From either perspective, the average ROS continues to be in the low single digits and well below levels which would indicate excessive profits.

As we noted in the beginning of this report, the medical malpractice market is going through its third crisis in the past three decades. It is also important to note that a number of Florida's current medical malpractice writers have been in business for only a relatively short time period and it is not possible to know how the companies would have performed during past historical cycles. Given the long "tail" nature of the medical malpractice market, the strong likelihood of future cycles, and the historically volatile results of the top Florida insurers, it is reasonable to focus on financial results over a time period roughly equal to the average historical medical malpractice cycle (e.g., cycle ranging from seven to nine years). Analysis of profit and ratemaking decisions made based upon a few quarters' profits without considering the cumulative results over the average cycle would not portray the economic realities of the medical malpractice business.

A long term focus by legislators, regulators, investors, actuaries, and healthcare providers is needed to help ensure that medical malpractice insurers will be able to build their surplus in a period of rising prices like Florida has been experiencing since 2001. The build up of surplus also allows Florida's insurers to withstand the pressures of a softer pricing environment and adverse reserve development which have an adverse impact on surplus. In situations where companies cannot replenish or build surplus, those who are weakly capitalized may find it more difficult to fulfill their obligations to policyholders. These companies may ultimately shift the burden of paying claims to the State Guaranty Fund (and other solvent insurers) or back to Florida healthcare providers when claim payments exceeded the \$300,000 Guaranty Fund maximum if companies were to become insolvent. For physicians and hospitals insured by risk retention groups, the inability to replenish or build up surplus is more severe since risk retention groups are not backed by the State Guaranty Fund, exposing healthcare providers to higher loss payments in the event of insolvency.

Adequate premium rates, solid leverage ratios and strong capitalization allows Florida's medical malpractice insurers to maintain their investment grade ratings from various rating agencies<sup>23</sup> and

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<sup>23</sup> Examples include A.M. Best, Moody's, Standard & Poor's, Duff & Phelps

helps them to satisfy their Risk Based Capital requirements<sup>24</sup>. Furthermore, the previous factors increase the probability that healthcare providers will be able to purchase sound and stable coverage with a much lower chance of having their insurer exit the market or potentially become insolvent.

Although net income and ROS is interesting from a profitability perspective, the trend in schedule P loss ratios and the trend in assumptions underlying each company's rate filing (see **Rate Filing Trend Analysis**) presents the most relevant picture of the direction that future rates will take for healthcare providers practicing in the State of Florida, since profit is primarily driven by the accident and report year loss ratio trends. These trends will be discussed below.

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<sup>24</sup> Risk Based Capital (RBC) standards for the Property/Casualty insurance industry were developed by the National Association of Insurance Commissioners (NAIC). The NAIC RBC formula looks at five different risk charges;  $R_0$  - investment in insurance affiliates,  $R_1$  - fixed income securities,  $R_2$  - equity investments,  $R_3$  - credit risk,  $R_4$  - reserving risk, and  $R_5$  - written premium risk in order to derive the total capital requirements (TCR) and authorized control level (ACL) for a company. The  $TCR = R_0 + (R_1^2 + R_2^2 + R_3^2 + R_4^2 + R_5^2)^{0.5}$  and the  $ACL = 50\% \times TCR$ . Depending upon the ratio of the insurers total adjusted capital to ACL, the following four levels of action are determined: Company Action Level at 2 x ACL (i.e., RBC ratio of 200%), Regulatory Action Level at 1.5 x ACL, Authorized Control Level at 1.0 x ACL and Mandatory Control Level at 0.7 x ACL.

## **Loss Ratio Analysis**

**Appendix A – Medical Malpractice Financial Metrics by Writing Company** displays a five year recap of the calendar year loss ratios, loss adjustment expense ratios, expense ratios and combined ratios for all lines of business. In addition, **Appendix A** also displays the Schedule P one-year and two-year development on prior accident years for the 2003 and 2002 calendar years for all lines of business. The one-year development helps to explain any unusual movement in the calendar year loss ratios that result from changes in prior year reserve estimates (see Table F12 above).

For example, FPIC's 2002 and prior year reserve estimates developed unfavorably by \$1.9 million or 1.8% of the prior year-end surplus over the past year. Excluding other lines of business, FPIC's medical malpractice estimate developed unfavorably by just under \$1 million. APAC's and PIC's 2002 and prior year reserve estimates were essentially unchanged over the past year. MPC's 2002 and prior year reserve estimates developed unfavorably by \$43.3 million or 10.8% over the past year. Excluding other lines of business, MPC's medical malpractice estimate developed unfavorably by approximately \$42.1 million. HCII's 2002 and prior year reserve estimates developed favorably by \$10.2 million or 2.1% over the past year.

CCC, a large national multiline carrier, experienced significant prior year adverse development of \$2.3 billion or 45.6% of the prior year-end surplus over the past year. Of this \$2.3 billion, only \$16.2 million was from medical malpractice occurrence development. \$85.6 million was from claims-made development. Total medical malpractice development explained less than 4.5% of CCC's 2002 and prior year reserve development.

In order to review the trend in loss ratios without the impact of changes in prior year reserve estimates that can distort calendar year ratios, Deloitte Consulting has prepared Table F14 (claims-made) and Table F15 (occurrence) using report year and accident year data from Schedule P – Part 1.

Table F14 displays medical malpractice claims-made direct and assumed loss and LAE ratios and net loss and LAE ratios by company and year.

TABLE F14											
CLAIMS-MADE MEDICAL MALPRACTICE											
DIRECT + ASSUMMED LOSS AND LAE RATIO'S											
REPORT YEAR	APAC	CCC	DCIE	EIC	FPIC	HCII	LIC	MMIC	MPC	PIC	TIC
1994	31.6	104.4	103.2	53.4	86.1		88.9	79.6	119.5	102.1	0.0
1995	101.0	129.9	88.3	78.5	109.3		132.9	67.9	116.1	97.9	7.0
1996	86.4	131.8	102.6	65.2	75.8		141.1	96.1	111.6	101.3	0.0
1997	131.4	141.1	88.7	63.4	122.9		180.0	107.4	120.6	118.1	85.4
1998	68.5	145.9	103.2	87.9	101.2		168.7	150.7	154.3	114.3	97.2
1999	102.4	152.9	74.6	110.1	103.4		362.8	162.3	157.8	130.0	144.9
2000	156.3	182.8	154.0	86.2	112.1		133.6	162.2	132.5	143.5	149.3
2001	133.3	165.3	114.6	67.8	89.3		85.2	172.5	113.9	117.6	168.1
2002	98.4	99.1	79.7	59.9	79.4	159.7	74.6	117.6	91.8	106.8	120.3
2003	106.9	74.5	82.3	60.8	80.0	103.5	75.3	94.6	83.4	94.8	82.9

NET LOSS AND LAE RATIOS											
REPORT YEAR	APAC	CCC	DCIE	EIC	FPIC	HCII	LIC	MMIC	MPC	PIC	TIC
1994	49.6	107.3	105.8	52.6	82.6		158.4	84.7	124.7	103.7	0.0
1995	102.2	129.9	90.6	79.7	102.3		206.6	82.3	129.5	99.3	20.2
1996	90.6	128.0	103.3	67.8	80.1		119.4	93.3	121.7	99.5	0.0
1997	81.0	137.7	91.2	64.9	120.0		279.9	96.0	130.1	118.3	121.8
1998	95.2	153.7	101.7	88.3	108.4		144.3	114.3	143.4	116.6	127.2
1999	101.4	141.7	75.4	107.9	96.6		452.3	114.6	153.0	123.3	137.3
2000	121.7	185.4	112.1	89.2	118.6		166.0	119.4	129.6	143.8	148.1
2001	96.8	267.3	120.0	72.6	95.0		97.8	144.4	118.4	114.8	164.0
2002	89.3	127.5	81.3	62.1	88.9	159.7	83.5	104.0	90.7	101.0	125.1
2003	93.0	74.5	89.8	61.8	93.2	103.5	86.0	86.1	86.9	96.0	86.1

On a direct + assumed and net basis, the numbers have been improving since the 2000 report year. This favorable trend is consistent with the rate increases filed by medical malpractice insurers over the past few years across the country. Focusing on the 2003 report year, all but one company has a net loss and LAE ratio under the 100% level. This is a significant improvement from the 2000 report year when only one company had a loss and LAE loss ratio under the 100% level. Adjusting for each company's expense ratio (e.g., industry average of 16%), net investment income and other income ratio (e.g., industry average of 16%), and tax position; the current loss and LAE ratio trends and 2003 results should help to ensure that medical malpractice insurers continue to offer stable and financially sound protection to healthcare providers across the country.

**Section 627.912(6), Florida Statutes, as amended by Senate Bill 2-D, (Ch. 2003-416)**

Table F15 displays medical malpractice occurrence direct and assumed loss and LAE ratios and net loss and LAE ratios by company and year.

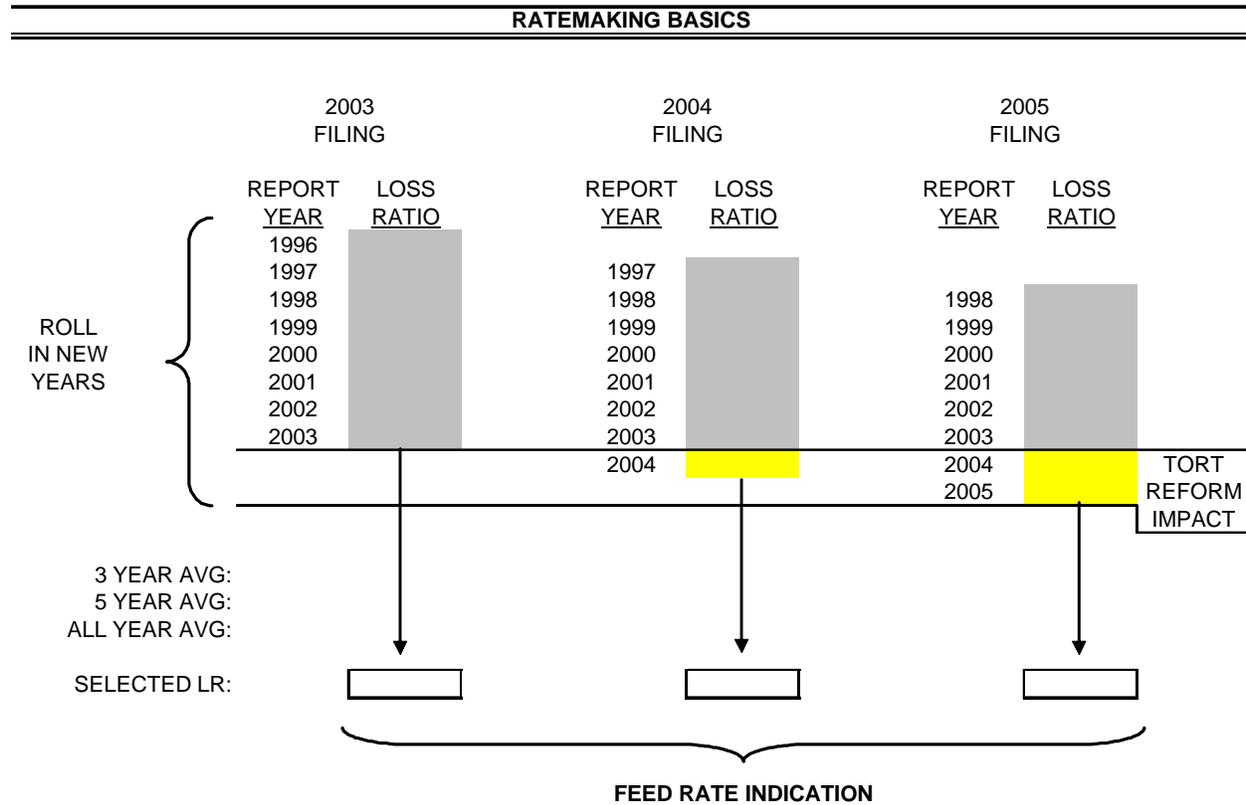
TABLE F15											
OCCURRENCE MEDICAL MALPRACTICE											
DIRECT + ASSUMMED LOSS AND LAE RATIO'S											
ACCIDENT											
YEAR	APAC	CCC	DCIE	EIC	FPIC	HCII	LIC	MMIC	MPC	PIC	TIC
1994		81.0	256.1			69.3		75.6	94.3	119.0	34.3
1995		56.7	214.9			90.7		70.9	93.9	105.0	42.2
1996		122.7	188.2			113.3		105.5	100.7	91.3	94.5
1997		77.7	216.3	0.0		124.3		82.5	102.9	107.3	97.9
1998	556.8	57.7	283.2	39.2	168.7	134.5		31.4	95.4	150.8	95.3
1999	104.2	59.4	62.8	0.0	79.1	148.0		61.9	103.9	221.7	171.2
2000	35.3	58.7	42.6		37.1	149.9		160.5	110.8	183.2	231.2
2001	69.9	44.1	119.6		93.7	122.0		129.9	92.9	149.2	138.9
2002	57.1	44.5	81.5		80.2	108.6		105.0	81.2	155.6	135.0
2003	57.5	48.0	60.2		89.0	111.6	98.4	64.1	81.0	128.0	116.0

NET LOSS AND LAE RATIOS											
ACCIDENT											
YEAR	APAC	CCC	DCIE	EIC	FPIC	HCII	LIC	MMIC	MPC	PIC	TIC
1994		130.7	359.8			71.0		60.2	95.7	106.4	55.4
1995		66.5	294.0			93.7		27.4	97.8	103.7	172.2
1996		145.7	238.0			110.0		121.4	102.3	90.8	116.6
1997		109.1	216.1	0.0		125.3		77.2	89.3	106.2	41.4
1998	676.5	82.6	282.0	39.2	156.7	136.8		23.9	78.1	147.1	92.8
1999	103.4	938.0	65.8	0.0	79.0	130.9		46.1	100.1	189.0	167.5
2000	32.1	41.5	300.4		34.2	147.3		112.8	109.1	171.6	292.1
2001	75.0	43.6	181.6		90.5	126.4		133.1	82.3	145.2	113.7
2002	57.7	52.8	182.2		58.0	112.8		124.7	79.5	145.1	108.9
2003	68.2	54.3	63.4		63.7	113.3	91.5	113.0	72.3	127.6	113.7

The occurrence numbers have also been improving. Given the heavy focus on claims-made business by a majority of Florida companies (except for HCII) and the countrywide shift away from writing occurrence policies (i.e., towards claims-made policies), Table F14 presents the more accurate picture of the overall loss and LAE ratio trends that would impact the majority of healthcare providers across the country and in Florida as will be discussed later.

Although ratemaking will be discussed in greater detail in the **Rate Filing Trend Analysis** section of this report, the exhibit below visually walks the reader through the importance of accident/report<sup>25</sup> year trends on medical malpractice insurance company rate filings.



Florida’s admitted medical malpractice insurers submit rate filings to the OIR on an annual basis. In each filing, a new report year is added to the ratemaking analysis while an older year is rolled off. If, consistent with Tables F14 and F15, the trend in report year and accident year loss and LAE ratios is favorable for Florida insurers, the final selected loss and LAE ratio underlying each

<sup>25</sup> Ratemaking for claims-made policies uses data grouped by report year (i.e., the date the loss was reported to the insurer). Ratemaking for occurrence policies uses data grouped by accident year (i.e., the date the accident occurred). We have used report year in the above example for illustration purposes only. Either type of data could have been used to illustrate our point.

company's rate indication will improve<sup>26</sup>. This is because the older years with higher loss ratios will be replaced over time with the lower loss ratios of the newer years.

In addition, as the benefits of SB2D roll into the data, the favorable impact of tort reform in Florida will also begin to impact the insurance company indications. Although not displayed in the above illustration, it is important to note that all Florida medical malpractice insurers were required to submit rate filings reflecting the "presumed factor" published by the OIR (or an adjusted "presumed factor" reflecting their own mix of business). These rate filings provided healthcare providers in the State of Florida with immediate relief, not a phased-in savings as would have happened if the savings had to phase-in over time with the reporting of claims impacted by SB2D.

Excluding tort reform adjustments like the "presumed factor", favorable report year and accident year loss ratio trends phase in over time. Depending upon how each insurer selects their ultimate loss and LAE ratio underlying their rate indication (e.g., 3 year average, 5 year average, etc.), the phase-in period can vary by company. If a company relies upon a 3 year average, their phase-in period would be shorter than a company relying upon on average in excess of 3 years. Given the long tail nature of the medical malpractice line of business, it would also be extremely risky to rely solely upon the current report year or accident year loss and LAE ratio. If companies relied solely upon the current year ultimate loss ratio as a basis for determining their indications, the annual rate changes would swing wildly in direct relationship to the immaturity and volatility associated with such a "green" estimate. By considering multiple years in the ratemaking formula, the annual rate indications become more stable and reduce the volatility in the annual premiums paid by Florida's healthcare providers.

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<sup>26</sup> Some insurers develop their rate indications using pure premiums instead of loss and LAE ratios. We have used loss and LAE ratios for illustration purposes only. Either ratemaking approach could have been used to illustrate our point.

**Section 627.912(6), Florida Statutes, as amended by Senate Bill 2-D, (Ch. 2003-416)**

Table F16 displays the medical malpractice direct loss ratio derived from “Page 14” of the Annual Statement for Florida.

TABLE F16						
FLORIDA DIRECT LOSS RATIO						
Companies	DIRECT EARNED PREMIUM			INCURRED LOSS RATIO		
	2003	2002	2001	2003	2002	2001
FPIC	173,787,185	152,449,954	89,044,736	59.1%	61.7%	67.6%
HCII	115,509,472	106,482,154	88,970,154	71.3%	81.1%	107.1%
PIC	73,325,000	60,347,429	57,149,827	24.6%	39.1%	90.0%
MPC	63,205,523	39,591,739	30,731,371	129.3%	91.1%	109.6%
MMIC	65,767,026	40,956,626	19,808,077	65.0%	103.4%	112.4%
LIC	56,202,628	31,925,627	2,144,367	97.7%	64.2%	105.6%
EIC	35,536,453	25,487,045	10,808,815	53.4%	65.9%	78.6%
DCIE	35,812,399	28,511,037	20,422,981	53.2%	80.3%	52.4%
CCC	24,216,430	11,082,742	22,609,659	152.7%	53.9%	23.9%
TIC	23,529,680	20,856,846	21,880,706	104.3%	212.5%	72.8%
APAC	19,277,498	14,284,978	10,699,479	130.0%	61.4%	33.1%
ALL COS	686,169,294	531,976,177	374,270,172	73.9%	75.5%	82.6%
MM FOCUS	546,684,103	442,623,917	316,826,625	68.0%	71.0%	87.4%

Table F17 displays the medical malpractice direct DCC ratio and direct loss and DCC ratio derived from “Page 14” of the Annual Statement for Florida.

TABLE F17						
FLORIDA DIRECT LOSS AND DCC RATIOS						
Companies	DCC RATIO			LOSS AND DCC RATIO		
	2003	2002	2001	2003	2002	2001
FPIC	30.0%	21.8%	22.3%	89.1%	83.5%	89.9%
HCII	6.3%	11.5%	16.5%	77.6%	92.6%	123.7%
PIC	47.4%	43.5%	38.4%	72.0%	82.6%	128.4%
MPC	31.0%	30.9%	41.7%	160.4%	122.1%	151.3%
MMIC	23.1%	19.5%	52.1%	88.1%	123.0%	164.5%
LIC	11.7%	12.1%	-45.2%	109.4%	76.3%	60.4%
EIC	11.1%	12.3%	-0.7%	64.4%	78.2%	77.9%
DCIE	39.8%	19.8%	46.1%	93.1%	100.1%	98.5%
CCC	48.0%	7.3%	5.2%	200.6%	61.3%	29.0%
TIC	52.7%	39.1%	10.2%	157.0%	251.6%	83.0%
APAC	31.1%	22.2%	8.8%	161.1%	83.6%	41.9%
ALL COS	26.8%	21.9%	24.7%	100.7%	97.5%	107.3%
MM FOCUS	27.3%	22.8%	28.4%	95.3%	93.8%	115.9%

**Section 627.912(6), Florida Statutes, as amended by Senate Bill 2-D, (Ch. 2003-416)**

Over the three year period, the medical malpractice focused companies' direct loss and DCC ratio improved from 115.9% to 95.3%. The calendar year ratios improved significantly for HCII, PIC and MMIC. FPIC and DCIE remained fairly consistent. MPC and APAC both deteriorated in 2003.

The following seven tables display direct earned premium, direct loss and DCC ratios, the percentage distribution of premium, and the loss and DCC ratio relativity for calendar years 2001 through 2003 for the top five states.

Table F18 displays the medical malpractice direct DCC ratio and direct loss and DCC ratio derived from "Page 14" of the Annual Statement for the top 5 MPC states.

TABLE F18							
MPC TOP 5 DIRECT LOSS AND DCC RATIOS							
Company		DIRECT EARNED PREMIUM			LOSS AND DCC RATIO		
		2003	2002	2001	2003	2002	2001
MPC	FL	63,205,523	39,591,739	30,731,371	160.4%	122.1%	151.3%
	TX	129,780,889	85,158,862	58,161,998	119.7%	120.3%	32.9%
	OH	109,951,559	69,998,445	53,637,444	113.0%	91.0%	107.0%
	PA	70,150,840	44,128,288	26,598,907	87.9%	81.6%	91.2%
	KY	32,639,609	24,051,204	19,309,409	106.4%	88.9%	35.2%
		405,728,420	262,928,538	188,439,129	117.7%	103.4%	81.8%
MPC	FL	15.6%	15.1%	16.3%	1.36	1.18	1.85
	TX	32.0%	32.4%	30.9%	1.02	1.16	0.40
	OH	27.1%	26.6%	28.5%	0.96	0.88	1.31
	PA	17.3%	16.8%	14.1%	0.75	0.79	1.11
	KY	8.0%	9.1%	10.2%	0.90	0.86	0.43
		100.0%	100.0%	100.0%	1.00	1.00	1.00

**Section 627.912(6), Florida Statutes, as amended by Senate Bill 2-D, (Ch. 2003-416)**

Table F19 displays the medical malpractice direct DCC ratio and direct loss and DCC ratio derived from “Page 14” of the Annual Statement for the top 5 DCIE states.

TABLE F19							
DCIE TOP 5 DIRECT LOSS AND DCC RATIOS							
Company		DIRECT EARNED PREMIUM			LOSS AND DCC RATIO		
		2003	2002	2001	2003	2002	2001
DCIE	FL	35,812,399	28,511,037	20,422,981	93.1%	100.1%	98.5%
	CA	117,505,240	129,179,598	78,454,833	77.5%	85.4%	41.0%
	OH	27,935,354	15,449,785	13,282,953	80.2%	104.2%	135.4%
	VA	18,247,274	6,860,018	4,366,527	74.0%	104.1%	103.6%
	WA	21,770,431	15,104,688	9,419,321	108.9%	114.7%	113.8%
		221,270,698	195,105,126	125,946,615	83.2%	91.9%	67.9%
DCIE	FL	16.2%	14.6%	16.2%	1.12	1.09	1.45
	CA	53.1%	66.2%	62.3%	0.93	0.93	0.60
	OH	12.6%	7.9%	10.5%	0.96	1.13	2.00
	VA	8.2%	3.5%	3.5%	0.89	1.13	1.53
	WA	9.8%	7.7%	7.5%	1.31	1.25	1.68
		100.0%	100.0%	100.0%	1.00	1.00	1.00

Table F20 displays the medical malpractice direct DCC ratio and direct loss and DCC ratio derived from “Page 14” of the Annual Statement for the top 5 PIC states.

TABLE F20							
PIC TOP 5 DIRECT LOSS AND DCC RATIOS							
Company		DIRECT EARNED PREMIUM			LOSS AND DCC RATIO		
		2003	2002	2001	2003	2002	2001
PIC	FL	73,325,000	60,347,429	57,149,827	72.0%	82.6%	128.4%
	MI	54,576,947	49,123,077	43,145,692	62.9%	87.2%	84.8%
	IL	20,772,752	17,805,508	17,287,026	112.6%	145.1%	155.6%
	PA	7,795,724	8,454,338	4,484,973	212.0%	262.7%	320.5%
	KY	7,124,932	4,810,916	2,567,939	129.0%	184.4%	158.3%
		163,595,355	140,541,268	124,635,457	83.3%	106.4%	124.6%
PIC	FL	44.8%	42.9%	45.9%	0.86	0.78	1.03
	MI	33.4%	35.0%	34.6%	0.76	0.82	0.68
	IL	12.7%	12.7%	13.9%	1.35	1.36	1.25
	PA	4.8%	6.0%	3.6%	2.55	2.47	2.57
	KY	4.4%	3.4%	2.1%	1.55	1.73	1.27
		100.0%	100.0%	100.0%	1.00	1.00	1.00

**Section 627.912(6), Florida Statutes, as amended by Senate Bill 2-D, (Ch. 2003-416)**

Table F21 displays the medical malpractice direct DCC ratio and direct loss and DCC ratio derived from “Page 14” of the Annual Statement for the top 5 HCII states.

TABLE F21							
HCII TOP 5 DIRECT LOSS AND DCC RATIOS							
Company		DIRECT EARNED PREMIUM			LOSS AND DCC RATIO		
		2003	2002	2001	2003	2002	2001
HCII	FL	115,509,472	106,482,154	88,970,154	77.6%	92.6%	123.7%
	TX	134,208,307	109,117,631	93,958,833	75.9%	92.1%	125.2%
	CA	12,208,873	12,957,555	11,285,110	87.6%	85.6%	73.9%
	LA	11,567,046	10,291,536	9,890,103	87.6%	97.2%	106.8%
	NV	11,149,979	10,291,630	7,796,549	105.6%	97.2%	127.0%
		284,643,677	249,140,506	211,900,749	78.7%	92.4%	121.0%
HCII	FL	40.6%	42.7%	42.0%	0.99	1.00	1.02
	TX	47.1%	43.8%	44.3%	0.96	1.00	1.03
	CA	4.3%	5.2%	5.3%	1.11	0.93	0.61
	LA	4.1%	4.1%	4.7%	1.11	1.05	0.88
	NV	3.9%	4.1%	3.7%	1.34	1.05	1.05
		100.0%	100.0%	100.0%	1.00	1.00	1.00

Table F22 displays the medical malpractice direct DCC ratio and direct loss and DCC ratio derived from “Page 14” of the Annual Statement for the top 5 APAC states.

TABLE F22							
APAC TOP 5 DIRECT LOSS AND DCC RATIOS							
Company		DIRECT EARNED PREMIUM			LOSS AND DCC RATIO		
		2003	2002	2001	2003	2002	2001
APAC	FL	19,277,498	14,284,978	10,699,479	161.1%	83.6%	41.9%
	TN	15,900	12,325	11,299	161.1%	0.0%	-12.7%
	TX	7,396,216	4,039,004	706,134	161.1%	86.3%	128.6%
	AL	890,749	614,295	700,437	161.1%	219.8%	63.5%
	GA	1,770,770	1,093,457	524,251	161.1%	38.9%	136.1%
		29,351,133	20,044,059	12,641,600	161.1%	85.8%	51.8%
APAC	FL	65.7%	71.3%	84.6%	1.00	0.97	0.81
	TN	0.1%	0.1%	0.1%	1.00	0.00	-0.24
	TX	25.2%	20.2%	5.6%	1.00	1.01	2.48
	AL	3.0%	3.1%	5.5%	1.00	2.56	1.23
	GA	6.0%	5.5%	4.1%	1.00	0.45	2.63
		100.0%	100.0%	100.0%	1.00	1.00	1.00

**Section 627.912(6), Florida Statutes, as amended by Senate Bill 2-D, (Ch. 2003-416)**

Table F23 displays the medical malpractice direct DCC ratio and direct loss and DCC ratio derived from “Page 14” of the Annual Statement for the top 5 MMIC states.

TABLE F23							
MMIC TOP 5 DIRECT LOSS AND DCC RATIOS							
Company		DIRECT EARNED PREMIUM			LOSS AND DCC RATIO		
		2003	2002	2001	2003	2002	2001
MMIC	FL	65,767,026	40,956,626	19,808,077	88.1%	123.0%	164.5%
	GA	129,076,738	90,772,038	68,716,286	108.1%	146.7%	126.2%
	NC	39,072,818	23,568,356	12,383,603	90.9%	111.6%	93.5%
	VA	7,474,957	4,643,901	1,003,493	79.0%	59.8%	84.8%
	AL	7,404,082	4,777,952	3,033,640	47.7%	101.1%	72.1%
		248,795,621	164,718,873	104,945,099	97.5%	132.0%	127.6%
MMIC	FL	26.4%	24.9%	18.9%	0.90	0.93	1.29
	GA	51.9%	55.1%	65.5%	1.11	1.11	0.99
	NC	15.7%	14.3%	11.8%	0.93	0.85	0.73
	VA	3.0%	2.8%	1.0%	0.81	0.45	0.66
	AL	3.0%	2.9%	2.9%	0.49	0.77	0.56
		100.0%	100.0%	100.0%	1.00	1.00	1.00

Table F24 displays the medical malpractice direct DCC ratio and direct loss and DCC ratio derived from “Page 14” of the Annual Statement for the top 5 FPIC states.

TABLE F24							
FPIC TOP 5 DIRECT LOSS AND DCC RATIOS							
Company		DIRECT EARNED PREMIUM			LOSS AND DCC RATIO		
		2003	2002	2001	2003	2002	2001
FPIC	FL	173,787,185	152,449,954	89,044,736	89.1%	83.5%	89.9%
	PA	17,462,640	14,541,685	10,670,866	123.4%	78.0%	99.2%
	GA	10,878,048	8,651,331	3,110,340	71.9%	74.8%	112.0%
	AR	6,642,286	3,749,260	4,068	64.6%	64.6%	0.0%
	OH	7,588,744	8,800,168	1,414,895	45.2%	61.5%	61.2%
		216,358,903	188,192,398	104,244,905	88.7%	81.3%	91.1%
FPIC	FL	80.3%	81.0%	85.4%	1.00	1.03	0.99
	PA	8.1%	7.7%	10.2%	1.39	0.96	1.09
	GA	5.0%	4.6%	3.0%	0.81	0.92	1.23
	AR	3.1%	2.0%	0.0%	0.73	0.79	0.00
	OH	3.5%	4.7%	1.4%	0.51	0.76	0.67
		100.0%	100.0%	100.0%	1.00	1.00	1.00

## **ANALYSIS OF CLOSED CLAIM DATABASE**

The Florida OIR Department of Financial Services collects closed claim reports filed by insurers. This information is stored in the closed claim database (CCD) and a copy of it, valued as of August 26, 2004, has been provided to Deloitte Consulting for the purposes of analyzing closed claim reports for those claims closed prior to August 26, 2004. It should be noted that the State of Florida takes no responsibility for the accuracy, completeness, or usefulness of the information filed by insurers and captured in the CCD. Deloitte Consulting has made every reasonable effort to scrutinize data entries and otherwise test the CCD in order to capture only those entries that may prove to be useful to the analysis. Appendix F of this report outlines the steps used to perform the data preparation process.

### **Trends in Frequency and Severity**

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

Given the long-tailed nature of medical malpractice claims and the “green” nature of the legislation, it is difficult to draw any conclusions on SB2D’s impact on claim frequency and severity. Deloitte Consulting has observed, however, an increase in the number of claims closing in recent years. Table C.1 demonstrates this upward trend over the past few years and continuing through the first 8 months of 2004 for all severity codes<sup>27</sup>. Table C.1.1 displays the trend for

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<sup>27</sup> Severity Code means the severity of injury scale found in the National Association of Insurance Commissioners (NAIC) medical professional liability insurance uniform claims report:

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

severity codes 1 to 3, Table C.1.2 displays the trend for severity codes 4 to 6, Table C.1.3 displays the trend for severity code 7, and Table C.1.4 displays the trend for severity codes 8 and 9.

TABLE C.1

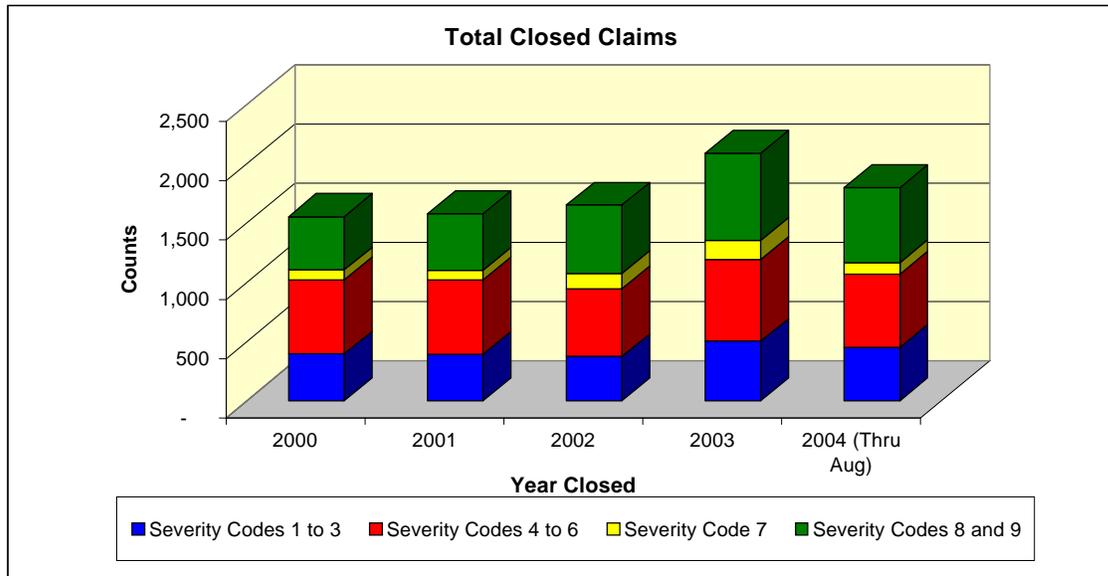


TABLE C.1.1

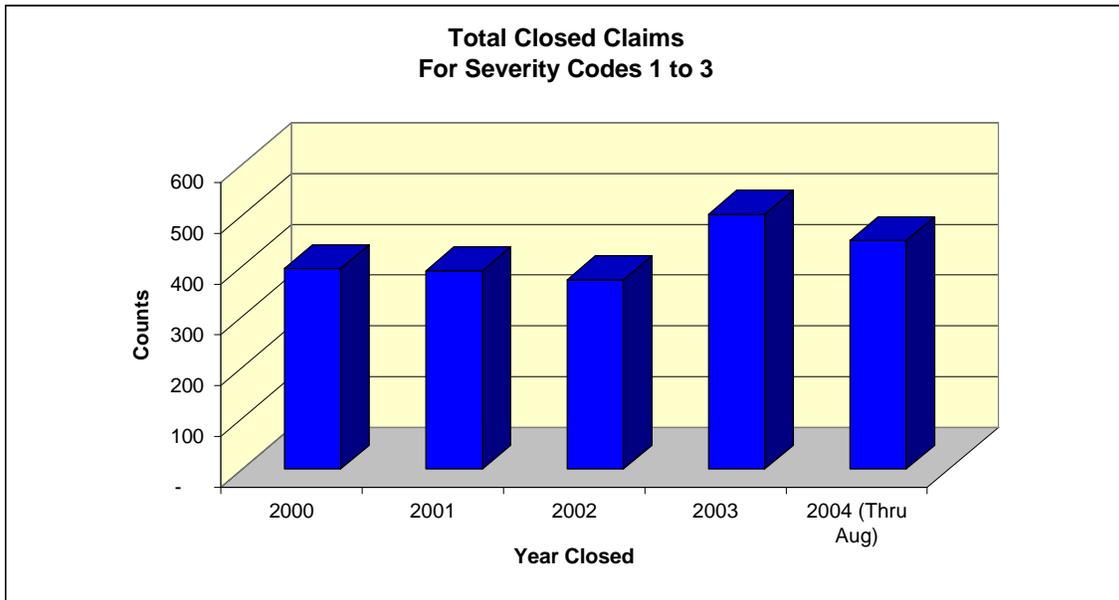


TABLE C.1.2

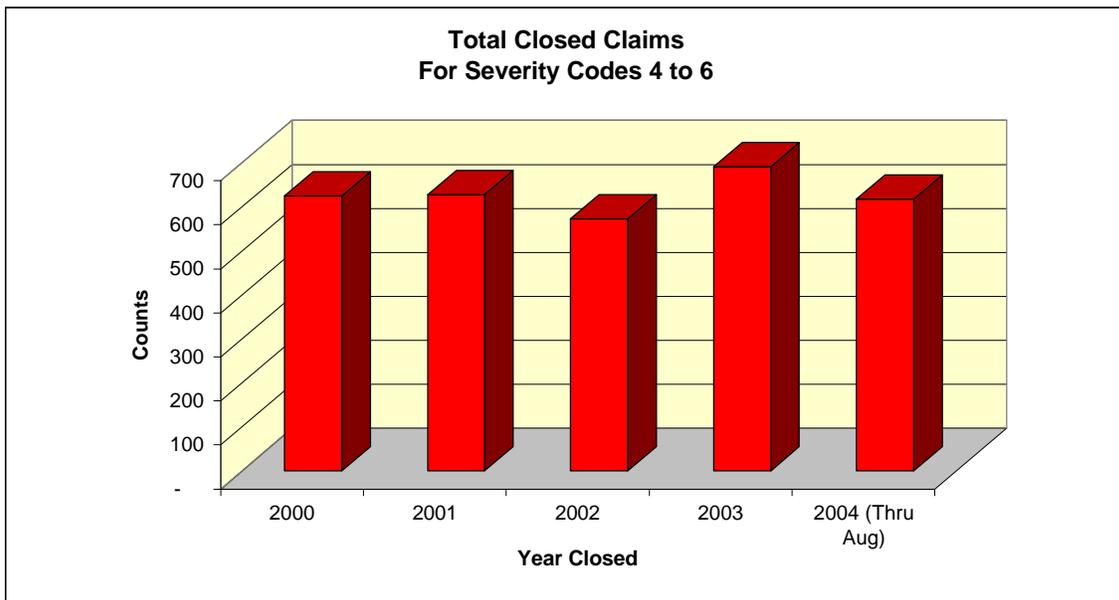


TABLE C.1.3

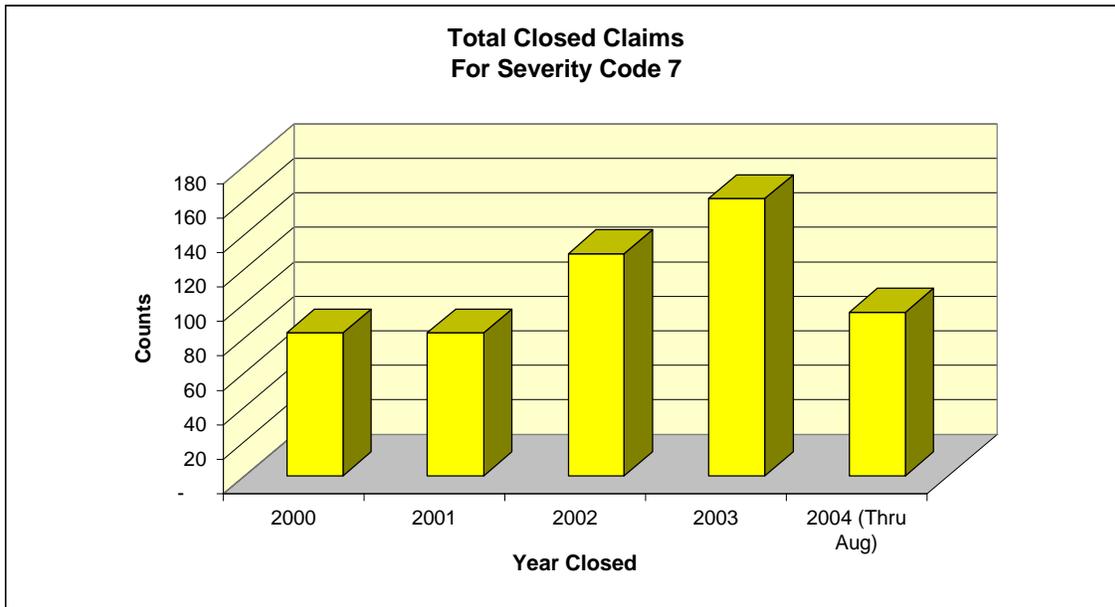
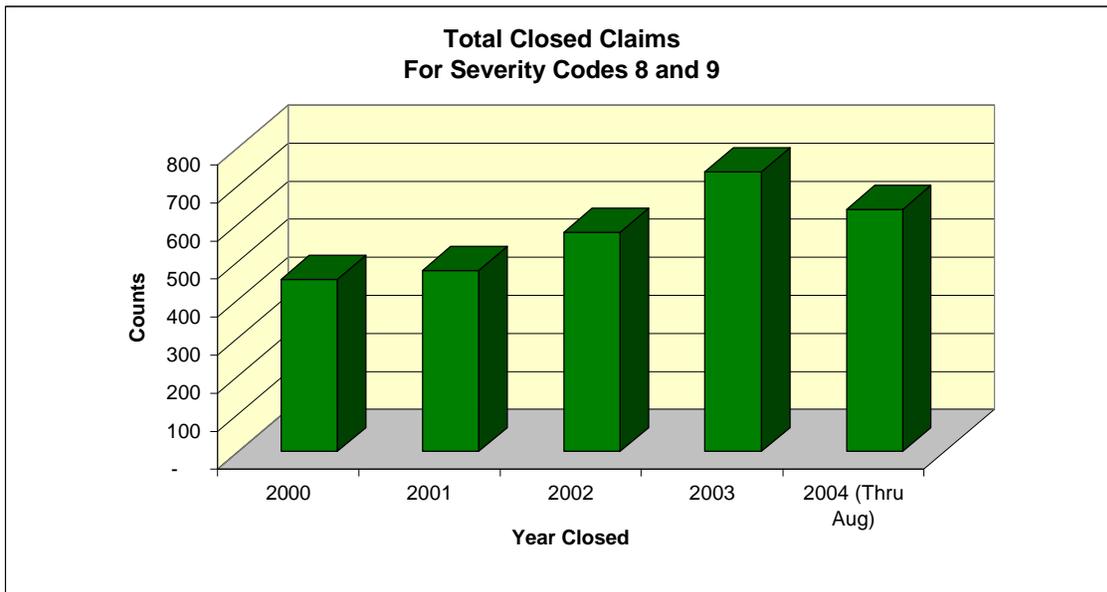


TABLE C.1.4



Tables C.2., C.3 and C.4 display the various lag times which have been compiled from the CCD. We have not noticed any material shift in the distributions from those published in our Presumed Factor Report, issued earlier this year.

TABLE C.2

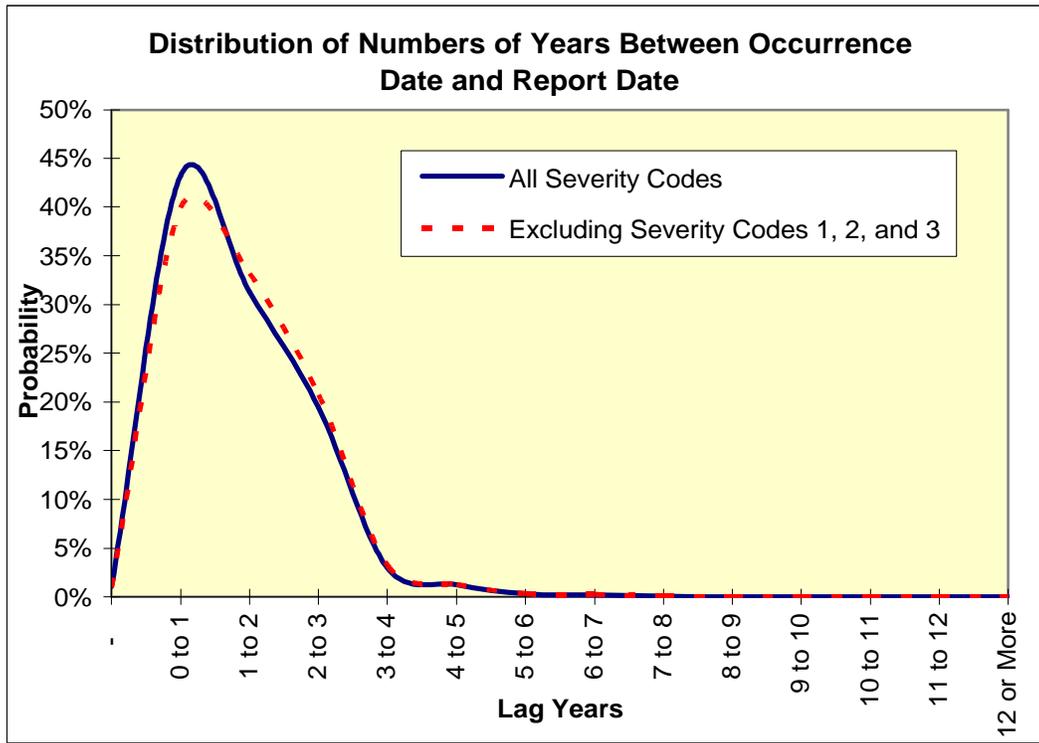


TABLE C.3

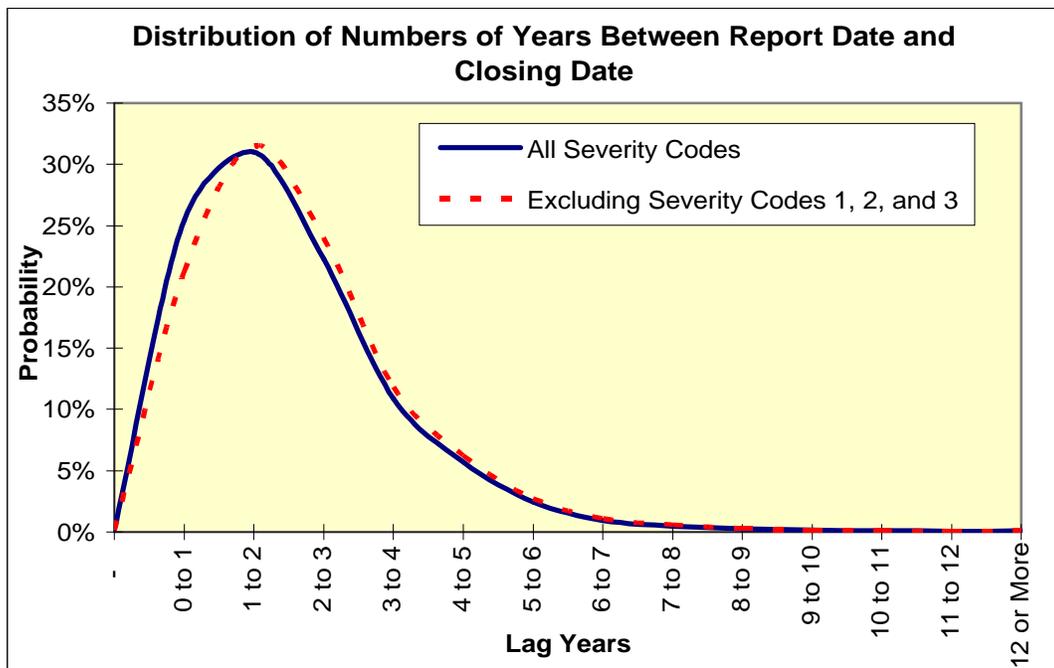


TABLE C.4

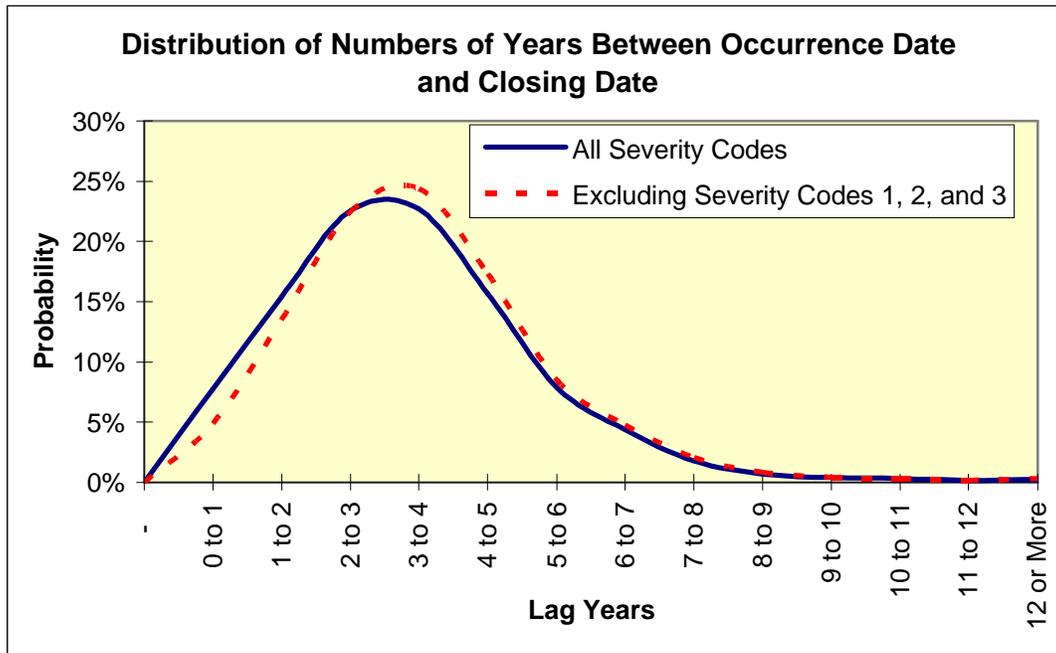


Table C.5 displays the lag distributions for claims with a severity code of 4 through 9.

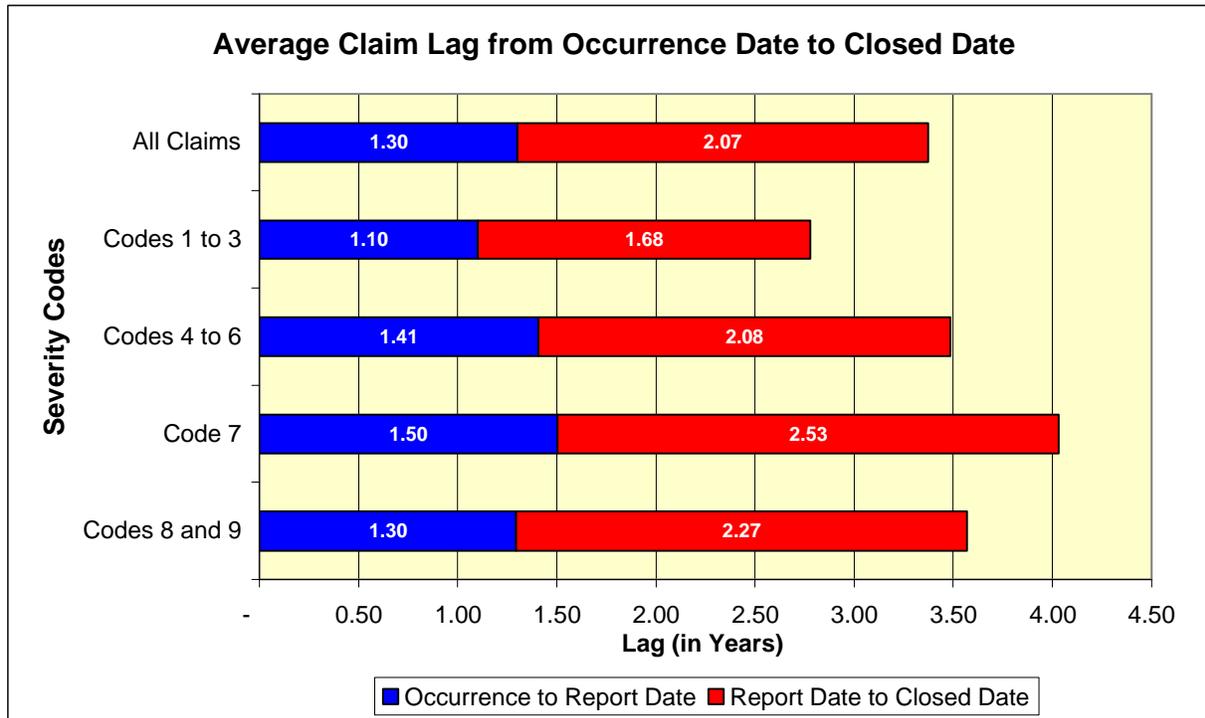
TABLE C.5

Lag Years	Distribution of Numbers of Years Between		
	Occurrence Date And Report Date	Report Date and Closing Date	Occurrence Date and Closing Date
-	0.9%	0.2%	0.0%
0 to 1	39.9%	21.2%	4.9%
1 to 2	33.2%	31.5%	13.5%
2 to 3	20.7%	24.0%	22.4%
3 to 4	3.2%	11.8%	24.4%
4 to 5	1.3%	6.2%	17.3%
5 to 6	0.3%	2.7%	8.5%
6 to 7	0.3%	1.1%	4.8%
7 to 8	0.1%	0.6%	2.1%
8 to 9	0.0%	0.3%	0.8%
9 to 10	0.0%	0.2%	0.4%
10 to 11	0.0%	0.1%	0.3%
11 to 12	0.0%	0.1%	0.2%
12 or More	0.0%	0.1%	0.3%
	100.0%	100.0%	100.0%
Mean*	1.36	2.19	3.56

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

As displayed in Table C.5, the mean or average time between occurrence date and the closing date for a claim with a severity code of 4 or greater is more than three and a half years. Table C.6 below displays the average lag times for different severity groups:

**TABLE C.6**



As stated earlier, distributions of the number of years between occurrence date and report date and the number of years between report date and closing date closely resemble those presented in our Presumed Factor Report. Although the third composite distribution, showing numbers of years between occurrence date and closing date, is also very similar to last year’s distribution, Deloitte Consulting has chosen to display it above exclusive of the indexing adjustment used in the Presumed Factor Report to ensure that the three distribution means were additive when rounding up results to the nearest lag year in our calculations of distribution means (i.e. we chose to round each increment up to the next highest full year value). The distribution of numbers of lag years between occurrence date and closing date shown above now ensures that the distribution means are additive when mean calculations are indexed at or near lag period

midpoints (i.e., we do not round each lag period up to the next highest full year value). As a result of this refinement, the distribution means displayed differ from those presented in our Presumed Factor Report. It should be re-emphasized however, that these differences result only from our indexing adjustments and are not as a result of changes in the underlying data or distributions.

We observed a significant increase in the number of reported claims during the month of September 2003. This is consistent with the feedback shared with Deloitte Consulting during our analysis of SB2D and the determination of the Presumed Factor.

The increase in reported claims is displayed in table C.7, which shows the number of claims reported by month from September 2002 to December 2003. This increase in reported claims is likely the result of plaintiff attorney's "better safe than sorry" approach to filing the claims which could potentially be impacted by the cap on non-economic damages. It is also likely that this "rush" to report claims in September 2003 has already affected the number of claims reported in the months following. More specifically, we expect that many of the claims that would have otherwise been reported after September 2003 have now been filed in September 2003. As a result, we might expect to observe, fewer reported claims during the subsequent months (e.g., in Table C.7 we note a drop in claims reported during the months of October 2003, November 2003 and December 2003). We expect that additional data from future CCD analysis will help us to further support this expectation.

TABLE C.7

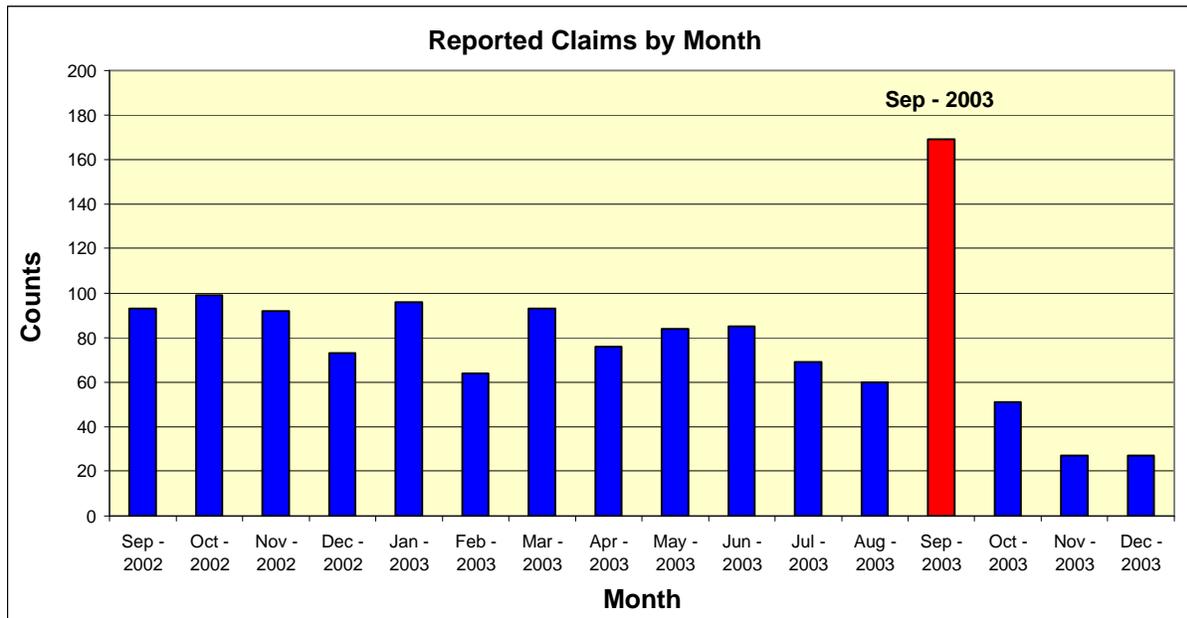
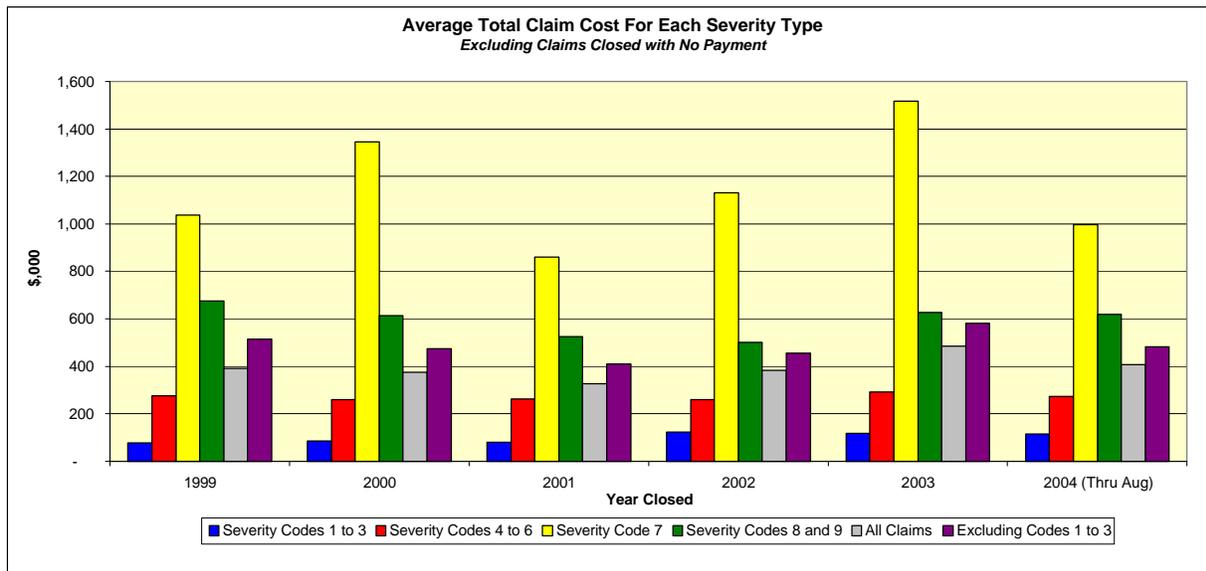


Table C.8 displays the severity of claims closed from 1999 through August of 2004. From the graph, note that for the latest full year of closed claims data, the average claims cost has risen above \$400,000 for all claims or just below \$600,000 for closed claims with a severity code of 4 or higher.

TABLE C.8



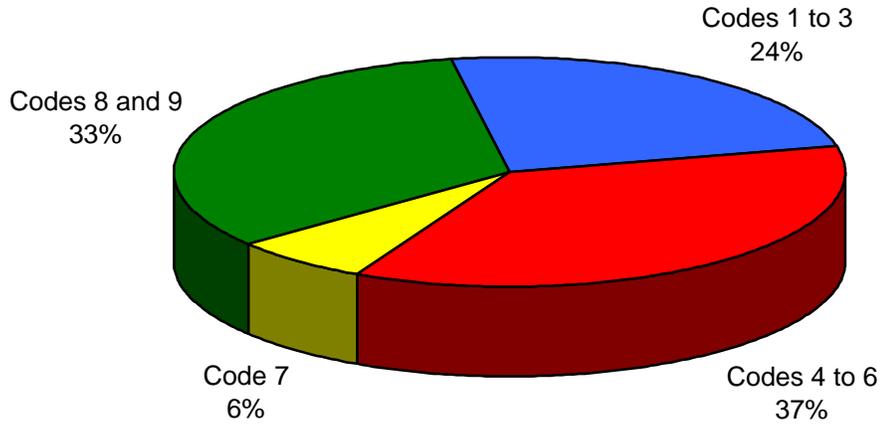
It is difficult to draw any significant conclusions on long term trends in the severity of claims which will be affected by the passage of SB2D, given the short time frame since the passage of SB2D and the limited amount of data in the closed claim database with the potential to have been impacted by SB2D.

### Nature of Errant Conduct

Given the relatively short amount of time since SB2Ds passage and the fact that more severe claims typically have a longer claim lag, it is difficult to draw substantial conclusions regarding the impact of SB2D on the nature of errant conduct. The portion of claim counts in the lower severity codes for the closed claims reported after September 2003 is higher than typical historical levels. Table C.9 demonstrates this observation. As additional claims are closed from the post September 2003 reporting period and collected in the CCD, further assessments of this shift in severity type can be made with increased credibility.

TABLE C.9

**Portion of Closed Claim Counts by Severity Code, Reported Prior to September 2003**



**Portion of Closed Claim Counts by Severity Code, Reported September 2003 & Subsequent**

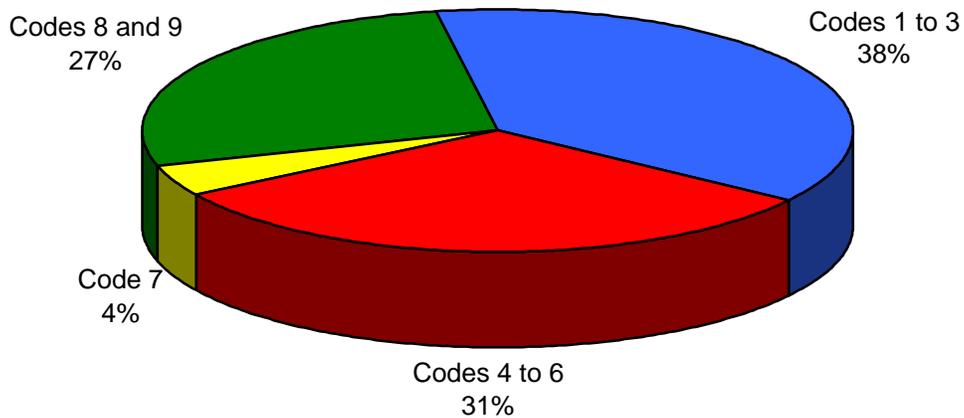
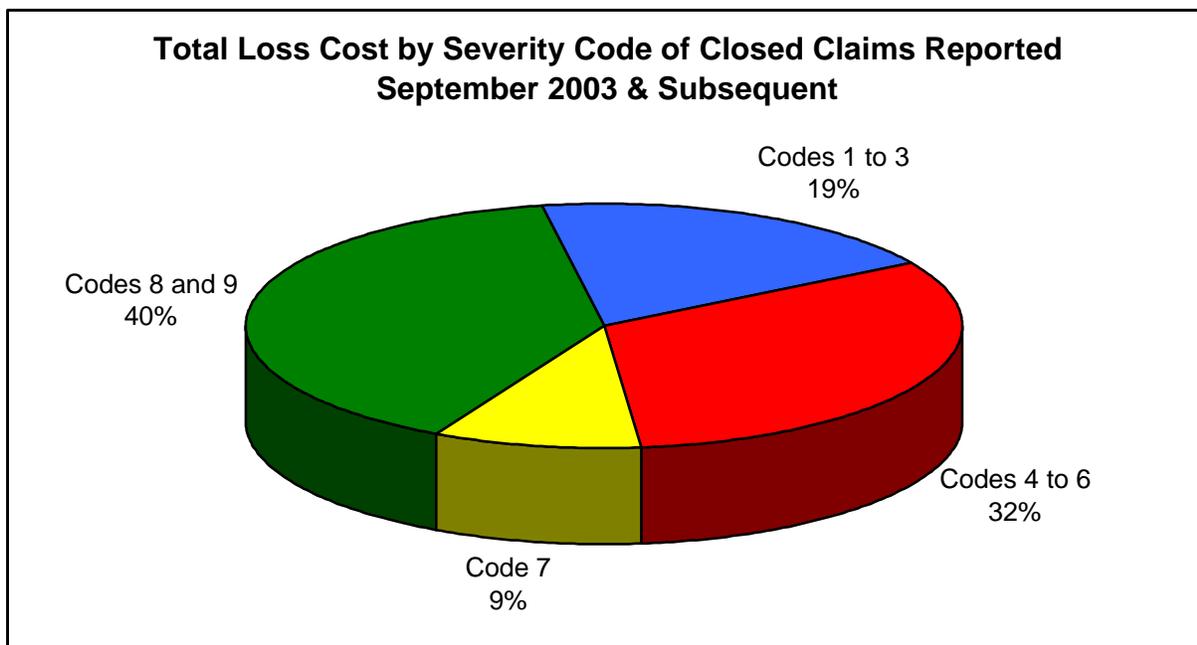
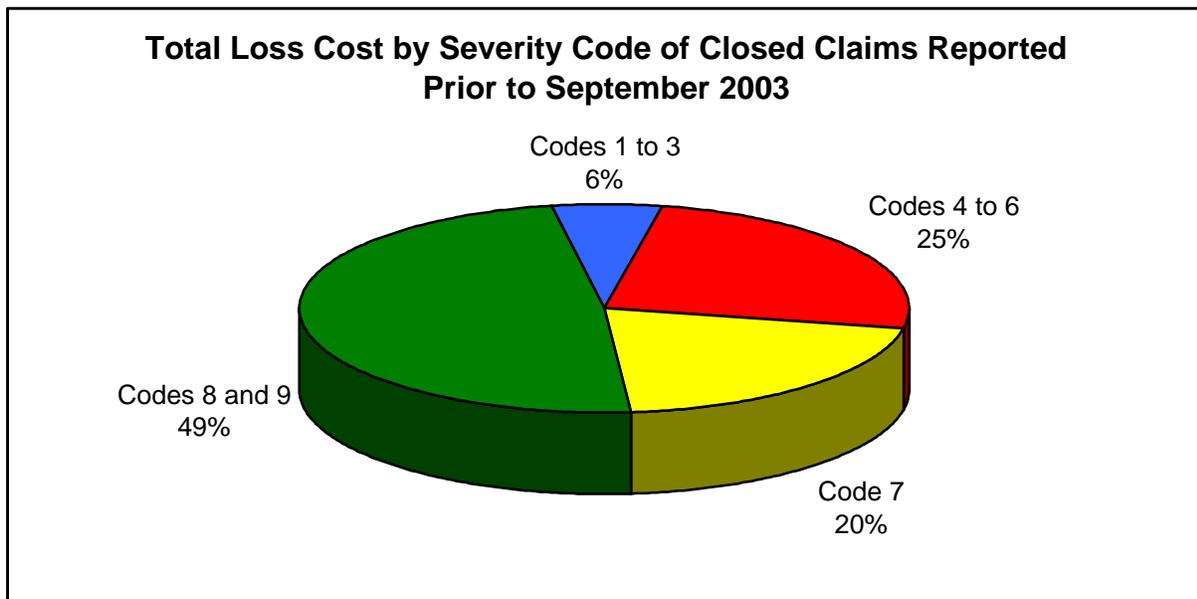


Table C.10 shows the breakdown of claims by severity code based on total dollars of cost.

TABLE C.10



### Itemization of Damages

Despite the limitations of the closed claim database with regard to certain claim entries which do not itemize loss costs between economic and non-economic components, Deloitte Consulting has been able to isolate only those CCD records that itemize these loss amounts for use in analyzing trends in economic and non-economic damages. Given the recent passage of SB2D and the observation that the average lag from occurrence to closing is more than 3 years for a typical claim (more than 3 ½ years for more severe injury types), it is difficult to use the CCD effectively to evaluate the impact of SB2D on non-economic damage awards. Tables C.11 and C.12 display the average total loss cost (C.11) and average cost of non-economic damages (C.12) for those closed claims with non-economic damages paid and with loss amounts itemized in the CCD. We note that there does not appear to be any significant decreases in either the average total loss cost or the average non-economic loss costs of claims closed through 2003.

TABLE C.11

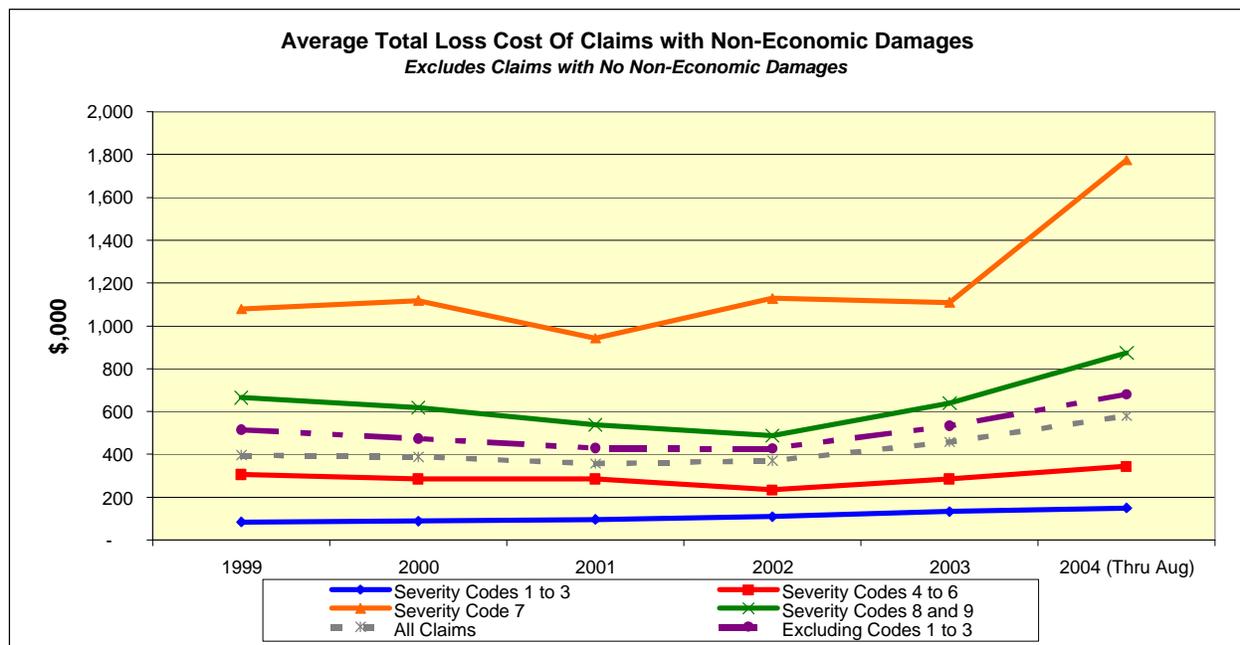
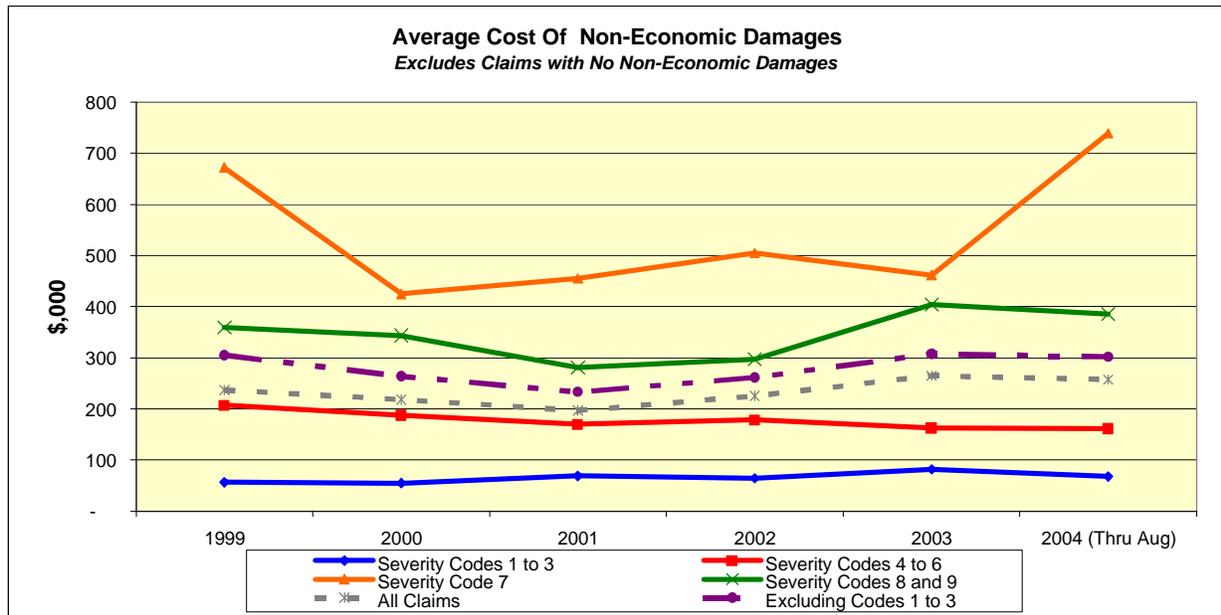
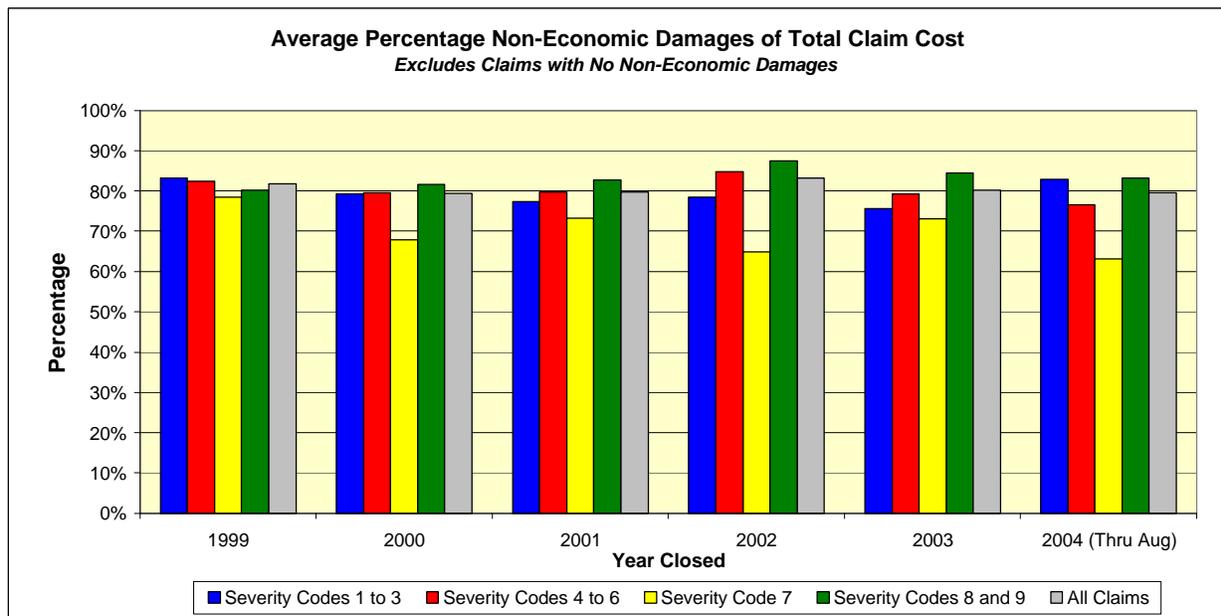


TABLE C.12



We also note that there does not appear to be any significant change in the average percentage of total loss costs resulting from non-economic damages for those claims with non-economic damages. Table C.13 displays this information by severity code group and by year of claim closing.

TABLE C.13



## **CASES ADDRESSING CONSTITUTIONALITY OF SB2D**

### **COMPLETED CASES**

As will be noted in the **Market Leader Data Request** section of this report, there has been little case activity addressing the constitutionality of SB2D. As of October 1, 2004, we are aware of only a single case that has found a portion of SB2D unconstitutional. As published on the eMediaWire web site:

*“A Circuit Court Judge in Seminole County, Florida, has found a portion of Florida’s 2003 medical malpractice reform legislation unconstitutional. It is believed this is the first case to address the constitutionality of the new law.”*

The article noted the following details of the case:

*“On April 22, 2004, Circuit Court Judge Marlene Alva issued a short written order stating that the application of the new law was unconstitutional because it retroactively took away vested rights of patients who were already injured by malpractice before the date the new legislation was enacted. The case before Judge Alva concerned the liability of CIGNA HMO for the alleged negligence of one of its member physicians leading to the death of a 16 year-old patient in October 2002. Although the medical incident occurred before the new law was passed, Cigna HMO claimed the new law granted it retroactive immunity from suit. Scott R. McMillen, the attorney for the teenager’s family, stated “The court’s ruling is limited solely to the retroactivity issue, and what it means is that there is no immunity for any negligence occurring before September 15, 2003. But the case has broader importance because the same legal reasoning should also apply to the retroactive application of the damage caps on doctors and hospitals.”*

*The court’s ruling was based on an earlier Florida Supreme Court case and on a provision in the Florida Constitution granting all Florida’s citizens the right of access to Florida’s courts for redress of injury.”*

On page 73 of our November 6, 2003 report titled **Review of Florida Committee Substitute for Senate Bill 2-D, Calculation of Section 40 “Presumed Factor” (Presumed Factor Report)**,

Deloitte Consulting stated the following:

*Section 86 expresses the Legislature’s intent that the law should apply retroactively, i.e., to incidents of medical negligence that occurred before the effective date of the law, with the provision that the changes to Chapter 766 should be applied only to cases of medical*

*negligence for which a notice of intent to initiate litigation was mailed on or after the effective date of the new law (September 15, 2003).*

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Judge Marlene Alva's written order is consistent with the findings discussed in Section 86 of our November 6, 2003 report.

## **ACTIVE CASES**

As of October 1, 2004, the Office is aware of the first case in Miami actively seeking to have the limit on non-economic damages declared unconstitutional. As published on August 31, 2004 by the Tampa Tribune, the case involved the following allegations:

*"The Bergesses had filed a lawsuit over the case of their daughter Mariaelena.*

*The doctors had treated Mariaelena for a cough and cold, but her symptoms got worse, the suit alleges.*

*Her mother later took her to the hospital. The girl eventually was seen by several specialists who diagnosed Stevens Johnson Syndrome, an adverse reaction to medication that can cause severe rashes, fever and swelling around the eyes. If left untreated, it can be fatal.*

*Marialena also suffered respiratory complications and severe skin problems that have left her disfigured, the complaint alleged.”*

Based on the August 30, 2004 Berges v. Lambkin-Alexander, M.D. et al. (case number 04-18664-CA-01) complaint filed in Miami-Dade County, we note the following issues identified in the complaint as “Primary Constitutional Claims”, which question the constitutionality of SB2D:

*“18. Prior to September 15, 2003, the recoverable damages in a medical malpractice case were not limited. Consequently, a plaintiff could seek the full measure of damages that a jury might award for any injuries that a jury might find were proximately caused by the negligence of the defendant doctors. The right to recover such unlimited damages as found by the jury reflect that persons who are innocent victims of wrongful conduct have the right and opportunity to obtain recourse and recompense from the tortfeasors.*

*19. Moreover, Article I, Section 21, of the Florida Constitution provides that the courts shall open for every person for redress of any injury, and justice shall be administered without sale, denial or delay.*

*20. It is uncontroverted, therefore, that there existed prior to September 15, 2003 a right to sue on and recover non-economic damages of any amount and that this right existed from the time the current Florida Constitution was adopted. The right to redress injury does not draw any distinction between economic and non-economic damages. Article I, Section 21, does not contain any language which would support the proposition that the right is limited, or may be limited, to suits above or below any given figure. It has, therefore, always been recognized under Florida law that great harm may befall victims of medical malpractice and the corresponding necessity for requiring those that are responsible to compensate such harms.*

*21. Chapter 2003-416, Laws of Florida, however, made far-reaching changes which affect compensable damages to such injured persons. Section 86 of that chapter provides for, among other things, caps on damages, changes to bad faith claims against insurers, and various procedural changes which would take effect September 15, 2003. The legislation purports to state that to the extent allowed by the Florida Constitution, such changes would apply to any prior medical incident for which a notice of intent to initiate litigation has not been mailed before September 15, 2003.*

22. *The Bergeses sent out their notice of intent on February 19, 2004. Consequently, the Act purports to affect the monetary recovery that Mr. and Mrs. Berges may make on behalf of their severely injured minor child, Mariaelena Berges.*

23. *In particular, Fla. Stat. §766.118 provides the following limitation on non-economic damages for the negligence of the Defendant treating physicians:*

*(a) With respect to a cause of action for personal injury or wrongful death arising from medical negligence of practitioners, regardless of the number of such practitioner defendants, non-economic damages shall not exceed \$500,000 per claimant. No practitioner shall be liable for more than \$500,000 in non-economic damages, regardless of the number of claimants.*

*(b) Notwithstanding paragraph (a), if the negligence resulted in a permanent vegetative state or death, the total non-economic damages recoverable from all practitioners, regardless of the number of claimants, under this paragraph shall not exceed \$1 million. In cases that do not involve death or permanent vegetative state, the patient injured by medical negligence may recover non-economic damages not to exceed \$1 million if:*

*1. The trial court determines that a manifest injustice would occur unless increased non-economic damages are awarded, based on a finding that because of the special circumstance of the case, the non-economic harm sustained by the injured patient was particularly severe; and*

*2. The trier of fact determines that the defendant's negligence caused a catastrophic injury to the patient.*

*(c) The total non-economic damages recoverable by all claimants from all practitioner defendants under this subsection shall not exceed \$1 million in the aggregate.*

*3. Limitation on non-economic damages for negligence of non-practitioner defendants --*

*(a) With respect to a cause of action for personal injury or wrongful death arising from medical negligence of non-practitioners, regardless of the number of such non-practitioner defendants, non-economic damages shall not exceed \$750,000 per claimant.*

*(b) Notwithstanding paragraph (a), if the negligence resulted in a permanent vegetative state or death, the total non-economic damages recoverable by such*

*claimant from all non-practitioner defendants under this paragraph shall not exceed \$1.5 million. The patient injured by medical negligence of a non-practitioner defendant may recover non-economic damages not to exceed \$1.5 million if:*

*(1) The trial court determine that a manifest injustice would occur unless increased non-economic damages are awarded, based on a finding that because of the special circumstances of the case, the non-economic harm sustained by the injured patient was particularly severe, and*

*(2) The trier of fact determines that the defendant's negligence caused a catastrophic injury to the patient.*

*(c) Non-practitioner defendants are subject to the cap on non-economic damages provided in this subsection regardless of the theory of liability, including vicarious liability.*

*(d) The total non-economic damages recoverable by all claimants from all non-practitioner defendants under this subsection shall not exceed \$1.5 million in the aggregate.*

*Pursuant to Fla. Stat. §766.118, catastrophic injury is defined to include second-degree or third-degree burns of 25% or more of the total body surface or third-degree burns of 5% or more to the face and hands. Fla. Stat. §766.118(1)(a)4. Mariaelena Berges sustained Stephen Johnson Syndrome. This is the equivalent of second degree or third degree burns because her entire skin was sloughed off and blistered; and, her gastrointestinal tract was also burned and blistered.*

*24. The statute defines practitioner as licensed physicians as well as any entity vicariously liable for such physicians. There are four practitioner defendants: Dr. Bellietha Lambkin-Alexander; Dr. Rozalyn Paschal; Rozalyn H. Paschal, M.D., Inc.; and Rozalyn Hestor Paschal, M.D., P.A. The theories against the latter two defendants are vicarious liability.*

*25. The Plaintiffs contend that absent the application of Fla. Stat. §766.118, which they maintain is unconstitutional, Mariaelena would be entitled to the full measure of damages from the four practitioners.*

*26. On the other hand, the defendants will contend that non-economic damage recovery is capped by Fla. Stat. §766.118 in the amount of \$500,000 total from the four practitioners.*

27. *The Plaintiffs contend that the limitation on non-economic damages is unconstitutional as will be more particularly set forth below. The Plaintiffs also contend that if this court finds that Fla. Stat. §766.118 is a constitutional limitation on non-economic damages, then the plaintiffs are subject to the limits pertaining to catastrophic injury. Therefore, the Plaintiffs are entitled to total non-economic damages from all four practitioner defendants in the amount of \$1 million in the aggregate.*

28. *Fla. Stat. §766.118 is unconstitutional inter alia for the following reasons: The statute caps the damages available to injured persons seeking redress through the courts. It has impermissibly burdened a plaintiff's ability to obtain access to the courts for full redress of all injuries. It has impaired a plaintiff's rights to all common law remedies without either providing an adequate alternative remedy or reflecting an overwhelming public necessity in the absence of less-restrictive alternatives, therefore denying access to courts in violation of Article I, Section 21, of the Florida Constitution, as well as access to courts under the Federal Constitution and the 14th Amendment.*

29. *The statute also denies equal protection by treating similarly situated natural person unequally and making invidious and irrational distinctions in violation of Article I, Section 2, and Article III of the Florida Constitution, and the Equal Protection Clause afforded under the 14th Amendment of the Federal Constitution. Among other things, it discriminates against the most seriously injured claimants by providing arbitrary compensation below a certain level of damages and partial compensation above a certain level against those injured persons who are less well off economically than plaintiffs who are able to financially bear the damages for which they are not compensated. The statute also discriminates by virtue of physical disability.*

30. *Moreover, the statute creates arbitrary classifications to benefit a particular industry, medical practitioners, and their insurers, in violation of Article III, Section 10 and 11 of the Florida Constitution and the 14th Amendment of the Federal Constitution. It impairs the right to trial by jury in violation of Article I, Section 22, of the Florida Constitution by turning the jury's determination of damages into an advisory opinion and by assigning to a judge the common-law authority of the jury. It denies due process because there is no compelling state interest effectuated by least restrictive means, as well as no reasonable relation to a legitimate or compelling governmental objective in violation of Article I, Section 9 of the Florida Constitution and the Fourteenth Amendment of the Federal Constitution. It does so in particular by creating arbitrary damage caps; by irrationally and arbitrarily defining various categories of injury; by irrationally and arbitrarily limiting damages recoverable from so-called non-practitioners; by protecting the medical practitioner rather than the medical practitioner's victim thereby irrationally extending its provisions to protect one class; and by serving no legislative objective related to the reduction of lawsuits against the protected class, medical practitioners, and their insurers.*

31. *In addition, Chapter 2003-416, Laws of Florida, which encompasses Fla. Stat. §766.118 violates the single subject requirement contained in Article III, Section 6 of the Florida Constitution. This is obvious from the description of the Act which is so lengthy that we will not repeat it here. Instead, we will attach it as Exhibit A. Suffice it to say that the Act purports to relate to medical incidents; involves the Agency for Healthcare Administration with respect to reviewing complaints against hospitals; deletes the requirement that persons act in good faith to avoid liability for disciplinary actions; relates to internal risk management programs; requires licensed facilities to annually report certain health care practitioners; provides for use of patient safety data; eliminates restrictions on licensure renewal fees for health care practitioners; deletes provisions with respect to criminal history checks; revises financial responsibility requirement of physicians; amends Fla. Stat. §624.462; provides guidelines for the formation and regulation of certain self-insurance funds; proscribes a health maintenance organization's right to control the professional judgment of a physician; amends Fla. Stat. §766.1115, .1112, .1113, .201, .303, and .21; creates Fla. Stat. §766.118 limiting non-economic damages; provides legislative findings and intent regarding emergency medical services; creates Fla. Stat. §766.1185; revises guidelines for immunity under the Good Samaritan Act; and many, many other revisions which will be seen in Exhibit A.*

32. *The statute is also unconstitutional under both the State and Federal Constitutions based on a violation of both substantive and procedural due process and equal protection because there is no rational basis for the caps on non-economic damages.*

33. *Fla. Stat. §766.118 also violates the separation of powers provision of Article II, Section 3, of the Florida Constitution.*

34. *The legislative enactment is a hodgepodge logrolling form of omnibus legislation that is obviously unconstitutional and embraces in the same bill incongruous matters having no rational relationship to each other or to the subjects specified in the titles. Distinct subjects affecting diverse interests have been combined in order to unite members who favored them. The Act is effectively the most gargantuan logroll in the history of Florida legislation.*

35. *The Plaintiffs are in doubt as to their legal rights and duties under the Act; and most specifically under Fla. Stat. §766.118 with respect to the applicability, or non-applicability of the caps on non-economic damages and the category into which this case fits, and specifically, whether the minor claimant has suffered a catastrophic injury. The Plaintiffs are equally uncertain as to the propriety of making a demand for policy limits from the Defendants or their insurers given the statutory changes to bad faith claims contained within this Act. These provisions are likewise subject to constitutional challenge, including but not limited to the following constitutional violations: (1) Article I, Section 21, Florida Constitution (access to courts); (2) 14th Amendment to the United*

*States Constitution (due process and access to courts); (3) Article I, Section 2 and Article III of the Florida Constitution; and the 14th Amendment of the United States Constitution (equal protection); (4) Article I, Section 22, Florida Constitution (right to jury trial); (5) Article I, Section 9, and the 14th Amendment to the United States Constitution (due process); (6) Article III, Section 6 of the Florida Constitution (single subject); (7) substantive and procedural due process of both the Florida and United States Constitutions; and (8) Article II, Section 3 of the Florida Constitution (separation of powers).*

*36. If this court enters a judgment declaring that the statute is unconstitutional and the Plaintiffs are entitled to their common law remedies uncapped, then there may be no need to pursue the case incurring costs of discovery and of trial, because the case may be able to be mediated or settled to conclusion.*

*37. On the other hand, at this point the Plaintiffs cannot make an intelligent determination as to whether they are entitled to demand \$500,000 for practitioners; or a total of \$1 million from practitioners, assuming a catastrophic injury, or the full value of the case.*

*38. Accordingly, this is an appropriate case for declaratory relief. It will produce an adjudication of the constitutionality of the caps on non-economic damages and the bad faith legislation; or alternatively, will produce an adjudication of the category in which the injured Plaintiff falls, and which is critical to the decisions which the Plaintiffs must make including but not limited to claims for bad faith.”*

On page 33 of our Presumed Factor Report, Deloitte Consulting stated the following:

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

*The specific cap amounts are discussed earlier in this report.*

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

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

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

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

The arguments in the Berges v. Lambkin-Alexander, M.D. et al. complaint are consistent with the legal observations discussed in Section 54 of our November 6, 2003 report. Essentially, our legal analysis was right on point.

It is not possible at this time to estimate when the trial court in Berges will rule on the issue of whether the cap is constitutional. The defendants may argue that the issue is not "ripe" for determination unless and until a jury verdict is rendered in excess of the cap. The trial court therefore may postpone a decision on constitutionality until after the case goes to trial, which may take one or two years. Whenever the trial court does rule, however, there is a possibility that the parties will request a "fast track" appeal to the Florida Supreme Court, bypassing the intermediate appellate court. If that occurs (it is within the discretion of the intermediate appellate court to decide), then the appeal time in our original report could be expedited by approximately one year. Accordingly, a final decision on constitutionality from the Florida Supreme Court could occur within 12 to 18 months of a ruling by the trial court.

A detailed discussion of the impact on rates and trend assumptions of the cap on non-economic damages being declared unconstitutional can be found in the **Observations and Conclusions** section of the report.

## **MARKET LEADER DATA REQUEST**

As part of Deloitte Consulting's work plan, Deloitte Consulting was asked by the OIR to prepare a market leader data request (MLDR) in order to survey the top medical malpractice writers in the state of Florida. Based upon the market share information provided by the OIR, we selected the top insurers necessary to satisfy the 80 percent benchmark established by SB2D.

The purpose of the MLDR was to request financial information and written responses aimed at helping Deloitte Consulting analyze the current state of the medical malpractice market post SB2D.

Given the long tail nature of the medical malpractice line of business and the "green" nature of SB2D, Deloitte Consulting recognized before sending the MLDR that it might be too early for companies to quantify certain sections of SB2D in terms of benefits, savings and court activity. Even with this fact in mind, Deloitte Consulting still asked for as much information as possible with the foreknowledge that many of the questions may not be answerable at this time.

Deloitte Consulting did request that each company do its best to describe their experiences with and concerns regarding SB2D. Deloitte Consulting also recognizes that certain information requested in the MLDR may be confidential and potentially impact the outcome of current litigation. In those situations, Deloitte Consulting let the companies know that it should do their best to provide general comments instead of specific references to specific events.

Based upon the quality discussions Deloitte Consulting had throughout the MLDR request period with company representatives, the "green" nature of the law, and the short time period for responding to our MLDR, Deloitte Consulting believes the top insurers made a good faith attempt to answer our questions to the best of their ability.

**General Comments**

In the written responses and verbal discussions with company representatives, the companies made it clear that they felt it was too early to tell what the impact of the law would be.

Essentially, companies stated that given the nature of medical malpractice and the fact that it is a long tail line of business, the timeframes involved in the legal system are much longer than the 10 month evaluation period since the passage of SB2D.

On page 38 of the Presumed Factor Report, Deloitte Consulting states the following in regards to time frames:

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

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

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

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

*There are three basic methods to propose amendments to the Florida constitution: a three-fifths vote of each house of the Legislature; a petition drive reflecting the appropriate number of required signatures (about 8% of the voters); or a constitutional*

*convention. Article XI, Fla. Const. Regardless of the method chosen to propose an amendment, the amendment must be approved by the electorate “at the next general election held more than ninety days after the joint resolution, initiative petition or . . . constitutional convention.” Article XI, Section 5(a). “If the proposed amendment or revision is approved by vote of the electors, it shall be effective as an amendment to or revision of the constitution of the state on the first Tuesday after the first Monday in January following the election, or on such other date as may be specified in the amendment or revision.” Article XI, Section 5(c). Thus, any proposed amendment would be required to be voted upon at the next general election after the amendment is validly proposed, which likely would be the year 2008 if the amendment is not proposed until after a ruling by the Florida Supreme Court on the constitutionality of the current legislation.*

There is a procedure in Florida for the trial court to rule that the statute is "unconstitutional" and then to "fast track" the appeal to the Supreme Court of Florida, bypassing the intermediate appellate court step discussed above (i.e., saving approximately one year).

For some of the questions, insurers also noted that their responses would be general in nature or not applicable at this point in time, for other questions the information requested by Deloitte Consulting was not available (e.g., not tracked in their systems), and depending on the business written by the insurer, some of the questions were not applicable (e.g., insurer does not write physicians).

**Future Handling of “Presumed Factor”**

As part of our MLDR, we asked medical malpractice insurers to discuss how it would handle the impact of the “Presumed Factor” (PF) in their next rate filing.

The responses varied significantly, ranging from companies who said it had not determined how the impact will be handled in their next rate filing; companies who discussed reflecting the November 6, 2003 PF of 7.8% as a reduction to their indicated loss and LAE pure premium with the intention of continuing to include the 7.8% PF in 2005 filings; and companies that noted for 2004 and subsequent coverage years, it is expected that the impact of the tort reforms will be reflected in the loss experience (i.e., no PF will be required), essentially treating the PF as a one time event.

Subsequent to receiving the MLDR responses, the OIR provided the following guidance to medical malpractice insurers:

*“Senate Bill 2-D (enacted in August, 2003) required the Office of Insurance Regulation to publish the Presumed Factor described in the Bill. The Presumed Factor was to reflect a prospective adjustment of rates in anticipation of the savings provided by all the sections of the Bill. The Bill then required insurers to recognize the Presumed Factor as published by the Office in their rates within 60 days after its publication or to provide an appropriate alternative.*

*The Office suggests that a medical malpractice rate filing made subsequent to the required Presumed Factor Filing should not recognize only the Presumed factor as was published in 2003, but the effects of each section of the Bill on an insurer's particular book of business. Since some of the experience in a medical malpractice rate filing may have taken place after the Bill became effective, it is important that an insurer's analysis recognize how the prospective estimates of the effects of the Bill will be replaced with actual experience as that experience becomes available.*

*The Office will return as incomplete any medical malpractice rate filing which does not include an analysis of the actual effects of the Bill on rates as well as the prospective analysis included in the Presumed Factor.”*

Deloitte Consulting believes the above guidance by the OIR will help medical malpractice insurers better understand how to consider tort reform in their upcoming filings, removing the uncertainty observed in the wide range of responses we received.

One insurer noted the following:

*“It is our intent that future rate filing will reflect an adjustment to loss experience pertaining to the period prior to the enactment of SB2D to account for the impact of the medical liability reform legislation. The adjustment will be made based upon the “presumed factor” or other more recent analysis as prescribed or deemed appropriate by the Florida Office of Insurance Regulation”*

This response appeared to be the most consistent with the recent OIR guidance.

### **Patient Safety (Section 6)**

As part of our MLDR, we asked medical malpractice insurers to discuss how the appointment of a patient safety officer and patient safety committee at each licensed facility has impacted patient safety in Florida.

The responses varied significantly, ranging from a number of companies who said it did not insure any facilities and therefore had no information or data; to an insurer who noted that **all** of its insured facilities in the State of Florida have a patient safety officer and a patient safety committee.

An exhibit provided by one of the insurers displayed its claim frequency by loss year (i.e., 1999 through 2003) for two territories. The reported frequency per 1,000 of exposure and claims with indemnity per 1,000 of exposure by territory provided little insight into trends. The reported frequency per 1,000 of exposure is shown below:

<b>Loss Year</b>	<b>Territory 1</b>	<b>Territory 2</b>
1999	46.5	35.0
2000	39.7	41.9
2001	43.1	38.3
2002	45.2	39.2
2003	44.7	34.7

The reported indemnity per 1,000 of exposure is shown below:

<b>Loss Year</b>	<b>Territory 1</b>	<b>Territory 2</b>
1999	25.6	16.1
2000	20.0	17.3
2001	25.1	14.0
2002	21.1	16.1
2003	21.5	10.3

As noted by the insurer:

*“Since the statute was effective in 2003, it is premature to draw conclusions from this data about the effect of having a patient safety officer and committee in place.”*

On page 8 of our November 6, 2003 report titled **Review of Florida Committee Substitute for Senate Bill 2-D, Calculation of Section 40 “Presumed Factor”**, Deloitte Consulting stated the following:

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

Deloitte Consulting also stated:

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

It is still premature to draw conclusions regarding the impact of patient safety on Florida's licensed facilities.

### **Notifying Patients of “Adverse Incidents” (Section 7/Section 8)**

As part of our MLDR, we asked medical malpractice insurers to discuss how successful its insured practitioners and non-practitioners (i.e., licensed facilities) have been at notifying patients of “adverse incidents” under SB2D.

#### **Practitioner**

All but one of the insurers focused on covering practitioners responded that it did not track the success of their practitioner insureds in notifying patients of “adverse incidents”. As noted by one insurer:

*“The primary duty for complying with this provision lies with the healthcare provider.”*

One insurer noted:

*“Our insureds have always been instructed to call us when an adverse incident occurs. We encourage, instruct, direct and help with directly informing patients of adverse outcomes when appropriate.”*

#### **Non-Practitioner**

A number of insurers noted that it did not insure licensed facilities and are not privy to data pertaining to the extent to which non-practitioners are reporting adverse incidents.

One insurer noted:

*“Our insured facilities have developed and implemented facility-specific guidelines that address patient notification of medical errors. The guidelines are derived from a model template. Hospital CEOs are accountable for making sure the process is successfully implemented and this implementation is validated as part of internal quality review. While individual hospitals keep detailed records of patient notification, that information is not aggregated or tracked by us. Anecdotally, as a percent of all inpatient and outpatient visits, that figure would be minuscule – considerably less than 1%.”*

### **Five Most Frequently Misdiagnosed Conditions (Section 10)**

As part of our MLDR, we asked medical malpractice insurers to list the five most frequently misdiagnosed conditions of its insured practitioners.

Some insurers noted that it did not compile this information (e.g., computer system does not track allegations), while one insurer noted that because of who it insures, misdiagnosed medical conditions are not an issue.

A sample of the lists provided:

One insurer reported:

1. Breast cancer
2. Acute Myocardial Infarction (MI) (a/k/a heart attack)
3. Cancer of the mouth and gums
4. Cancer of the male genital organs
5. Cancer of the lung & Larynx

*Note: Last three tied for third*

*Previous studies included fractures and appendicitis*

Another insurer reported:

1. Breast cancer
2. Lung cancer
3. Appendicitis
4. Heart disease and related illnesses
5. Pulmonary embolism (i.e., a blockage of an artery in the lungs by fat, air, tumor tissue, or blood clot)

Another insurer reported:

1. Radiology – mammography – breast cancer
2. Emergency room – pulmonary embolism
3. Emergency room - aneurysm
4. OB/GYN – cesarean section vs. vaginal delivery
5. Primary care physicians - appendicitis

Another insurer focused on dentists reported:

1. Periodontal disease
2. Decay
3. Infection
4. Tooth fracture
5. Cancer

### **Practitioner Profiles (Section 14/Section 15)**

As part of our MLDR, we asked medical malpractice insurers to comment on the usefulness of the practitioner profiles shown on the Florida Department of Health (DOH) website

<http://www.doh.state.fl.us/MQA/profiling>.

The responses varied from one insurer who noted it did not use the website as part of their underwriting process, to a number of insurers who said it uses the practitioner profiles in the underwriting process and find the profiles useful in this regard (e.g., researching of education, confirmation of board certification, licensing, practice location, etc.). One insurer noted:

*“The Company utilizes this data base on all new applicants during the underwriting process. The data base is used to verify information contained on the application completed by the doctor and also is used to verify insurance history which is helpful to the Company. We have found that the information is not always up to date as some doctors have not updated their profile after the initial profile. In these instances, we will have to call the doctor to verify information or pursue another source. Overall the database is a useful tool used by the Underwriting Department.”*

However, none of the insurers have surveyed its insured practitioners or are aware of any data regarding practitioner satisfaction with the profiles on the DOH website.

**Suspension for Non-Payment (Section 23)**

As part of our MLDR, we asked medical malpractice insurers to list and describe any instances where physicians have been suspended for non-payment of awards.

All of the insurers responded that the companies were not aware of any instances where physicians have been suspended. One insurer stated:

*“To the best of our information and knowledge, we are unaware of any instances where physicians have been suspended for non-payment of awards under Section 23 of SB2D.”*

Another insurer stated:

*“Since we provide our physicians with financial protection against liability awards, we have not been directly involved in any instance where a physician has been suspended for non-payment of an award.”*

Another insurer stated:

*“As Section 23 pertains to physicians who maintain an escrow account or obtain a letter of credit as proof of financial responsibility, with failure to timely pay an award or judgment relative to the maintenance of either form of financial responsibility, our Company does not have any information regarding this issue.”*

**Expert Witness Testimony (Section 48)**

As part of our MLDR, we asked medical malpractice insurers to discuss the impact of SB2D on expert witness testimony.

All the responses from the insurers noted that it is too early to evaluate the impact of Section 48.

One insurer noted:

*“While it is too soon relative to the effective date of SB2D to assess the impact of Section 48 of SB2D on the availability of expert witnesses, thus far our Company has not seen a shortage of defense experts and is without knowledge as to any limitation of plaintiff’s*

*experts. Medical malpractice lawsuits in Florida lacking in merit should not be characterized as frivolous because the adoption of the pre-suit requirement to file a verified expert opinion generally eliminates “frivolous” claims.”*

Another insurer noted:

*“To date, we have not observed any discernible impact on the qualifications of expert witnesses in medical malpractice files submitted after September 15, 2003. Because the statutory changes are less than one year old and because the typical medical malpractice claim takes much longer than one year to fully litigate, we do not have a statistically significant pool of cases to draw from in order to adequately respond to this request. To date, there has been no limitation on either the plaintiff’s side or the defense side with regard to the introduction of expert witnesses. Likewise, we have not seen any reduction or elimination of frivolous claims that can no longer be supported as a result of the new parameters for expert witnesses under SB2D. We do not anticipate much, if any, favorable impact on our Florida cases.”*

Another insurer noted:

*“Because these lawsuits are in the early stages of discovery and the courts have not addressed the issue yet, Our Company has not observed any limitations on plaintiff or defense experts. From a defense standpoint, the Company is not experiencing any difficulty locating qualified experts to review cases in the pre-suit period. The Company has no knowledge as to whether the plaintiff attorneys are having difficulty locating experts to sign affidavits in order to file a Notice of Intent. The Company has not experienced any reduction in the number of frivolous claims.”*

Another insurer noted:

*“Too early to evaluate. We believe the impact of SB2D will require several years to evaluate.”*

Another insurer noted:

*“While the definition of “limitation” in the query requires further clarification, our Company has not observed any express limitations on plaintiff or defense experts. From our perspective, the provisions pertaining to expert witnesses have not deterred the filing of frivolous lawsuits or constrained expert witness testimony.”*

Another insurer noted:

*“Yes, plaintiff’s attorneys are reluctant to proceed with a lawsuit unless they have a bona fide expert. There has been very little impact on the elimination of frivolous claims that can no longer be supported by experts defined under SB2D.”*

Another insurer noted:

*“It is too early to assess the impact of Section 48 of SB2D dealing with expert witness testimony. We have not yet observed any limitation of defense of plaintiff experts. We are not able to determine if claims have not been brought against our insureds because they can no longer be supported by experts as defined under SB2D.”*

On page 85 of our November 6, 2003 report titled **Review of Florida Committee Substitute for Senate Bill 2-D, Calculation of Section 40 “Presumed Factor”**, Deloitte Consulting stated the following:

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

Based upon the responses from the MLDR, it is too early to establish the impact of SB2D on expert witness testimony.

**Notice (Section 49)**

As part of our MLDR, we asked medical malpractice insurers to discuss the impact of SB2D dealing with issues such as notice before filing of a claim and pre-suit screening.

One insurer noted:

*“It is too early to determine if there is any impact of Section 49 of SB2D. Our company would not have any knowledge of the percentage of plaintiffs sending copies of complaints to the DOH or the percentage of plaintiffs providing pre-suit information regarding all known doctors who have seen the claimant.”*

Another insurer noted:

*“However, as there has only been 14 incidents reported where the new law is applicable, we lack sufficient information to comment. Regarding the reports to DOH, we are not recipients of that information, as it does not apply to insurance carriers.”*

Another insurer noted:

*“Most plaintiff attorneys copy the DOH on the Notice of Intent that we receive. A significant number of plaintiff attorneys do not provide the names of potential co-defendants.”*

Another insurer noted:

*“We can note that the Company has seen a small percentage of plaintiff attorneys actually comply with the requirement of sending copies of complaints to the DOH. As for the requirement that a list of all treating physicians be included with the Notice of Intent, it is our experience that most plaintiff attorneys simply send a copy of the medical records along with the NOI. In more cases than not, the medical records are incomplete. This information would be best gathered from the plaintiff attorneys for an accurate assessment of compliance with the requirement noted.”*

Another insurer noted:

*“Our company does not have information regarding the percentage of plaintiffs who are sending copies of complaints to the DOH and of those who are providing pre-suit information regarding all known physicians who have seen the claimant for the relevant injuries. Unless there is an inquiry from a state professional licensing board, we do not receive such notices on a consistent basis. Mechanisms to track this information should reside with the state.”*

Another insurer noted:

*“The impact on new filings is difficult to assess since the number of insureds has declined during the same period. Almost all plaintiffs are sending copies of complaints to the DOH and providing pre-suit information.”*

Another insurer noted:

*“Our company does not track this data.”*

**Arbitrations and Mediations (Section 50)**

As part of our MLDR, we asked medical malpractice insurers to provide information on the ratio of settlements under binding arbitrations to all claims closed both before and after SB2D. We also asked for a similar ratio for mediations.

One insurer noted:

*“Our Company has not and does not participate into binding arbitration agreements either before or after September 15, 2003. Our Company occasionally participates in pre-suit mediation, however, we have seen in many instances, the plaintiff will waive early mediation because 120 days of discovery is not adequate time to evaluate a case and enter into meaningful settlement discussions. Although the Company occasionally participates in pre-suit mediations, we do not believe these occur frequently enough to develop a meaningful ratio.”*

Another insurer noted:

*“Our Company has never participated in a binding arbitration.”*

Another insurer noted:

*“Prior to SB2D, the rate of matters closed via binding arbitration would be less than 1%; subsequent to SB2D we have no cases “settled” via binding arbitration. We have not noticed any change in the ratio of settlements either through binding arbitration or through mediation based upon the introduction of the new medical malpractice provisions that went into effect on September 15, 2003. First, as a practical matter, given the duration of the typical medical malpractice lawsuit, we do not have enough settlements of post-September 15, 2003 claims in order to provide a statistically significant analysis. We are not aware of anyone who has arbitrated any post-September 15, 2003 claim. Further, we do not have statistics reflecting the ratios of binding arbitrations to overall claims, or mediations to overall claims, to be able to answer this question.”*

Another insurer noted:

*“In our several year history in Florida, we have only offered to arbitrate 6 cases and all of the cases have been settled before the formal arbitration panel. We have only offered to arbitrate one case since 9/15/03.”*

Another insurer noted:

*“Due to a Florida Supreme Court ruling concerning statutory binding arbitration, this method of resolving medical malpractice claims has not been used by the Company for, at least, the past five years. As to Section 50 of SB2D, our Company has not had any cases that have been settled in accordance with this new law.”*

Another insurer noted:

*“There are no known claims closed under binding arbitration before or after SB2D.”*

Another insurer noted:

*“Our company does not track this data.”*

Another insurer noted:

*“There is no means by which to track the ratio of settlements under binding arbitration or mediation to claims closing both before and after SB2D. This information could probably be obtained through the National Practitioner Database (NPDB). Medical liability insurers supply information to the NPDB regarding the means by which a claim was closed, e.g., verdict, mediation, settlement, or other. However, our Company does not compile data regarding the ratios.”*

### **Cap on Non-Economic Damages (Section 54)**

As part of our MLDR, we asked medical malpractice insurers to answer seven questions related to the cap on non-economic damages.

**Question 1:** Please list any court cases in the state of Florida that have imposed a cap on non-economic damages.

None of the companies were aware of any court cases in Florida that have imposed a cap on non-economic damages.

One insurer noted:

*“One Seminole County judge recently entered an order enforcing the non-economic cap provisions of the Medical Malpractice Act. However, it is not a case being handled by*

*our company and therefore we do not have any details on statistics arising out of that claim.”*

**Question 2:** Please list any claims your company is currently litigating that have a high probability of resulting in non-economic damages that exceed the SB2D caps.

A number of the companies responded that it didn't have the information available, didn't track it in an organized fashion, or felt that if it provided the information, it could potentially jeopardize the defense of the company's current cases and possibly increase the exposure of the Company and their insureds.

One insurer in this category did note:

*“We are currently handling lawsuits that could invoke the non-economic damages caps. Many of these claims are still in pre-suit, or it is premature to precisely evaluate the potential non-economic portion of the claims. Non-economic damages in such cases would ordinarily be well in excess of the economic damages. Application of the caps in these cases would significantly reduce the non-economic damages value of the claims. We do not think it would be appropriate to comment on specific pending litigation.”*

Another insurer in this category noted:

*“Given the nature of medical malpractice claims, a majority of our Company's claims have situations that, if determined adversely to the Company, have a high probability of resulting in non-economic damage that exceed the caps. Many of our cases involve wrongful death and people with permanent injuries that require long-term care or involve significant loss of income. It is not possible to provide non-economic and economic dollar estimates given the high volume of active cases and the very subjective nature of this analysis. For post September 15, 2003 cases, it is still too early to predict since most of the cases are still in the initial discovery stages.”*

Two of the companies did provide economic and non-economic damage estimates regarding cases that could potentially exceed the cap on non-economic damages<sup>28</sup>.

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<sup>28</sup> The information provided by the two companies displayed economic and non-economic damage estimates only. No other confidential suit specific information was provided to Deloitte Consulting.

One insurer listed 10 suits all filed before September 19, 2004 with potential non-economic damages in excess of \$1,000,000 that could be subject to the cap.

Another insurer listed 23 suits with non-economic damages ranging from \$210,000 to \$1,000,000 that could be subject to the cap.

**Question 3:** Please discuss your perception of the constitutionality of the non-emergency room caps on non-economic damages for practitioners and non-practitioners?

One insurer noted:

*“We have not analyzed the constitutionality of the non-emergency room caps on non-economic damages as there has been insufficient experience to offer a comment on this issue.”*

Another insurer noted:

*“No comment.”*

Another insurer noted:

*“Our company does not have an official opinion as to whether the damage caps imposed by the passage of SB2D will ultimately be held to be valid under Florida’s constitution.”*

Another insurer noted:

*“The language regarding both the cap on non-economic damages in emergency and non-emergency cases was drafted in a manor to withstand constitutional challenge based on prior Florida Supreme Court decisions. We anticipate there will be cases in which the constitutionality of these caps is challenged, and it is unknown what the courts will rule”*

Another insurer noted:

*“Florida courts have historically been reluctant to uphold limits on damages in lawsuits. As a result, our claims personnel are reluctant to give great credibility to the caps until such time as they are tested. Having said that, we have adopted the presumed factors in our two most recent rate filings. These factors assume that the caps will in fact be held constitutional. However, if the caps are found to be unconstitutional, our rates may be inadequate.”*

Another insurer noted:

*“We estimate that there is a 50% chance that the cap will be declared constitutional. We have no legal opinion.”*

Another insurer noted:

*“The constitutionality of the non-emergency room caps will have to be tested by a court of law. The Company has no way to gauge what the courts in Florida will decide and it would be fruitless to speculate on the outcome.”*

Another insurer noted:

*“Our company believes the various caps enacted by the State of Florida as part of SB2D to be constitutional. Our company does, however, recognize that the Florida courts have struck prior limitations on damages, while others have been upheld. However, based on the findings of the Legislature in enacting the medical practice damage limitations, and the actual crisis impacting the medical malpractice insurance market at the time SB2D was enacted, our Company is cautiously optimistic that the courts will uphold the limitations on non-economic damages contained in SB2D. However, if the example of other states is followed in the case of Florida, it will be a period of years before all challenges to the constitutionality of the various provisions statute are brought and fully resolved. During that period, it is unlikely that the State will realize the full benefit of the caps enacted as part of SB2D.”*

**Question 4:** Please discuss your perception of the constitutionality of the non-emergency room caps on non-economic damages for practitioners and non-practitioners?

Most of the insurers repeated their answers from question 3. The following companies provided unique answers to question 4.

One insurer noted:

*“The constitutionality of the cap on non-economic damages in emergency cases stands a good chance of being upheld on public policy grounds, i.e., shortage of physicians who provide emergency room services.”*

Another insurer noted:

*“We estimate that there is a more than 50% chance that the emergency room caps will be declared constitutional.”*

**Question 5:** Please discuss and provide any available data showing whether the cap on non-economic damages has helped your negotiating position in any of the cases you have settled in 2004 (e.g., speed up in claim settlement, elimination of frivolous claims, etc.)?

A number of the companies responded that it is too early to comment on this question since the caps have not been tested and most of the cases filed after September 15, 2003 are still in the very early stages of discovery (i.e., not close to settlement). However, a few companies added the following commentary.

One insurer noted:

*“The plaintiff counsel that we encounter in the defense of claims refuse to recognize any value in the cap on non-economic damages imposed by SB2D and, therefore, it is our current perception that it is having no effect in the settlement of claims. Medical malpractice lawsuits in Florida lacking merit should not be characterized as frivolous because the adoption of the pre-suit requirement to file a verified expert opinion generally eliminates “frivolous” claims.”*

*The company also provided a summary of the average cost of closed claims before 9/15/2003 and after 9/15/2003:*

<b>Category</b>	<b>Before 9/15</b>	<b>After 9/15</b>
Average Total Cost	\$32,140	\$38,809
Average Indemnity Payment	\$200,740	\$229,885

*Note: Indemnity limited to \$500,000, Claims reported after January 1, 1999*

Another insure provided the following summary of the average cost of closed claims before 9/15/2003 and after 9/15/2003:

<b>Category</b>	<b>Before 9/15</b>	<b>After 9/15</b>
Average Total Cost	\$40,987	\$75,713
Average Indemnity Payment	\$222,167	\$253,909

*Note: Indemnity limited to \$500,000, Claims reported after January 1, 1999*

Another insurer noted:

*“As noted above, because the statutory changes are less than one year old and because the typical medical malpractice claim takes much longer than one year to fully litigate, we do not have a statistically significant pool of cases to draw from in order to adequately respond to this request. To date, we can say that we have yet to see any discernable change in any of the three areas identified in the July 8, 2004 memorandum. However, this is subject to change once we do have a statistically significant pool of cases to analyze.”*

Another insurer noted:

*“The average indemnity payment for claims in Florida for the fourth quarter of 2003 was approximately 60% higher than the average indemnity payment for claims in the first three quarters of 2003 and the average ALAE for the fourth quarter 2003 was approximately 23% higher than it was for the first three quarters of 2003. While this increase is significant, it cannot be totally attributable to the effects of SB2D as the data does not include any post September 15, 2003, SB2D judgments as it is still too premature for those cases to enter the court system.”*

Another insurer noted:

*“To date, the cap on non-economic damages has not helped our negotiating position with respect to any claims settled in 2004.”*

**Question 6:** How is your perception of the constitutionality of the cap on damages being reflected in your post SB2D rate filings?

A number of the companies referred to its previous responses discussing the constitutionality of the caps and how it would handle the PF in future rate filings.

One insurer noted:

*“Rate filings submitting following the enactment of SB2D reflected the “presumed factor” as directed by the Florida Office of Insurance Regulation.”*

Another insurer noted:

*“Our Company provided full credit for the presumed factor as required by law.”*

Another insurer noted:

*“The Company’s most recent filing submission employed the presumed factor calculated by Deloitte & Touche LLP in their November 6, 2003 review of SB2D (7.8%) as a reduction to the Company’s indicated loss and loss adjustment expense pure premium, without any adjustment to reflect the possibility of the damage caps being ruled unconstitutional. Thus, the assumption implicit in the Company’s filing is that the damage caps will be upheld as constitutional. If they are instead found invalid, then the presumed factor employed by the Company will need to be reduced to reflect this development.”*

Another insurer noted:

*“The Company has not made a rate filing as of today’s date. The Company has not changed the way it computes its rates based on the constitutionality of the cap on damages. It will continue to develop rates based on current and past data. The Company will, however, modify the assumptions made during the ratemaking process given the ramifications of the caps on damages.”*

Another insurer noted:

*“At this time, we do not anticipate our perception of the constitutionality of the cap on damages to have an impact on our post SB2D PF rate filings.”*

**Question 7:** How did you reflect the \$150,000/\$300,000 emergency room caps in your recent PF filing required under SB2D?

One insurer noted:

*“The impact of the emergency room caps on non-economic damages was presumed to have been included in the scope of the “presumed factor”. No separate adjustment was expressly incorporated for this element.”*

Another insurer noted:

*“Our Company provided full credit for the presumed factor as it applied to emergency room physicians as the calculated presumed factor reflected in the last rate filing included the impact of this cap.”*

Another insurer noted:

*“On September 15, 2003, we had a pending rate filing with the Florida Office of Insurance Regulation requesting, among other items, an increase in the class relativity for emergency medicine. This filing was withdrawn. We did not request the class relativity increase in our later approved filing.”*

Another insurer noted:

*“The Company’s most recent filing submission reflected the lower emergency room caps under SB2D by reducing the class factors applicable to those specialties.”*

Another insurer noted:

*“The Company followed the requirements of the legislation and the insurance department in regard to the implementation of the presumed factor for its January 1, 2004 rate filing. There was no specific adjustment for emergency medicine.”*

Another insurer noted:

*“In our prior filing, we did not make an explicit adjustment to the emergency room rates beyond that contemplated by the overall PF.”*

Deloitte Consulting regularly attends the quarterly and year-end earnings calls of the major publicly traded medical malpractice insurers listed on the New York Stock and NASDAQ Exchanges. During a second quarter earnings call, the management of one company noted that it had not seen any tort reform benefit from the effects of SB2D. The Company also noted that plaintiff attorneys generally view the law as unconstitutional. To date, the Company has only recognized the Presumed Factor.

**Bad Faith (Section 56)**

As part of our MLDR, we asked medical malpractice insurers to answer five questions related to the bad faith. For some of the questions, companies noted that it did not capture the information or it was unavailable. We have not included those responses below.

**Question 1:** Please discuss how many times your company has tendered policy limits since September 15, 2003.

One insurer noted:

*“None for claims opened after 9/15/2003.”*

Another insurer noted:

*“The meaning of the word “tender” under Florida law is “offered” and we do not track or record this specific category of data in any organized format whatsoever that would permit access or analysis.”*

Another insurer noted:

*“None.”*

Another insurer noted:

*“2 times.”*

Another insurer noted:

*“None of the cases filed where the act applies. It is our belief that Section 56 does not apply to cases pending or for incidents occurring prior to September 15, 2003. Otherwise we have tendered policy limits on 25 cases since September 15, 2003 but most if not all were for incidents occurring prior to September 15, 2003.”*

Another insurer noted:

*“We have not tendered policy limits in any case since September 15.”*

Another insurer noted:

*“Please be advised, the tendering of policy limits does not constitute “bad faith” payments. Bad faith payments imply that for whatever reason, the insurer breached its duty to the insured and damages resulted. The Company has tendered policy limits 26 times since September 15, 2003 in the state of Florida.*

*Occasionally, the Company will pay in excess of policy limits to protect its insured from personal exposure. However, the Company has only received 5 NOIs since September 15, 2003 where the incident date is after September 15, 2003 and none of these cases have been resolved.”*

**Question 2:** Please provide the approximate number of plaintiff attorney demand letters received before and after SB2D.

Most insurers noted that it did not track this information.

One insurer noted:

*“It can be generally stated that our Company almost always receives a demand letter at some point in all lawsuits both before and after SB2D.”*

Another insurer noted:

*“As a general rule, we receive demand letters on all litigation cases sometime prior to trial.”*

Another insurer noted:

*“We were unable to determine at this time, as we did not previously capture this information. For the cases filed where SB2D applies: none.”*

Another insurer noted:

*“The phrase “plaintiff attorney demand letters” is not defined and could have different meanings in various cases. The Company would require further explanation of what constitutes a demand letter. In addition, the Company does not separately code whether it receives correspondence of this type and determination of a number would require a manual review of all claim files.”*

**Question 3:** Please provide the number of claim settlements per policy both before and after SB2D.

One insurer noted:

*“Given the short period of time that has passed since the effective date of SB2D, and the fact that it takes an average of approximately 2 – 2.5 years to settle claims, there is no meaningful data on the number of claim settlements before and after SB2D.”*

Another insurer noted:

*“151 claims were closed with loss payment before September 15, 2003 and 20 claims were closed with loss payment on or after September 15, 2003.”*

Another insurer noted:

*“This question is not clear. Our policies are written on a per individual insured basis. If a settlement is made it is done per insured defendant and allocated accordingly.”*

Another insurer noted:

*“We write an occurrence policy and therefore this question does not apply to our Company.”*

Another insurer noted:

*“The Company has not settled any claims that have been reported after September 15, 2003 with an incident date that occurred after September 15, 2003. The timing is premature for any meaningful data comparison. In addition, we note that the Company historically has not determined claims settlement on a per policy basis.”*

**Question 4:** Please provide the average severity of settled claims both before and after SB2D.

One insurer noted:

*“The following average severities (which include both incurred loss and ALAE) were determined for closed Florida professional liability insurance claims for our Company’s medical malpractice and specified medical product lines, as of 7/31/2004.*

*Claims closed with >0\$ incurred loss+ALAE, which were opened on or after 1/1/2000, but before 9/15/2003 (172 claims):\$141,559.*

*Claims closed with >0\$ incurred loss+ALAE, which were opened on or after 9/15/2003 (only 6 claims, very green!): \$43,402.*

*Claims closed with >0\$ incurred loss (not including ALAE), which were opened on or after 1/1/2000, but before 9/15/2003 (115 claims): \$207,664.*

*Claims closed with >0\$ incurred loss (not including ALAE), which were opened on or after 9/15/2003 (only 2 claims, very green!): \$125,207.”*

Another insurer provided the following summary of the average cost of closed claims before 9/15/2003 and after 9/15/2003:

<b>Category</b>	<b>Before 9/15</b>	<b>After 9/15</b>
Average Total Cost	\$32,140	\$38,809
Average Indemnity Payment	\$200,740	\$229,885

*Note: Indemnity limited to \$500,000, Claims reported after January 1, 1999*

Another insurer provided the following summary of the average cost of closed claims before 9/15/2003 and after 9/15/2003:

<b>Category</b>	<b>Before 9/15</b>	<b>After 9/15</b>
Average Total Cost	\$40,987	\$75,713
Average Indemnity Payment	\$222,167	\$253,909

*Note: Indemnity limited to \$500,000, Claims reported after January 1, 1999*

Another insurer noted:

*“The average severity for the 151 claims closed with loss payment before September 15, 2003 was \$206,168. The average severity for the 20 claims closed with loss payment after September 15, 2003 is \$319,301.”*

Another insurer noted:

*“The average severity of all claims closed with payment prior to September 15, 2003 is \$248,463. The average severity of all claims closed with payment on or after September 15, 2003 is \$231,444. The credibility of this number is difficult to evaluate provided that the severity average prior to September 15, 2003 is based on a larger population of closed claims than those after September 15, 2003 (only 10 months of data).”*

Another insurer noted:

*“If the intent is to measure the impact of SB2D on claim severity then, given the duration of the typical medical malpractice lawsuit, we do not have enough settlements of post-September 15, 2003 claims in order to provide a statistically significant analysis.”*

Another insurer noted:

*“The Company has not settled any claims that have been reported after September 15, 2003 with an incident date that occurred after September 15, 2004. The timing is premature for any meaningful data comparison.”*

**Question 5:** Have your defense mitigation strategies changed since the passage of SB2D?

One insurer noted:

*“No.”*

Another insurer noted:

*“Yes. We have modified our defense strategies to ensure compliance with the new “bad faith” provisions.”*

Another insurer noted:

*“We are still evaluating the effect, if any, SB2D will have on claim negotiation strategies.”*

Another insurer noted:

*“Our defense strategies have always been to act in utmost good faith to our policyholders. At this point, it is premature to comment on how the passage of SB2D may affect our defense mitigation strategies.”*

Another insurer noted:

*“No. We have not and do not expect that bad faith will be an issue.”*

Another insurer noted:

*“Our defense mitigation strategies have not changed since the enactment of SB2D. The Company will most likely not modify its strategies until the constitutionality of the caps is upheld in the courts.”*

**Good SAM (Section 56)**

As part of our MLDR, we asked medical malpractice insurers to comment on the impact of “good SAM” under Section 56 of SB2D.

One insurer noted:

*“None.”*

Another insurer noted:

*“To the best of our knowledge, we are not aware of any information that would provide insight on the impact of the “good SAM” section 56 of SB2D, nor are we aware of any claims where good SAM has had a favorable impact.”*

Another insurer noted:

*“We have no claims impacted by the good Samaritan statute.”*

Another insurer noted:

*“No data available.”*

Another insurer noted:

*“We have not seen an impact of Section 56.”*

Another insurer noted:

*“The Good SAM provision has not been tested in the courts and has not impacted any of our cases. It has been our early experience that the lower courts seem hesitant to apply the provision except under extreme circumstance.”*

Another insurer noted:

*“We have not experienced good SAM claims.”*

**Policy Limit Trends**

As part of our MLDR, we asked medical malpractice insurers to comment on the breakdown of policy limits sold by policy count both before and after SB2D.

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**Section 627.912(6), Florida Statutes, as amended by Senate Bill 2-D, (Ch. 2003-416)**

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One insurer noted:

*“The minimum limits purchased by Florida dentists are \$1,000,000/\$3,000,000. Therefore, the limit profile of our company has not changed as we have not experienced the purchase of lower policy limits by these Insureds since enactment of SB2D.”*

Another insurer noted:

*“Between 2002 and 2003 we observed:*

- 1. fewer purchases of insurance at any limit*
- 2. on an absolute number as a percentage of total policies, fewer were purchased at a limit of \$1MM/\$3MM.*

*We believe that the trend toward fewer applicants buying coverage and those that do purchase coverage purchasing lower limits is due to the cost of insurance.”*

Another insurer provided the following data:

PER OCCURRENCE LIMIT	1999	2000	2001	2002	2003 - Pre 9/15	2003 - Post 9/15	2004 Through June 30
\$100,000	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
<b>\$250,000</b>	<b>25.0%</b>	<b>24.0%</b>	<b>32.0%</b>	<b>41.0%</b>	<b>54.0%</b>	<b>52.0%</b>	<b>61.0%</b>
\$500,000	22.0%	22.0%	18.0%	20.0%	20.0%	21.0%	18.0%
\$1,000,000	44.0%	42.0%	41.0%	32.0%	21.0%	24.0%	18.0%
\$1,500,000	5.0%	5.0%	3.0%	2.0%	1.0%	1.0%	1.0%
\$2,000,000	3.0%	4.0%	3.0%	3.0%	3.0%	1.0%	2.0%
\$3,000,000	0.0%	0.0%	1.0%	1.0%	0.0%	0.0%	0.0%
\$4,000,000	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
\$5,000,000	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
UNKNOWN	2.0%	3.0%	1.0%	1.0%	1.0%	1.0%	0.0%
TOTAL	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

**Section 627.912(6), Florida Statutes, as amended by Senate Bill 2-D, (Ch. 2003-416)**

Another insurer provided the following data:

PER OCCURRENCE LIMIT	1999	2000	2001	2002	2003 - Pre 9/15	2003 - Post 9/15	2004 Through June 30
\$100,000	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
<b>\$250,000</b>	<b>16.0%</b>	<b>13.0%</b>	<b>13.0%</b>	<b>21.0%</b>	<b>50.0%</b>	<b>60.0%</b>	<b>59.0%</b>
\$500,000	15.0%	9.0%	6.0%	11.0%	6.0%	3.0%	11.0%
\$1,000,000	68.0%	78.0%	81.0%	68.0%	44.0%	36.0%	30.0%
\$1,500,000	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
\$2,000,000	0.0%	0.0%	0.0%	0.0%	1.0%	0.0%	0.0%
\$3,000,000	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
\$4,000,000	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
\$5,000,000	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
UNKNOWN	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
TOTAL	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

Another insurer noted:

*“Over the past two years we have seen a trend toward physicians purchasing lower policy limits. We believe this trend is in response to increased price and not a specific reaction to the non-economic caps or other aspects of SB2D.”*

LIMITS PURCHASED	DISTRIBUTION AS OF 8/31/2003	CURRENT DISTRIBUTION
\$100K/\$300K	0.03%	0.03%
<b>\$250K/\$750K</b>	<b>16.54%</b>	<b>20.78%</b>
\$500K/\$1.5M	19.05%	21.30%
\$1M/\$1M	0.07%	0.06%
\$1M/\$3M	61.41%	57.83%
\$2M/\$4M	1.10%	0.00%
\$3M/\$5M	1.80%	0.00%
TOTAL	100.0%	100.0%

Another insurer noted:

*“The table below provides distributions of policies sold by limits for the six-month periods before and after enactment of SB2D. As these are not annual periods, there may be some difference due to the different cohort of policies reflected in the two periods.”*

PER OCCURRENCE LIMIT	04/01/03 THROUGH 09/30/03	04/01/03 THROUGH 09/30/03
\$100,000	0.3%	0.3%
\$200,000	0.1%	0.0%
<b>\$250,000</b>	<b>47.7%</b>	<b>46.4%</b>
\$500,000	19.8%	16.9%
\$1,000,000	30.7%	34.9%
\$1,500,000	0.6%	0.9%
\$2,000,000	0.6%	0.3%
\$3,000,000	0.1%	0.1%
\$4,000,000	0.1%	0.0%
\$5,000,000	0.0%	0.0%
TOTAL	100.0%	100.0%

Another insurer noted:

*“It is premature to draw conclusions about the effect on the purchase of limits.”*

Another insurer noted:

*“We see a continuing trend toward the purchase of lower limits of liability. Additionally, we have lost a number of policyholders who have indicated that they are leaving the insurance market and will practice without insurance.”*

Distribution Policy Limits	12/31/2002	12/31/2003	03/31/2004
<b>\$250,000</b>	<b>49.6%</b>	<b>60.4%</b>	<b>62.0%</b>
\$500,000	15.5%	15.4%	14.5%
\$1,000,000	34.8%	24.2%	23.6%

### Targeting Lower Policy Limits

In reviewing the above results, one has to ask the following question:

*“Who is driving the shift towards lower policy limits; physicians or insurers?”*

Although we think the primary driving force behind the purchase of lower policy limits is physicians looking to offset large premium increases with lower cost reduced policy limits, we note the comments made by one of Florida’s newest medical malpractice reciprocal insurers in a May A.M. Best Bestwire news article:

*“Our Company’s focus will be on making insurance products available and affordable for doctors, he said. One way to do that is to offer across-the-board low-limit coverage that meets the statutory limits of \$100,000 per claim or \$300,000 annual aggregate for physicians not admitting patients to a hospital and \$250,000 per claim or \$750,000 annual aggregate for physicians who do admit patients into a hospital setting.”*

The article also noted:

*“Physicians can save thousands of dollars a year with lower limits, but the industry has hurt doctors by offering high-limit insurance. That made doctors a very attractive financial target.”*

### **Going Bare**

In response to questions raised by a stock analyst during a second quarter earnings call, the management of one company responded that the number of doctors going bare in the state of Florida is a huge problem. Company management noted that plaintiff attorneys, who target insured doctors for their insurance company backed policy limits, are essentially compounding the rate problem by letting “bare” doctors off the hook.

During the same Company’s first quarter earnings call, management similarly noted that it was worried about Florida cases where its insured physicians have been sued along with “bare” doctors as co-defendants. In these situations, the Company stated that it had been viewed as the “deep pocket”. In addition, the Company noted that it was worried that plaintiffs who truly deserve compensation won't be able to recover what they should be able to recover.

On page 7 of our November 6, 2003 titled **Review of Florida Committee Substitute for Senate Bill 2-D, Calculation of Section 40 “Presumed Factor”**, Deloitte Consulting stated the following:

*It is important to note that these practices also include measures to be taken to limit or avoid liability. One phenomenon that we have noted elsewhere in this report is that physicians are purchasing lower policy limits. This trend is not simply the result of shrinking insurance capacity and skyrocketing rates; it reflects a belief that plaintiffs’ attorneys will gravitate toward practitioners carrying higher limits. Not wanting to be a*

*primary target of a plaintiff attorney by carrying higher policy limits (while others physicians suffer smaller claims because of lower policy limits), physicians have acted rationally by reducing their liability limits to avoid being targeted as the first among several in any multiple defendant action.*

Deloitte Consulting also stated on page 40:

*Given the size of rate increases filed in 2003, the continuing after-effects of major insurance companies that have exited the Florida market, and the reduction in capacity offered by Florida's remaining insurers, we expect this trend to continue.*

Based upon the MLDR responses, medical malpractice studies<sup>29</sup>, recent news stories and statements made by insurers during public company earnings calls, the trend towards lower policy limits and doctors going bare will likely continue in the near future. Although some new insurers have entered the market, we don't anticipate any drastic differences in the cost of coverage that would create a sudden interest in purchasing higher policy limits in the state of Florida.

### **Other Impacts**

As part of our MLDR, we asked medical malpractice insurers to discuss any other impacts of SB2D that should be noted from a financial perspective that we did not address in our MLDR.

Some of the insurers had no additional comments.

One insurer noted:

*"Our Company appreciates the opportunity to provide feedback on this survey and cannot cite any other impact of SB2D from a financial perspective."*

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<sup>29</sup> For example, in the NAIC's May 2004 study "Medical Malpractice Insurance Report – A Study of Market Conditions and Possible Solutions to the Recent Crisis", the executive summary noted that "there are many reports of providers establishing plans of self-insurance or doing without vital liability coverage entirely."

Another insurer noted:

*“At this time we have seen no financial impact from SB2D. SB2D applies to claims that both occurred and were reported after 9/15/03. It will take time for us to measure any differences as these claims work their way through the system.”*

Another insurer noted:

*“We believe it is too early to tell of any financial impact resulting from SB2D.”*

Another insurer noted:

*“From a financial standpoint, it should be noted that in the event the constitutionality of the caps is not upheld in court, the effect of the presumed factor rate adjustment and any other consideration of tort reform will most likely render inadequate the rates charged during 2004 and thereafter. Under present law, there will be no way to recoup these shortfalls. However, because the damage caps alter the assumptions that underlie the Company’s rate filing, an adverse decision would necessitate an immediate rate filing with appropriate changes in assumptions. It should be noted that the longer it takes for the caps to be tried in the courts, the greater the impact on rates becomes due to annual compounding of the deficiency.”*

**III. SECTION 45(6)(c)**

**SUMMARY OF PRIOR YEAR RATE FILINGS**

As requested by SB2D, we have provided a summary of the 2003 calendar year medical malpractice rate filings which have been approved by the OIR.

INSURER NAME	PROGRAM TYPE	INSURER INDICATED RATE NEED*	APPROVED STATEWIDE RATE CHANGE	EFFECTIVE DATE NEW	EFFECTIVE DATE RENEWAL
ISO	(P&S)	7.4%	7.4%	6/1/2003	6/1/2003
MEDICAL PROTECTIVE CO.	(P&S)	42.9%	39.7%	1/1/2003	1/1/2003
MEDICAL PROTECTIVE CO.	Dental	7.9%	5.7%	3/1/2003	3/1/2003
FIRST PROFESSIONALS INS. CO.	(P&S)	24.0%	21.1%	12/1/2002	12/1/2002
PRONATIONAL INS. CO.	(P&S)	31.4%	27.9%	1/1/2003	1/1/2003
MEDICAL ASSURANCE CO.	(P&S)	57.6%	57.6%	1/1/2003	1/1/2003
GULF INS. CO.	(Chiro.)	Rule filing			
ISO	(P&S)	6.0%	6.0%	6/1/2003	6/1/2003
MEDICAL PROTECTIVE COMPANY	(P&S)	Rule filing			
MEDICAL PROTECTIVE COMPANY	(P&S)	Rule filing			
NATIONAL UNION FIRE INS. CO.	(P&S)	Rule filing			
HEALTH CARE INDEMNITY, INC	(Hospitals)	39.9%	39.9%	1/1/2003	1/1/2003
PICA GROUP	(Chiro.)	12.4%	12.4%	1/1/2003	1/1/2003
MAG MUTUAL INS. CO.	(P&S)	Rule filing			
HEALTH CARE INDEMNITY	(P&S)	New Program		1/1/2003	1/1/2003
CONNECTICUT INDEMNITY COMPANY	(Dentist)	30.0%	20.0%	1/1/2003	1/1/2003
TRUCK INSURANCE EXCHANGE	(P&S)	37.1%	22.9%	3/1/2003	3/1/2003
MEDICAL PROTECTIVE COMPANY (THE)	(Dentist)	Rule filing		3/1/2003	3/1/2003
DOCTOR'S COMPANY, AN INTERINSURANCE EXCHANGE	(P&S)	0.0%	-4.0%	3/1/2003	4/1/2003
AMERICAN PHYSICIANS ASSURANCE CORPORATION	(P&S)	47.6%	19.0%	12/1/2002	12/1/2002
MEDICAL ASSURANCE COMPANY, INC (THE)	(P&S)	8.0%	8.0%	2/1/2003	2/1/2003
NATIONAL FIRE INSURANCE COMPANY OF HARTFORD	(P&S)	New Program		2/5/2003	2/5/2003
AMERICAN CASUALTY COMPANY OF READING, PA	(P&S)	New Program		2/5/2003	2/5/2003
PHYSICIANS INSURANCE COMPANY	(P&S)	New Program		3/1/2003	3/1/2003
FIREMAN'S FUND INSURANCE COMPANY	(Dentist)	16.7%	15.0%	4/15/2003	4/15/2003
FLORIDA MEDICAL MALPRACTICE JUA	(P&S)	9.8%	9.8%	7/1/2003	7/1/2003
MEDICAL PROTECTIVE COMPANY (THE)	(Dentist)	Rule filing		3/1/2003	3/1/2003
CONTINENTAL CASUALTY COMPANY	(Hospitals)	Withdrawn from Market		5/9/2003	5/9/2003
FIRST PROFESSIONAL'S INSURANCE COMPANY, INC	(P&S)	Rule filing	0.0%	5/1/2003	5/1/2003
HEALTHCARE UNDERWRITERS GROUP OF FLORIDA	(Dentist)	New Program		7/1/2003	7/1/2003
ANESTHESIOLOGISTS PROFESSIONAL ASSURANCE	(Aneth.)	34.1%	28.0%	7/1/2003	7/1/2003
STATE FARM FIRE AND CASUALTY COMPANY	(Dentist)	New Program		8/15/2003	8/15/2003
CONTINENTAL CASUALTY COMPANY	(P&S)	New Program		8/1/2003	8/1/2003
AMERICAN CASUALTY COMPANY OF READING, PE	(P&S)	Rule filing		9/15/2003	9/15/2003
CONNECTICUT INDEMNITY COMPANY	(Dentist)	Rule filing		11/15/2003	11/15/2003
FLORIDA HEALTHCARE PROVIDERS INSURANCE EXCHANGE	(P&S)	New Program			

NOTE: (P&S) – Physicians and Surgeons

## SUMMARY OF “PRESUMED FACTOR” FILINGS

In addition to the summary of the 2003 calendar year medical malpractice rate filings which have been approved by the OIR, we have also included a list of rate filings which have been approved by the OIR subsequent to the passage of SB2D (i.e., reflect the PF promulgated by the OIR).

INSURER NAME	PROGRAM TYPE	INSURER INDICATED RATE NEED*	APPROVED STATEWIDE RATE CHANGE	EFFECTIVE DATE NEW	EFFECTIVE DATE RENEWAL
PRONATIONAL INSURANCE COMPANY	(P&S)	22.0%	17.3%	1/1/2004	1/1/2004
MEDICAL PROTECTIVE COMPANY	(P&S)	69.8%	45.0%	1/1/2004	3/1/2004
FIRST PROFESSIONALS INSURANCE	(P&S)	10.9%	8.0%	1/1/2004	3/1/2004
CHICAGO INSURANCE COMPANY	(Nurses)	106.2%	8.2%	2/15/2004	2/15/2004
MAG MUTUAL INSURANCE COMPANY	(P&S)	15.4%	7.0%	1/1/2004	1/1/2004
GRANITE STATE INSURANCE COMPANY	(P&S)	95.0%	16.8%	2/27/2004	2/27/2004
TRUCK INSURANCE EXCHANGE	(P&S)	45.4%	6.0%	1/1/2004	1/1/2004
CHICAGO INSURANCE COMPANY	(P&S)	110.3%	15.8%	2/15/2004	2/15/2004
NATIONAL CASUALTY COMPANY	(Dental)	-7.8%	-7.8%	1/1/2004	1/1/2004
PODIATRY INS CO OF AMERICA	(Podiatrist)	RRG Conv.	19.9%	1/1/2004	1/1/2004
INSURANCE SERVICES OFFICE (ISO)	(P&S)	41.6%	25.0%	10/1/2004	10/1/2004
CONTINENTAL CASUALTY COMPANY	(Dental)	6.7%	6.7%	1/1/2004	1/1/2004
PHYSICIANS INSURANCE COMPANY	(P&S)	8.7%	6.3%	3/1/2004	3/1/2004
ANESTHESIOLOGISTS PROFESSIONAL	(Anesth.)	13.7%	10.0%	4/1/2004	4/1/2004
THE DOCTORS COMPANY AN	(P&S)	18.6%	8.9%	3/1/2004	3/1/2004
MEDICAL ASSURANCE COMPANY	(P&S)	12.2%	11.8%	1/1/2004	1/1/2004
AMERICAN CASUALTY CO OF	(Nurses)	70.6%	59.8%	1/15/2004	1/15/2004
FORTRESS INSURANCE COMPANY	(Dental)	16.6%	5.0%	12/23/2003	12/23/2003
EXECUTIVE RISK INDEMNITY INC.	(P&S)	no data	-7.8%	1/1/2004	1/1/2004
GUIDEONE MUTUAL INSURANCE CO.	(P&S)	no data	-7.8%	1/1/2004	1/1/2004
NATIONAL FIRE INSURANCE CO	(P&S)	11.7%	11.7%	2/15/2004	2/15/2004
CONTINENTAL CASUALTY COMPANY	(P&S)	no data	-7.8%	2/15/2004	2/15/2004
CONTINENTAL CASUALTY COMPANY	(Hospital)	no data	-7.8%	2/15/2004	2/15/2004
CINCINNATI INSURANCE COMPANY	(Dental)	2.7%	1.3%	1/1/2004	1/1/2004
CINCINNATI INSURANCE COMPANY	(P&S)	-2.3%	-2.3%	1/1/2004	1/1/2004
CINCINNATI INDEMNITY COMPANY	(P&S)	6.4%	3.5%	1/1/2004	1/1/2004
HEALTH CARE INDEMNITY INC.	(P&S)	-1.6%	-1.6%	1/1/2004	1/1/2004
ACE AMERICAN INSURANCE COMPANY	(Podiatrists)	no data	-7.8%	1/1/2004	1/1/2004
ACE AMERICAN INSURANCE COMPANY	(Chiropractors)	no data	-7.8%	1/1/2004	1/1/2004
ACE AMERICAN INSURANCE COMPANY	(Dental)	no data	-7.8%	1/1/2004	1/1/2004
FIRST PROFESSIONALS INS CO	(Dental)	-3.0%	-3.0%	4/1/2004	4/1/2004
MAG MUTUAL INSURANCE COMP	(HC Facilities)	0.0%	0.0%	1/1/2004	1/1/2004
AMERICAN ALTERNATIVE INS CORP	(P&S)	0.0%	0.0%		
GULF INSURANCE COMPANY	(Podiatrists)	17.7%	0.0%	1/1/2004	1/1/2004
AMERICAN CASUALTY CO OF	(P&S)	4.9%	0.0%		
FLORIDA HEALTHCARE PROVIDERS		5.4%	5.4%	4/1/2004	4/1/2004
FLORIDA MEDICAL MALPRACTICE JUA	(P&S)	4.0%	4.0%	7/1/2004	7/1/2004
AIU INSURANCE COMPANY	(P&S)	7.4%	0.0%		
CONNECTICUT INDEMNITY COMPANY	(P&S)	27.5%	0.0%	4/1/2004	4/1/2004

NOTE: \* - Reflects the “Presumed Factor”  
(P&S) – Physicians and Surgeons

**Reflecting the PF**

The indicated rate need reflecting the PF and the company's filed rate change are displayed above. A review of the rate filings submitted by insurers indicates that companies mainly reflected the PF in their filings using the following three approaches;

1. The insurer accepted the OIR's PF of 7.8% without modification in their rate filing by explicitly reflecting the PF in the ratemaking calculation and the development of the indicated rate need (i.e., included in the ratemaking calculation and the development of the indicated rate need).
2. The insurer accepted the OIR's PF of 7.8% without modification in their rate filing by implicitly reflecting the PF in the selection of the filed rate change (i.e., not included in the ratemaking calculation and the development of the indicated rate need).

For example, one company noted the following:

*"At the time of this filing, the Office of Insurance Regulation has not promulgated the "presumed factor" intended to reflect an estimate of the impact of tort reform. The Company estimates that the "presumed factor" will fall in the range of 8% to 15% of premium."*

A comparison of the above Company's indicated rate need to their filed rate change verified that the insurer reduced their filed rate change by more than the PF promulgated by the OIR.

3. The insurer adjusted the OIR's PF of 7.8% to reflect their company's mix of business

For example, one company noted the following:

*"The Company's selected base rate increase reflects the presumed factor released by the Office of Insurance Regulation on November 10, 2003. The presumed factor was adjusted to the Company's book of business as prescribed by Deloitte & Touche."*

The above company then replicates Deloitte Consulting's calculation of the Section 54 PF illustrated on page 52 of our November 6, 2003 report titled **Review of Florida Committee Substitute for Senate Bill 2-D, Calculation of Section 40 "Presumed Factor"** using their own distribution of policy limits.

The Company walks through the following five steps recommended by Deloitte Consulting on page 54 of the Presumed Factor Report:

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

\* - *Company substituted their distribution of policy limits for practitioner only, non-practitioner only, or both depending upon the mix of business they wrote in place of Deloitte Consulting's distribution based upon industry.*

On page 79 of the Presumed Factor Report, Deloitte Consulting noted the following in regards to modifying the Section 54 PF:

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

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

1. *The medical malpractice insurer must walk through the five steps in order to complete the calculation of the presumed factor.*
2. *If the practitioner versus non-practitioner split assumption is changed from our current reliance on the closed claim database mix, the medical malpractice insurer must add an additional step. This step would illustrate their assumed split assumption. The five steps should then be followed.*

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

Based upon our review of the PF Filings, it appears that companies using the third approach adequately addressed the above OIR considerations in the original filing or in responses to detailed questions asked by OIR staff.

### **OIR Review**

During our review of the PF rate filings, Deloitte Consulting also reviewed the correspondence between the OIR and insurance company representative responsible for answering questions regarding the rate filing. Based upon the correspondence we reviewed, we believe the OIR did a thorough job of reviewing the assumptions in the rate filings and asking for additional support.

Their review included some of the following:

- Review of footnotes, titles and line items, including the identification of incorrect items
- Requests for clarification of assumptions, terminology and methodologies and where appropriate, further detailed exhibits supporting the responses
- Request for support on classification and territorial relativity changes including a discussion of the maximum and minimum rate changes in the filing
- Specific focus on the handling of the PF and a discussion of the overall impact on the Company's book of business
- Request for revised exhibits and assumptions

For example, in one PF rate filing approved by the department, the OIR staff asked over thirty questions. In addition, the OIR brought to the Company's attention that their rate filing did not include the 2.5% bad faith savings promulgated by the OIR in Section 56. As a result of the OIR's review, the insurance company revised their filing support to include the 2.5% savings.

For those interested in experiencing the level of review performed by the OIR staff, Deloitte Consulting recommends that the reader visit the on-line filing system and review some of the medical malpractice filings approved by the OIR. The PDF files available from the web site include the Company's original filing, OIR questions, company responses and all exhibits supporting the filed rates.

## RATE FILING TREND ANALYSIS

The following analysis compares the current assumptions underlying the PF rate filings to the rate filings in effect before the passage of SB2D. We have included in **Appendix C – Ratemaking Primer** a brief description of the ratemaking process and definitions for readers unfamiliar with the process of ratemaking.

Table PF1 displays the death, disability and retirement loading (DDR).

TABLE PF1					
DDR LOADING					
PF FILINGS			CHANGE FROM PRIOR		
Min	Max	Average	Min	Max	Average
3.50%	6.50%	4.83%	0.00%	1.50%	0.68%

DDR, often referred to as “free tail”, protects the insured physician from claims filed after a policy has expired. The physician receives “free tail” tail coverage upon retirement (assuming the physician reaches retirement age and has been insured by the Company for the required number of years in the policy), if the physician suffers permanent and total disability or in the event the physician dies.

As one can see from above, the DDR loading underlying the individual rate filings vary from a low of approximately 3.5% to a high of 6.5%. On average, the DDR loading increased since last year’s filing, with a maximum increase of 1.5%.

Table PF2 displays the loss trend factor<sup>30</sup> assumed in the rate filing to bring historical losses to the current loss level.

TABLE PF2					
LOSS TREND					
PF FILINGS			CHANGE FROM PRIOR		
Min	Max	Average	Min	Max	Average
6.00%	12.40%	8.55%	0.00%	6.40%	2.47%

In developing the loss trend assumptions utilized in the filings, the insurers reviewed used the following approaches:

1. The insurer relied upon their own historical loss data to develop the selected loss trend;
2. The insurer used their own historical loss data credibility weighted with outside sources (e.g., Insurance Services Office (ISO), actuarial consulting firm internal proprietary database, etc.) to develop the selected loss trend; and
3. The insurer relied upon outside sources to develop the selected loss trend.

On page 103 of the Presumed Factor Report, Deloitte Consulting selected the following trend factors for economic and non-economic damages:

*The next step in our Phase II data preparation efforts was to trend the claim values to current levels based on the disposition date of the claim. An annual trend of 6% was selected for the economic component of loss. An annual trend of 6% was selected for the non-economic loss component through 1993 with a 10% annual trend selected for the 1994 through 2003 years. The higher trend selection for non-economic loss during the 1994 through 2003 years is intended to be reflective of the faster rate at which non-economic loss has been increasing in recent years. As is often noted in the media, there has been an increase in the “lottery mentality” of jury awards in recent years. We believe the 4% adjustment helps to reflect this fact.*

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<sup>30</sup> For a majority of the rate filings, the “loss” implies a trend factor applied to loss and ALAE combined. In some filings, insurers derived separate trend factors for loss and ALAE. In these filings, loss and ALAE were trended by separate factors then combined in the final ratemaking exhibit.

We believe the trend selections in Table PF2 are directionally consistent with the selections used by Deloitte Consulting in our SB2D PF analysis (i.e., trends in the 6% to 10% range). In addition, we would expect loss trend selections to vary by company depending upon the mix of business written (e.g., specialty mix, county mix, hospital mix if target non-practitioners, etc.).

As one can see from above, the loss trend underlying the individual rate filings vary from a low of approximately 6.0% to a high of 12.4%. On average, the loss trend increased almost 2.2% since last year's filing.

Table PF3 displays the expenses assumed in the rate filings.

<b>TABLE PF2</b>					
<b>EXPENSES</b>					
<b>PF FILINGS</b>			<b>CHANGE FROM PRIOR</b>		
<b>Min</b>	<b>Max</b>	<b>Average</b>	<b>Min</b>	<b>Max</b>	<b>Average</b>
14.84%	29.70%	21.57%	-8.25%	16.70%	2.16%

The expenses shown above include:

1. Commission & brokerage expense
2. Other acquisition expense
3. General expense
4. Premium taxes
5. Misc. Licenses and Fees, other taxes
6. Other expenses
7. Expected profit margin & contingency factor (i.e., Rule 69O-170.003, F.A.C.)

As one can see from above, the expense ratios underlying the individual rate filings vary from a low of approximately 15% to a high of almost 30%. A majority of the differences in expense ratios are explained by the first three items and differences in the expected profit margin & contingency factor. The expense ratios also increased on average since last year's filing, partially

driven by changing assumptions and lower expected profit margin & contingency factors impacted by declining investment returns.

The expected loss ratio, equal to 100% minus the expense ratio, indicates that company expected loss ratios range from 70% to 85%. The impact of the changes in the above assumptions can be seen using the simplified manual rate indication formula discussed in **Appendix C**:

**Manual Rate Indication**

Sample Calculation:

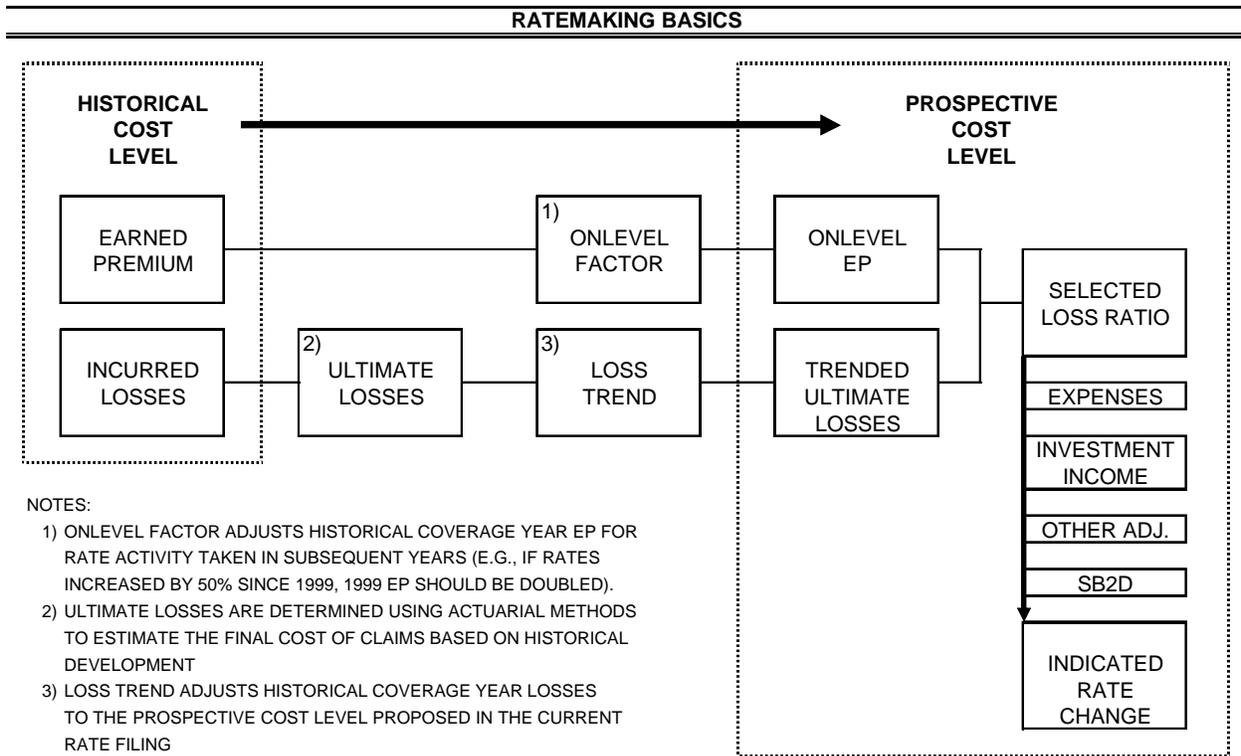
- (1) Ultimate Loss and LAE Ratio
- (2) Death, Disability and Retirement Load (DDR)
- (3) Expected Loss Ratio
- (4) Average Policy Discount

$$\text{Indication} = [ (1) \times (2) ] / [ (3) \times \{ 1.0 - (4) \} ] - 1.0$$

	LOW ELR	POINT ELR	HIGH ELR	
(1)	75.0%	75.0%	75.0%	← Impacted by Loss Trend
(2)	<u>1.050</u>	<u>1.050</u>	<u>1.050</u>	
	78.8%	78.8%	78.8%	= (1) x (2)
(3)	<b>70.0%</b>	<b>77.5%</b>	<b>85.0%</b>	← Impacted by Expense Trends
(4)	0.000	0.000	0.000	
	12.5%	1.6%	-7.4%	= [ (1) x (2) ] / [ (3) x { 1.0 - (4) } ] - 1.0

As one can see from above, changes to loss trend directly impact the ultimate loss and LAE ratio underlying the calculation of the indication. If loss trends are increasing, the final manual rate indication will have increased upward pressure. Similarly, if expenses are increasing because of rising costs or lower profit and contingency margins driven by lower investment returns, the final manual rate indication will have increased upward pressure. If loss trend and expenses are decreasing, the final manual rate indication will have increased downward pressure.

By using the below diagram to drill down into the derivation of the ultimate loss and LAE ratio, we can also see how past rate increases, actuarial assumptions, and tort reform impact the final indicated rate change.



As one can see from above, prior year rate increases exert downward pressure on the selected ultimate loss and LAE ratio (i.e., historical premiums have to be grossed up to reflect rate activity taken subsequent to the earning of the premium). Loss trend exerts upward pressure on the selected ultimate loss and LAE ratio (i.e., losses paid three years ago need to be trended to the prospective level underlying the rate filing today). Shown in mathematical form:

$$\text{Ultimate Loss and LAE Ratio} = \frac{\text{Ultimate Loss and LAE}}{\text{Onlevel Earned Premium}}$$

Loss Trend ↙ ↘  
Rate Changes

Based upon our review of the pre-SB2D rate filings and post-SB2D rate filings, we believe the trend in direct incurred losses has increased from last year's rate filings driven by higher loss trend selections. In addition, higher expense ratios driven by rising costs and a lower profit & contingencies have also put some upward pressure on rates. This upward pressure from losses and expenses has been partially offset by the compound effect of recent year rate change activity and the impact of reflecting the PF required by the passage of SB2D.

## **IV. OBSERVATIONS AND CONCLUSIONS**

This section of the report addresses our observations and conclusions regarding the financial information, rate filings, closed claim database analysis and responses to our market leader data request discussed above.

### **OVERALL COMMENTS**

- **“Green” Nature of SB2D**

SB2D was passed on September 15, 2003. As will be discussed below in some of the commentary, it is too early to evaluate and establish the ultimate impact of SB2D. Due to the long tail nature of the medical malpractice line of business, the uncertainty regarding the Berges case and constitutionality of SB2D’s various Sections, and the phase-in time required to impact the data underlying the ratemaking process in Florida medical malpractice rate filings, more time is required to evaluate and establish the ultimate impact of SB2D.

- **Complexity of Report**

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

## **RATE FILINGS**

- Based upon our review of the pre-SB2D rate filings and post-SB2D rate filings, the Office in consultation with Deloitte Consulting believes the trend in direct incurred losses has increased from last year's rate filings driven by higher loss trend selections. In addition, higher expense ratios driven by rising costs and a lower profit & contingencies have also put some upward pressure on rates. This upward pressure from losses and expenses has been partially offset by the compound effect of recent year rate change activity and the impact of reflecting the PF required by the passage of SB2D.

Given the cumulative impact of the large rate increases taken over the past few years and the heavy focus on the medical malpractice crisis in the State of Florida, rate increases should moderate over the next few years driven by the following items:

- Interest rates appear to be on the rise again, as witnessed by recent Federal Reserve activity and current expectations regarding interest rates. As interest rates rise, medical malpractice insurance companies with a majority of their investments in bonds will also see an increase in their average portfolio yield. The increase in average portfolio yield will exert downward pressure on insurance rates as medical malpractice insurers will be able to reflect more investment income in their rate filings. Higher investment income means lower rates charged to Florida healthcare providers. This is a reversal of the trends in the 1990s that saw interest rates drop to multi-decade lows.
- Based on comments made during recent public company earnings calls, some writers in the state of Florida believe that rates have finally reached a level where rates appear to be adequate. Assuming no significant shift in the legal environment or claim settlement patterns, this would imply that some Florida

medical malpractice insurers should only have to keep pace with loss severity trends in future rate filings.

- Patient safety initiatives appear to be gaining additional momentum across the country. Multiple organizations appear to be spearheading the charge on making healthcare safer, less error prone and a more satisfying experience<sup>31</sup>. We believe this momentum (which is driving a change in the healthcare culture), combined with root cause analysis, national patient safety goals, continuing education, and strategies to reduce errors at the entry level (e.g., computerized physician order entry systems) will help lower medical malpractice claims over time.
  
- A comparison of the rate increases filed before the passage of SB2D, to the rates filed after the passage of SB2D, illustrate the moderation of rate changes on a year over year basis. In addition, we note that the moderation in the filed rates took place at the same time a number of insurers strengthened their ratemaking assumptions. If these assumptions do not strengthen further in future rate filings (e.g., loss severity trend selections remain stable), we would expect rate increases to continue to moderate. The moderation would occur because there would be less upward pressure from assumption changes as we have observed in the recent past, when insurers were forced to play catch up because the companies underestimated the true level of loss trend impacting their Florida policyholders.
  
- Companies have re-focused their efforts on underwriting and the charging of adequate premium rates. This focus on properly priced business increases the

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<sup>31</sup> We recommend visiting some of the following web sites: National Patient Safety Foundation ([www.npsf.org](http://www.npsf.org)), Joint Commission on Accreditation of Healthcare Organizations (JCAHO) ([www.jcaho.org](http://www.jcaho.org)), American Medical

likelihood that insurers will not need to file large rate increases because of the accumulation of poor underwriting decisions and inappropriate pricing driven by competitive market pressures.

- Actuarial Standards of Practice (ASOP) #9 promulgated by the American Academy of Actuaries (AAA) states the following four principles regarding ratemaking:

*II. PRINCIPLES*

*Ratemaking is prospective because the property and casualty insurance rate must be developed prior to the transfer of risk.*

*Principle 1: A rate is an estimate of the expected value of future costs. Ratemaking should provide for all costs so that the insurance system is financially sound.*

*Principle 2: A rate provides for all costs associated with the transfer of risk. Ratemaking should provide for the costs of an individual risk transfer so that equity among insureds is maintained. When the experience of an individual risk does not provide a credible basis for estimating these costs, it is appropriate to consider the aggregate experience of similar risks. A rate estimated from such experience is an estimate of the costs of the risk transfer for each individual in the class.*

*Principle 3: A rate provides for the costs associated with an individual risk transfer. Ratemaking produces cost estimates that are actuarially sound if the estimation is based on Principles 1, 2, and 3. Such rates comply with four criteria commonly used by actuaries: reasonable, not excessive, not inadequate, and not unfairly discriminatory.*

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Association ([www.ama-assn.org](http://www.ama-assn.org)), The Leapfrog Group ([www.leapfroggroup.org](http://www.leapfroggroup.org)), State patient safety organizations (e.g., Virginia [www.vipcs.org](http://www.vipcs.org)); or look at patient safety books (e.g., “The Satisfied Patient” – James W. Saxton).

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*Principle 4: A rate is reasonable and not excessive, inadequate, or unfairly discriminatory if it is an actuarially sound estimate of the expected value of all future costs associated with an individual risk transfer.*

Based upon our review of the market leader rate filings and the correspondence between the OIR and insurance company representatives, Deloitte Consulting believes the OIR has adequately ensured that the four principles of ratemaking are being followed by Florida medical malpractice insurers. The rate filings approved by the OIR are prospective in nature (i.e., do not recoup past costs) as identified in Principle 1, and that rates are reasonable, not excessive, not inadequate, and not unfairly discriminatory.

- During our review of the PF rate filings, Deloitte Consulting also reviewed the correspondence between the OIR and insurance company representative responsible for answering questions regarding the rate filing. Based upon the correspondence we reviewed, we believe the OIR did a thorough job of reviewing the assumptions in the rate filings and asking for additional support (e.g., the OIR asked one insurer for support on over thirty items). For those interested in experiencing the level of review performed by the OIR staff, we recommend that you visit the on-line filing system and review some of the medical malpractice filings approved by the OIR. We believe the documentation demonstrates the thoroughness and professionalism of the OIR staff.

**CLOSED CLAIM DATABASE (CCD)**

- On page 50 of the Presumed Factor Report, we displayed graphs of the distribution of the number of years between occurrence date and closing date for all NAIC severity codes combined and all NAIC severity codes excluding codes 1, 2, and 3. We also displayed graphs of the distribution of the number of years between the report date and closing date for the two categories. As noted above, since the passage of SB2D, we have yet to see any material shift in either the distribution or the mean lag between the claims specific dates (i.e., occurrence date, report date, close date) tracked in the CCD.
  
- We did observe a significant increase in the number of reported claims during the month of September 2003. This is consistent with the feedback shared during our analysis of SB2D and the determination of the PF. During our review, a number of plaintiff attorneys had informed the department that they were going speed up the reporting of claims in order to beat the September 15, 2003 effective date of SB2D. A speed up in reporting just before the passage of most medical malpractice tort reform bills is fairly common and is driven by the following:
  - Plaintiff attorneys often want to make sure that they file claims before the passage of tort reform bills, hopefully protecting themselves against new laws that may adversely impact the success rate of their current cases.
  - Up until the final passage of the law, some plaintiff attorneys may have been uncomfortable or did not understand the phase-in period of the law. If a plaintiff attorney believed SB2D would apply to occurrences that were reported on or after the effective date of the law, then a case reported by a plaintiff attorney after the passage of the law would be capped. The filing of claims before SB2D passed would eliminate any uncertainty in the Plaintiff attorney's mind that his/her case would be capped.

In reality, SB2D actually applies to incidents that occur on or after the passage of SB2D. No matter what the law actually does, plaintiff attorneys will still be able to say that "it is better to be safe than sorry."

- It is likely that the increase in reported claims will have an impact on the reporting patterns of claims in the remainder of 2003 and 2004. More specifically, the claims that would have otherwise been reported after September 2003 have now been filed in September 2003. Therefore, fewer reported claims should be expected during the subsequent months (e.g., we note a drop in claims reported during the months of October 2003, November 2003 and December 2003).
- It is difficult to draw significant conclusions on the long term trend in the severity of claims from the passage of SB2D, given the short time frame since the passage of SB2D and limited amount of data reflecting the impact of SB2D in the closed claim database.
- Given the longer claim lag for more severe claims, it is difficult to draw substantial conclusions regarding the impact of SB2D on the nature of errant conduct. We note however, the portion of claim counts in the lower severity codes for those closed claims reported after September 2003 is higher than historical levels.
- Given the application of SB2D to claims that have occurred after September 15, 2003 and the occurrence to closing lag in excess of 3 years per claim, it is difficult at this time to observe any effects of SB2D on non-economic damage costs.

## **CALENDAR YEAR PROFITABILITY**

- From an industry perspective, 54 organizations representing over two-thirds of the 2003 medical malpractice industry net written premium, lost \$439 million in 2003. On \$5.4 billion of earned premium, the 54 organizations produced an after tax operating ratio of 108.1% and a return on average surplus of -7.6%. Stated another way, the industry lost 8.1 cents on every dollar of premium earned after considering investment income, realized capital gains and income taxes.

Over the past three years, the 54 organizations have lost \$1.67 billion. Over the past five years, they have lost \$522 million. As the recently filed rate increases continue to flow into earned premiums, we would expect the net income of the 54 organizations and the industry to continue its favorable trends towards break-even in 2004. If development on prior year reserves continues to stabilize, net income could potentially result in a positive 2004 return on surplus (i.e., net income > 0) for the first time since 2000.

- From a Florida perspective, the top 80% of Florida's medical malpractice insurers lost \$1.2 billion in 2003 with an ROS of -5.7%. Excluding CCC, TIC, LIC and EIC who write 69% or more of their business in non-medical malpractice lines of business, the medical malpractice focused companies (i.e., FPIC, MPC, DCIE, HCII, APAC, PIC and MMIC) earned \$2.1 million in 2003 with an ROS of 0.1%. The medical malpractice focused companies produced an after tax operating ratio ranging from 93.4% to 115.1% in 2003 and from 84.1% to 105.3% in first quarter 2004.

Over the past four years, the medical malpractice focused companies earned \$182.6 million with an average ROS of 2.5%. Removing the impact of the \$52.2 million in adverse development over the four year period, the medical malpractice focused companies produced an adjusted average ROS of 3.0%. From either perspective, the average ROS over the four

year period continues to be in the low single digits and far below the levels which would indicate excessive profits.

- It would appear that the favorable first quarter 2004 operating ratios may indicate that Florida's companies will continue to be profitable through year-end 2004, helping to stabilize the need for future rate changes in the State of Florida.
- Given the long "tail" nature of the medical malpractice market, the strong likelihood of future cycles, and the historically volatile results of the top Florida insurers, it is reasonable to focus on financial results over a time period roughly equal to the average historical medical malpractice cycle (e.g., cycle ranging from seven to nine years). Analysis of profit and ratemaking decisions made based upon a few quarter's profits without considering the cumulative results over the average cycle would not portray the economic realities of the medical malpractice business.
- The calculation of after-tax net income includes net investment income realized on investments (e.g., interest payments on bonds) and realized capital gains/(losses). As one can see from the below chart, Florida's medical malpractice focused companies have almost 85% of their invested assets placed in bonds or cash.

PERCENTAGE OF ASSETS IN BONDS AND CASH

Companies	2003	2002	2001	2000	1999
FPIC	93.2%	83.8%	90.2%	91.3%	94.0%
MPC	99.0%	98.8%	98.4%	98.8%	99.0%
CCC	79.8%	77.4%	63.8%	62.6%	59.1%
TIC	55.1%	40.4%	40.8%	45.3%	52.4%
DCIE	74.2%	63.9%	74.7%	65.4%	69.7%
HCII	63.4%	65.6%	62.5%	70.9%	66.7%
APAC	100.0%	100.0%	100.0%	100.0%	100.0%
PIC	77.1%	76.2%	76.5%	74.6%	82.7%
MMIC	86.3%	90.8%	91.0%	85.3%	82.8%
LIC	80.6%	81.7%	76.7%	81.2%	89.6%
EIC	75.9%	82.0%	81.2%	76.9%	78.1%
ALL COS*	80.4%	78.2%	77.8%	77.5%	79.5%
MM FOCUS*	84.7%	82.7%	84.8%	83.8%	85.0%

\* - AVERAGE

Most of the bonds held by these insurance companies fall in the highest rated NAIC classes (e.g., 1, 2) as shown on Schedule D – Part 1A – Section 1 of the annual statement, otherwise known as investment grade bonds (i.e., low risk).

PERCENTAGE OF ASSETS IN STOCKS

Companies	2003	2002	2001	2000	1999
FPIC	5.4%	5.4%	6.6%	7.3%	4.5%
MPC	0.3%	0.4%	0.7%	0.1%	0.0%
CCC	12.6%	14.1%	26.6%	26.7%	34.5%
TIC	38.5%	49.6%	46.7%	54.4%	47.4%
DCIE	22.1%	19.1%	22.6%	31.2%	27.7%
HCII	34.1%	29.2%	33.9%	27.1%	28.1%
APAC	0.0%	0.0%	0.0%	0.0%	0.0%
PIC	22.2%	23.1%	22.7%	24.5%	16.2%
MMIC	11.9%	7.8%	7.4%	12.9%	15.5%
LIC	12.9%	7.5%	8.1%	2.9%	3.0%
EIC	23.8%	17.8%	18.8%	21.6%	21.0%
ALL COS*	16.7%	15.8%	17.6%	19.0%	18.0%
MM FOCUS*	13.7%	12.1%	13.4%	14.7%	13.1%

\* - AVERAGE

Less than 14% of medical malpractice focused insurance company assets are in stock investments. As one can see from the above distribution by company, stock investments can range from 0% to 39% of the invested assets. Stock investments typically expose insurers to more risks as stock prices move up and down with the economy, interest rates and political environment.

Other assets (e.g., mortgage loans, real-estate, etc.) represent less than 2.0% of invested assets for the medical malpractice focused companies.

With such a heavy investment of assets in bonds and cash, the medical malpractice focused companies appear to be conservatively invested.

#### **REPORT YEAR/ACCIDENT YEAR LOSS RATIO TREND**

- The trend in Schedule P loss ratios and the trend in the assumptions underlying each company's rate filing presents the most relevant picture of the direction that future rates will take for healthcare providers practicing in the State of Florida, since profit is primarily driven by the accident year and report year loss ratios.
- The trend in Schedule P – Part 1 claims-made loss and LAE ratios, Schedule P – Part 1 occurrence loss and LAE ratios, and “Page 14” Florida direct loss and DCC ratios appear to be improving. Adjusting for each company's expense ratio, net investment income and other income ratio, and tax position; the current loss and LAE ratio trends through 2003 and first quarter 2004 results should help to ensure that medical malpractice insurers continue to offer stable and financially sound protection to healthcare providers across the country.

## **LEVERAGE RATIOS**

- The NLSR provides a measure of underwriting leverage, and thus risk. Surplus serves as a financial buffer to guard against adverse events and changes in financial condition, such as can result when reserve strengthening is required. A lower ratio signifies greater financial strength and a greater capacity to absorb adverse development in reserves. In lines of insurance such as medical malpractice that have significant potential for this to occur, it is important that the NLSR be relatively low, especially for companies that are not diversified insurance writers. Excluding PIC which is slightly above the industry composite, the medical malpractice focused companies have NLSR well below the industry composite NLSR of 2.9.
- The NPSR measures the insurer's capacity to write additional business. Of the medical malpractice focused companies, only APAC (1.25) and MPC (1.61) exceed the industry composite NPSR of 0.9. MPC's high ratio is largely driven by the size of the rate increases MPC has filed across the country over the past few years.

## **RBC RATIOS**

- NAIC Risk Based Capital (RBC) requirements calculate the amount of capital an insurer should hold as a function of the types of risks it has assumed. The NAIC RBC formula looks at five different risk charges; fixed income securities, equity investments, credit risk, reserving risk and written premium risk. Insurers whose capital falls below pre-specified percentages of its authorized control level requirement are subject to various actions intended to mitigate insolvency, varying from company action level to mandatory control level where the company is placed under the control of the domiciliary regulator<sup>32</sup>. The following table displays the RBC ratios for the past five years.

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<sup>32</sup> The NAIC's RBC Model Act may not be followed by all states (e.g., New York).

RBC RATIO

Companies	2003	2002	2001	2000	1999
FPIC	345.9%	349.0%	360.3%	356.5%	441.9%
MPC	427.5%	437.1%	536.0%	396.6%	334.3%
CCC	292.3%	338.1%	292.3%	397.5%	381.0%
TIC	212.7%	208.0%	240.9%	205.9%	213.1%
DCIE	431.6%	489.3%	941.3%	883.1%	582.4%
HCII	298.4%	240.8%	317.6%	304.2%	260.0%
APAC	234.4%	286.0%	481.6%	509.8%	1039.7%
PIC	299.6%	388.3%	368.7%	613.3%	596.0%
MMIC	418.9%	373.9%	550.2%	808.5%	941.8%
LIC	503.1%	676.5%	805.3%	846.0%	854.7%
EIC	332.0%	265.5%	339.9%	339.1%	317.3%
CAL	200.0%	200.0%	200.0%	200.0%	200.0%
RAL	150.0%	150.0%	150.0%	150.0%	150.0%
ACL	100.0%	100.0%	100.0%	100.0%	100.0%
MCL	70.0%	70.0%	70.0%	70.0%	70.0%

Although the RBC ratios have declined since the 1999 years, the 2003 RBC ratios appear to be stabilizing for most companies. In addition, a majority of the companies are close to an RBC ratio of 300% (i.e., 100% above the company action level (CAL)). Only TIC and APAC are below an RBC ratio of 250%. Given the favorable impact of recent rate changes, rising interest rates, and favorable trend in net income, the 2004 RBC ratios should improve as insurers continue to build surplus.

**A.M. BEST RATING**

- A.M. Best's Financial Strength Ratings<sup>33</sup> provide an opinion of an insurer's financial strength and ability to meet ongoing obligations to policyholders. The A.M. Best rating scale is comprised of 16 individual ratings grouped into 10 categories, consisting of three secure categories (Superior (A++, A+), Excellent (A, A-), Very Good (B++, B+)) and seven Vulnerable categories. The following table displays the ratings of Florida's to writers:

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<sup>33</sup> A.M. Best Company ([www.ambest.com](http://www.ambest.com))

A.M. BEST RATING

Companies	RATING	
FPIC	B++	VERY GOOD
HCII	A-	EXCELLENT
PIC	A-	EXCELLENT
MPC	A-	EXCELLENT
MMIC	A-	EXCELLENT
LIC	A++	SUPERIOR
EIC	A	EXCELLENT
DCIE	B++	VERY GOOD
CCC	A	EXCELLENT
TIC	B+	VERY GOOD
APAC	B++	VERY GOOD

Florida's top writers all fall in the secure categories. According to A.M. Best, the B+ and B++ ratings are assigned to companies that have, in A.M. Best's opinion, a good ability to meet their ongoing obligations to policyholders. The A and A- ratings are assigned to companies that have, in A.M. Best's opinion, an excellent ability to meet their ongoing obligations to policyholders. The A++ and A+ ratings are assigned to companies that have, in A.M. Best's opinion, a superior ability to meet their ongoing obligations to policyholders.

The above categories demonstrate an absence of any vulnerable ratings (i.e., B, B-, C++, C+, etc.) for Florida's top writers.

**MLDR**

- It is too early to determine the effect of SB2D. This is consistent with the answers provided by the insurers in response to our MLDR.
- In regards to the constitutionality of the cap on non-economic damages, insurers fell in the following three categories:
  1. No comment or opinion;

2. Commentary on the drafting of SB2D or the historical activity of Florida courts; noting that a couple insurers felt the emergency room cap on non-economic damages had a better chance of being held on public policy grounds; and
  3. One company was willing to provide an estimate for the probability of the cap will be declared constitutional:
    - Non-emergency room – 50% chance
    - Emergency room - > 50% chance
- In regards to the impact of the cap on non-economic damages and the insurer’s negotiating position, insurers commenting on this subject generally noted that the cap on non-economic damages didn’t help its negotiations. One insurer noted that the plaintiff counsel it encounters refuses to recognize any value in the cap on non-economic damages. During a second quarter earnings call, a Company noted that plaintiff attorneys generally view the law as unconstitutional.
  - The trend towards lower policy limits and doctors “going bare” will likely continue in the near future. Although some new insurers have entered the market, we don’t anticipate any drastic differences in the cost of coverage that would create a sudden interest in purchasing higher policy limits in the State of Florida.
  - It is important to repeat the following insurance company response to our MLDR question focused on the impact of SB2D from a financial perspective:

*“From a financial standpoint, it should be noted that in the event the constitutionality of the caps is not upheld in court, the effect of the presumed factor rate adjustment and any other consideration of tort reform will most likely render inadequate the rates charged during 2004 and thereafter. Under present law, there will be no way to recoup these shortfalls. However, because the damage caps alter the assumptions that underlie the Company’s rate filing, an adverse decision would necessitate an immediate rate filing with appropriate changes in assumptions. It should be noted that the longer it takes for the caps to be tried in the courts, the greater the impact on rates becomes due to annual compounding of the deficiency.”*

Re-cap of important conclusions:

1. If the cap is declared unconstitutional, medical malpractice rates that reflected the PF will be inadequate by the amount of PF reflected in the rate filings (e.g., 5.3% PF for cap on non-economic damages);
2. Insurance companies will have no way to recoup the lost premium since the ratemaking process is prospective (i.e., insurers cannot go back in time and ask physicians to mail in checks for the incremental amount of PF premium dollars that would have been paid);
3. If the caps are declared unconstitutional, companies in the state of Florida would need to file rates to remove the impact of the PF; and
4. The longer it takes for the constitutionality of the caps to be determined, the greater the deficiency in rates will become. As is noted in the Contingencies article *The Million-Dollar Challenge: Measuring the Impact of Medical Liability Tort Reform*<sup>34</sup>:

*“For example, Ohio reforms enacted in 1975 were challenged in the courts in 1982 and eventually overturned in 1985. Ohio insurance company rates became inadequate the moment the reforms were overturned because the premium collected for their current and most recent policies still reflected the full impact of the tort reform.”*

The fourth point is important given our legal expert’s estimate of when the trial court in the Berges case will rule and whether or not the appeal will be “fast tracked” to the Supreme Court. In the event that the Berges case takes another two years to complete, Florida’s insurers will have to reflect the impact of the PF savings for two more years. In the event that the Berges case takes another four years or more to complete, Florida’s insurers would have to reflect the savings for four or more years. In either scenario, Florida’s insurers would have no way of recouping the lost premiums if the cap was declared unconstitutional. The rate filing submitted immediately after the decision would include: the removal of the PF

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<sup>34</sup> September/October 2003 Contingencies Magazine [The Million-Dollar Challenge: Measuring the Impact of Medical Liability Tort Reform](#), Kevin Bingham.

factor; a review of the loss trend assumptions; and the flowing of uncapped losses into the ratemaking calculations for all incidents occurring on or after September 15, 2003; resulting in significant upward pressure on the rate indications.

## **CONSTITUTIONALITY**

- It is not possible at this time to estimate when the trial court in Berges will rule on the issue of whether the cap is constitutional. The defendants may argue that the issue is not "ripe" for determination unless and until a jury verdict is rendered in excess of the cap. The trial court therefore may postpone a decision on constitutionality until after the case goes to trial, which may take one or two years. Whenever the trial court does rule, however, there is a possibility that the parties will request a "fast track" appeal to the Florida Supreme Court, bypassing the intermediate appellate court. If that occurs (it is within the discretion of the intermediate appellate court to decide), then the appeal time in our original report could be expedited by approximately one year. Accordingly, a final decision on constitutionality from the Florida Supreme Court could occur within 12 to 18 months of a ruling by the trial court.
- The outcome of the Berges case will likely determine if the cap on non-economic damages is constitutional or unconstitutional. If the cap is declared unconstitutional, rates for insurance companies in the state of Florida will essentially be inadequate by the amount of the PF reflected in their most recent rate filing<sup>35</sup>. Stated another way, insurance companies gave policyholders a credit equal to the PF factor which turned out to be worth less than originally thought (e.g., 5.3% less).

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<sup>35</sup> On page 54 of the Presumed Factor Report, we selected a PF of 5.3% for Section 54 of SB2D (i.e., cap on non-economic damages). We note that individual companies modified their rate filings to reflect their own mix of policy limits and other assumptions. For companies that modified the OIR published PF for Section 54, one would substitute their PF for the 5.3% PF in the above discussion.

Using a simple analogy, the removal of the PF would be similar to a car dealer who sells a car at a 5.3% discount assuming the auto manufacturer will provide them with a 5.3% rebate. If the rebate is taken away, the car is essentially under priced by 5.3%.

Although Florida companies could submit new rate filings which would remove the impact of the PF from future policies sold in Florida, the PF adjusted premiums collected on their current in force policies would likely be inadequate. This is because ratemaking is a prospective process and does not allow insurers to recoup past losses or the amounts policies are under priced because of unconstitutional tort reforms.

- Going forward, we believe the true impact of SB2D (e.g., cap on non-economic damages, bad faith, patient safety, patient notification, etc.) will phase-in to the policy year data underlying each company's rate filing. The phase-in period will correspond directly with time it takes to defend, litigate and settle claims occurring on or after September 15, 2003 that would reflect savings driven by SB2D.

As Deloitte Consulting noted on page 51 of the Presumed Factor Report:

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

If the cap on non-economic damages is declared constitutional, we would expect the phase-in to speed up as medical malpractice insurers could use the leverage of a "tested" cap on non-economic damages in current and future settlement negotiations. This would be an important shift from the current environment where most plaintiff attorneys are behaving as if the cap on non-economic damages is going to be declared unconstitutional. Plaintiff attorneys would

have to shift from an environment of giving little or no credit in settlement discussions to full credit for a potential cap on non-economic damages.

If the cap on non-economic damages is declared unconstitutional, we would expect no material change in loss severity trends selected by companies. This is because the historical data underlying the current rate filing process does not include any cases that have been favorably impacted by SB2D reforms. Essentially, Florida insurers would be back to “business as usual”.

Although we do not expect any spike in loss severity trends underlying medical malpractice rate filings, it would be important to monitor trends going forward to see if awards continue to inflate at recent levels or accelerate due to the successful elimination of the cap if it is declared unconstitutional.

**V. APPENDIX**

**APPENDIX A**

**Medical Malpractice Financial Metrics by Writing Company**

Surplus (S)

Net Written Premium (NWP)

NWP to S

NWP to Gross Written Premium

Net L&LAE Reserves (L)

L to S

Calendar Year Combined Ratio

Loss Ratio

LAE Ratio

Expense Ratio

RBC Ratio

Investment Allocation

Bonds

Cash

Stock

Mortgage Loans

Real Estate

Other

**FLORIDA SB2D  
MEDICAL MALPRACTICE FINANCIAL METRICS BY WRITING COMPANY**

WRITING COMPANY	SURPLUS (S)			NET WRITTEN PREMIUM (NWP)			NWP TO S		NWP TO GWP		NET L&LAE RESERVES (LIAB)			LIAB TO S	
	2003	2002	% CHANGE	2003	2002	% CHANGE	2003	2002	2003	2002	2003	2002	% CHANGE	2003	2002
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)	(13)	(14)	(15)	(16)
<b>CNA INSURANCE</b>															
Continental Casualty Co	6,045,822	5,115,932	18.2%	7,403,129	7,073,312	4.7%	1.225	1.383	0.690	0.801	16,364,336	12,211,397	34.0%	2.707	2.387
California % of DWP	9.78%			Oth Liab Clm:	1,154,599	16%				1 YR Dev:	2,331,312	-167,170			
New York % of DWP	7.91%			Group A&H:	19,219	0%				% of Prior S:	45.6%	-3.6%			
Florida % of DWP	6.91%			Inland Marine:	136,580	2%				2 YR Dev:	2,218,952	1,525,840			
All Other States % of DWP:	75.40%			All Other:	6,092,731	82%				% of Prior S:	47.2%	24.1%			
<b>TIG INSURANCE</b>															
Tig Insurance Company	695,928	1,095,257	-36.5%	122,375	699,330	-82.5%	0.176	0.639	0.251	0.670	1,111,441	1,512,234	-26.5%	1.597	1.381
Hawaii % of DWP	19.00%			Med Malpr Clm:	20,578	17%				1 YR Dev:	-345	97,359			
California % of DWP	11.27%			Oth Liab Clm:	53,021	43%				% of Prior S:	0.0%	7.5%			
Florida % of DWP	11.15%			Comm Auto Liab:	48,060	39%				2 YR Dev:	98,524	88,613			
All Other States % of DWP:	58.58%			All Other:	716	1%				% of Prior S:	7.6%	8.4%			
<b>MAG MUTUAL INSURANCE GROUP</b>															
Mag Mutual Insurance Co	177,177	142,978	23.9%	159,355	143,881	10.8%	0.899	1.006	0.550	0.658	299,516	291,431	2.8%	1.690	2.038
Georgia % of DWP	52.00%			Med Malpr Clm:	144,174	90%				1 YR Dev:	14,061	20,930			
Florida % of DWP	25.14%			Med Malpr Occ:	9,987	6%				% of Prior S:	9.8%	13.2%			
North Carolina % of DWP	15.56%			Cml Mltip Peril:	2,161	1%				2 YR Dev:	25,334	-18,176			
All Other States % of DWP:	7.30%			All Other:	3,033	2%				% of Prior S:	16.0%	-12.1%			
<b>GE GLOBAL INSURANCE</b>															
Medical Protective Co	442,881	401,726	10.2%	713,505	538,436	32.5%	1.611	1.340	0.840	0.918	1,228,981	943,997	30.2%	2.775	2.350
Texas % of DWP	16.84%			Med Malpr Clm:	428,869	60%				1 YR Dev:	43,272	95,720			
Ohio % of DWP	12.63%			Med Malpr Occ:	281,075	39%				% of Prior S:	10.8%	23.4%			
Pennsylvania % of DWP	8.81%			Oth Liab - Occ:	2,817	0%				2 YR Dev:	153,506	32,710			
All Other States % of DWP:	61.72%			All Other:	744	0%				% of Prior S:	37.6%	8.8%			
<b>DOCTORS COMPANY</b>															
Doctors Co An Interinsurance Exchn	350,190	341,412	2.6%	336,426	396,353	-15.1%	0.961	1.161	0.772	0.907	732,649	627,681	16.7%	2.092	1.838
California % of DWP	32.79%			Med Malpr Clm:	287,603	85%				1 YR Dev:	78,109	105,014			
Florida % of DWP	8.02%			Med Malpr Occ:	40,157	12%				% of Prior S:	22.9%	27.3%			
Ohio % of DWP	7.82%			Inland Marine:	2,725	1%				2 YR Dev:	153,911	96,770			
All Other States % of DWP:	51.37%			All Other:	5,942	2%				% of Prior S:	40.1%	25.4%			

**MEDICAL MALPRACTICE FINANCIAL METRICS BY WRITING COMPANY**

WRITING COMPANY	SURPLUS (S)			NET WRITTEN PREMIUM (NWP)			NWP TO S		NWP TO GWP		NET L&LAE RESERVES (LIAB)			LIAB TO S	
	2003	2002	% CHANGE	2003	2002	% CHANGE	2003	2002	2003	2002	2003	2002	% CHANGE	2003	2002
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)	(13)	(14)	(15)	(16)
<b>HEALTH CARE IND</b>															
Health Care Indemnity Inc	626,526	482,536	29.8%	377,000	318,633	18.3%	0.602	0.660	0.975	0.924	1,399,165	1,259,178	11.1%	2.233	2.609
Texas % of DWP	34.52%			Med Malpr Occ:	368,384	98%				1 YR Dev:	-10,241	-22,247			
Florida % of DWP	30.41%			Med Malpr Clm:	8,589	2%				% of Prior S:	-2.1%	-3.8%			
California % of DWP	3.21%			Surety:	27	0%				2 YR Dev:	-13,973	-55,257			
All Other States % of DWP:	31.86%			All Other:	0	0%				% of Prior S:	-2.4%	-10.2%			
<b>AIG</b>															
Lexington Insurance Company	2,116,406	1,763,654	20.0%	2,809,967	1,859,962	51.1%	1.328	1.055	0.462	0.378	2,916,688	1,611,596	81.0%	1.378	0.914
California % of DWP	15.72%			Fire:	630,770	22%				1 YR Dev:	148,347	159,140			
New York % of DWP	9.65%			Oth Liab Clm:	626,838	22%				% of Prior S:	8.4%	9.1%			
Florida % of DWP	8.38%			Med Malpr Clm:	433,544	15%				2 YR Dev:	305,120	163,523			
All Other States % of DWP:	66.25%			All Other:	1,118,814	40%				% of Prior S:	17.5%	10.0%			
<b>EVANSTON</b>															
Evanston Insurance Company	457,608	313,850	45.8%	699,445	568,962	22.9%	1.528	1.813	0.689	0.680	876,243	640,272	36.9%	1.915	2.040
California % of DWP	23.76%			Oth Liab - Occ:	150,953	22%				1 YR Dev:	4,020	5,337			
Texas % of DWP	9.07%			Med Malpr Clm:	137,289	20%				% of Prior S:	1.3%	2.3%			
Florida % of DWP	8.96%			Oth Liab Clm:	124,990	18%				2 YR Dev:	34,803	-3,332			
All Other States % of DWP:	58.21%			All Other:	286,212	41%				% of Prior S:	15.1%	-2.0%			
<b>FPIC</b>															
First Professionals Ins Co	118,873	110,858	7.2%	103,429	94,011	10.0%	0.870	0.848	0.360	0.318	211,487	190,139	11.2%	1.779	1.715
Florida % of DWP	80.86%			Med Malpr Clm:	90,765	88%				1 YR Dev:	1,948	1,404			
Pennsylvania % of DWP	7.58%			Med Malpr Occ:	12,370	12%				% of Prior S:	1.8%	1.5%			
Georgia % of DWP	4.67%			Oth Liab Clm:	293	0%				2 YR Dev:	10,111	9,436			
All Other States % of DWP:	6.89%			All Other:	0	0%				% of Prior S:	11.0%	10.3%			
Anesthesiologists Pro Assur Co	15,009	14,612	2.7%	18,771	19,988	-6.1%	1.251	1.368	0.224	0.250	38,403	37,143	3.4%	2.559	2.542
Tennessee % of DWP	39.65%			Med Malpr Clm:	16,278	87%				1 YR Dev:	68	605			
Florida % of DWP	33.14%			Workers' Compen:	0	0%				% of Prior S:	0.5%	3.9%			
Texas % of DWP	12.37%			Med Malpr Occ:	2,440	13%				2 YR Dev:	2,011	408			
All Other States % of DWP:	14.84%			All Other:	53	0%				% of Prior S:	13.1%	2.6%			

## MEDICAL MALPRACTICE FINANCIAL METRICS BY WRITING COMPANY

WRITING COMPANY	SURPLUS (S)			NET WRITTEN PREMIUM (NWP)			NWP TO S		NWP TO GWP		NET L&LAE RESERVES (LIAB)			LIAB TO S	
	2003	2002	%	2003	2002	%	2003	2002	2003	2002	2003	2002	%	2003	2002
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)	(13)	(14)	(15)	(16)
<b>PROASSURANCE</b>															
Pronational Insurance Co	187,937	196,955	-4.6%	193,034	148,722	29.8%	1.027	0.755	0.948	0.886	583,439	511,268	14.1%	3.104	2.596
Florida % of DWP	41.58%			Med Malpr Clm:	162,170	84%					1 YR Dev:	65	-10,118		
Michigan % of DWP	29.36%			Med Malpr Occ:	25,112	13%					% of Prior S:	0.0%	-5.8%		
Illinois % of DWP	11.81%			Oth Liab Clm:	5,615	3%					2 YR Dev:	-13,770	17,833		
All Other States % of DWP:	17.25%			All Other:	137	0%					% of Prior S:	-7.8%	7.0%		

**FLORIDA SB2D  
MEDICAL MALPRACTICE FINANCIAL METRICS BY WRITING COMPANY**

WRITING COMPANY	RATIO TO EP	CALENDAR YEAR COMBINED RATIO					RBC RATIO (TAC TO ACL)					NET L&LAE RESERVES (LIAB)					
		2003	2002	2001	2000	1999	2003	2002	2001	2000	1999	INVESTMENT	2003	2002	2001	2000	1999
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)	(13)	(14)	(15)	(16)	(17)	(18)
<b>CNA INSURANCE</b>																	
Continental Casualty Co	LOSS	83.7%	60.2%	120.4%	65.7%	77.0%	292.3%	338.1%	292.3%	397.5%	381.0%	BONDS	59.5%	61.4%	56.9%	50.6%	52.5%
	LAE	33.4%	16.1%	22.5%	13.0%	15.4%						CASH	20.3%	16.0%	6.9%	12.0%	6.6%
	EXPENSE	<u>36.0%</u>	<u>33.9%</u>	<u>44.6%</u>	<u>34.3%</u>	<u>34.2%</u>						STOCKS	12.6%	14.1%	26.6%	26.7%	34.5%
		153.1%	110.2%	187.5%	113.0%	126.6%						MORT. LOANS	0.0%	0.0%	0.0%	0.0%	0.0%
												REAL ESTATE	0.0%	0.0%	0.1%	0.1%	0.1%
												OTHER	7.6%	8.5%	9.5%	10.6%	6.3%
<b>TIG INSURANCE</b>																	
Tig Insurance Company	LOSS	67.0%	72.3%	60.4%	54.8%	76.4%	212.7%	208.0%	240.9%	205.9%	213.1%	BONDS	44.2%	26.0%	36.0%	37.6%	49.2%
	LAE	64.1%	26.7%	29.7%	36.0%	23.0%						CASH	10.9%	14.4%	4.8%	7.7%	3.2%
	EXPENSE	<u>39.4%</u>	<u>33.7%</u>	<u>37.7%</u>	<u>39.4%</u>	<u>40.3%</u>						STOCKS	38.5%	49.6%	46.7%	54.4%	47.4%
		170.5%	132.7%	127.8%	130.2%	139.7%						MORT. LOANS	0.0%	0.0%	0.0%	0.0%	0.0%
												REAL ESTATE	0.0%	0.0%	0.0%	0.0%	0.0%
												OTHER	6.4%	10.0%	12.5%	0.3%	0.2%
<b>MAG MUTUAL INSURANCE GROUP</b>																	
Mag Mutual Insurance Co	LOSS	61.9%	81.3%	58.4%	66.8%	69.5%	418.9%	373.9%	550.2%	808.5%	941.8%	BONDS	83.1%	75.3%	79.8%	79.6%	75.9%
	LAE	37.3%	28.5%	37.7%	33.0%	24.1%						CASH	3.2%	15.5%	11.2%	5.7%	6.9%
	EXPENSE	<u>20.4%</u>	<u>16.7%</u>	<u>21.9%</u>	<u>21.6%</u>	<u>20.7%</u>						STOCKS	11.9%	7.8%	7.4%	12.9%	15.5%
		119.6%	126.5%	118.0%	121.4%	114.3%						MORT. LOANS	0.0%	0.0%	0.0%	0.0%	0.0%
												REAL ESTATE	0.0%	0.0%	0.0%	0.0%	0.0%
												OTHER	1.8%	1.4%	1.6%	1.8%	1.7%
<b>GE GLOBAL INSURANCE</b>																	
Medical Protective Co	LOSS	63.0%	78.9%	50.4%	41.1%	53.8%	427.5%	437.1%	536.0%	396.6%	334.3%	BONDS	94.1%	80.1%	91.6%	97.9%	96.8%
	LAE	26.0%	30.6%	27.1%	27.4%	35.9%						CASH	4.9%	18.7%	6.8%	0.9%	2.2%
	EXPENSE	<u>15.7%</u>	<u>17.7%</u>	<u>17.0%</u>	<u>18.5%</u>	<u>19.3%</u>						STOCKS	0.3%	0.4%	0.7%	0.1%	0.0%
		104.7%	127.2%	94.5%	87.0%	109.0%						MORT. LOANS	0.0%	0.0%	0.0%	0.0%	0.0%
												REAL ESTATE	0.6%	0.8%	1.0%	1.1%	1.1%
												OTHER	0.1%	0.0%	-0.1%	0.0%	-0.1%
<b>DOCTORS COMPANY</b>																	
Doctors Co An Interinsurance Exchn	LOSS	69.4%	69.1%	73.5%	42.5%	51.1%	431.6%	489.3%	941.3%	883.1%	582.4%	BONDS	67.8%	54.0%	59.8%	63.6%	67.7%
	LAE	40.2%	35.9%	25.0%	35.7%	35.1%						CASH	6.4%	9.9%	14.9%	1.8%	2.0%
	EXPENSE	<u>16.9%</u>	<u>23.8%</u>	<u>24.6%</u>	<u>26.7%</u>	<u>27.8%</u>						STOCKS	22.1%	19.1%	22.6%	31.2%	27.7%
		126.5%	128.8%	123.1%	104.9%	114.0%						MORT. LOANS	0.0%	0.1%	0.1%	0.0%	0.0%
												REAL ESTATE	1.1%	1.1%	1.4%	1.6%	1.4%
												OTHER	2.6%	15.8%	1.2%	1.8%	1.2%

**MEDICAL MALPRACTICE FINANCIAL METRICS BY WRITING COMPANY**

WRITING COMPANY	RATIO TO EP	CALENDAR YEAR COMBINED RATIO					RBC RATIO (TAC TO ACL)					NET L&LAE RESERVES (LIAB)					
		2003	2002	2001	2000	1999	2003	2002	2001	2000	1999	INVESTMENT	2003	2002	2001	2000	1999
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)	(13)	(14)	(15)	(16)	(17)	(18)
<b>HEALTH CARE IND</b>																	
Health Care Indemnity Inc	LOSS	89.1%	88.1%	97.2%	74.4%	86.1%	298.4%	240.8%	317.6%	304.2%	260.0%	BONDS	55.1%	60.6%	55.9%	56.6%	62.8%
	LAE	22.1%	23.9%	13.0%	32.9%	22.4%						CASH	8.3%	5.0%	6.6%	14.3%	3.9%
	EXPENSE	<u>1.3%</u>	<u>4.6%</u>	<u>4.6%</u>	<u>5.2%</u>	<u>5.4%</u>						STOCKS	34.1%	29.2%	33.9%	27.1%	28.1%
		112.5%	116.6%	114.8%	112.5%	113.9%						MORT. LOANS	0.0%	0.0%	0.0%	0.0%	0.0%
												REAL ESTATE	0.0%	0.0%	0.0%	0.0%	0.0%
												OTHER	2.5%	5.2%	3.6%	2.0%	5.2%
<b>AIG</b>																	
Lexington Insurance Company	LOSS	69.7%	70.0%	81.5%	66.1%	80.4%	503.1%	676.5%	805.3%	846.0%	854.7%	BONDS	79.7%	77.6%	71.6%	73.1%	89.4%
	LAE	12.4%	14.9%	13.4%	19.7%	8.7%						CASH	0.9%	4.1%	5.1%	8.1%	0.2%
	EXPENSE	<u>11.2%</u>	<u>9.9%</u>	<u>10.7%</u>	<u>15.7%</u>	<u>0.0%</u>						STOCKS	12.9%	7.5%	8.1%	2.9%	3.0%
		93.3%	94.8%	105.6%	101.5%	89.1%						MORT. LOANS	0.0%	0.0%	0.0%	0.0%	0.0%
												REAL ESTATE	0.0%	0.0%	0.0%	0.0%	0.0%
											OTHER	6.5%	10.8%	15.2%	15.9%	7.4%	
<b>EVANSTON</b>																	
Evanston Insurance Company	LOSS	50.0%	56.2%	58.4%	49.9%	57.6%	332.0%	265.5%	339.9%	339.1%	317.3%	BONDS	73.6%	72.3%	78.0%	71.2%	78.3%
	LAE	13.9%	14.3%	11.6%	5.4%	6.6%						CASH	2.3%	9.7%	3.2%	5.7%	-0.2%
	EXPENSE	<u>29.5%</u>	<u>30.4%</u>	<u>34.9%</u>	<u>43.2%</u>	<u>41.4%</u>						STOCKS	23.8%	17.8%	18.8%	21.6%	21.0%
		93.4%	100.9%	104.9%	98.5%	105.6%						MORT. LOANS	0.0%	0.0%	0.0%	0.0%	0.0%
												REAL ESTATE	0.0%	0.0%	0.0%	0.0%	0.0%
											OTHER	0.3%	0.2%	0.0%	1.5%	0.9%	
<b>FPIC</b>																	
First Professionals Ins Co	LOSS	55.8%	64.1%	72.9%	70.6%	52.7%	345.9%	349.0%	360.3%	356.5%	441.9%	BONDS	84.4%	72.2%	76.6%	90.6%	93.8%
	LAE	36.4%	27.4%	28.6%	34.6%	19.0%						CASH	8.8%	11.6%	13.6%	0.7%	0.2%
	EXPENSE	<u>16.6%</u>	<u>15.3%</u>	<u>27.0%</u>	<u>27.0%</u>	<u>24.8%</u>						STOCKS	5.4%	5.4%	6.6%	7.3%	4.5%
		108.8%	106.8%	128.5%	132.2%	96.5%						MORT. LOANS	0.0%	0.0%	0.0%	0.0%	0.0%
												REAL ESTATE	0.9%	1.0%	1.3%	1.4%	1.5%
											OTHER	0.5%	9.8%	1.9%	0.0%	0.0%	
Anesthesiologists Pro Assur Co	LOSS	61.0%	65.0%	63.8%	73.0%	27.8%	234.4%	286.0%	481.6%	509.8%	1039.7%	BONDS	77.6%	81.7%	75.7%	95.4%	93.6%
	LAE	29.3%	27.9%	27.8%	17.9%	-3.0%						CASH	22.4%	18.3%	24.3%	4.6%	6.4%
	EXPENSE	<u>18.5%</u>	<u>11.2%</u>	<u>29.4%</u>	<u>26.8%</u>	<u>26.7%</u>						STOCKS	0.0%	0.0%	0.0%	0.0%	0.0%
		108.8%	104.1%	121.0%	117.7%	51.5%						MORT. LOANS	0.0%	0.0%	0.0%	0.0%	0.0%
												REAL ESTATE	0.0%	0.0%	0.0%	0.0%	0.0%
											OTHER	0.0%	0.0%	0.0%	0.0%	0.0%	

## MEDICAL MALPRACTICE FINANCIAL METRICS BY WRITING COMPANY

WRITING COMPANY	RATIO TO EP	CALENDAR YEAR COMBINED RATIO					RBC RATIO (TAC TO ACL)					NET L&LAE RESERVES (LIAB)							
		(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)	INVESTMENT	(13)	(14)	(15)	(16)	(17)
<b>PROASSURANCE</b>																			
Pronational Insurance Co	LOSS	50.8%	61.4%	93.8%	82.4%	29.6%	299.6%	388.3%	368.7%	613.3%	596.0%	BONDS	72.5%	72.1%	65.1%	64.9%	79.8%		
	LAE	52.4%	41.9%	47.7%	43.7%	59.4%						CASH	4.6%	4.1%	11.4%	9.7%	2.9%		
	EXPENSE	<u>16.1%</u>	<u>16.3%</u>	<u>19.1%</u>	<u>16.6%</u>	<u>21.0%</u>						STOCKS	22.2%	23.1%	22.7%	24.5%	16.2%		
		119.3%	119.6%	160.6%	142.7%	110.0%						MORT. LOANS	0.1%	0.1%	0.1%	0.1%	0.0%		
												REAL ESTATE	0.6%	0.6%	0.7%	0.7%	0.8%		
												OTHER	0.0%	0.0%	0.0%	0.1%	0.3%		

**APPENDIX B**

**Market Leader Data Request**

## Data Request

Date: July 8, 2004

To: Mr. John Doe  
XYZ Insurance Company  
1000 TBD Street  
City, CT 00000

From: Kevin Bingham, ACAS, MAAA, Deloitte Consulting LLP  
Richard Simring, Attorney at Law, Stroock

Subject: Request for medical malpractice information (ROI) in regards to Section 54(6)(b) and (c) of CS for SB 2-D, 1<sup>st</sup> Engrossed (SB2D) – Market Leader Data Request

### Background

Deloitte Consulting was engaged by the Office of Insurance Regulation (OIR) to assist the OIR with the completion of Section 45(6)(b) and (c) of CS for SB 2-D, 1st Engrossed which states:

*“(b) OIR shall prepare an annual report by October 1 of each year, beginning in 2004, which shall be available on the Internet, which summarizes and analyzes the closed claim reports and the annual financial reports filed by insurers writing medical malpractice insurance in Florida. The report must include: (1) an analysis of closed claim reports of prior years in order to show trends in the frequency and amount of claims payments; (2) the itemization of economic and noneconomic damages; (3) the nature of the errant conduct; and (4) such other information that OIR determines is illustrative of the trends in closed claims. The report must also analyze the state of the medical malpractice insurance market in Florida including: (1) an analysis of the financial reports of those insurers with a combined market share of at least 80 percent of the net written premium in the state for medical malpractice for the prior calendar year; (2) loss ratio analysis for medical malpractice written in Florida; and (3) a profitability analysis of each such insurer. The report shall compare the ratios for medical malpractice in Florida compared to other states, based on financial reports filed with the National Association of Insurance Commissioners and such other information that OIR deems relevant*

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

As part of our proposed work plan, we have been asked by the OIR to prepare a market leader data request (MLDR) that will survey the top medical malpractice writers in the state of Florida. Based upon the actual net written premium in the state for 2003, your company falls in the top eleven insurers necessary to satisfy the 80 percent benchmark established by SB2D.

The purpose of this MLDR is to request financial information and written responses that will help Deloitte Consulting analyze the current state of the medical malpractice market post SB2D. Given the long tail nature of the medical malpractice line of business and the “green” nature of SB2D, we recognize that it may be somewhat early to quantify some sections of SB2D in terms of benefits, savings and court activity. We request that you will do your best to describe your Company’s experiences with and concerns regarding SB2D to the best of your ability. We also recognize that certain information may be confidential and may potentially impact the outcome of current litigation. In those situations, we fully understand that general comments may be necessary instead of specific references to specific events.

## Data Request

### Requested Financial Information

- I. A hard copy of your Company’s December 31, 2003 Annual Statement
- II. A copy of your “Page 14” data for all states
  - a. 12/31/2003
  - b. 12/31/2002
  - c. 12/31/2001
- III. Please provide us with a 10-year summary of bad faith payments made by your Company.
  - a. Information displayed by year of closing
    - i. (A) Paid losses limited to policy limits (e.g., \$250,000, \$500,000, etc.)
    - ii. (B) Losses in excess of policy limits (i.e., bad faith payments)
    - iii. (C) Ratio in excess of policy limits = (B) / (A)
    - iv. Please identify in the footnotes the amount of bad faith payments made post-SB2D
    - v. Please identify in the footnotes how paid losses limited to policy limits are calculated (e.g., do you limit all claims to \$250,000, do you use actual policy limits which may vary by claim?, etc.)
- IV. For medical negligence suits filed in court, please provide us with a 5-year history of suits sorted by the following SB2D categories:
  - a. catastrophic vs. non-catastrophic
  - b. death vs. non-death
  - c. number of claimants
  - d. number of defendants
  - e. ER suits sorted by practitioner vs. non-practitioner
  - f. Non-ER suits sorted by practitioner vs. non-practitioner
- V. For “notices of intent to initiate litigation” (SB2D Section 49), please provide us data on how many notices were mailed after September 15, 2003 and whether the incidents described occurred before or after September 15, 2003.
- VI. Please provide us with your current policy limit distribution. A format similar to our “Matrix of Indemnity Savings” shown in Section 54 of our November 6, 2003 PF Report would be helpful.

## SB2D Questions

- I. Please discuss how your Company will handle the impact of the “Presumed Factor” (PF) in your next rate filing.
- II. Please discuss how the appointment of a patient safety officer and patient safety committee at each licensed facility as required under Section 6 of SB2D has impacted patient safety in Florida. Please provide any available information on average loss ratio, claim frequency, or claim severity differences between facilities with patient safety officers and those without patient safety officers. Please note if the comparisons are distorted by rate differentials between facilities with or without safety officers, differences in usual geographic location, profit vs. non-profit, charity hospitals vs. all others, etc.
- III. Please discuss (or provide data on) how successful your insured non-practitioners (i.e., licensed facilities) have been notifying patients of “adverse incidents” under Section 7 of SB2D. Please provide data (approximate if need be) on what percentage of inpatient and outpatient patients have been notified of “adverse incidents” under Section 7 of SB2D.
- IV. Please discuss (or provide data on) how successful your insured practitioners have been notifying patients of “adverse incidents” under Section 8 of SB2D. See above
- V. Please list the five most frequently misdiagnosed conditions of your insured practitioners. This is aimed at improving education regarding root-cause analysis, error reduction and prevention, and patient safety discussed under Section 10 of SB2D.
- VI. Please comment on the usefulness of the practitioner profiles shown on the Florida Department of Health website <http://www.doh.state.fl.us/MQA/profiling> discussed under Section 14/Section 15 of SB2D. If possible, please also comment on the following:
  - a. Insured practitioner satisfaction with profile (e.g., readability of explanation for disciplinary action taken, basis to change the profile and frequency)
  - b. Insured practitioner satisfaction with linking of profile to practitioner’s web-site
  - c. Insured practitioner satisfaction with update process
  - d. Timeliness of information included in practitioner profile (Section 17 of SB2D)
- VII. Please list and describe any instances where physicians have been suspended for non-payment of awards under Section 23 of SB2D.
- VIII. Please discuss the impact of Section 48 of SB2D dealing with expert witness testimony. Has your Company observed any limitation of plaintiff or defense experts? Has your Company observed the elimination of frivolous claims that can no longer be supported by experts defined under SB2D?

IX. Please discuss the impact of Section 49 of SB2D dealing with issues such as notice before filing of a claim and pre-suit screening. What percentage of plaintiffs are sending copies of complaints to the DOH and what percentage of plaintiffs are providing pre-suit information regarding all known doctors who have seen the claimant for the relevant injuries?

X. Please show the ratio of settlements under binding arbitrations to all claims closings both before and after SB2D. Similarly for mediations (See Section 50 of SB2D).

XI. SECTION 54 – CAP ON NON-ECONOMIC DAMAGES

- a. Please list any court cases in the state of Florida that have imposed a cap on non-economic damages? Include any available economic and non-economic dollar information on the total actual cost of the claim
- b. Please list any claims your company is currently litigating that have a high probability of resulting in non-economic damages that exceed the SB2D caps? Show economic and non-economic dollar amount estimates only and do not include claimant name or other information that could allow opposing counsel to obtain information off your submission.
- c. Please discuss your perception of the constitutionality of the non emergency room caps on non-economic damages for practitioners and non practitioners.
- d. Please discuss your perception on the constitutionality of the emergency room cap on non-economic damages for practitioners and non-practitioners.
- e. Please discuss and provide any available data showing whether the cap on non-economic damages has helped your negotiating position in any of your cases you have settled in 2004 in areas such as:
  - i. Speed up in claim settlement (e.g., changing settlement lag)
  - ii. Elimination of frivolous claims
  - iii. Please provide the developed average cost of a settled claim both before and after SB2D
- f. How is your perception of the constitutionality of the cap on damages being reflected in your post SB2D PF rate filings?
- g. How did you reflect the \$150,000/\$300,000 emergency room caps in your recent PF filing required under SB2D?

XII. SECTION 56 – BAD FAITH

- a. Please discuss how many times your company has tendered policy limits since September 15, 2003.

- b. Please provide the approximate number of plaintiff attorney demand letters received both before and after SB2D.
  - c. Please provide the number of claim settlements per policy both before and after SB2D
  - d. Please provide the average severity of settled claims both before and after SB2D
  - e. Have your defense mitigation strategies changed since the passage of SB2D? If so, how?
- XIII. Please comment on the impact of good SAM under Section 56 of SB2D. Can you provide any examples of claims where good SAM has had a favorable impact?
- XIV. Please provide a breakdown of policy limits sold by policy count both before and after SB2D. As we noted in our PF Report, healthcare providers have been purchasing lower policy limits or are choosing not to purchase coverage at all. Can you comment on the current trends regarding the purchase of lower policy limits?
- XV. Are there any other court cases that you think we should be aware of that may impact the constitutionality of SB2D?
- XVI. Are there any other impacts of SB2D that should be noted from a financial perspective that we have not addressed above or you would like to share with us?

## Report

Consistent with our "Presumed Factor" report published on November 6, 2003, to the extent possible, we will remove all references to the Company providing the answers. The purpose of our report is not to single out any one individual insurer, but to evaluate how effective SB2D has been for practitioners in the State of Florida.

## Timing

In order to meet our tight time frames, we need to receive your written response via email or U.S. mail by August 6, 2004.

## Contact Information

Should you have any questions, please feel free to contact Kevin Bingham at (860) 543-7345 or email Kevin at [kbingham@deloitte.com](mailto:kbingham@deloitte.com).

MLDR information can be emailed to [kbingham@deloitte.com](mailto:kbingham@deloitte.com) or mailed in paper format to:

Kevin Bingham  
Deloitte Consulting LLP  
City Place, 33<sup>rd</sup> Floor  
185 Asylum Street  
Hartford, CT. 06103-3402

## APPENDIX C

### Ratemaking Primer

On March 13, 2003, Mr. James Hurley presented testimony to the United States Senate titled “*Causes of the Medical Liability Insurance Crisis*”<sup>36</sup>. 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.*

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<sup>36</sup> 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:

<b>Accident Year</b>	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.
<b>Report Year</b>	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.
<b>Paid Losses</b>	The cumulative loss amount paid for a claim as of a particular point in time.
<b>Reserves</b>	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.
<b>Incurred Losses</b>	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.
<b>Ultimate Losses</b>	Total losses for a particular report year or accident year. This equals the sum of all payments, case reserves and IBNR.
<b>Reported Counts</b>	The cumulative number of claims reported as of a particular point in time.
<b>Loss Components</b> <i>Indemnity-</i>	The portion of a claim relating to compensation for a claimant's economic and noneconomic damages.

<b><i>ALAE-</i></b>	The portion of a claim relating to the cost of settlement. This includes defense costs, court costs, medical reports, investigative reports, etc.
<b>Loss Ratio</b>	Ratio of losses (paid, incurred, or ultimate) to net earned premium as a percentage.
<b>Claims Frequency</b>	Ultimate number of claims divided by an exposure base (e.g., occupied beds, net earned premium).
<b>Claims Severity</b>	Ultimate losses divided by ultimate number of claims.
<b>Development Factor</b>	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.
<b>Manual Rate Indication</b>	<p>Sample Calculation:</p> <ul style="list-style-type: none"><li>(1) Ultimate Loss and LAE Ratio</li><li>(2) Death, Disability and Retirement Load (DDR)</li><li>(3) Expected Loss Ratio</li><li>(4) Average Policy Discount</li></ul> <p>Indication = [ (1) x (2) ] / [ (3) x { 1.0 - (4) } ] - 1.0</p> <p>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.</p>

## APPENDIX D

### **SB2D Definitions**

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

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

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

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

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

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

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

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

**Helpful abbreviations**

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

APPENDIX E

**BERGES CASE TESTING CAP ON NON-ECONOMIC DAMAGES**

Page 1 – Claimants

Page 1 – Defendants

Page 2 – Underlying Facts

Page 5 – Diagnosis

**Page 6 – Primary Constitutional Claims**

**CIVIL COVER SHEET**

The civil cover sheet and the information contained herein does not replace the filing and service of pleadings or other papers as required by law. This form is required for the use of the Clerk of Court for the purpose of reporting judicial workload data pursuant to Florida Statute 25.075.

1. STYLE OF CASE

IN THE CIRCUIT COURT OF THE 11TH  
JUDICIAL CIRCUIT IN AND FOR MIAMI  
DADE COUNTY, FLORIDA

Case No. \_\_\_\_\_

Judge: \_\_\_\_\_

FEDERICO BERGES and SONIA  
BERGES, as parents and natural  
guardians of their minor child,  
MARIAELENA BERGES,

Plaintiffs,

vs.

BELLEITHA LAMBKIN-ALEXANDER,  
M.D., et al.,

Defendants.

FILED FOR RECORD  
2004 AUG 30 AM 11:24  
CLERK OF COURT  
DADE COUNTY, FLA.

2. TYPE OF CASE (Place an X in one box only. If the case fits more than one type of case, select the most definitive.)

DOMESTIC RELATIONS

- Simplified dissolution
- Dissolution
- Support-IV-D
- Support-Non IV-D
- URESA-IV-D
- URESA - Non IV-D
- Domestic Violence
- Other domestic relations

TORTS

- Professional Malpractice
- Products liability
- Auto Negligence
- Other negligence

OTHER CIVIL

- Contracts
- Condominium
- Real property/Mortgage foreclosure
- Eminent domain
- Other

3. IS JURY TRIAL DEMANDED IN COMPLAINT? [ X ] YES [ ] NO

DATE: 8/30/04

ATTORNEY: Neal A. Roth  
NEAL A. ROTH  
Fla. Bar #220876

IN THE CIRCUIT COURT OF THE 11TH  
JUDICIAL CIRCUIT IN AND FOR  
MIAMI-DADE COUNTY, FLORIDA

GENERAL JURISDICTION DIVISION

CASE NO.

04-18664

FEDERICO BERGES and SONIA  
BERGES, as parents and natural  
guardians of their minor child,  
MARIAELENA BERGES,

Plaintiffs,

vs.

BELLEITHA LAMBKIN-ALEXANDER,  
M.D.; ROZALYN H. PASCHAL, M.D.;  
ROZALYN H. PASCHAL, M.D., INC.;  
AND ROZALYN HESTER PASCHAL,  
M.D., P.A.,

Defendants.

*Handwritten notes:*  
236  
1550  
2041  
7479

FILED FOR RECORD  
JUL 13 2004  
CLERK OF COURT  
MARIANNE J. HARRIS

**COMPLAINT FOR DECLARATORY JUDGMENT**

The Plaintiffs, FEDERICO BERGES and SONIA BERGES, as parents and natural guardians of their minor child, MARIAELENA BERGES, sue the Defendants, BELLEITHA LAMBKIN-ALEXANDER, M.D.; ROZALYN H. PASCHAL, M.D.; ROZALYN H. PASCHAL, M.D., INC.; and ROZALYN HESTER PASCHAL, M.D., P.A., and allege the following:

**JURISDICTIONAL STATEMENT AND IDENTIFICATION OF PARTIES**

1. This is an action for a declaratory judgment brought pursuant to Chapter 86, Florida Statutes. This court has jurisdiction of this action pursuant to Fla. Stat. §86.011 (2003).

2. The Plaintiffs, Federico and Sonia Berges, are the parents and natural guardians of the minor child, Mariaelena Berges.

3. The Berges have a presently pending action in the Circuit Court in the Eleventh Judicial Circuit in and for Miami-Dade County, Florida, General Jurisdiction Division, Case No. 04-15284 CA 09. Because this action challenges the constitutionality of a Florida statute, a copy of this Complaint will be served on the Attorney General, State of Florida.

4. Venue is proper in Miami-Dade County, Florida where the underlying incident, a medical malpractice action, occurred and to which this complaint for declaratory relief is addressed.

5. All of the Defendants are residents of, have offices in, and provide medical services and care in Miami-Dade County, Florida.

#### **UNDERLYING FACTS**

6. On October 24, 2003, Mr. Berges took Mariaelena to her pediatrician's office, the offices of Defendants, Rozalyn H. Paschal, M.D., Inc. and Rozalyn Hester Paschal, M.D. P.A. Mariaelena was seen by Defendant Dr. Lambkin-Alexander. Mariaelena presented with a cough and cold which had continued for 6-7 weeks. Mariaelena had complaints of a headache and the cough was wet. Physical examination revealed that Mariaelena's left tympanic membrane had serous fluid. Her lungs had scattered expiratory wheezes and she did have a wet cough.

7. Defendant Dr. Lambkin-Alexander diagnosed Mariaelena with hyperactive airway disease, sinusitis and left otitis media. She prescribed Bactrim, 1½ teaspoons PO BID for 10 days; nebulizers every 6 hours; and Tanafed 1 teaspoon BID for 2 weeks. Mr. Berges was instructed to follow up in 2 weeks.

8. On November 5, 2003, Mr. Berges took Mariaelena back to the same office. Her presenting complaints were that her eye was hurting particularly when she rubbed it. Also, she had thick mucous drainage from her eyes. Mariaelena vomited once before arriving at the doctor's office. Her temperature was at 100.6°. Defendant Dr. Lambkin-Alexander again evaluated Mariaelena. She noted that both eyes were infected; had discharge; and diagnosed her with bilateral conjunctivitis. Defendant Dr. Lambkin-Alexander instructed Mr. Berges to instill 2 drops of Ciprodex TID for one week; to continue the nebulizer treatments until the cough subsided; and to follow up if the eyelids became swollen or there was pain in the eyes.

9. On or about November 6, 2003, Mrs. Berges took Mariaelena back to the Defendant pediatrician's office. Mariaelena had fever, was vomiting, coughing, had "pinkeye", and complained of burning with urination. On this visit, Mariaelena was seen by Defendant Dr. Paschal who documented that the child had a recent history of pinkeye, an ear infection, asthma and fever for 2

days. The night prior to the office visit, Mariaelena had developed dysuria. She had a temperature of 102.3°.

10. Defendant Dr. Paschal's examination revealed erythematous tonsils, supple neck, clear lungs, normal tympanic membranes, but swollen erythematous labia. Defendant Dr. Paschal's impressions included bilateral conjunctivitis, tonsillitis, a history of asthma and urethritis.

11. A urinalysis was normal. A throat C&S was obtained. A CBC with a WBC of 7.9; Hgb 13.9 and Hct 41.1; and platelets of 297 were noted. Defendant Dr. Paschal instructed Mrs. Berges to use mild soap, A&D ointment, Motrin or Tylenol and prescribed Bactrim 2½ teaspoons every 12 hours.

12. On November 7, 2003, Mr. Berges called the Defendant doctors' office. Before the office returned the call, however, Mrs. Berges took Mariaelena to Memorial Hospital West to be evaluated for fever, rash, conjunctivitis and blistered, sore, dry lips. The child was drooling and would not swallow fluids. On examination, she was found to have a temperature of 101.7° with a heart rate of 156. The emergency room physician documented a blanchable erythematous papular rash on her palms, chest and behind her ears. Her oral mucosa was erythematous and ulcerations were on the tongue tip. Her vaginal mucosa was also erythematous. Dr. Greissman was consulted. He evaluated Mariaelena at 15:30. He ordered her transferred to Joe DiMaggio Children's Hospital.

13. Mariaelena was transferred at 17:25 with the diagnosis of erythema multiforme and rule out Kawasaki disease. On arrival to Joe DiMaggio Children's Hospital, Mariaelena was seen and evaluated by numerous specialists who immediately diagnosed Stephens Johnson Syndrome.

14. Subsequently, Mariaelena was admitted to Joe DiMaggio Children's Hospital where she remained from November 7, 2003 through November 29, 2003 where she was treated for Stephens Johnson Syndrome.

15. The Plaintiffs filed the aforementioned medical malpractice complaint based on alleged acts of negligence which occurred after September 15, 2003 against the Defendants for both active negligence and vicarious liability. After compliance with the presuit requirements of Chapter 766 the Defendants and their insurers denied the claims.

16. While in the hospital, Mariaelana suffered from drooling; blistering skin; blistering gastrointestinal tract; eyes swollen shut; severe respiratory complications; papular rash on palms, chest, and ears; tongue ulcerations; erythematous vaginal mucosa; corneal ulcerations; third degree burns over her body; sloughed her skin; placement of a feeding tube; and subsequent hair loss. The Bergeses claimed compensatory damages as follows: bodily injury; pain and suffering; disability; disfigurement; mental anguish; loss of the capacity for the enjoyment of life; medical and other health care related expenses; loss of wage

earning capacity; rehabilitation expenses; and aggravation of a pre-existing condition on behalf of their minor child, Mariaelena Berges.

17. The Bergeses, as parents, also claimed medical, hospital, and related expenses in the past and in the future. A jury trial was also demanded.

**PRIMARY CONSTITUTIONAL CLAIMS**

18. Prior to September 15, 2003, the recoverable damages in a medical malpractice case were not limited. Consequently, a plaintiff could seek the full measure of damages that a jury might award for any injuries that a jury might find were proximately caused by the negligence of the defendant doctors. The right to recover such unlimited damages as found by the jury reflect that persons who are innocent victims of wrongful conduct have the right and opportunity to obtain recourse and recompense from the tortfeasors.

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

20. It is uncontroverted, therefore, that there existed prior to September 15, 2003 a right to sue on and recover noneconomic damages of any amount and that this right existed from the time the current Florida Constitution was adopted. The right to redress injury does not draw any distinction between economic and noneconomic damages. Article I, Section 21, does not contain any language which would support the proposition that the

right is limited, or may be limited, to suits above or below any given figure. It has, therefore, always been recognized under Florida law that great harm may befall victims of medical malpractice and the corresponding necessity for requiring those that are responsible to compensate such harms.

21. Chapter 2003-416, *Laws of Florida*, however, made far-reaching changes which affect compensable damages to such injured persons. Section 86 of that chapter provides for, among other things, caps on damages, changes to bad faith claims against insurers, and various procedural changes which would take effect September 15, 2003. The legislation purports to state that to the extent allowed by the Florida Constitution, such changes would apply to any prior medical incident for which a notice of intent to initiate litigation has not been mailed before September 15, 2003.

22. The Bergeses sent out their notice of intent on February 19, 2004. Consequently, the Act purports to affect the monetary recovery that Mr. and Mrs. Berges may make on behalf of their severely injured minor child, Mariaelena Berges.

23. In particular, Fla. Stat. §766.118 provides the following limitation on noneconomic damages for the negligence of the Defendant treating physicians:

(a) With respect to a cause of action for personal injury or wrongful death arising from medical negligence of practitioners, regardless of the number of such practitioner defendants, noneconomic

damages shall not exceed \$500,000 per claimant. No practitioner shall be liable for more than \$500,000 in noneconomic damages, regardless of the number of claimants.

(b) Notwithstanding paragraph (a), if the negligence resulted in a permanent vegetative state or death, the total noneconomic damages recoverable from all practitioners, regardless of the number of claimants, under this paragraph shall not exceed \$1 million. In cases that do not involve death or permanent vegetative state, the patient injured by medical negligence may recover noneconomic damages not to exceed \$1 million if:

1. The trial court determines that a manifest injustice would occur unless increased noneconomic damages are awarded, based on a finding that because of the special circumstance of the case, the noneconomic harm sustained by the injured patient was particularly severe; and
2. The trier of fact determines that the defendant's negligence caused a catastrophic injury to the patient.

(c) The total noneconomic damages recoverable by all claimants from all practitioner defendants under this subsection shall not exceed \$1 million in the aggregate.

3. Limitation on noneconomic damages for negligence of nonpractitioner defendants --

(a) With respect to a cause of action for personal injury or wrongful death arising from medical negligence of nonpractitioners, regardless of the number of such nonpractitioner defendants, noneconomic damages shall not exceed \$750,000 per claimant.

(b) Notwithstanding paragraph (a), if the negligence resulted in a permanent vegetative state or death, the total noneconomic damages recoverable by such claimant from all nonpractitioner defendants under this paragraph shall not exceed \$1.5 million. The patient injured by medical negligence of a nonpractitioner defendant may recover noneconomic damages not to exceed \$1.5 million if:

(1) The trial court determines that a manifest injustice would occur unless increased noneconomic damages are awarded, based on a finding that because of the special circumstances of the case, the noneconomic harm sustained by the injured patient was particularly severe; and

(2) The trier of fact determines that the defendant's negligence caused a catastrophic injury to the patient.

- (c) Nonpractitioner defendants are subject to the cap on noneconomic damages provided in this subsection regardless of the theory of liability, including vicarious liability.
- (d) The total noneconomic damages recoverable by all claimants from all nonpractitioner defendants under this subsection shall not exceed \$1.5 million in the aggregate.

Pursuant to Fla. Stat. §766.118, catastrophic injury is defined to include second-degree or third-degree burns of 25% or more of the total body surface or third-degree burns of 5% or more to the face and hands. Fla. Stat. §766.118(1)(a)4. Mariaelena Berges sustained Stephen Johnson Syndrome. This is the equivalent of second degree or third degree burns because her entire skin was sloughed off and blistered; and, her gastrointestinal tract was also

burned and blistered.

24. The statute defines practitioner as licensed physicians as well as any entity vicariously liable for such physicians. There are four practitioner defendants: Dr. Bellietha Lambkin-Alexander; Dr. Rozalyn Paschal; Rozalyn H. Paschal, M.D., Inc.; and Rozalyn Hestor Paschal, M.D., P.A. The theories against the latter two defendants are vicarious liability.

25. The Plaintiffs contend that absent the application of Fla. Stat. §766.118, which they maintain is unconstitutional, Mariaelena would be entitled to the full measure of damages from the four practitioners.

26. On the other hand, the defendants will contend that noneconomic damage recovery is capped by Fla. Stat. §766.118 in the amount of \$500,000 total from the four practitioners.

27. The Plaintiffs contend that the limitation on noneconomic damages is unconstitutional as will be more particularly set forth below. The Plaintiffs also contend that if this court finds that Fla. Stat. §766.118 is a constitutional limitation on noneconomic damages, then the plaintiffs are subject to the limits pertaining to catastrophic injury. Therefore, the Plaintiffs are entitled to total noneconomic damages from all four practitioner defendants in the amount of \$1 million in the aggregate.

28. Fla. Stat. §766.118 is unconstitutional inter alia for the following reasons: The statute caps the damages available to injured persons seeking

redress through the courts. It has impermissibly burdened a plaintiff's ability to obtain access to the courts for full redress of all injuries. It has impaired a plaintiff's rights to all common law remedies without either providing an adequate alternative remedy or reflecting an overwhelming public necessity in the absence of less-restrictive alternatives, therefore denying access to courts in violation of Article I, Section 21, of the Florida Constitution, as well as access to courts under the Federal Constitution and the 14th Amendment.

29. The statute also denies equal protection by treating similarly situated natural persons unequally and making invidious and irrational distinctions in violation of Article I, Section 2, and Article III of the Florida Constitution, and the Equal Protection Clause afforded under the 14th Amendment of the Federal Constitution. Among other things, it discriminates against the most seriously injured claimants by providing arbitrary compensation below a certain level of damages and partial compensation above a certain level against those injured persons who are less well off economically than plaintiffs who are able to financially bear the damages for which they are not compensated. The statute also discriminates by virtue of physical disability.

30. Moreover, the statute creates arbitrary classifications to benefit a particular industry, medical practitioners, and their insurers, in violation of Article III, Sections 10 and 11 of the Florida Constitution and the 14th

Amendment of the Federal Constitution. It impairs the right to trial by jury in violation of Article I, Section 22, of the Florida Constitution by turning the jury's determination of damages into an advisory opinion and by assigning to a judge the common-law authority of the jury. It denies due process because there is no compelling state interest effectuated by least restrictive means, as well as no reasonable relation to a legitimate or compelling governmental objective in violation of Article I, Section 9 of the Florida Constitution and the Fourteenth Amendment of the Federal Constitution. It does so in particular by creating arbitrary damage caps; by irrationally and arbitrarily defining various categories of injury; by irrationally and arbitrarily limiting damages recoverable from so-called nonpractitioners; by protecting the medical practitioner rather than the medical practitioner's victim thereby irrationally extending its provisions to protect one class; and by serving no legislative objective related to the reduction of lawsuits against the protected class, medical practitioners, and their insurers.

31. In addition, Chapter 2003-416, *Laws of Florida*, which encompasses Fla. Stat. §766.118 violates the single subject requirement contained in Article III, Section 6 of the Florida Constitution. This is obvious from the description of the Act which is so lengthy that we will not repeat it here. Instead, we will attach it as Exhibit A. Suffice it to say that the Act purports to relate to medical incidents; involves the Agency for Healthcare

Administration with respect to reviewing complaints against hospitals; deletes the requirement that persons act in good faith to avoid liability for disciplinary actions; relates to internal risk management programs; requires licensed facilities to annually report certain health care practitioners; provides for use of patient safety data; eliminates restrictions on licensure renewal fees for health care practitioners; deletes provisions with respect to criminal history checks; revises financial responsibility requirements of physicians; amends Fla. Stat. §624.462; provides guidelines for the formation and regulation of certain self-insurance funds; proscribes a health maintenance organization's right to control the professional judgment of a physician; amends Fla. Stat. §766.106 specifying sanctions for failure to cooperate with presuit investigations; revises requirements for presuit notice; amends Fla. Stat. §766.1115, .1112, .1113, .201, .303, and .21; creates Fla. Stat. §766.118 limiting noneconomic damages; provides legislative findings and intent regarding emergency medical services; creates Fla. Stat. §766.1185; revises guidelines for immunity under the Good Samaritan Act; and many, many other revisions which will be seen in Exhibit A.

32. The statute is also unconstitutional under both the State and Federal Constitutions based on a violation of both substantive and procedural due process and equal protection because there is no rational basis for the caps on noneconomic damages.

33. Fla. Stat. §766.118 also violates the separation of powers

provision of Article II, Section 3, of the Florida Constitution.

34. The legislative enactment is a hodgepodge logrolling form of omnibus legislation that is obviously unconstitutional and embraces in the same bill incongruous matters having no rational relationship to each other or to the subjects specified in the titles. Distinct subjects affecting diverse interests have been combined in order to unite members who favored them. The Act is effectively the most gargantuan logroll in the history of Florida legislation.

35. The Plaintiffs are in doubt as to their legal rights and duties under the Act; and most specifically under Fla. Stat. §766.118 with respect to the applicability, or nonapplicability of the caps on noneconomic damages and the category into which this case fits, and specifically, whether the minor claimant has suffered a catastrophic injury. The Plaintiffs are equally uncertain as to the propriety of making a demand for policy limits from the Defendants or their insurers given the statutory changes to bad faith claims contained within this Act. These provisions are likewise subject to constitutional challenge, including but not limited to the following constitutional violations: (1) Article I, Section 21, Florida Constitution (access to courts); (2) 14th Amendment to the United States Constitution (due process and access to courts); (3) Article I, Section 2 and Article III of the Florida Constitution; and the 14th Amendment of the United States Constitution (equal protection); (4) Article I, Section 22, Florida

Constitution (right to jury trial); (5), Article I, Section 9, and the 14th Amendment to the United States Constitution (due process); (6) Article III, Section 6 of the Florida Constitution (single subject); (7) substantive and procedural due process of both the Florida and United States Constitutions; and (8) Article II, Section 3 of the Florida Constitution (separation of powers).

36. If this court enters a judgment declaring that the statute is unconstitutional and the Plaintiffs are entitled to their common law remedies uncapped, then there may be no need to pursue the case incurring costs of discovery and of trial, because the case may be able to be mediated or settled to conclusion.

37. On the other hand, at this point the Plaintiffs cannot make an intelligent determination as to whether they are entitled to demand \$500,000 for practitioners; or a total of \$1 million from practitioners, assuming a catastrophic injury, or the full value of the case.

38. Accordingly, this is an appropriate case for declaratory relief. It will produce an adjudication of the constitutionality of the caps on noneconomic damages and the bad faith legislation; or alternatively, will produce an adjudication of the category in which the injured Plaintiff falls, and which is critical to the decisions which the Plaintiffs must make including but not limited to claims for bad faith.

WHEREFORE, the Plaintiffs pray for a judgment declaring that Chapter 2003--416, *Laws of Florida*, including of course, Fla. Stat. §766.118, is unconstitutional. Alternatively, the Plaintiffs pray for a judgment declaring that the injuries sustained by the minor Plaintiff fall within the definition of catastrophic injury and that a manifest injustice would occur unless increased noneconomic damages are awarded based on a finding that because of the special circumstances of the case, the noneconomic harm sustained by the injured minor patient was particularly severe; thus, allowing the case to go forward before a jury to determine that the Defendants' negligence caused the catastrophic injury to the minor Plaintiff.

DATED this 30<sup>th</sup> day of August, 2004.

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1  
2 An act relating to medical incidents; providing  
3 legislative findings; creating s. 395.0056,  
4 F.S.; requiring the Agency for Health Care  
5 Administration to review complaints submitted  
6 if the defendant is a hospital; amending s.  
7 395.0191, F.S.; deleting a requirement that  
8 persons act in good faith to avoid liability or  
9 discipline for their actions regarding the  
10 awarding of staff membership or clinical  
11 privileges; amending s. 395.0197, F.S.,  
12 relating to internal risk management programs;  
13 requiring a system for notifying patients that  
14 they are the subject of an adverse incident;  
15 requiring that an appropriately trained person  
16 give notice; requiring licensed facilities to  
17 annually report certain information about  
18 health care practitioners for whom they assume  
19 liability; requiring the Agency for Health Care  
20 Administration and the Department of Health to  
21 annually publish statistics about licensed  
22 facilities that assume liability for health  
23 care practitioners; repealing the requirement  
24 that licensed facilities notify the agency  
25 within 1 business day of the occurrence of  
26 certain adverse incidents; repealing s.  
27 395.0198, F.S., which provides a public records  
28 exemption for adverse incident notifications;  
29 creating s. 395.1012, F.S.; requiring  
30 facilities to adopt a patient safety plan;  
31 providing requirements for a patient safety

# EXHIBIT A

1 plan; requiring facilities to appoint a patient  
2 safety officer and a patient safety committee  
3 and providing duties for the patient safety  
4 officer and committee; creating s. 395.1051,  
5 F.S.; requiring certain facilities to notify  
6 patients about adverse incidents under  
7 specified conditions; creating s. 456.0575,  
8 F.S.; requiring licensed health care  
9 practitioners to notify patients about adverse  
10 incidents under certain conditions; providing  
11 civil immunity for certain participants in  
12 quality improvement processes; defining the  
13 terms "patient safety data" and "patient safety  
14 organization"; providing for use of patient  
15 safety data by a patient safety organization;  
16 providing limitations on use of patient safety  
17 data; providing for protection of  
18 patient-identifying information; providing for  
19 determination of whether the privilege applies  
20 as asserted; providing that an employer may not  
21 take retaliatory action against an employee who  
22 makes a good-faith report concerning patient  
23 safety data; amending s. 456.013, F.S.;  
24 requiring, as a condition of licensure and  
25 license renewal, that physicians and physician  
26 assistants complete continuing education  
27 relating to misdiagnosed conditions as part of  
28 a continuing education course on prevention of  
29 medical errors; amending s. 456.025, F.S.;  
30 eliminating certain restrictions on the setting  
31 of licensure renewal fees for health care

1 practitioners; amending s. 456.039, F.S.;  
2 revising requirements for the information  
3 furnished to the Department of Health for  
4 licensure purposes; amending s. 456.041, F.S.,  
5 relating to practitioner profiles; requiring  
6 the Department of Health to compile certain  
7 specified information in a practitioner  
8 profile; establishing a timeframe within which  
9 certain health care practitioners must report  
10 specified information; providing for  
11 disciplinary action and a fine for untimely  
12 submissions; deleting provisions that provide  
13 that a profile need not indicate whether a  
14 criminal history check was performed to  
15 corroborate information in the profile;  
16 authorizing the department or regulatory board  
17 to investigate any information received;  
18 requiring the department to provide an  
19 easy-to-read narrative explanation concerning  
20 final disciplinary action taken against a  
21 practitioner; requiring a hyperlink to each  
22 final order on the department's website which  
23 provides information about disciplinary  
24 actions; requiring the department to provide a  
25 hyperlink to certain comparison reports  
26 pertaining to claims experience; requiring the  
27 department to include the date that a reported  
28 disciplinary action was taken by a licensed  
29 facility and a characterization of the  
30 practitioner's conduct that resulted in the  
31 action; deleting provisions requiring the

1 department to consult with a regulatory board  
2 before including certain information in a  
3 health care practitioner's profile; providing a  
4 penalty for failure to comply with the  
5 timeframe for verifying and correcting a  
6 practitioner profile; requiring the department  
7 to add a statement to a practitioner profile  
8 when the profile information has not been  
9 verified by the practitioner; requiring the  
10 department to provide, in the practitioner  
11 profile, an explanation of disciplinary action  
12 taken and the reason for sanctions imposed;  
13 requiring the department to include a hyperlink  
14 to a practitioner's website when requested;  
15 providing that practitioners licensed under ch.  
16 458 or ch. 459, F.S., shall have claim  
17 information concerning an indemnity payment  
18 greater than a specified amount posted in the  
19 practitioner profile; amending s. 456.042,  
20 F.S.; providing for the update of practitioner  
21 profiles; designating a timeframe within which  
22 a practitioner must submit new information to  
23 update his or her profile; amending s. 456.049,  
24 F.S., relating to practitioner reports on  
25 professional liability claims and actions;  
26 revising requirements for a practitioner to  
27 report claims or actions for medical  
28 malpractice; amending s. 456.051, F.S.;  
29 establishing the responsibility of the  
30 Department of Health to provide reports of  
31 professional liability actions and

1 bankruptcies; requiring the department to  
2 include such reports in a practitioner's  
3 profile within a specified period; amending s.  
4 456.057, F.S.; allowing the department to  
5 obtain patient records by subpoena without the  
6 patient's written authorization, in specified  
7 circumstances; amending s. 456.072, F.S.;  
8 providing for determining the amount of any  
9 costs to be assessed in a disciplinary  
10 proceeding; amending s. 456.073, F.S.;  
11 authorizing the Department of Health to  
12 investigate certain paid claims made on behalf  
13 of practitioners licensed under ch. 458 or ch.  
14 459, F.S.; amending procedures for certain  
15 disciplinary proceedings; providing a deadline  
16 for raising issues of material fact; providing  
17 a deadline relating to notice of receipt of a  
18 request for a formal hearing; excepting gross  
19 or repeated malpractice and standard-of-care  
20 violations from the 6-year limitation on  
21 investigation or filing of an administrative  
22 complaint; amending s. 456.077, F.S.; providing  
23 a presumption related to an undisputed  
24 citation; revising requirements under which the  
25 Department of Health may issue citations as an  
26 alternative to disciplinary procedures against  
27 certain licensed health care practitioners;  
28 amending s. 456.078, F.S.; revising standards  
29 for determining which violations of the  
30 applicable professional practice act are  
31 appropriate for mediation; amending s. 458.320,

1 F.S., relating to financial responsibility  
2 requirements for medical physicians; requiring  
3 maintenance of financial responsibility as a  
4 condition of licensure of medical physicians;  
5 providing for payment of any outstanding  
6 judgments or settlements pending at the time a  
7 physician is suspended by the Department of  
8 Health; requiring the department to suspend the  
9 license of a medical physician who has not  
10 paid, up to the amounts required by any  
11 applicable financial responsibility provision,  
12 any outstanding judgment, arbitration award,  
13 other order, or settlement; amending s.  
14 459.0085, F.S., relating to financial  
15 responsibility requirements for osteopathic  
16 physicians; requiring maintenance of financial  
17 responsibility as a condition of licensure of  
18 osteopathic physicians; providing for payment  
19 of any outstanding judgments or settlements  
20 pending at the time an osteopathic physician is  
21 suspended by the Department of Health;  
22 requiring that the department suspend the  
23 license of an osteopathic physician who has not  
24 paid, up to the amounts required by any  
25 applicable financial responsibility provision,  
26 any outstanding judgment, arbitration award,  
27 other order, or settlement; amending s.  
28 458.331, F.S., relating to grounds for  
29 disciplinary action against a physician;  
30 redefining the term "repeated malpractice";  
31 revising the minimum amount of a claim against

1 a licensee which will trigger a departmental  
2 investigation; requiring that administrative  
3 orders issued by an administrative law judge or  
4 board for certain practice violations by  
5 physicians specify certain information;  
6 creating s. 458.3311, F.S.; establishing  
7 emergency procedures for disciplinary actions;  
8 amending s. 459.015, F.S., relating to grounds  
9 for disciplinary action against an osteopathic  
10 physician; redefining the term "repeated  
11 malpractice"; amending conditions that  
12 necessitate a departmental investigation of an  
13 osteopathic physician; revising the minimum  
14 amount of a claim against a licensee which will  
15 trigger a departmental investigation; creating  
16 s. 459.0151, F.S.; establishing emergency  
17 procedures for disciplinary actions; amending  
18 s. 461.013, F.S., relating to grounds for  
19 disciplinary action against a podiatric  
20 physician; redefining the term "repeated  
21 malpractice"; amending the minimum amount of a  
22 claim against such a physician which will  
23 trigger a departmental investigation; requiring  
24 that administrative orders issued by an  
25 administrative law judge or board for certain  
26 practice violations by physicians specify  
27 certain information; creating s. 461.0131,  
28 F.S.; establishing emergency procedures for  
29 disciplinary actions; amending s. 466.028,  
30 F.S., relating to grounds for disciplinary  
31 action against a dentist or a dental hygienist;

1 redefining the term "dental malpractice";  
2 revising the minimum amount of a claim against  
3 a dentist which will trigger a departmental  
4 investigation; requiring that the Division of  
5 Administrative Hearings designate  
6 administrative law judges who have special  
7 qualifications for hearings involving certain  
8 health care practitioners; creating ss. 1004.08  
9 and 1005.07, F.S.; requiring schools, colleges,  
10 and universities to include material on patient  
11 safety in their curricula if the institution  
12 awards specified degrees; directing the Agency  
13 for Health Care Administration to conduct or  
14 contract for a study to determine what  
15 information to provide to the public comparing  
16 hospitals, based on inpatient quality  
17 indicators developed by the federal Agency for  
18 Healthcare Research and Quality; requiring the  
19 Agency for Health Care Administration to  
20 conduct a study on patient safety; requiring a  
21 report and submission of findings to the  
22 Legislature; requiring the Office of Program  
23 Policy Analysis and Government Accountability  
24 and the Office of the Auditor General to  
25 conduct an audit of the health care  
26 practitioner disciplinary process and closed  
27 claims and report to the Legislature; creating  
28 a workgroup to study the health care  
29 practitioner disciplinary process; providing  
30 for workgroup membership; providing that the  
31 workgroup deliver its report by January 1,

1 2004; amending s. 624.462, F.S.; authorizing  
2 health care providers to form a commercial  
3 self-insurance fund; amending s. 627.062, F.S.;  
4 prohibiting the submission of medical  
5 malpractice insurance rate filings to  
6 arbitration; providing additional requirements  
7 for medical malpractice insurance rate filings;  
8 providing that portions of judgments and  
9 settlements entered against a medical  
10 malpractice insurer for bad-faith actions or  
11 for punitive damages against the insurer, as  
12 well as related taxable costs and attorney's  
13 fees, may not be included in an insurer's base  
14 rate; providing for review of rate filings by  
15 the Office of Insurance Regulation for  
16 excessive, inadequate, or unfairly  
17 discriminatory rates; requiring insurers to  
18 apply a discount based on the health care  
19 provider's loss experience; requiring the  
20 Office of Insurance Regulation to calculate a  
21 presumed factor that reflects the impact of  
22 medical malpractice legislation on rates;  
23 requiring insurers to make a rate filing  
24 reflecting such presumed factor; allowing for  
25 deviations; requiring that rates remain in  
26 effect until new rate filings are approved;  
27 requiring that the Office of Program Policy  
28 Analysis and Government Accountability study  
29 the feasibility of authorizing the Office of  
30 the Public Counsel to represent the public in  
31 medical malpractice rate hearings; amending s.

1 627.357, F.S.; providing guidelines for the  
2 formation and regulation of certain  
3 self-insurance funds; amending s. 627.4147,  
4 F.S.; revising certain notification criteria  
5 for medical and osteopathic physicians;  
6 requiring prior notification of a rate  
7 increase; creating s. 627.41495, F.S.;  
8 providing for notice to policyholders of  
9 certain medical malpractice rate filings;  
10 amending s. 627.912, F.S.; revising  
11 requirements for the medical malpractice closed  
12 claim reports that must be filed with the  
13 Office of Insurance Regulation; applying such  
14 requirements to additional persons and  
15 entities; providing for access by the  
16 Department of Health to such reports; providing  
17 for the imposition of a fine or disciplinary  
18 action for failing to report; requiring that  
19 reports obtain additional information;  
20 authorizing the Financial Services Commission  
21 to adopt rules; requiring that the Office of  
22 Insurance Regulation prepare summaries of  
23 closed claim reports of prior years and prepare  
24 an annual report and analysis of closed claim  
25 and insurer financial reports; amending s.  
26 641.19, F.S.; revising definitions; providing  
27 that health care providers providing services  
28 pursuant to coverage provided under a health  
29 maintenance organization contract are not  
30 employees or agents of the health maintenance  
31 organization; providing exceptions; amending s.

1 641.51, F.S.; proscribing a health maintenance  
2 organization's right to control the  
3 professional judgment of a physician; providing  
4 that a health maintenance organization shall  
5 not be vicariously liable for the medical  
6 negligence of a health care provider; providing  
7 exceptions; amending s. 766.102, F.S.; revising  
8 requirements for health care providers who  
9 offer corroborating medical expert opinion and  
10 expert testimony in medical negligence actions;  
11 prohibiting contingency fees for an expert  
12 witness; requiring certification that an expert  
13 witness not previously have been found guilty  
14 of fraud or perjury; amending s. 766.106, F.S.;  
15 specifying sanctions for failure to cooperate  
16 with presuit investigations; requiring the  
17 execution of medical release to allow taking of  
18 unsworn statements from claimant's treating  
19 physicians; imposing limits on use of such  
20 statements; deleting provisions relating to  
21 voluntary arbitration in conflict with s.  
22 766.207, F.S.; revising requirements for  
23 presuit notice and for an insurer's or  
24 self-insurer's response to a claim; requiring  
25 that a claimant provide the Agency for Health  
26 Care Administration with a copy of the  
27 complaint alleging medical negligence against  
28 licensed facilities; requiring that the agency  
29 review such complaints for licensure  
30 noncompliance; permitting written questions  
31 during informal discovery; amending s. 766.108,

1 F.S.; providing for mandatory mediation;  
2 amending ss. 766.1115, 766.112, 766.113,  
3 766.201, 766.303, 768.21, F.S.; revising  
4 references to "medical malpractice" to "medical  
5 negligence"; amending s. 766.113, F.S.;  
6 requiring that a specific statement be included  
7 in all medical negligence settlement  
8 agreements; creating s. 766.118, F.S.; limiting  
9 noneconomic damages in medical negligence  
10 actions; providing legislative findings and  
11 intent regarding provision of emergency medical  
12 services and care; creating s. 766.1185, F.S.;  
13 providing that an action for bad faith may not  
14 be brought against a medical malpractice  
15 insurer if such insurer offers to pay policy  
16 limits and meets other specified conditions of  
17 settlement within a specified time period;  
18 providing for factors to be considered in  
19 determining whether a medical malpractice  
20 insurer has acted in bad faith; providing for  
21 the delivery of a copy of an amended witness  
22 list to the insurer of a defendant health care  
23 provider; providing a limitation on the amount  
24 of damages which may be awarded to certain  
25 third parties in actions alleging bad faith by  
26 a medical malpractice insurer; amending s.  
27 766.202, F.S.; redefining the terms "economic  
28 damages," "medical expert," and "noneconomic  
29 damages"; defining the term "health care  
30 provider"; creating s. 766.2021, F.S.;  
31 providing a limitation on damages against

1 considered agents of a state university board  
2 of trustees; amending s. 768.77, F.S.;  
3 prescribing a method for itemization of  
4 specific categories of damages awarded in  
5 medical malpractice actions; preserving  
6 sovereign immunity and the abrogation of  
7 certain joint and several liability; amending  
8 s. 1006.20, F.S.; requiring completion of a  
9 uniform participation physical evaluation and  
10 history form incorporating recommendations of  
11 the American Heart Association; deleting  
12 revisions to procedures for students' physical  
13 examinations; requiring the Department of  
14 Health to study the efficacy and  
15 constitutionality of medical review panels;  
16 requiring a report; amending s. 391.025, F.S.;  
17 adding infants receiving compensation awards as  
18 eligible for Children's Medical Services health  
19 services; amending s. 391.029, F.S.; providing  
20 financial eligibility criteria for Children's  
21 Medical Services; amending s. 766.304, F.S.;  
22 limiting the use of civil actions when  
23 claimants accept awards from the Florida  
24 Birth-Related Neurological Injury Compensation  
25 Plan; amending s. 766.305, F.S.; deleting a  
26 requirement for provision of certain  
27 information in a petition filed with the  
28 Florida Birth-Related Neurological Injury  
29 Compensation Plan; providing for service of  
30 copies of such petition to certain  
31 participants; requiring that a claimant provide

1 the Florida Birth-Related Neurological Injury  
2 Compensation Association with certain  
3 information within 10 days after filing such  
4 petition; amending s. 766.309, F.S.; allowing  
5 for claims against the association to be  
6 bifurcated; amending s. 766.31, F.S.; providing  
7 for a death benefit for an infant in the amount  
8 of \$10,000; limiting liability of the claimant  
9 for expenses and attorney's fees; amending s.  
10 766.314, F.S.; revising obsolete terms;  
11 providing procedures by which hospitals in  
12 certain counties may pay the annual fees for  
13 participating physicians and nurse midwives;  
14 providing for annually assessing participating  
15 physicians; requiring that the Office of  
16 Program Policy Analysis and Government  
17 Accountability study and report to the  
18 Legislature on requirements for coverage by the  
19 Florida Birth-Related Neurological Injury  
20 Compensation Association; providing  
21 appropriations and authorizing positions;  
22 providing for construction of the act in pari  
23 materia with laws enacted during the 2003  
24 Regular Session or a 2003 special session of  
25 the Legislature; providing for severability;  
26 providing effective dates.

27  
28 Be It Enacted by the Legislature of the State of Florida:

29  
30 Section 1. Findings.--  
31



**PAYMENT WORKSHEET  
CIRCUIT CIVIL**

**CHARON SANDS**

CLERK ID \_\_\_\_\_

CASE NO. 04-18664 CA 3 2

PLAINTIFF Beiges

FILING FEE \$ \_\_\_\_\_

RECORDING \$ \_\_\_\_\_

REG. MAIL \$ \_\_\_\_\_

REFUND \$ \_\_\_\_\_

OTHER \$ \_\_\_\_\_

TOTAL \$ 26

ATTORNEY BAR # \_\_\_\_\_

NAME \_\_\_\_\_

ADDRESS \_\_\_\_\_

AREA: \_\_\_\_\_

**NOTE: THIS IS NOT A RECEIPT**

## APPENDIX F

### **Florida Office of Insurance Regulation Medical Professional Liability Closed Claim Database**

#### **I. DATA BACKGROUND AND LIMITATIONS**

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

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

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

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

Additional details regarding the OIR closed claim database:

- Until mid-July 1999 closed claim data was manually keyed in as received (the “Archive” file). After mid-July 1999, forms and the data collection system were re-

designed to allow for electronic collection, mainly by diskette. An outside vendor helped to create a revised file layout. The “Current” file resulted, containing all claims submitted for the first time after mid-July 1999.

- For the purposes of this report, Deloitte Consulting has chosen not to use any information from the Archive file and concentrate exclusively on the Current file. It is believed that the Current file is a more credible source of information.
- The MPL database does not provide historical information on the number of claimants associated with each claim (e.g., wife and five kids versus wife and no kids).
- The MPL database does not track the actual dollars paid (i.e., comparative fault) by each defendant. Instead, the database requires the input of the total dollar award for each claimant, regardless of their share of the damages. Therefore, when multiple defendants have inputted their claims into the MPL database, there will be duplicate dollars in the database.
- Until the passage of SB2D, only Florida authorized insurers were required to report closed claims to the OIR database. This would have excluded self-insurers and “unauthorized” insurers such as offshore and surplus lines insurers. Since SB2D, virtually all insurers and self-insureds are required to report claims to the OIR.
  - In September 2004, an Operational Audit of the Closed Claim Database was performed by State of Florida, Auditor General, William O. Monroe, CPA. Including the audit findings, outlined in report number 2005-031, is a recommendation that the department develop and enforce more stringent rules regarding the reporting of closed claims. According to the report, there are indications that all closed claims may not have been reported by insurers. The reader is referred to the aforementioned report for further details.

- The actual occurrence dates of individual MPL incidents are often several years prior to the date of closure. As a result, OIR closed claim data cannot be expected to be representative of current MPL trends and conditions without some adjustment or other consideration. Deloitte Consulting notes that the database has claims closed as recently as summer 2004 and the instructions for the database mandate that claims be reported to the department within 30 days of closing.
- The version of the closed claim database provided to us contained claims closed through August 26, 2004.

## **II. DATA PREPARATION**

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

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

**TABLE APPENDIX F.1**

<u>Group</u>	<u>Portion of Total Counts</u>	<u>Criteria</u>
A	51%	Total Indemnity Paid = the Sum of the Individual Parts
B	2%	Total Indemnity Paid = the Deductible + Sum of Parts OR Deductible + Total = Sum of Parts
C	22%	Total Indemnity Paid > \$0, Sum of Parts = \$0
D	2%	Sum of Parts is >\$0, Total Indemnity Paid = \$0
E	17%	Still Error after A-D and Sum of Parts is larger than Total
F	7%	Still Error after A-D and Total is larger than Sum of Parts

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

**TABLE APPENDIX F.2**

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