

SENATE COMMITTEE ON
JUDICIARY

Meeting
Monday, July 15, 2003
1:00 p.m. - 3:45 p.m.
Room 412
The Knott Building
Tallahassee, Florida

VOLUME 3 OF 3
(Pages 256 - 354)

SENATOR J. ALEX VILLALOBOS, CHAIR
SENATOR DAVE ARONBERG, VICE CHAIR

SENATOR CHARLES W. "CHARLIE" CLARY, III
SENATOR DURELL PEADEN, JR.
SENATOR ROD SMITH
SENATOR DANIEL WEBSTER

To receive testimony from invited parties regarding Medical
Malpractice.

Reported by: Susan Willis, RPR, RMR, CRR

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100 SALEM COURT
TALLAHASSEE, FLORIDA 32301
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AFTERNOON SESSION

1
2 SENATOR VILLALOBOS: Take your seats. I'd like to get
3 started.

EXAMINATION

4
5 BY SENATOR VILLALOBOS:

6 Q Mr. Meros, I want to ask you a favor.

7 A Yes, sir.

8 Q We had a witness testify yesterday, who some members
9 want to ask two or three questions, just to clarify something,
10 and she had a procedure done on her eyes today, and I am sure
11 she is uncomfortable and would like to go back.

12 A Of course.

13 Q So with your indulgence, I would like to ask her the
14 question so that she can answer it and go home.

15 A Absolutely.

16 SENATOR VILLALOBOS: Elizabeth Dudek.

EXAMINATION

17
18 BY SENATOR VILLALOBOS:

19 Q You're still under oath.

20 A Still under oath, okay.

21 Q Thank you for coming, particularly --

22 A It was just having them dilated. It wasn't that big a
23 procedure, other than I couldn't see for a while.

24 Q Yeah, but I've had that done to me, and it's not a
25 pleasant experience.

1 us about that process. They have on -- as I mentioned
2 yesterday, we had three occasions upon which we were notified
3 for closure. Those are the ones that I mentioned.

4 Q Three occasions?

5 A Right, where they told us. They are not mandated to
6 tell us, however.

7 Q Okay. Was that based on a business decision, lack of
8 physicians to furnish service, or any other conditions?

9 A Those were probably fairly historical, several years
10 ago. We are trying to pull those particular exemptions now to
11 see why they requested those. I haven't gotten that
12 information yet.

13 Q Was there any evidence that those patients might have
14 been referred to a teaching center or some other facility to
15 more adequately address their high-risk pregnancies or
16 something like that?

17 A What I'll need to do is go back and double check to be
18 able to respond to that. As I said yesterday, typically,
19 providers let us know in advance, and typically would make
20 arrangements for patients to go elsewhere.

21 Q In addition, would your agency have jurisdiction over
22 outpatient surgical centers under the purview of hospitals?

23 A To some extent. Outpatient services were deregulated
24 in 1987. They would not have to tell us about any changes that
25 they had in those services.

1 Q Are you aware whether there is an increase in the
2 actual construction of new outpatient surgery units, either
3 independent or in conjunction with a hospital?

4 A I don't know that there is an increase. Clearly, what
5 we have right now are a lot of facilities that, if you will,
6 are upgrading from what they had in the past.

7 I could check with our Plans and Construction office.
8 But most of the construction that we're seeing is related to,
9 if you will, upgrading existing facilities.

10 Q So actually there is an expansion of market, expansion
11 of services that are available, is your sense?

12 A No, I wouldn't necessary say that. I think a lot of
13 it is just meeting current standards as opposed to something
14 that's dated 10 or 15 years. But, again, I can double check.

15 Q Okay. But intrinsic to that, they don't usually build
16 smaller units than they have in place; do they?

17 A Not typically.

18 Q The other, as far as outpatient clinics, now, you
19 don't have jurisdiction directly with the outpatient clinics
20 unless they are associated or -- associated with an emergency
21 room or with hospitals?

22 A Well, we do have some licensure requirements related
23 to those, but not in some other sense. There is a lot of work
24 that can go on, and unless they are looking to go through some
25 plans of construction, we wouldn't know about that. And I have

1 not checked if there is an increased number of clinics.

2 Q But you don't --

3 A Many of those are freestanding.

4 Q Right. The ones under your purview, there is no
5 knowledge of those having an extraordinary number of closures
6 or any closure at all in the areas that are being denied care?

7 A I'm not specifically aware of any. But, then again,
8 they wouldn't need to tell us about that. That would not be
9 something they would need to report to us.

10 Q In association with that, if there were closures, more
11 than likely somebody would take that pool of patients and have
12 to have new construction in areas, to take in outpatients or
13 inpatients or have other coverage as far as surgical or OB
14 services?

15 A Typically that would be the case, yes.

16 Q Now, do you also license independent outpatient
17 obstetric units, whatever they are called today, as far as --

18 A If you're talking about birthing centers --

19 Q Birthing centers.

20 A Yes.

21 Q And do we, are we losing those, or are they continuing
22 to grow as far as services available?

23 A I am not aware that there's been any change,
24 increasing or decreasing. If I were to say anything, I think
25 they remained about static.

1 Q About static, okay. Thank you.

2 SENATOR VILLALOBOS: Okay. Anymore questions? Thank
3 you very much.

4 MS. DUDEK: You're welcome.

5 EXAMINATION

6 BY SENATOR VILLALOBOS:

7 Q Mr. Meros, thank you for letting us do that. You're
8 very kind.

9 A Certainly.

10 SENATOR VILLALOBOS: I had interrupted you to break
11 for lunch. Senator Smith, did you have your answer?

12 EXAMINATION

13 BY SENATOR SMITH:

14 Q I think I had one further question. It was just
15 really this: You have said that one-size-fits-all concerns
16 you. We share that same concern. We simply believe, some of
17 us, at least, that what's being proposed in terms of a \$250,000
18 cap, non-pierceable is, in fact, a one-size solution. Do you
19 agree with that?

20 A No, sir, because the bulk of the compensation in all
21 of those cases, even the most egregious, will be compensated by
22 economic damages. The cases we have heard about yesterday, I
23 have absolute fundamental disagreement with.

24 And the loss of an arm, an eye is a million, million
25 dollar case or millions of dollars of case, tomorrow, if there

1 is a 250 cap or today.

2 Q And to follow up on that, you are -- you do not, I
3 guess, then agree that there ought to be any standards for
4 pierceability?

5 A Well, standing here for myself, if there were a
6 provision that said, in an elective procedure, and someone cuts
7 off an arm or a leg, then that's not entitled to any immunity,
8 I have no problem with that.

9 But anything beyond something like that is -- the
10 exceptions literally swallow the rule, and you can't, you can't
11 define it. And, I mean, let me give you specific examples. If
12 a physician is operating under the influence of alcohol or
13 drugs.

14 Q How would you feel about that?

15 A Absolutely.

16 Q How about --

17 A No immunity whatsoever.

18 SENATOR VILLALOBOS: Let him answer.

19 A If they were operating without a license, clear-cut
20 wrong doing. Cut off a wrong appendage in an elective
21 procedure -- and understand, emergency physicians don't cut off
22 arms and legs, anyway. They stabilize. But in an elective
23 procedure, that wouldn't create an immunity, that's fine. But
24 beyond that, you can't have exceptions that do not swallow the
25 rule, in my opinion.

1 BY SENATOR SMITH:

2 Q Would gross misconduct as a standard be an exception
3 that would swallow the rule?

4 A No. The words, "gross misconduct," would absolutely
5 swallow the rule, yes, sir.

6 Q Would wanton and willful disregard swallow the rule?

7 A In 1999, this Legislature, as a policy matter,
8 recognized that the terms wanton and willful were so ambiguous,
9 so unsusceptible of a meaningful application, they changed the
10 punitive damage statute for that reason in 99-225.

11 Q So the only pierceability would be based on just
12 outlining a specific set of facts, kind of like you have
13 outlined for us here?

14 A Beyond that, with the terms you're talking about, yes,
15 sir. Now, if you have a standard of conduct that is, that is
16 susceptible of reasonable interpretation, not wanton and
17 willful, but the sort of, the sort of conduct that is now
18 defined in a punitive damage statute in 99-225, then that sort
19 of thing might be, might be doable.

20 But, again, if the standards are anything other than,
21 other than absolutely clear, let's face it, the exceptions
22 swallow the rule, and they don't lead to better outcomes in the
23 future.

24 SENATOR SMITH: Thank you.

25 EXAMINATION

1 BY SENATOR VILLALOBOS:

2 Q Mr. Meros, can you give me a couple more examples,
3 just so that I can understand your illustrations of cases
4 where, where do you not believe there ought to be a cap?

5 A That I do not believe what?

6 Q That there ought to be a cap on elective procedures,
7 as you said --

8 A Well, I can tell you, I have thought long and hard
9 about that, and but for that sort of list, I can't think of any
10 that would be --

11 Q It would be elective procedures?

12 A No. An amputation of a limb from an elective
13 procedure, certainly, to me, I personally don't have any
14 objection to that not being capped. And I say elective
15 because, again, if you're in a situation -- well, first of all,
16 in the emergency room situation, practically speaking, they
17 don't amputate. They stabilize. But, again, if you have an
18 emergent situation, and it goes beyond there, who knows?

19 Q But you wouldn't have a problem, though, with another
20 physician, not in the emergency room, if they made that type of
21 mistake on a limb?

22 A On an elective procedure on a limb, certainly not.

23 Q Okay.

24 A I don't have a problem with that. But, again --

25 Q Loss of sight. Loss of sight.

1 A There is no way that -- that's where the exception
2 swallows the rule, because you cannot say -- if you operated on
3 the wrong eye in an elective procedure, sure.

4 The loss of sight and the result is the precise
5 problem that we are getting back to, that I talked about
6 before. That sort of exception just goes back to the situation
7 where there is a second-guessing of incredibly difficult
8 medical judgment, and the result dictates the remedy, as
9 opposed to a realistic exception for outrageous conduct. You
10 can't do that.

11 Q No, but we are getting someplace because, obviously, I
12 went in for an elective procedure, and I lost my sight, I
13 would --

14 A No, sir. No, sir. If I have suggested for a second,
15 that that would be appropriate to, to pierce the cap, then let
16 me, let me change that, that view. It absolutely would be
17 inappropriate.

18 What I have said, and what makes sense is if you
19 operate on the wrong limb in an elective procedure, or on one
20 eye rather than another eye, then I personally don't have a
21 problem with that, because it doesn't lead to the exceptions
22 becoming not only unworkable, but creating a bigger problem.

23 Now, let me again say that, personally, those sorts of
24 exceptions aren't going to improve patient outcomes. And they
25 are not going to lead to cases where someone is going to be

1 compensated; whereas, without it, they won't be compensated.

2 And again --

3 Q I understand. But the pain and suffering part of a
4 judgment will not improve, you know, standard of care, anyway.
5 I mean, it is to make a person whole that has suffered a loss.

6 A Right. But the cases you were talking about yesterday
7 and the case you're talking about today, just like losing an
8 eye, is a case worth millions of dollars in economic damages.
9 Notwithstanding what was said yesterday, that will
10 substantially compensate a victim, and whether the pain and
11 sufficient suffering is \$250,000 or \$250 million.

12 And the problem, Senator, is again, not only do you
13 have the system that, that is not only imperfect, but
14 functionally unworkable in the malpractice setting, you have
15 the pain and suffering standards where the jury is told -- I
16 cannot tell you what, what is the proper standard or how to
17 judge pain and suffering. It is only within you.

18 Q Let me ask you a question, and I will -- an example,
19 loss of sight --

20 A Right.

21 Q -- would be worth millions in economic damages?

22 A Yes, sir.

23 Q Well, how about if one of my constituents, who is, you
24 know, 70 years old and retired, you know, loses their sight?

25 A Absolutely. That is a million-dollar case in economic

1 damages.

2 Q What economic damages? If they are not making anymore
3 money, they are retired?

4 A Loss of the ability to do things will give damages, in
5 modifying your house, in having help, in having services
6 brought in, in -- you'll have rehab experts everywhere
7 testifying about the millions of dollars --

8 Q That's -- the people that go to your house to help you
9 is not economic damages. That is medical expense.

10 A No, sir.

11 Q Damages is loss of, say, I, you know, I could see your
12 point if I were 30 years old, and I had a job which required my
13 sight. I was a bus driver. I mean, I would get compensated
14 for not being able to work anymore.

15 A No, sir. Medical expenses, rehabilitation expenses,
16 out-of-pocket expenses, the cost of other services that are
17 required now that you did not have all of those --

18 Q In that situation, would be loss of my income, right?

19 A No. No, sir. It would be, it would be rehabilitation
20 or other services necessary by virtue of the injury, which is
21 an economic damage issue. It is not a pain and suffering
22 issue.

23 Q Is my salary a pain and suffering issue, or is that an
24 economic damage issue?

25 A That is an economic damage issue.

1 Q Okay. In other words, I am a bus driver, and I can't
2 drive anymore because I can't see. I would be compensated for
3 not being able to drive anymore.

4 A Certainly, certainly.

5 Q So that has a value.

6 A Absolutely.

7 Q However, if I were 70 years old and retired and not
8 making a salary, I wouldn't be entitled to that money. And my
9 point is, on the one hand, someone who is 30 years old would
10 be, and someone who is 70 years old would be up the creek
11 without a paddle.

12 A No, sir, that's where we part ways. They wouldn't
13 receive lost wages because they don't work anymore.

14 Q Exactly. That is my point.

15 A But they would receive economic damages that are
16 unlimited. They would receive it because economic damages are
17 not limited to lost wages. They encompass far more than lost
18 wages, including rehabilitation expenses and the other expenses
19 that would make that person as whole as possible.

20 What you have instead is a situation where you can
21 have a million or millions of dollars of case like that.

22 But then you have pain and suffering damages, which
23 the jury is told, I can't tell you what they are, and so every
24 jury has to look within itself to determine what that number
25 is. That is the height of unpredictability.

1 Q Mr. Meros, let me ask you one more question. And I
2 guess you and I differ here in opinion because, you know, based
3 on your testimony, you know, what you're saying is if you're
4 elderly, then something better not happen to you, because, you
5 know, you're going to be very limited in your recovery --

6 A No, sir.

7 Q -- under your scenario?

8 A No, sir, that is not what I'm saying one bit.

9 Q Then do you care to explain it a little bit?

10 A I would say again, whether you were one year old or 90
11 years old, a case of the sort that we are talking about and
12 that we have spoken about today and yesterday will come with
13 substantial economic damages, substantial, whether you're
14 working or not.

15 What we are talking about instead is whether you have
16 a situation where, because of the inherent fundamental
17 unpredictability of pain and suffering damages, many people
18 don't receive the care that they need. And I'm happy to
19 discuss with you the reality of what is happening in the
20 emergency rooms and the hospitals around the state that
21 particularly affect the elderly.

22 And, in fact, right now in Palm Beach County -- and I
23 have a doctor here, Dr. Herraro (phonetic), from Palm Beach
24 County, that would love to testify under oath today where
25 stroke victims, the elderly come into the hospital, and you

1 can't get a neurologist to provide the care. When time is of
2 the essence, when you have to have the blood thinning process
3 started immediately, our elderly in hospitals are not getting
4 the neurological care that they have and the intracranial -- I
5 can't believe it, the --

6 Q Don't worry. If you could pronounce it, I wouldn't
7 know what it was.

8 A Whatever. I apologize. Those things are happening to
9 the elderly as we sit here today, and neurologists and
10 neurosurgeons aren't available. Whereas, you might get them in
11 an hour in a healthy system, or in the system that exists in
12 the sovereign immunity hospitals in the state, now there is six
13 and nine and 10 hours before that care occurs, and that hurts
14 the elderly.

15 Q Can you give me a quick definition of what you believe
16 is elective, an elective procedure?

17 A A quick definition, I think, would be meaningless,
18 because it would be that quick.

19 Q An explanation --

20 A Elective surgery is one that is voluntary, one that is
21 scheduled, and one that is not required to preserve the present
22 state of a patient's health. And that is George Meros on
23 elective surgery, and that's it.

24 Q If I broke my left arm, you know, that's obviously not
25 scheduled, but -- and my right arm was cut off as a result of a

1 procedure at the emergency room, because I don't think that
2 rises to that level -- I mean, is that an example where you can
3 be compensated?

4 A Again, George Meros on medicine, if that break was
5 stabilized, and you didn't have an internal bleeding in the
6 arm --

7 Q A simple break.

8 A And you came back for a reduction two or three days
9 later, and instead of operating on the right arm, they operate
10 on the left arm, or vice-versa, whichever, sure, I would
11 believe that to be an elective procedure.

12 I would not, however, believe that creating that
13 exception is going to make any difference in improved medical
14 care whatsoever. I don't think it will. I don't have a
15 problem with that.

16 Q To narrow it down for me, what you're talking about is
17 pre-stabilization, is not elective? After stabilization is
18 elective?

19 A I think that is a part of my, my quick analysis
20 standing up here. It certainly, in my view, would not be
21 elective if part of the reason why you're getting the care is
22 the need to do it quickly, and if you are not stabilized by
23 definition, theoretically, there is a need to perform services
24 more quickly than you might otherwise do so. But that's me.

25 SENATOR VILLALOBOS: Senator Aronberg.

1 SENATOR ARONBERG: Thank you, Mr. Chair.

2 EXAMINATION

3 BY SENATOR ARONBERG:

4 Q Thanks for being here, Mr. Meros.

5 A Sure.

6 Q Do you believe that juries should be the fact finder
7 in medical malpractice cases?

8 A Certainly. And nothing I have said today impugns
9 juries whatsoever. The problem with lawsuits in this area is
10 not juries. It is the fact that the standards and the rules
11 the juries are given are not susceptible to truly accurate and
12 fair evaluations, because of the very nature of the medical
13 system.

14 I don't have a problem with a jury making factual
15 decisions. What I have a problem with is not, is not
16 recognizing that the rules have to be adapted to particular
17 crucial elements of what you're talking about. And medicine is
18 different, as has been recognized by this Legislature for 20
19 years.

20 Q And how would you change that to make juries better at
21 deciding medical malpractice cases?

22 A Well, I think one of the -- I think a number of the
23 elements that we are talking about here will do just that. I
24 think the standard of care for emergency room provisions has to
25 be tightened because of the reality of the situation.

1 I think that there are others that could be included
2 that are not included in this. I think a clear and convincing
3 standard of evidence is more than warranted in the medical
4 world, although I have my doubts as to how effective that would
5 be.

6 But, certainly, there is any number of improvements in
7 the, in the area of what a jury hears in the way of
8 instructions, that could, that could make it fairer. But,
9 again, we are starting from a premise that a jury is ever going
10 to make decisions that help regulate the profession or make the
11 next service to a patient better, and that's -- and 30 years,
12 40 years of data suggests that is not the case.

13 Q I believe you said earlier that one problem juries
14 have is that it can't distinguish between reckless disregard
15 and bad outcomes; is that correct?

16 A That is not entirely correct. But what I said was
17 when you had a general standard of whether you knew or should
18 have known, or general language as to whether the doctor made a
19 mistake, there is a huge difference between a bad outcome and a
20 wrongful act.

21 Q Right. But on that line, specifically, in the statute
22 it says -- this is Section 766.102 on medical negligence, it
23 says the existence of medical injury shall not create any
24 inference or presumption of negligence against the healthcare
25 provider. And then later it says the Legislature is cognizant

1 of the changing trends and techniques for delivery of
2 healthcare in the State. And it goes on and says the failure
3 of a healthcare provider to order, perform, or administer
4 supplemental diagnostic tests shall not be actionable if the
5 healthcare provider acted in good faith, with due regard for
6 the prevailing professional standard of care. That is higher
7 than negligence.

8 A That was an excellent point. I have had have problems
9 with that language for 10 years, and here is the reality of
10 what happens. Here is really what happens. That language was
11 put in there because medicine is different.

12 Juries don't hear that language. Juries don't hear
13 that the Legislature has said it is not actionable to not give
14 a test.

15 And you also heard the language in the back end of
16 that, provided that you fulfill the appropriate standard of
17 care. Well, what that has meant in practice is that juries
18 just have the typical jury instruction of knew or should have
19 known, and there is nothing whatsoever given to the jury about
20 that reality.

21 There is a big difference between what this
22 Legislature has said in statute and what it recognizes, and
23 what juries hear and what actually occurs.

24 Q Would you suggest perhaps that changing the jury
25 instruction to include that language would help resolve these

1 matters?

2 A Well, I would be pleased to have a jury instruction
3 that says the failure to give a diagnostic test is not
4 actionable. Frankly, a jury wouldn't hear that. If that were
5 the language, then you would have summary judgment. But the
6 problem is it doesn't just say that. It goes on to back off
7 from that statement so completely that the words in the
8 beginning don't mean anything.

9 Q Do you support the sovereign immunity proposal that
10 has been floating around?

11 A Yes, sir. Yes, sir.

12 Q Do you know how many cases, how many healthcare
13 professionals would be covered by that? How many cases would
14 that cover, do you think, a year? Do you have an idea?

15 A Well, as best we could determine presently,
16 approximately 20 percent of emergency room visits are, are
17 covered, or occur in facilities where physicians and hospitals
18 have that immunity, and so theoretically, it would cover 100
19 percent of that.

20 Q I am trying to figure out the potential cost to the
21 State, because if we do assume sovereign liability, the State
22 could face some costs. So do you have an idea of how much the
23 State would assume in costs?

24 A In present costs, the State would incur nothing,
25 because our provisions were that the physician, any physician

1 sued would be -- would indemnify the State, pay the State,
2 absolutely be required to pay all costs of defense and
3 indemnity up to the limits of liability.

4 The only cost that would be incurred thereafter is if,
5 in fact, there were a claims bill which the Legislature chose,
6 elected to pass. And at that point, that would be a cost.

7 There is two things about that, Senator, very
8 important to understand. The first is that it is a State
9 mandate that we have a system where emergency physicians and
10 emergency providers have an absolute duty to treat. If you
11 have a State mandate, you should pay for that State mandate.

12 You could have a different situation where the State
13 could have emergency care in community health facilities. But
14 the Legislature hasn't chosen to do that.

15 The Legislature has said you, at the point of losing
16 your license, will provide this care. That is a State cost.

17 Secondly, what is the cost of the present system?
18 Where, again, I have Dr. Lopez, I have Dr. Herraro (ph), and
19 Dr. Page here to testify under oath about what's really
20 happening in emergency situations, where people are not getting
21 care in 10 hours. People are losing hands where they could
22 have gotten it if there were people around. What is the cost
23 to the State for that delay in care? I can tell you it's
24 enormous and far greater than any claims bills that would be
25 paid by this Legislature.

1 SENATOR VILLALOBOS: Your last question.

2 SENATOR ARONBERG: Thank you.

3 BY SENATOR ARONBERG:

4 Q Mr. Meros, I have an Analysis of Florida Claims,
5 Medical Malpractice Closed Claims Data Reported to the DOI,
6 that packet produced by the Florida Senate. It shows that the
7 number of closed claims has not increased over the past few
8 years. It starts in 1990, number of claims, 43, and it goes
9 up, peaks in 1997, 72, and then 2002, it was 46 again. And
10 then, the year before that was 52.

11 Do you have, do you have data -- I mean, that is the
12 same, about -- when you're talking about the total amount of
13 claims, that the amount of claims has not jumped. So you do
14 agree with the data? If not, is there other data you have?

15 A Excellent point. I really appreciate you bringing it
16 up. The problem is, this Legislature has been focusing on the
17 last three, four, five years of data, and there is a suggestion
18 that claims haven't gone up.

19 I urge this Senate to look at the data since 1975 to
20 today, with tort claims generally and medical malpractice
21 claims specifically. What you will find is an astronomical
22 increase in tort litigation over the past 30 years. And in a
23 period from 1981 to 1991, the State Court Administrator data
24 shows an increase of approximately 80 percent in tort claims
25 when the population increased by 40 percent, over double the

1 population.

2 What you will see, if you look at data that is a, a
3 full set of data, the system now, where there is redress based
4 on litigation far greater than there was in the previous
5 generation. And in the last three or four years, I don't
6 dispute that there are not a greater number, because it's
7 absolutely saturated. It is a saturated system. But if you
8 look at 20 years, in a realistic time frame of data, you will
9 see a huge increase.

10 SENATOR VILLALOBOS: Senator Peaden.

11 SENATOR PEADEN: Thank you, Mr. Chairman.

12 EXAMINATION

13 BY SENATOR PEADEN:

14 Q You lost me on some of your chain of arguments there.
15 You talked about absolute duty to treat of emergency room
16 physicians, and apparently you're talking about all emergency
17 rooms physicians.

18 Then you talked about standard of care and the use of
19 anti-coagulants in taking care of patients who arrive in the
20 emergency room, say, for instance, with an acute heart attack.
21 Are you considering the fact it is prohibited for an emergency
22 room to use anti-coagulants without some specialist standing by
23 his side? And that's why the patients have to wait so long?

24 I mean, I thought that those were based on the basis
25 of protocol, to save people lives. How do you have this sort

1 of obstructionist view that you have to have someone there?
2 This is an emergency room doctor, who doesn't know the patient,
3 to take care of a patient who he can diagnose adequately either
4 in the field or in the ER, to begin treatment?

5 A Well, first of all, I don't think it's an
6 obstructionist view. Secondly, what I am saying is precisely,
7 in Palm Beach now, and Dr. Herraro (ph) could tell you, that
8 when the elderly come in with a stroke, they can't get, get a
9 neurologist in there to help with the service.

10 And it is, it is because they can't get the
11 neurologist in. They can't the get the OB in there. They
12 can't get the orthopods to come in, that that is one of the
13 main reasons why the care is delayed so drastically.

14 The ER docs can try to stabilize, and even under the
15 stabilization, they face the most challenging task of all,
16 because they have patients that are having an acute MI or a
17 stroke. But, secondly, they have to have the tools. Emergency
18 rooms aren't closing down. They are crippled, because they
19 don't have the specialists that they must to protect our
20 citizens.

21 Q You define -- and you're talking about back-up call,
22 not emergency room call.

23 A I am talking about -- and, again, you know, the
24 specifics of what is back-up call versus emergency room call,
25 you know a lot more than I do. But I can tell you and these

1 gentlemen can tell you that every day when they get a situation
2 in such as a stroke, they can't get the specialist. They will
3 call specialists, and they can't get them, if at all, in many,
4 many hours.

5 EXAMINATION

6 BY SENATOR VILLALOBOS:

7 Q And why is that?

8 A Why is that?

9 Q Yeah.

10 A Because this situation has become so out of control
11 that the specialists are either not taking call, or instead of
12 taking call, ER call in six hospitals, they are taking it down
13 to one. Or they are just not doing it at all. They are going
14 to stay in their office practice, or --

15 Q So -- wait a second. So the reason the physician
16 isn't in the emergency room is because the physician chose to
17 stay in his office rather than go to the hospital on call; is
18 that what you are saying?

19 A And that's precisely the result of a situation where
20 litigation drives everything. They are saying, "Why in the
21 world should I go into the emergency room when I can choose my
22 patients and not, and not be compelled to treat the patient?"

23 Q See, I believe that that is the problem. I believe
24 some physicians say that, think that, and they choose not to go
25 into the emergency room or provide help to some patients

1 because they feel that way. Yet I believe others don't think
2 that and think of a patient first. I agree with you, I believe
3 that is a problem also.

4 A Well, and in looking at that, Senator, what you have
5 to look at, I suggest, and I respectfully suggest the Senate
6 should look at is: What are the motivations behind that? Is
7 there proof that the doctors are just uncaring people? Or is
8 it because there is a real situation when, when a doctor says,
9 "I am making \$200,000 a year and my, and my insurance rates are
10 \$100,000."

11 Q Do you know what that begs? Obviously, some
12 physicians are doing it, and others choose not to, and everyone
13 is in the same boat. So what that tells me is some physicians
14 are willing to go that extra yard, you know, for their patients
15 and some aren't.

16 A And --

17 Q Because, because if it would be otherwise, then
18 wouldn't you agree that no doctor would do this?

19 A At some point, Senator, if this isn't addressed
20 comprehensively, that's where we're going to be. And just
21 because there are some people that have been more heroic in
22 doing it doesn't mean that those that have said, "My family
23 comes first, and I cannot put myself in that position anymore,"
24 doesn't mean those people aren't good people. It means the
25 system is broken, and that the incentives are all wrong, and

1 that's what the Legislature, I hope, is going to do, is going
2 to get the incentives right again so the best --

3 Q We --

4 A -- and the brightest will be motivated to do so. But
5 I do not think there is a shred of evidence to suggest that if
6 a physician knows that he is going to put himself in a higher
7 risk situation for him and his family -- and you talked before
8 about this is only money. I respectfully disagree with it.

9 This is a person's livelihood. This is a person's
10 integrity being impugned. This is a person that has to spend a
11 year to three years of his life in a lawsuit. And that is a
12 horrible situation under any circumstance. And is it wrong for
13 that person to say, "For me and my family, there comes a point
14 when I have to say enough is enough," I don't think that's -- I
15 don't think that's selfish. I think that's a reality that is
16 in part driving the tragedy of the situation.

17 SENATOR VILLALOBOS: Senator Peaden.

18 SENATOR PEADEN: Thank, Mr. Chairman.

19 EXAMINATION

20 BY SENATOR PEADEN:

21 Q Mr. Meros, wouldn't you agree most of these hospital
22 bylaws require a physician, if he is on the staff or has a
23 service at the hospital, is required to take emergency room
24 back-up call?

25 A Senator, all I can say is --

1 Q I am asking you a question. These folks -- whoever
2 you're representing should know. Is that the fact? When
3 you're on a hospital, don't the bylaws require you to be on
4 back-up call?

5 A I am sure some do. I don't know. But I can tell you
6 the reality.

7 Q I am going to get down to reality in just a minute.
8 But every hospital I have ever been around, they had bylaws --
9 we can get somebody over here and swear them in. They required
10 you to take back-up call if you were on the hospital staff,
11 unless if you were sick, lame, or 95 years old. That's the way
12 it is. You understand?

13 A Absolutely.

14 Q And it doesn't matter what specialty you are, you're
15 on the rotation, and that is the way it happens. Is this more
16 about reimbursement for back-up call, or is it more about
17 changes in the tort system and about reform? That's the big
18 quandary.

19 Do they want to get a guarantee there is reimbursement
20 every time they come to the emergency room? Or is it a problem
21 of liability? You need to separate those two.

22 A Yes, sir, I will be happy to separate them. I can
23 tell you right now that notwithstanding what the bylaws say,
24 every day as we sit here, there are times when there are no
25 on-call physicians available to the emergency room doctors.

1 And, again, if you have any question about that, these doctors
2 can testify to that under oath, sitting here today.

3 And regardless of whether they are violating the
4 bylaws, whether they don't have the bylaws in place, I don't
5 know. But I can tell you, that I have the facts here, and
6 these doctors are here and can testify under oath that the care
7 is not available, and that the doctors do not come in because
8 of the liability crisis that's going on.

9 And I urge you, Senator to talk to Dave Pierce, Dr.
10 Dave Pierce at Weems Hospital in Apalachicola. He is the only
11 board certified emergency room physician within, goodness
12 knows, 50, 75 miles. And he can tell you the reality that he
13 can't do it anymore. He has had no claims. He has -- he's the
14 only guy there, and he's going to go back to Sopchoppy pretty
15 soon. And, again, please -- I've had him here to try to
16 testify before. Talk to him about what's going to happen in
17 the rural areas. You're going to get, in the rural areas in
18 particular, some emergency room care, but it is going to be
19 doc-in-the-box sort of stuff.

20 SENATOR VILLALOBOS: Mr. Meros, you made your point.
21 You testified on behalf of someone who wasn't here. I am
22 sure they appreciate that.

23 MR. MEROS: I will be happy to get them here if you
24 would like.

25 SENATOR VILLALOBOS: Any other questions of Mr.

1 Meros? Thank you, sir.

2 MR. MEROS: Thank you.

3 SENATOR VILLALOBOS: Gerald Wester. Raise your right
4 hand. Do you swear or affirm that the evidence you're
5 about to give will be the truth, the whole truth, and
6 nothing but the truth?

7 MR. WESTER: I do.

8 EXAMINATION

9 BY SENATOR VILLALOBOS:

10 Q State your name and your occupation, sir.

11 A Gerald Wester. I'm a lobbyist consultant with Capital
12 City Consultants.

13 Q And who are you representing?

14 A I represent American Protective Insurance Company,
15 American Insurance Association, Aetna, CIGNA, and Humana.

16 Q Okay. Are they all making money?

17 A Pardon me?

18 Q Are they all making money?

19 A I hope so.

20 Q Good.

21 SENATOR VILLALOBOS: Senator Smith, are you ready?

22 EXAMINATION

23 BY SENATOR SMITH:

24 Q Thank you, Mr. Wester, for coming today and helping us
25 through some of these issues. Because I know your background,

1 but I think it's important for this record. Not only are you
2 now working for these associations, but you have substantial
3 background with the Department of Insurance; do you not?

4 A Yes, sir.

5 Q Would you share for the record what that background
6 includes?

7 A All right. I was with the Department of Insurance for
8 13 years in a senior management position. The last four years,
9 I was Deputy Insurance Commissioner over all the regulatory
10 activities of the department.

11 Q There's a couple of areas that I want to talk to you
12 about and get some information for this Committee. One would
13 be in the area of bad faith.

14 A Yes, sir.

15 Q I know that you have addressed that previously, and
16 you have watched the changes and evolution or devolution, as
17 the case may be, of bad faith in Florida.

18 We have currently a proposal that would change the bad
19 faith law in Florida. It's kind of a two-track proposal, Mr.
20 Wester, and I know you're somewhat familiar with it.

21 The first track would say that you have 90 days, which
22 is called pre-suit, and a time period after that -- and I think
23 our number right now is 210 days, although I admit that's a
24 floating number that changes regularly, but some number
25 from 180 to 350 is going to be in play there.

1 Are those time frames sufficient to allow the
2 insurance companies to properly evaluate claims?

3 A I'll try my best to answer that question, Senator.
4 And I will go from the time frame being from the date the
5 insurance company receives the complaint. At that point --

6 Q Actually, I think, Mr. Wester, our language we use is
7 on service.

8 A Service, yes, sir.

9 Q I know there is a requirement. I think service has
10 been -- not for the pre-suit. The pre-suit is the, of course,
11 the initial letter. But the last time frame runs from service.
12 Now, so let's assume you have 180 days from service. You had
13 90 days pre-suit. Is that sufficient time for the insurance
14 companies to evaluate a claim to make a decision about whether
15 or not they should pay policy limits?

16 A Senator, I think -- and I am going to be evasive here.
17 I am going to try and answer your question the best I can. I
18 think, obviously, it depends on the particular case, because
19 some cases are more complex than other cases. You've got
20 multiple defendants, or you've got multiple claimants. Every
21 case is going to be a little different.

22 Certainly, in that kind of approach, it's far superior
23 to today, where all insurance companies have to base decisions
24 on unsworn testimony or unsworn information. So anything that
25 gets us into the formal discovery process, which that would do,

1 would have the opportunity to get information under a sworn
2 situation, I think, Senators, y'all have seen -- going through
3 this process, that people react differently when they are under
4 oath.

5 Q We have a second track that's been outlined. That
6 second track is what -- and this is what, once again, unartful
7 use of the language, but we have called it information driven.

8 A Yes, sir.

9 Q The idea is if certain things are done, you don't need
10 that length of time; that for the very reasons you have just
11 stated to us, that if you have certain information, if you, if
12 you've had mediation, if you've had depositions taken of the
13 principal medical witnesses and the principals to the dispute,
14 if you've had the disclosures that I think we require, which
15 are some exchange of documents, et cetera, that 30 days after
16 you've had all those depositions and all that's taken place, we
17 also would require that that would trigger, that that could
18 trigger, whichever of those two events is earlier, meaning if
19 you have all the information to you in the very first few
20 weeks, and if all those actions take place in, you know, 60,
21 90, 100 days, that should be ample.

22 Do you agree if you had the depositions of the
23 defendant, the plaintiff, and the medical witnesses of the
24 plaintiff, that should tell you enough about your case to make
25 a decision as to whether or not this is a valid claim?

1 A We would agree that having the information -- again,
2 the key is valid information and complete information, you
3 should be able to evaluate the claim. And we believe that the
4 proposals that we are talking about would vastly improve the
5 current system. Is it perfect? Do they tell you we need a
6 year? Yes, we'd rather have a year. Would we rather have two
7 years? That's better than one year.

8 Q Some -- there are those who say at some point you
9 might be floating money rather than getting information.

10 A Well, Senators, you know, I could sit here and talk
11 about that for about an hour, but I won't.

12 I will just -- and this is an effort to answer your
13 question. I think Neil Roth really summarized, really made our
14 case today, and I really appreciate y'all, you know, doing that
15 because I couldn't have said it better.

16 This is what we have been trying to say all along
17 about medical malpractice cases, and I' going to do my best to
18 quote him. If I misquote him, we'll read the transcript, and I
19 will certainly give him the opportunity to say he didn't say
20 it.

21 These cases are complex, and a lot of, a lot of
22 attorneys want the case to develop with time and through
23 depositions. We save the experts for last.

24 And, Senators, all we were asking is give us some time
25 period. We have access to those that information through

1 depositions. And, hopefully, we have some access to their
2 experts in order that we can make that decision of whether we
3 should settle that claim. And should -- you know, I think,
4 again, Mr. Roth pointed out that the jury instruction says
5 could have and should have.

6 The key is: Should we have? And we can't make that
7 decision without the appropriate information, because if we
8 just settle them, when we don't have that information, it finds
9 its way into your losses, which finds its way into our rates.

10 Q Is bad faith -- excuse me, if you know, from your
11 experience, either now or from your experience of having
12 reviewed the history of the operation of such companies, what
13 percentage of cases in Florida result in bad faith, in a bad
14 faith judgment?

15 A Senator, I can only tell you what I am told from my
16 clients, and they tell me very few.

17 Q Very few cases in Florida actually result in a bad
18 faith judgment against the carrier?

19 A Yes, sir. And the reason was because they settle.
20 They feel like they settle too many cases.

21 Q There is also a current debate that's been raised by a
22 recent Supreme Court decision called Villazon. I don't have
23 the cite in front of me or the whole name. You know the cases
24 probably better than most.

25 There is a proposal out there that we ought to, if we

1 are going to bring HMOs in as a potential category of
2 defendants -- I think we have decided to use that phrase rather
3 than silos, which just doesn't work for me. The category of
4 defendants, if we are going to do that, we do need to somewhat
5 outline the parameters of the liability for HMOs.

6 We have proposed some language that says that where
7 the action of the HMO has a direct and express, whether it was
8 directed -- it was expressly directed, was expressly directed
9 by or controlled by the HMO, then and only then, would the HMO
10 be a potential defendant and in an action of medical
11 malpractice. Our idea being that medical malpractice -- to
12 make sure medical decisions are made by doctors that aren't
13 effectively controlled by HMOs, which is not the direction we
14 want to see things going. First of all, do you believe we
15 should address Villazon in this legislation?

16 A Yes, sir.

17 Q And if so, is a standard of expressly direct and
18 control -- or controls an appropriate response?

19 A Senator, our view and the attorneys on our side of
20 things that looked at the case and advising us, feel like that
21 the word control would be problematic because that was somewhat
22 what Villazon was all about.

23 The court, while -- and, again, I understand it's not
24 a final decision. They sent it back to the trial court. But
25 it's 27 pages, developing a road map on how the trial courts

1 get there, or how the plaintiff's attorney can get there. And
2 how they get there, they define what control is. And I will
3 tell you, control is everything, what an HMO does, you know,
4 including having a closed network, and your members are
5 restricted to using doctors within those networks, and you
6 credential those doctors.

7 And under that decision, it was suggested that that
8 could be considered control or the lack of control, and that
9 word, we think, gets us right back into suit. And we feel like
10 if that HMO is not directly involved in that treatment
11 decision, they did everything according to the law, there was
12 no denial of payment; there was no intervention in the
13 treatment decision, one way or the other; that they shouldn't
14 be held, by virtue of the fact of that doctor being on their
15 network, vicariously responsible for that negligent act of that
16 doctor. We think that's going to cause havoc out there in your
17 health plans, and now is the time to fix it before it goes any
18 further.

19 Q Well, the Senate has obviously addressed Villazon,
20 as you know. My concern is expressly direct, that without
21 control -- and I ask you to address this. I am not trying to
22 be argumentative. I will tell you what our concern is.

23 A Okay.

24 Q We have read the language. We are not simply trying
25 to codify it. We are concerned that we don't create vicarious

1 liability too broadly. On the other hand, if we say expressly
2 direct, without at least the conjunctive of control, then we
3 are worried that the defense would be we had a protocol in
4 place, that our contractual protocol limited certain things
5 that could be done. But that's not expressly directed,
6 expressly directed meaning that we did not tell them what they
7 had to do. We simply had a protocol within which, or outside
8 of which they couldn't operate.

9 And so what I would challenge you to do, on behalf of
10 your clients to do is to -- you know Villazon is really just
11 about summary judgment, anyway.

12 We haven't had a lot of advice, and Senator Lee,
13 particularly, had questions of whether we ought to go there.
14 We have pretty much decided we want to address Villazon, but
15 expressly direct is probably more narrow than we want to go.
16 And I don't want to broaden Villazon in any way, but I would
17 like you to work with us on that. The last thing is you want
18 to be within 766; is that correct?

19 A Yes, sir.

20 Q HMOs now do want to be included, so if we throw you in
21 here as one of these silos, and we put you under silo 766 with
22 all the procedural protections, you understand we are not
23 trying to create a cause of action; we are not trying to do
24 away with a created cause of action. You agree to that?

25 A Yes, sir, I agree with that.

1 Q And our including you in 766 is actually for your
2 protection.

3 A Yes, sir, and there's a lot of ambiguity in today's
4 laws. And the HMOs are asking for clarification again while
5 you're addressing this whole issue.

6 SENATOR VILLALOBOS: Senator Peaden.

7 SENATOR PEADEN: Thank you, sir.

8 EXAMINATION

9 BY SENATOR PEADEN:

10 Q Mr. Wester, I have got some questions about business
11 procedures. Yesterday, we heard from one of the carriers
12 saying that they happened to own stock in three other carriers
13 in the state. Is that the usual and customary action for a
14 insurance company in the State of Florida, especially a
15 malpractice insurance company?

16 A Well, my guess would be they owned that stock so they
17 could get all the reports, financial reports as a stockholder.
18 And, again, I am just guessing why they do that. To my
19 knowledge, that's not uncommon.

20 Q It is just not the customary practice of insurance
21 companies therefore to --

22 A No, maybe to, again, for that purpose, to get
23 information from your competitors. That's the only reason I
24 can think of, unless you happen to think the stock is a good
25 investment.

1 Q Another question, and we are not trying to regulate
2 business and all, but is it unfair competition, or do you think
3 it hurts competition of bringing insurance companies into
4 Florida to have the overwhelming endorsement that one of the
5 companies has by the Florida Medical Association?

6 A What firm? I better not say. Respective of my
7 clients, you know, they haven't had any problems with that.
8 They can still be competitive in the marketplace.

9 I don't think it's unusual, by the way, that you see
10 endorsements. You know, ADRP, for instance, endorsed certain
11 insurance programs, and they get a fee. So that's not unusual
12 to see that kind of arrangement.

13 Q What about the arrangements of officers that are
14 elected by associations or placed on boards, have options for
15 stock purchases or preferred stock?

16 A I just really don't have an opinion on that, Senator.
17 I don't have knowledge. That's the first I've ever heard of it
18 yesterday.

19 Q The companies that you represent who are malpractice
20 carriers, is that the atmosphere that prevails there? You
21 choose local individuals to be on your board or someone with
22 certain professional credentials or certain professionals and
23 political histories? Is that the prerequisite? Or do you have
24 a local board for the malpractice companies you represent?

25 A Senator, I really can't answer that question. I don't

1 know.

2 BY SENATOR VILLALOBOS:

3 Q You don't have what? You don't know? You don't have
4 what? You don't know?

5 A I don't know. I can give you my opinion, what I
6 think.

7 Q All right. I didn't hear the last part.

8 BY SENATOR PEADEN:

9 Q You do not have a local board for -- I think you
10 represent GE.

11 A Yes, sir, they are an Indiana company owned by GE, so
12 I suspect they don't have a local board, but I don't know that
13 for certain.

14 Q In the Villazon case Senator Smith mentioned, are you
15 more concerned about the definition of control? And control, I
16 think what you meant or what you were -- what I understood you
17 said is control is primarily what you refer to as the
18 development of a network quality and network and things like
19 that, but you weren't as concerned about the directions?

20 A We were not concerned about directions.

21 Q That might come from your protocol?

22 A Right. If I may, sir, what we feel like the Villazon
23 case did, it defined what's meant by control, and said either
24 you control it, or you have the right to control. And then the
25 case, if you read the case, they outline certain features of

1 the HMO model.

2 The fact he has got a network, even though they are
3 independent contractors, notwithstanding the fact they are
4 independent contractors, the fact you have got a network, you
5 decide which doctors go on that network, and I understand under
6 the law we have to follow very strict guidelines on
7 credentialing. That constitutes -- or could constitute, let me
8 clarify that -- the right to control, i.e., that could be
9 sufficient reason to find an HMO vicariously responsible for
10 the acts of a negligent doctor.

11 I was saying in that case, I think, you know, the
12 court is very careful to point out there was no evidence that
13 the HMO did anything wrong. They did everything perfectly like
14 y'all would expect them to, like you have been asking them to
15 do for years. You have got a whole body of law directing them
16 to do that. But they went -- they took it a step further.
17 That is why Villazon is different than what we have seen
18 before.

19 SENATOR PEADEN: Mr. Chair, I have got one more.

20 BY SENATOR PEADEN:

21 Q So you're saying basically that whatever prevailing
22 protocol for, say backaches, or kidney infections, that should
23 be the standard of care -- and that's the community and state
24 standard of care that we should observe in Florida, and
25 physician practices within those parameters, that should she

1 the standard of care?

2 A Are you saying should the HMO set that standard of
3 care or --

4 Q I'm saying if you have protocols, and I understand
5 some have protocols, say, for treatment of kidney infections or
6 back pain or things like that in general, lumbosacral strain,
7 that protocol should be the standard of care?

8 A Senator, I really don't know how to answer that. I
9 mean, because I am not sure what the question is.

10 Q Thank you.

11 EXAMINATION

12 BY SENATOR VILLALOBOS:

13 Q Mr. Wester, you were your working with the Department
14 of Insurance, did I get that right, up until when?

15 A From -- let's see. I left in '87. From about '76
16 to --

17 Q To '87?

18 A Yes, sir.

19 Q Okay. Thank you, sir.

20 SENATOR VILLALOBOS: Any other questions for Mr.
21 Wester?

22 MR. WESTER: That's 11 years. Thank you, sir.

23 SENATOR VILLALOBOS: William Large.

24 MR. LARGE: How are you doing, Mr. Chairman?

25 SENATOR VILLALOBOS: Good. Welcome. Please raise

1 your right hand. Do you swear or affirm that the evidence
2 you're about to give will be the truth, the whole truth,
3 and nothing but the truth?

4 MR. LARGE: Yes.

5 EXAMINATION

6 BY SENATOR VILLALOBOS:

7 Q Please state your name and your occupation.

8 A My name is William Wells Large, and I am General
9 Counsel for the Florida Department of Health. And I also
10 served as Executive Director for the Governor's Task Force on
11 Healthcare Professional Liability Insurance.

12 Q And I certainly thank you for coming to our
13 invocation.

14 A Thank you for inviting me.

15 Q I also thank you for your patience. This has been
16 very long. Were you here yesterday?

17 A Yes, I was.

18 Q So you have seen everything we have done?

19 A Yes, I have.

20 Q Now, you also convened, I guess, a committee and took
21 testimony also; did you not?

22 A Correct.

23 Q Did you hear similar testimony to what you all heard
24 in general?

25 A Yes.

1 Q Okay. Do you take any offense that the Senate would
2 do the same thing and wish to do this on our own?

3 A No. We invited to our Task Force a member of the
4 House of Representatives from the State of Mississippi. He
5 indicated that the State of Mississippi put certain
6 stakeholders under oath in hearings in Mississippi, and thought
7 it was a good idea and recommended it be done. So that was an
8 option we actually heard about. And Mr. Neil Roth, it also was
9 an option he advocated for when he testified before the
10 Committee.

11 Q Do you think it was a good idea the Senate did this
12 also and placed people under oath yesterday and today and took
13 sworn testimony to help us reach a conclusion?

14 A I think it's a good idea to get to the facts, all the
15 facts involved in the, in this issue.

16 Q And you take no offense at the Senate, even though you
17 did a study and held committee hearings on the same thing?

18 A No.

19 Q Good. Thank you.

20 SENATOR VILLALOBOS: Do you have any other questions?

21 I think we do.

22 MR. LARGE: Okay.

23 SENATOR VILLALOBOS: Senator Smith.

24 EXAMINATION

25 BY SENATOR SMITH:

1 Q At the time that the -- at the time that you convened
2 the meeting of the Task Force, had the Governor, to your
3 knowledge, already -- at the time and selection of the Task
4 Force members, had he advocated for a \$250,000 cap on
5 non-economic damages?

6 A I don't believe so. In fact, when I was first
7 contacted potentially to work on this issue, it was in August
8 of 2002. And, initially, the Task Force was going to be a
9 stakeholder type model. In other words, where maybe perhaps an
10 FMA member, and FHA member, Academy of Trial Lawyer members,
11 and we were working under the impression through August that it
12 might be a stakeholder model.

13 At the end of August, it turned out to be an academic
14 university leader model. But in terms of the Governor taking
15 the position on that, I am not aware of that.

16 Q Did the Governor advocate for \$250,000 caps during the
17 time period that the -- openly during the time period that
18 decisions were being made by the Task Force?

19 A I do recall the Governor coming to a Task Force
20 meeting here in Tallahassee where he, in front of the Task
21 Force, did make that statement.

22 Q Prior to the Governor's having recommended the
23 \$250,000 number for non-economic damages to the Task Force, is
24 it true, isn't it, the Chairman, Mr. Hitt, H-i-t-t, that
25 Chairman Hitt had expressed some concerns as to whether or

1 not -- he and others had expressed concern as to whether or not
2 a \$250,000 cap was an adequate number?

3 A I think if you review the record, you will see all of
4 the Task Force members, to some extent, comment upon the
5 efficacy of a cap on non-economic damages.

6 What I believe was the most determinative factor for
7 the Task Force determination was the presentation we did on the
8 constitutionality of the cap on non-economic damages.

9 At that time, I invited former First District Court of
10 Appeals Judge Robert Smith. He is the Smith in Smith versus
11 the Department of Insurance, the 1987 case. I invited Justice
12 Grimes to appear, and I also invited Barry Richard to appear.

13 And, likewise, there were other attorneys who made
14 comments regarding the cap on non-economic damages. When we
15 looked at the cases that outlined the constitutionality of the
16 cap, that's the Kluger case, the Smith case, the Echarte case
17 and looked at the test that was established in those three
18 cases, which is two prongs, the first prong being: Is there a
19 commensurate benefit? The second prong being: Is there an
20 overwhelming public necessity? Or is there not an alternative
21 remedy?

22 The Task Force, upon hearing that legal advice from
23 Justice Grimes, from Barry Richard, hearing that test, they
24 wanted to make sure that there was something that could satisfy
25 both prongs in all three elements of that test.

1 And they were very concerned about the second prong
2 and the second factor in that second prong, no alternative
3 remedy.

4 The Task Force wanted to make sure that their
5 recommendation would stay, or their recommendation would be
6 upheld by the Florida Supreme Court. So they wanted to look at
7 a laboratory, so to speak, to prove that a number would indeed
8 work. We did have other numbers to look at.

9 Q What other numbers were suggested?

10 A Well, we received data from all states. For example,
11 yesterday, Senator Villalobos mentioned the states that also
12 have a cap.

13 Q Did you review all of those?

14 A Yes, we did. Here is the problem. All those states
15 don't have the, basically the time frame that the California
16 model does. There is basically --

17 Q Time frame, meaning what?

18 A They haven't been in existence as long as California
19 was.

20 Q Which is 27 years?

21 A Well, the cap was passed in 1975 and declared
22 constitutional in 1986, so in terms of a laboratory to prove
23 that a cap on non-economic damages would work, the Task Force
24 looked at the California model as a model that would satisfy
25 the second prong and the second factor in the Kluger, Smith,

1 and Echarte case. Although there were other states --

2 EXAMINATION

3 BY SENATOR VILLALOBOS:

4 Q Excuse me, if you are using that California model,
5 which now I understand -- you're actually the first person that
6 has told me why that is the case. But if you're doing that,
7 and you want to mimic California, why didn't you adjust the 250
8 number in today's dollars and have an actual number just like
9 California, or did you consider that?

10 A We did. I believe the CPI index for that number would
11 be approximately \$724,000, so that was a consideration. But we
12 know that California is still using that number. So in terms
13 of the efficacy of the cap and the experiment working in the
14 second prong of -- and that second factor in that second prong,
15 the Task Force felt that they needed to prove that 250 would
16 work.

17 And in terms of evidence, there was only one
18 laboratory experiment out there that proved that indeed
19 \$250,000 would work, and that was the California model.

20 Several of the others states that you mentioned, for
21 example, Senator Villalobos, are under litigation today about
22 their cap. So that is not a viable model to base our decision
23 making on.

24 And, likewise, some of the states that had a cap
25 declared constitutional, they don't have the same amount of

1 time span as the California model.

2 For example, some states had their cap declared
3 constitutional in the mid to late 1990s, and there isn't that
4 much data like there is in California.

5 EXAMINATION

6 BY MR. SMITH:

7 Q If the goal of your decision, if what drove your
8 decision to adopt the \$250,000 California model was the fact it
9 had been upheld by the courts; and if you were driven by a
10 concern to make sure that whatever you did was upheld by the
11 courts, why did you so apparently disregard the dicta in St.
12 Mary's that talked about per claimant in the context of
13 Florida's own history of litigation on the equal protection
14 issue as it applied to arbitration?

15 I mean, if what was driving this set of lawyers and
16 this Task Force was a concern for its being upheld, why did you
17 so apparently ignore the dicta in St. Mary's in reaching your
18 decision which was not per-claimant driven?

19 A Because the St. Mary's case, the starting point in the
20 St. Mary's case, that that court found the voluntary, binding
21 arbitration statute, Florida Statute 766.207 through 212, was
22 vague and ambiguous. That was their starting point.

23 We believe that this Legislature could craft
24 legislation finding that a \$250,000 cap per incident was not
25 vague and ambiguous. And, therefore, the analysis the Florida

1 Supreme Court made in St. Mary's would not be necessary.

2 Q Mr. Large, let me say this. I don't think I addressed
3 the whole thing. I was addressing the dicta. There's very
4 plain dicta in which the court talked about the equal
5 protection concerns.

6 They, they didn't only talk about it, they actually
7 said that equal protection concern, making it per claimant,
8 because to do otherwise would suggest that people -- that a
9 wife and two children as opposed to a surviving spouse alone
10 would not be entitled to the same kind of relief for the same
11 or similar injury.

12 Now, what I am saying to you, I recognize that you
13 have anticipated the holding, but the dicta couldn't have been
14 more clear in telling this Legislature that it had to address
15 per claimant.

16 If what was driving the \$250,000 was your concern that
17 it was upheld in California, why were you so willing to expose
18 yourself against a year 2000 Florida Supreme Court case, the
19 dicta which couldn't have been clearer?

20 A The dicta could have been clearer. In that case, it
21 would have been a holding. They never reached a holding in
22 that case.

23 Q The reason you don't reach -- the Supreme Court's
24 rules -- and I don't want to debate this, but you would concede
25 to me the holding is supposed to be narrow, that that is what

1 the decision is based on.

2 If the court goes beyond it do give dicta, that's
3 because the court chooses to tell the Legislature or someone,
4 sometimes practitioners, if you happen to be so unfortunate,
5 something they want you to know.

6 They have raised the equal protection in year 2000 and
7 said per claimant. Are you willing to tell this Committee now
8 that you believe a \$250,000 cap that is not per claimant would
9 be upheld by the Florida Supreme Court?

10 A I believe it would be, yes.

11 Q Do you have a case since the year 2000 to suggest
12 that?

13 A The basis for that answer would be dependent upon the
14 Legislature writing a cap in non-vague and non-ambiguous terms.

15 SENATOR VILLALOBOS: You sure assume a lot.

16 BY SENATOR SMITH:

17 Q At the time -- just another area for just a moment.

18 SENATOR VILLALOBOS: Senator Aronberg has some
19 questions. Senator Webster.

20 SENATOR WEBSTER: Thank you.

21 EXAMINATION

22 BY SENATOR WEBSTER:

23 Q The area we were on, what other remedies other than
24 the 250 cap were explored, and why were they deficient?

25 A We had actually 59 other recommendations.

1 Q Okay. Answer this question, then. How can you say
2 that a cap is the only -- well, not the only, but would be the
3 driving solution when you did have about 60 total
4 recommendations?

5 A We felt that a cap was certainly the most important
6 solution. We had 59 other recommendations which broke down
7 into five separate categories: Quality of healthcare,
8 physician discipline, tort reform, alternative dispute
9 resolution matters, and insurance reform.

10 So a cap certainly has gotten all the attention and is
11 certainly an important factor, but there were other factors in
12 our decision-making process.

13 And part of our decision-making process was looking at
14 the test in Kluger, Smith, and Echarte, trying to develop a
15 commensurate benefit, trying to prove that there was an
16 overwhelming public necessity, and trying to prove that there
17 was no alternative remedy.

18 In terms of no alternative remedy in a cap, the Task
19 Force basically looked at the legislative history in Florida,
20 and found that Florida's legislative history is a 28-year
21 history of failure to address the medical malpractice problem
22 in Florida.

23 We tried to address it in the mid-1970s and failed.
24 We tried to address it in the mid-1980s and failed. We have to
25 a certainly tried to address it in 1999 and were not

1 successful.

2 The only solution out there in terms of no alternative
3 remedy that has not been tried in our 28-year failure is a cap
4 on non-economic damages. That's why it is the most important
5 solution, because every other solution in the first-generation
6 and second-generation reforms have been tried in this state and
7 they have failed in this state.

8 SENATOR VILLALOBOS: Senator Webster.

9 BY SENATOR WEBSTER:

10 Q Just one more. It is Kluger that established the two
11 prongs; is that correct?

12 A (Nods affirmatively).

13 Q I feel that the cap or whatever remedy there is would
14 have to be the solution. Is that not true, or is it?

15 A In the second prong, in that second prong, is there's
16 an overwhelming public necessity, and number two, is there's no
17 alternative remedy.

18 If we were to come up -- if the Task Force had come up
19 with a number and had picked it up out of a hat without a basis
20 for its decision making, I would fear that the Florida Supreme
21 Court might declare it unconstitutional if there was not
22 evidence in the Task Force record, which there is now, that the
23 cap would work.

24 The only laboratory experiment for a long period of
25 time that proves caps work is the Florida -- is the California

1 model.

2 So in terms of that second prong, the second factor,
3 no alternative remedy, it is the \$250,000 cap that works
4 because everything else that has been tried in Florida has
5 failed.

6 SENATOR VILLALOBOS: Senator Webster, anything else?
7 Senator Aronberg.

8 SENATOR ARONBERG: Thank you, Mr. Chairman. I defer
9 to Senator Smith, and come back to me.

10 SENATOR VILLALOBOS: Well, Senator Smith, you have
11 asked so many, let me ask Senator Clary, and we'll come
12 right back to you.

13 SENATOR CLARY: Thank you, Mr. Chairman.

14 EXAMINATION

15 BY SENATORY CLARY:

16 Q And thank you, Mr. Large, for being here. In the
17 two-prong, I guess rationale for upholding constitutionality,
18 you have to pass both of those to be upheld? Or do you just
19 have to pass one?

20 A We wanted to make sure both prongs were met. As I
21 read the case, though, one prong could be met, the latter prong
22 being an overwhelming public necessity or no alternative
23 remedy. And I believe we have met that. One issue that I have
24 just commented on is no alternative remedy, why we felt that
25 the evidence had to be there.

1 But we also believe that we met the first prong -- the
2 first factor in that second prong, that there is an
3 overwhelming public necessity.

4 We found that there was increase in the frequency of
5 claims. We found that there was an increase in the severity of
6 claims. We found that there was a crisis in the affordability
7 and availability of insurance.

8 We found that there was a crisis in the affordability
9 and availability of healthcare. And we found that the medical
10 malpractice insurance business is not viable because we found
11 that they had a loss ratio of 184 percent.

12 Q We yesterday had some interesting testimony that
13 talked about the actual increase of the number of doctors
14 coming into the state and making application to come into the
15 state, and that there was no real evidence that could be shown
16 that doctors were leaving the state; that FPIC maybe testified,
17 actually showed Florida the most profitable state that they
18 sold insurance in, and it just went on from there.

19 A Yes, sir.

20 Q And then the one question that I asked was: What was
21 the difference between the crisis that we are experiencing now
22 and what it was back in '86 and '87 when the court ruled that a
23 the \$450,000 cap was unconstitutional. And it was testified
24 that the crisis back then as was actually much more severe than
25 what we are experiencing now, due to the fact that there were

1 actual closings of trauma centers, emergency rooms, and
2 evidently more evidence of doctors actually leaving the state;
3 and that we might be hard pressed to show or prove a better
4 case now than what was ruled unconstitutional back in '87. Do
5 you have any thoughts on that?

6 A Yes, sir. Let me try and answer your points, because
7 I believe in total you raised approximately seven points in
8 your question.

9 The first point you raised was: Isn't it true that
10 more physicians are applying to Florida? Diane Orcutt
11 yesterday testified that the number had actually increased.

12 But the conclusions that have been drawn from that
13 statement are wrong. What currently happens is a resident or a
14 physician, upon passing the United States Medical Licensure
15 Exam, can choose to practice in any state.

16 So what they typically do is they send out
17 applications to various states. They can send it out to Texas,
18 Louisiana, Indiana, Georgia, and Florida. So the fact that we
19 are getting applications, the number may be going up, but the
20 conclusion that more physicians will come to Florida is
21 incorrect.

22 Unlike, for example, the Bar exam -- if an attorney
23 takes the Florida Bar exam, it's probably with a very high
24 likelihood they are coming to Florida.

25 If a physician who has just passed the USMLE, sends

1 out an application to Florida, among other states, there is a
2 percentage of likelihood that they are going to come to
3 Florida. But in and of itself, you can't say that more doctors
4 are coming to Florida. So that -- the conclusion to be -- that
5 was drawn yesterday that more physicians are coming to the
6 state is an incorrect conclusion.

7 The next statement that you raised was: What about
8 the number of physicians in the state? There was -- Ms. Orcutt
9 yesterday testified there was some 38,100 physicians in the
10 state with a Florida address. We have 46,000 physicians in the
11 state, licensed.

12 So the difference means those other physicians don't
13 have a Florida address. What we know is that there is 38,100
14 physicians. What it doesn't tell us is: Are those physicians
15 still admitting patients to hospitals?

16 It doesn't tell us that those physicians may be
17 cutting back on certain procedures. It doesn't tell us that
18 some physicians may not be seeing high-risk patients. That's
19 probably what is indeed happening.

20 But the raw number, 38,100 licensees doesn't tell you
21 anything. So the conclusion that the number of actual
22 licensees in Florida has increased doesn't tell you what the
23 physicians with a Florida license are actually doing.

24 Q Let me stop --

25 SENATOR VILLALOBOS: One second, Senator Clary, one

1 second.

2 EXAMINATION

3 BY SENATOR VILLALOBOS:

4 Q But what it does tell you, though, is that it is false
5 to say that there are less. That is definitely false. And the
6 other thing that you said, if they could be doing this or they
7 could be doing that, that is speculation on your part, because
8 you have no evidence of that; isn't that correct?

9 A No, sir, I have evidence from the Task Force report
10 that a lot of physicians are not seeing high-risk patients.

11 Q I don't doubt that. But see, you know, the rhetoric
12 that has been driving this train, because it had been rhetoric
13 up to now, in my opinion, okay, has not been, you know, as
14 specific as some of the testimony that you have. Because we've
15 not had the benefit of having some more testimony until
16 yesterday.

17 Okay. Yesterday, on TV in Miami, you know, people
18 were saying that frivolous lawsuits, uncontrolled frivolous
19 lawsuits, increasing frivolous lawsuits and large numbers of
20 doctors leaving the state are the problem. Yet, you know, our
21 own Department of Health testified that that's not the case.
22 And if, if -- you know, when you file a lawsuit, you get a case
23 number.

24 A They talked about frivolous lawsuits yesterday?

25 Q No, sir. They talked about the number of physicians

1 and whether or not there has been an increase or decrease.

2 And then when you talk about frivolous lawsuits,
3 that's done with a case number in court, 93 -- whatever,
4 whatever that case number is. And if someone were to come here
5 and show me that there are more of those numbers now than there
6 were five years ago, then I would agree with them that there is
7 an increase in lawsuits on medical malpractice.

8 However, since no one has done that, that is why I
9 can't reach that conclusion. That's all I am saying. You
10 know, I am not picking and choosing the information. But, you
11 know, what people testified to yesterday is, you know, those
12 are the numbers.

13 A Well, let me, Senator Clary, let me try and answer
14 your four remaining points as soon as I address the remarks
15 that Senator Villalobos made.

16 Senator Villalobos, what the Task Force found is that
17 upon an independent review of a body of medical malpractice
18 cases, that 80 percent, 80 percent of the medical malpractice
19 cases that are filed are, in fact, maloccurrences in the
20 absence of a deviation from the appropriate standard of care.

21 That study was done and published in June 2002, by Dr.
22 Brennan from Harvard and Dr. Mello from Harvard. Their study
23 appears in The Deterrence of Medical Errors: Theory and
24 Evidence for Malpractice Reform.

25 Based upon that particular study, I invited Dr.

1 Brennan and Dr. Mello to address the Task Force.

2 Dr. Brennan was not able to attend, but Dr. Mello
3 attended. Dr. Mello believes that, indeed, the majority of the
4 cases that are actually filed, upon an independent review, when
5 you are looking at the elements of a tort, duty, a breach of
6 duty, causation, and damages, when you have independent
7 individuals who are not advocates for either side look at that
8 second prong, the breach of duty, 80 percent of the time, those
9 are not -- those are maloccurrences in the absence of a
10 deviation from the appropriate standard of care.

11 Now, Dr. Mello and Dr. Brennan did opine that there
12 are a universe of cases where there is negligence that are not
13 brought. She did make that statement, and that's part of her
14 findings.

15 Drs. Brennan and Mello believe the system is so broken
16 that a no-fault model is perhaps what's needed. But that's
17 probably the best study out there. And it appeared in June of
18 2002.

19 So I know a lot of people have used the term
20 frivolous. The Task Force did not like that term. The proper
21 term should be maloccurrences in the absence of a deviation
22 from the appropriate standard of care.

23 Q So did you find there is an increase in maloccurrences
24 from the deviation of the standard of care?

25 A Well, if we know that 80 percent of the cases are

1 indeed maloccurrences in the absence of a deviation from the
2 standard of care -- and we also found that there is an increase
3 in frequency and severity of cases in Florida, then we believe
4 that there is indeed an increase in the frequency and severity
5 of those cases.

6 Q Those are all numbers. I am not concerned about the
7 percentage of the overall numbers. My question to you is: Did
8 you find that there is an increase in those numbers? Not the
9 percentage-wise.

10 A That study that was done by Drs. Brennan and Mello
11 involves patients in New York, so it's --

12 Q Well, is there anyone with patients in Florida? I
13 mean, what I am trying get at --

14 A There has been never been a study this comprehensive
15 like this before.

16 Q Mr. Large, you know, I don't live in New York. What I
17 am trying to get at -- and, you know, testimony that has been
18 presented before the Committee yesterday was that there are no
19 more lawsuits now than there were before on medical
20 malpractice. If you call them maloccurrences, fine. Let's use
21 that term.

22 Is there an increase in those cases of maloccurrences
23 now versus five years ago in Florida? Not New York. If you
24 have that information -- if you don't, I appreciate that, too.

25 A You would have to draw a logical nexus, that this

1 particular study --

2 Q The answer is you do not. Do you have one in Florida
3 without a nexus anywhere else? Yes or no?

4 A I have an opinion.

5 Q Then the answer is no, you have no evidence other than
6 your opinion; is that correct?

7 A I'd have to say that's correct.

8 Q Okay. Thank you.

9 A May I -- Senator Clary, may I continue to answer some
10 of the points that you raised?

11 EXAMINATION

12 BY SENATOR CLARY:

13 Q I was just going to comment that when I shared the
14 comment about the increase in applications over the last few
15 years, each year progressively increasing above the other, I
16 think what it goes to show is that there is not any reason to
17 believe that doctors are not interested in staying in the state
18 or coming into the state, because we are continuing to see an
19 increase in the applications, even though Florida may be one of
20 a certain number of states that are viewed as in crisis by
21 various groups, the AMA. And so it just kind of, to me, it
22 leads to the maybe the opinion that it may not be as critical a
23 problem as being projected from what we have heard over the
24 last year. But please continue.

25 A Okay. You indicated what about FPIC? I was here

1 yesterday. Apparently, FPIC is a profitable, viable insurance
2 company. We did our research, though, on all the insurers in
3 Florida, including FPIC. And that's where we got our data
4 from.

5 You asked about trauma center closings. Liz Dudek was
6 up here earlier. Her agency, the Agency for Health Care
7 Administration, does not regulate trauma centers. We do.

8 I know that my office, the General Counsel's office,
9 has been working on this issue with two trauma centers that
10 were on the verge of closing, Orlando Regional Medical Center
11 and Halifax Medical Center.

12 We did everything possible legally to keep them open.
13 Neither of them have closed, but that certainly was a fear at
14 some time. We certainly were working with them to keep their
15 doors open.

16 Q Where I was going with the overall comment was in
17 trying to compare the crisis that we're experiencing now with
18 what we saw back then is that I haven't seen -- I was trying to
19 imagine what the Supreme Court might look at when you say we
20 passed a law, 250 caps, or whatever the number is. What would
21 be compelling for them to look at of the crisis that we may be
22 experiencing today as being the --

23 A I think the answer to that question is this crisis is
24 different. We had Dr. Bill Sage from Columbia address the Task
25 Force, and he talked about the crisis being different this time

1 around.

2 And the crisis is different because it's crisis in
3 affordability and availability of not just insurance, but
4 healthcare as well. And the important difference is: What was
5 done in the mid-eighties? What have we -- what did we try in
6 the mid-eighties that failed?

7 We tried pre-suit screening and investigation. We
8 tried voluntarily binding arbitration. We did changes to the
9 offer of judgment statute, changes to periodic payments, other
10 changes. So those issues were addressed in the mid-eighties.

11 They apparently didn't work, because we are back
12 again. So the difference is in the mid-eighties, the idea of a
13 cap for non-economic damages in medical malpractice cases was
14 not passed as a result of the special session regarding medical
15 malpractice and wasn't a recommendation of the Governor's Task
16 Force in the mid-1980s on capping non-economic damages. So
17 we've learned our lesson. That's why it's different.

18 Q Thank you.

19 SENATOR VILLALOBOS: Senator Peaden.

20 SENATOR PEADEN: Thank you, Mr. Chairman.

21 EXAMINATION

22 BY SENATOR PEADEN:

23 Q You were talking about trauma centers and closing
24 trauma centers. Isn't it true we have trauma centers in the
25 state that function as trauma centers, may not have the

1 classification, but that offer that quality of care, and they
2 might have chosen, because of a business decision or because of
3 the lack of in-house service to be declassified as a top-level
4 trauma center?

5 A Not quite correct, because, for example, every trauma
6 center deals with specialized trauma surgeons. There is a
7 severity of scoring index, for example, they use for trauma
8 admissions.

9 Q I'm very aware of the scoring index on all those. Do
10 we have a trauma center in Gainesville at the University of
11 Florida?

12 A Okay.

13 Q Don't they have back-up call 24 hours a day in place?

14 A They do, but there's policy and procedures that they
15 might have in place that the other trauma centers do.

16 Q I'm not asking you that. Is it a business decision,
17 when you say closing trauma centers, we just down-stage it?
18 Maybe the guy at beach is 30 miles away instead of 5 minutes
19 away in that upstairs apartment, and that's what you're talking
20 about in changing the status because of a business decision in
21 trauma centers. Not closing the door.

22 A I don't know why the trauma center would go -- I mean,
23 I don't know their decision making in terms of why they went
24 into business in the first place.

25 Q Thank you.

1 SENATOR VILLALOBOS: Senator Webster.

2 SENATOR WEBSTER: Thank you, Mr. Chairman.

3 EXAMINATION

4 BY SENATOR WEBSTER:

5 Q I had a question on something we were talking about a
6 minute ago, but I don't remember when --

7 SENATOR VILLALOBOS: It doesn't matter when, as long
8 as you remember what it was.

9 BY SENATOR WEBSTER:

10 Q It may not mean anything now. I wanted to ask, does
11 an increase in the number of licensed physicians mean an
12 increase in the number of practicing physicians?

13 A No. Does an increase in the number of licensed
14 physicians mean -- no. You can become -- the number in Florida
15 is 46,000 licensed physicians.

16 If they become licensed, I don't know what they're
17 doing. They may have active privileges, but they may not be
18 practicing for whatever reason.

19 For example, we know that in Florida, that 25 percent
20 of the physicians are 65 or older, according to the American
21 Medical Association study. I don't know what all the
22 licensees, of that 45,000 licensee universe, I don't know what
23 they are all doing. I don't --

24 Q Okay. I don't, I don't know my next question. I
25 probably had one, I just can't express what it ought to be. I

1 guess -- so maybe one more. The number of incidents of
2 malpractice would not necessarily be related to the number of
3 licensed physicians? It maybe would be more related to the
4 number of practicing physicians?

5 A That's a hypothesis. I don't know the answer to that.

6 SENATOR VILLALOBOS: Anything further? Senator
7 Aronberg.

8 SENATOR ARONBERG: Thank you, Mr. Chair.

9 EXAMINATION

10 BY SENATOR ARONBERG:

11 Q Thank you, Mr. Large. Who drafted the language in
12 this report?

13 A This was drafted by primarily the following
14 individuals: Myself, Dorothy Johnson, Jennifer Gergan, to a
15 limited extent, Richard Longan, and Nancy Zircowski, and Amy
16 Jones. Those are individuals in my office. Yesterday, Senator
17 Campbell made the insinuation that perhaps some of the
18 information had been given to the Task Force.

19 In listening to his question, I believe he was
20 referring to the Governor's bill that was -- that I also
21 drafted, and I did get language for specific provisions, for
22 example, periodic payments, set-offs, the Villazon language, I
23 I did get that language from stakeholders. I didn't draft it
24 myself, and I think that is where he was going with that
25 particular question.

1 Q Because you mentioned it, I want to follow up with
2 that. The periodic payment language, let's start with that.
3 Who gave you that language?

4 A The periodic payment language, as with all, every
5 stakeholder, this is how we ran the Task Force. We had two
6 days where everybody basically got a chance to say --
7 everything and every issue on the table. People wanted, for
8 example, not to have the jury process. People wanted issues --

9 EXAMINATION

10 BY SENATOR VILLALOBOS:

11 Q That is testimony, not the --

12 A That was like the general first meeting, with every
13 issue.

14 Q But was it your members or --

15 A Those were stakeholders who came up with every idea
16 under the sun. They wanted expert witness reform. They didn't
17 want you to be licensed if you were an expert witness. They
18 didn't want the jury system. They wanted caps on attorney's
19 fees. There were just all these issues. From there --

20 Q They didn't want the jury system?

21 A We heard, we heard so many different things that are
22 not included. I wish I had done a chapter in retrospect,
23 "Ideas We Heard That We Have Didn't Vote In Favor Of." Because
24 there were a lot of those ideas that we voted down, and I just
25 don't believe the format of this report has got that record.

1 A It's on pages 258 through 262. I don't recall, but I
2 do recall the stakeholder behind this as Mark Delegal. And I
3 wouldn't be surprised if I went and looked at my 13 volumes if
4 this -- if there was a memo that served as a skeleton for this
5 section and would have been a starting point.

6 Q What about the set-off language? Who was responsible
7 for that section?

8 A Let me look that up. I don't recall precisely. I do
9 remember that Bucky Hurt was an attorney that has written a
10 long, set-off type memo, and I believe that that is going to
11 also be in my 136 volumes.

12 Q How about the non-economic damages cap language?

13 A This section was perhaps the easiest issue of the Task
14 Force. Almost every stakeholder presented something in this
15 regard. I believe that we had a plethora of information on
16 this. I believe that -- as I recall, we started drafting this,
17 and sometime on January 8th, I sent out a memo to all
18 interested stakeholders on my list, if they wanted to
19 supplement information, they could.

20 I recall that people did supplement the information
21 and did provide additional information.

22 SENATOR VILLALOBOS: Senator Aronberg and Mr. Large,
23 with your indulgence, our court reporter needs to change
24 her tape and take a very quick break. So if you wouldn't
25 mind hanging around just until three o'clock, so we can

1 take a five-minute break so our court report can change the
2 tape. Those of who need to go, can go.

3 (Brief recess taken).

4 SENATOR VILLALOBOS: Members, take your seats so we
5 can continue. Mr. Large, thank you. I hope you took
6 advantage of the break as I did. Senator Aronberg --
7 ladies and gentlemen, can we please have a little bit of
8 quiet?

9 Senator Aronberg, I interrupted you in the middle of a
10 question, I apologize. You may continue.

11 SENATOR ARONBERG: Thank you, Mr. Chair.

12 EXAMINATION

13 BY MR. ARONBERG:

14 Q Thank you, Mr. Large.

15 A I thought I was in the middle of answering the
16 question.

17 Q I guess, just take a step back, and we'll go through
18 this. You have said Mark Delegal had drafted a bunch of the
19 language in the periodic payment section. Did you or your
20 staff change any of the language submitted to you by Mr.
21 Delegal before putting it in the report?

22 A Yes. And you were asking about the cap on
23 non-economic damages. When I sent that e-mail out,
24 stakeholders again provided me with language. I acted as the
25 master editor.

1 I can't recall each of the subjects that I assigned to
2 each of the attorneys. But each attorney -- and those are the
3 attorneys I mentioned -- richard is not an attorney, I believe
4 everyone else is -- worked the document up.

5 I served as the master editor. And then from there,
6 the first time the Task Force saw the language, I believe, was
7 on January 16th. And from there, the document, the language
8 was again edited extensively during the last three meetings.

9 Q Do you recall who was the primary drafter of the caps
10 language then?

11 A I would say the primary drafter of the caps language
12 would have been a combination of several stakeholders, myself,
13 Mark Delegal.

14 Q Who were the stakeholders?

15 A Stakeholders is a term that I use --

16 Q Who are they in this context?

17 A Mark Delegal, who represents an insurance interest,
18 FPIC. I believe that Florida Medical -- no, I take that back.
19 That's the -- stakeholders are a term that I use for --

20 Q Right.

21 A -- people that advocate for certain positions.

22 Q No. I was just wondering who they were. Mark Delegal
23 worked with you, and who else participated in that session?

24 A To a limited extent, I believe Bill Bell may have
25 helped me, and to a limited extent, George Meros. Because

1 during the pendency of the Task Force report, I took the
2 position that it was a public record, and several stakeholders
3 asked for my drafts. And they would they would ask to see
4 them.

5 Q Who is Bill Bell again?

6 A He is with the Florida Hospital Association.

7 Q Okay. How about the sovereign immunity for emergency
8 rooms language?

9 A As I recall that, that was drafted by a former staffer
10 from this Committee, Dorothy Johnson. I assigned her that
11 topic. I believe Dorothy's starting point was George Meros's
12 memo.

13 Dorothy worked that issue up from his memo, using his
14 memo as the skeleton. And then from there, I would have edited
15 the final product. And then from there, the Task Force would
16 have continued to re-edit the final product.

17 Q How about the Villazon language?

18 A Well, the Villazon language is not in the Task Force
19 report. That's what I think Senator Campbell was insinuating,
20 who wrote that language that appeared in the bill. The
21 Villazon case is nowhere in this Task Force report. The
22 Villazon language that I got, I got that from several different
23 stakeholders. I believe that Jason Unger sent me a draft. I
24 recall that Gerald Wester sent me a draft.

25 I believe that Scott Keller sent me a draft, and that

1 draft was put in the bill.

2 Q And what about the bad faith section, who was the
3 primary drafter of that section?

4 A As I recall, the Genesis of that would have been Vince
5 Rio. Vince Rio was an attorney that appeared before the Task
6 Force. He had a memo. I believe it was about a three-page
7 memo outlining bad faith. That was the starting point.

8 Mark Delegal also supplied additional information that
9 would have been used as the skeleton for the document. And it
10 would have been from there edited by me, and then given to the
11 Task Force for editing.

12 Q The only name I don't recognize is Bucky Hurt. I know
13 Vince Rio represents an insurance company. But who is Bucky
14 Hurt? Who does he represent?

15 A Bucky Hurt is a defense attorney in Orlando, Florida.
16 Bucky Hurt, I invited to speak on the issue that we combined at
17 one time, and because it is so complicated, joint and several,
18 set-off, Fabre became one master subject. And Bucky Hurt, as I
19 recall, did have a paper that he presented that I thought was
20 very helpful, and that was the first skeleton in developing
21 those sections.

22 Q Did it trouble you or any members of the Task Force
23 that a lot of this material in here was drafted by people with
24 interest in this one side? It sounds like the people who
25 drafted this were mainly advocates for the insurance companies.

1 A No. Every issue that came up was stakeholder driven.
2 In other words, we're here today because stakeholders are
3 concerned about this issue, and they've raised that issue. So
4 the Task Force to some extent acts like a judge. Income to
5 stakeholders, income to stakeholder with a written suggestion.
6 And the Task Force voted yes or no in terms of that. That
7 written submission became the skeleton for eventually drafting
8 the chapters which were then eventually edited.

9 Q And my final area of inquiry is about you had -- in
10 this, you base a lot on the California model, the 250 cap and
11 the effects. But there was nothing here about the California
12 rate rollback. Did that not play into your analysis or -- and
13 why did you include that in your recommendation?

14 A In retrospect, as I recall that, the only -- there was
15 one person that really kind of honed on the proposition here.
16 He was the insurance -- the former insurance commissioner from
17 Missouri.

18 I remember he had approximately 15 minutes of time.
19 And right at the end, he kind of brought up this proposition.
20 I heard more about Proposition 103 in the regular session than
21 I did during the pendency of the Task Force.

22 In retrospect, because so much was brought up about
23 Proposition 103, I wish we had addressed it more. But the
24 stakeholders that we did bring in from California, Charles
25 Biondi, Dr. Anderson, believed that 103 was not the reason for

1 the decrease in premiums; rather, they believed it was the cap
2 on non-economic damages.

3 Since this Task Force report was written, and since so
4 much time was spent on talking, debating about Proposition 103
5 and the rate rollback, I, you know, have looked at this issue.
6 I even called the general counsel for Norcount, which is one of
7 the insurers in California. And I am convinced that
8 Proposition 103 had nothing to do with the rate rollback --
9 excuse me, with the decrease in premiums. The decrease in
10 premiums was a direct result of the cap on non-economic
11 damages.

12 I wish, in retrospect, more of that information was in
13 the report and because a big deal is made out of Proposition
14 103 during regular session and special sessions that I don't
15 think was emphasized as much during the Task Force report.
16 Perhaps that was just my perception.

17 Q Right. And then, finally, how do you reconcile what
18 you just said with the testimony we heard from Bob White that
19 at \$250,000 cap on non-economic damages in Florida won't affect
20 rates unless we do some bad faith reform?

21 A Well, I think one thing that I took from Mr. White's
22 presentation, I think, is very important and everyone should
23 hear, is FPIC primarily sells \$250,000 policies. That's their
24 primary line of business.

25 If we had a market, theoretically, a robust insurance

1 market where insurers came back to the State and offered higher
2 policy limits, such as 1 million, 3 million, that traditionally
3 is not offered right now in Florida, there would be a bigger
4 impact on the cap. So I think what Mr. White is saying is
5 true. But, remember, his universe is primarily \$250,000
6 policies.

7 SENATOR VILLALOBOS: Before we go any further, I
8 received a letter from Mr. Bob White, and it says the
9 following: Please find enclosed the affidavit of Bob
10 White, President of First Professionals Insurance Company.
11 (The affidavit was read).

12 Senator Smith.

13 BY SENATOR SMITH:

14 Q I would like to go back to the deliberations of the
15 Task Force for a moment. I think I earlier established, but,
16 again, to be clear on this, that even on the day in which a
17 vote was taken on this \$250,000 by the Task Force, there were
18 persons, including the Chairman, who expressed his concern that
19 the \$250,000 cap, while that might be acceptable, he was
20 concerned that it might not be flexible enough to touch on all
21 situations, correct?

22 A What day are you reading from?

23 Q Even the day of the vote which was taken on the
24 \$250,000, I believe that date is a conference call of 1-8-03.

25 A That sounds reasonable. Yeah, I would agree with that

1 statement.

2 Q At that time, after a vote was taken on the \$250,000
3 cap -- excuse me, before the vote was taken you were asked for
4 your opinion on things, and you told us, as I understand it,
5 that -- you cited that Kluger and Smith and Echarte, the three
6 of the cases you talked about today, that no matter what the
7 amount was set, whether it was zero or \$250,000 or \$1,000 or
8 \$1 million, the test of the court would be exactly the same.

9 A Can you please read what you're reading from?

10 Q I guess my question to you was: Didn't you tell them
11 on that day, as citing to them Kluger, Smith, and Echarte, that
12 whether the amount -- because you were asked by some people who
13 were concerned -- and somebody even said to you, "What if we
14 made it zero?" You said, did you not, that, "Whether the
15 amount is zero, 250, or a million, I think they are going to
16 use the same test."

17 A I absolutely believe they are going to use the same
18 test. But the evidence that's needed to meet the second factor
19 in the second prong is, I think, very important. And that will
20 be very different, whether it's 250, 500, or a million. But I
21 do believe it is going to be the same test. They are going to
22 cite Kluger, Echarte, and Smith and use that same test.

23 Q And that was the opinion you gave?

24 A Yes.

25 Q A vote was taken on \$250,000 for non-economic damages

1 which passed by a vote of 3 to 1. Do you recall that?

2 A Yes.

3 Q At the time that the vote was taken -- and you were
4 actually the one that framed the question, and the question was
5 that the Task Force recommends that medical malpractice cases,
6 non-economic damages be based at \$250,000 per incident, and you
7 asked for a vote to be taken, and the vote was taken. After
8 the vote was taken, Mr. Large, there was a request to take
9 another vote. Do you recall that?

10 A Request to take another vote? No, please refresh my
11 recollection on it.

12 Q There was a request to take another vote, and the
13 statement by Ms. Shalala, who apparently was one of the
14 participants, Ms. Shalala said: Let's take a vote on another
15 recommendation. Simply, that the Task Force recommends that
16 there must be a catch of some sort that I can write up. Is
17 that what you're asking me to do?

18 Then it's unclear here, but it says: Ms. Shalala:
19 Yes, and I'll help you write up that section so everybody can
20 look at it. I am on page 125, if you will.

21 Mr. Large: What would be the vote on that?

22 Mr. Bearden, another participant: The question would
23 be, it needs to be constitutionally approved. I don't want to
24 submit something that does not have a chance.

25 Mr. Large: Since we don't have something up on that,

1 perhaps we should not vote. I can work with Ms. Shalala.
2 Someone said: I would like to see an attempt made, if there
3 was something that we could propose that had a chance of being
4 held constitutional. I had earlier expressed the need for some
5 flexibility. My only reason for backing off on that concern is
6 that absent a database upon which we -- to which we can
7 refer -- and I don't need to read on.

8 But what I am saying here is this: Apparently, even
9 after the vote on \$250,000 was taken, members of the board had
10 some concern about another vote which you said you were going
11 to work with them on, because they were concerned about it
12 being constitutional. But they were looking for more
13 flexibility. Did you ever advise this board on a way in which
14 they could vote to give more flexibility even after the
15 \$250,000 vote?

16 A Am I correct that you're reading from the January 16th
17 transcript?

18 Q I think that's -- yeah, I'm sorry, this would be 1-16,
19 correct. I am sorry. The early statement was from 1-8. This
20 is another transcript from 1-16. I am sorry.

21 A It is my recollection we rehashed those issues again
22 on January 28th, 29th, and 30th. I must say that based upon
23 Donna Shalala's comments on January 16th, I was of the belief
24 that perhaps she would not vote in favor of a cap, but she did
25 on January 28th and 29th and 30th.

1 Q Well, actually, there was a vote taken, though -- as I
2 understand it, there already had been a vote on 250, because on
3 page 124 you took the vote, that the vote was 3 to 1 on the
4 250.

5 After the vote on the 250 was taken, the Chairman and
6 Ms. Shalala and I guess Mr. Beard, all expressed some concern
7 about still having more flexibility.

8 I guess my question to you is: Wasn't -- even after
9 250 was agreed upon, weren't there board members who expressed
10 to you their desire to vote for something more flexible if you
11 believed it could be upheld as constitutional?

12 A Apparently, there was. President Shalala apparently
13 made that statement.

14 Q And Chairman Hitt?

15 A Apparently he did.

16 Q Thank you.

17 SENATOR VILLALOBOS: Anymore questions? Senator
18 Peaden.

19 SENATOR PEADEN: Thank you, Mr. Chairman.

20 EXAMINATION

21 BY SENATOR PEADEN:

22 Q Senator Jones was concerned about this question. In
23 our first bill we had a rollback in the bill that was very
24 unpopular. A couple of weeks later after we left the session
25 it became more popular. Is there any reason why there was not

1 a rollback in this particular study that was presented that was
2 the basis of the Governor's bill?

3 A I believe the issue of a rate rollback was presented,
4 and maybe it was either on January 8th or January 16th. I do
5 recall it was the data Steve Roddenberry presented to the Task
6 Force. I am not sure what date that was.

7 That issue was raised. The Task Force felt with all
8 the insurers leaving the state, that that would not be
9 advisable. And so that was an issue that we didn't pick up.
10 In retrospect, that would be in the section of issues raised,
11 discussed, debated, but not written about in here. So --

12 Q Well, why did this become such a popular issue and
13 become so productive after the session was over with, and after
14 the Legislature left town, that I think PIPCA and the Governor
15 had an agreement, and there was a letter issued. What changed
16 in the meantime after the, after the session after the
17 Legislature left to have this problem, this one issue?

18 A I think it really had to do with the Proposition 103
19 debate. We heard so much about Proposition 103 over and over
20 again, that that's what one stakeholder wanted to solve this
21 problem. And seeing that was sort of an impasse, so it was
22 decided, but the Task Force didn't recommend that, that I know
23 it was included in the Governor's bill, even though the Task
24 Force didn't recommend it. There was just so much discussion,
25 so many people put so much on the rate rollback as being a

1 factor, that that is why it was addressed.

2 SENATOR VILLALOBOS: Any further questions. Thank
3 you, sir.

4 A Okay. Just in conclusion, every -- we found that
5 there was an increase in frequency and severity of claims, and
6 every document -- we did get documents from stakeholders.
7 Everything was --

8 BY SENATOR VILLALOBOS:

9 Q Is that the conclusion to what question?

10 A Everything was approved by the Task Force.

11 Q I am sorry, what was your conclusion?

12 A That we increase -- that there was an increase in the
13 frequency of claim, increase in the severity of claims.

14 Q Wait a second. You testified earlier, though, that
15 you had no evidence of that?

16 A Increase in the frequency and severity of claims?

17 Q Yes.

18 A No, sir, that was contained in the findings of the
19 report. That's contained in Chapter 5, findings of our report.

20 Q As based on what evidence?

21 A What you had asked me was to make a correlation
22 between the Brennan and Mello study, which indicated that 80
23 percent of the cases were maloccurrences in the absence of
24 deviation from the standard of care.

25 Q That's based on New York, though, right?

1 A Correct, it was a New York study.

2 Q Florida, excuse me, Florida, do you have any evidence
3 that there is an increase in the number of claims in Florida?

4 A Yes, in frequency and severity of claims, yes, sir.
5 Perhaps I misspoke, because when you asked me, I thought you
6 were asking me to draw a correlation between that maloccurrence
7 in the absence of a deviation of standard of care number to
8 frequency and severity. Because there is no study that says
9 that, that would just be an opinion. Okay.

10 But in terms of frequency and severity of claims, on
11 page 121 of the report in Chapter 5 of our findings, we did
12 find there was an increase in frequency and severity of claims.

13 Q In Florida?

14 A In Florida. That information was based upon the
15 Milliman study and our own independent analysis.

16 Q Okay, but based on what? I mean, you know, I can come
17 before a committee, and I can say based on my analysis. But
18 can you cite --

19 A Certainly, certainly. We had basically three reviews
20 of the data, and there was two sets of data. One was the
21 Department of Insurance data okay. One was the National
22 Practitioners Data Bank data.

23 Q The Department of Insurance of Florida?

24 A Correct.

25 Q Okay. The Department of Insurance of Florida

1 yesterday said that there were no increases in lawsuits
2 according to claims. So are they wrong?

3 A I believe that the status of the Department of
4 Insurance data bank is suspect. And I don't know that very
5 many conclusions can be drawn from that, or if the conclusions
6 are drawn, they certainly are subject to much debate.

7 But the Milliman report used two data sets, the
8 National Practitioner Data Bank and the Office of Insurance
9 Regulation --

10 Q But, Mr. Large, I am not interested in a study in the
11 rest of the states when we are talking about Florida. Okay.
12 And the reason is, I mean, if a study shows that something
13 worked some other place, that I am interested in. But when we
14 are talking about raw numbers, and you make a claim that
15 there's increase based on a study someplace else, that, that
16 doesn't tell me anything here.

17 A I have somehow confused you, and I apologize.

18 Q Yes.

19 A Florida claims frequency per 100,000 population
20 increased over the same period for a low of 4.82 in 1991 to a
21 high of 7.56 in 2000, Graph 3, footnote 547, page 121 of the
22 Task Force report. That is from the Milliman report, which is
23 one stakeholder group that looked at the data.

24 Q So a stakeholder group that has a financial incentive
25 in this issue is a person that you cite. Yet the Department of

1 Insurance of the State of Florida is wrong?

2 A The Department of Insurance data of is problematic, I
3 will agree with you on that. We had three --

4 Q Look. I want to clarify this in my mind. So the
5 information that the Task Force used to justify its position,
6 right or wrong, to justify its position, is based on
7 stakeholder that has a financial incentive in the outcome?

8 A Correct. Milliman was sponsored by the Florida
9 Hospital Association, that is correct.

10 Q Okay. But our on Florida Department of Insurance,
11 what you're telling me is that the Task Force, or at least you
12 question the reliability of the information that they provided
13 to the Legislature or the Senate; is that correct?

14 A Correct.

15 Q Okay. Thank you.

16 A We also had Lance deHaven-Smith, who was sponsored by
17 the Florida Academy of Trial Lawyers. He looked at only the
18 Department of Insurance data, and then we did our own
19 independent analysis of both those studies.

20 Q You are using a source that has an interest in the
21 outcome of this?

22 A We relied heavily on the Milliman report. The
23 Milliman report was sponsored by the Florida Hospital
24 Association.

25 SENATOR VILLALOBOS: Senator Smith.

1 MR. SMITH: You asked my question.

2 SENATOR VILLALOBOS: Anything else? Thank you, sir.
3 We have one more presenter. Cindy Harris. Please raise
4 your right hand. Do you swear or affirm that the evidence
5 you're about to give will be the truth, the whole truth,
6 and nothing but the truth?

7 MS. HARRIS: Yes, sir.

8 EXAMINATION

9 BY SENATOR VILLALOBOS:

10 Q Thank you for attending. Senator Aronberg had asked
11 me to include your name, since yesterday, Senator Cowin had a
12 doctor who she wished to testify that was on the list, and we
13 accommodated him yesterday since he had to return to practice
14 today.

15 Senator Aronberg had asked you to attend today, and
16 you were not on the list, so thank you. Please state your name
17 and your occupation.

18 A Cindy Harris. I am the case management coordinator at
19 a law firm in Orlando, Florida.

20 Q You have been employed in that capacity for how long?

21 A For about a year and a half.

22 Q What did do you before that?

23 A Before that I was with St. Paul Insurance.

24 SENATOR VILLALOBOS: Senator Aronberg.

25 SENATOR ARONBERG: Thank you, Mr. Chairman.

EXAMINATION

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BY SENATOR ARONBERG:

Q Thank you, Ms. Harris for being here. What information do insurance companies typically have before pre-suit?

A Usually, the insurance company has an abundance of information before pre-suit starts, because under the claims-made policy provision, the physician will report any untoward event prior to the pre-suit period beginning. That was one of the benefits of having a claims-made policy.

Q Okay. And do insured physicians in hospitals have a contractual duty to notify a carrier as soon as an incident occurs that could be the subject of a malpractice case?

A I think it all depends on the policy language. I know specifically St. Paul did. I know that their hospitals have specific guidelines of what will direct immediate report.

I think a lot of it correlates to what is called a Code 15 report, where if you have a head injury or a spinal cord injury as a result of a hospital stay, that will invoke an immediate report. It all depends on the policy language, but most times it is reported immediately.

Q What constitute a notice of claim?

A Again, I think that varies by interpretation. With St. Paul, a notice of claim is if you have the information that would direct you that you have a potential problem, or that

1 you've had an untoward event, you've had an occurrence that
2 could be related as physician driven, an error in medication,
3 wrong side surgery, anything like that.

4 Q So it's not when a lawsuit is filed, it's before then?

5 A Most times it's before then, right.

6 Q We heard some testimony about reserves, and I was
7 still a little confused about that. What are the key elements
8 that drive an insurance company's reserves?

9 A I think you evaluate -- the standard language to St.
10 Paul -- and I can only speak on St. Paul, I certainly can't
11 speak about everybody -- is the probable ultimate potential of
12 the case.

13 Q I am sorry?

14 A The probable ultimate potential of a case.

15 Q Do insurance -- what kind of discretion do you have as
16 far as how much in reserves that you have? Who makes that
17 decision? And how much discretion do you have by law on how
18 much you can keep in reserve?

19 A I don't know how much discretion by law. I know that
20 the -- we are audited every other year, every year, I am not
21 really sure specifically to that. But a claim adjuster will
22 get a case in. We will evaluate what they have and make
23 recommendations. And the ability to set a reserve is within
24 the company's purview as far as the liability issues, the
25 damages, the venue, a lot of different things go into

1 evaluating a reserve.

2 Q Today we talked about bad faith, and yesterday Bob
3 White from FPIC testified about a frivolous lawsuit problem.
4 In your experience, does your company have to settle
5 non-meritorious claims because of fear of bad faith exposure?

6 A I am no longer with St. Paul, but I have to go back to
7 the time that I spent with St. Paul, which was about 17 years.
8 Settling non-meritorious claims -- I think you have to look at
9 what you're determining a non-meritorious claim to be.

10 I agree with Mr. White on the point that there are no
11 frivolous lawsuits or very few frivolous lawsuits filed, as a
12 result of the tort reform we had in the mid-eighties, '88
13 specifically. I think the affidavit has driven that train into
14 genuine suits being filed, genuine issues of fact, and
15 maloccurrences, as someone stated, but true malpractice.

16 Q But are you aware of instances where an insurance
17 company settles a non-meritorious case because of fear of an
18 excess judgment out of a bad faith lawsuit?

19 A I think you have to look at a case from -- whether you
20 settle a case based on -- it's not winning or losing. I think
21 you're evaluating risk, and you're evaluating risk to the
22 insureds that you have that fiduciary duty to. If you have
23 only have a \$250,000 policy, I think there is a lot of dialog
24 that has to go into that evaluation with your insured.

25 As a defense lawyer, you would have to evaluate the

1 case and tell your insured, your client -- because your carrier
2 can no longer be your client -- it should be the physician or the
3 hospital -- what the ups and downs of the case are and be
4 genuine with them and be honest.

5 Q Do you think there is a need for bad faith reform here
6 in Florida?

7 A I think if we have bad faith reform from what we have
8 right now it will disincant the process that is in place at
9 this point in time.

10 Q What do you mean by disincant the process?

11 A I think to do the right thing at the right time is why
12 the bad faith law is effective, and why it's important. And I
13 thought it was important when I was with St. Paul, and I think
14 it's important now.

15 Q What about just extending the amount of time so that
16 insurance companies can investigate and make a good faith
17 attempt to try to settle lawsuits? What about extending the
18 time, that was in the Senate bill?

19 A Ninety days is more than adequate time. That was the
20 modification made in 1988. Ninety days in pre-suit is plenty
21 of time to investigate, evaluate, and take the proper steps
22 necessarily to protect the insured at the time.

23 SENATOR VILLALOBOS: Senator Peaden.

24 SENATOR PEADEN: Thank you, Mr. Chairman.

25 EXAMINATION

1 BY SENATOR PEADEN:

2 Q You weren't here yesterday. I asked to hear the
3 questions I asked about reserves. You say you set aside your
4 reserves when a the concerned physician called about a
5 complaint. But in targeting reserves, would you say that St.
6 Paul was over or under or right on the target as far as what
7 they reserved for each one of these cases?

8 A I thought they did a very good job of evaluating all
9 of the elements of the risk. There was an actuarial study done
10 that would evaluate the defense cost. So I am only talking
11 about the actual indemnity when I am talking about the
12 evaluation of the reserve. They would automatically factor in
13 a percentage of it based on actuarial studies to include the
14 defense cost for the entire case.

15 Q And did I understand you to say that if you had your
16 way, that we would keep bad faith statutes in place as they are
17 in Florida now?

18 A I believe if we change the bad faith statute, or if
19 you all change the bad faith statute, it will disincent doing
20 the right thing.

21 Q Do you think -- and this is just a general question
22 based on your background and your experience and your exposure
23 to other companies. In identifying those reserve at whatever
24 stage, whether it's the time of filing or the time of initial
25 complaint, there could be a misrepresentation of the adequacy

1 of reserves or a misrepresentation of the amount of the
2 reserves or a need to augment the reserves or an effort to
3 misrepresent the policies of -- or there profits of particular
4 insurance companies, is that possible in the regulations we
5 have today or regulatory scheme?

6 A I can't speak directly to the regulatory scheme. It's
7 always a possibility that you could be creative in your
8 reserving practices, and I think there are companies who have
9 been creative, and I think that is evidenced by the companies
10 that have gone out of business and been driven into bankruptcy.

11 Q So you think that their business policies put them out
12 of business as far as augmenting what reserves they identified?

13 A I honestly don't know what put them out of business.
14 I think that it was driven by a lot of things, and I am not
15 aware of -- certainly, I am not a part of their organization.

16 But I do think that some of the premiums that were
17 charged in the nineties in a soft insurance market really
18 generated a difficult situation to become a profitable company
19 when you have that claims-made policy, and you have that
20 five-year maturity. At the fifth year, you have a difficult
21 time in trying to have your funds available to pay mature
22 claims.

23 Q With St. Paul, do they have a policy of having a local
24 board or a national board? How do they operate within the
25 State of Florida? Do they have a Florida board operation?

1 A We don't have a board. We have a board at the home
2 office level. They are a publicly traded company.

3 Q Only at the home office level?

4 A But we would have regions. We would divide it into
5 regions, the southeast region, for example. We had people in
6 place in Florida. We had licensed insurance adjusters in place
7 in Florida.

8 Q So you didn't even have an advisory panel, say, in
9 Florida to keep you up to speed as far as rules, regulations,
10 changes, or --

11 A We would generally get our information through the
12 home office information system, and it was pretty good about
13 informing us of any changes. For example, in '88 when those
14 laws changed, how we would put in place the new pre-suit
15 screening process.

16 Q Is there any particular reason that we might not know
17 about for a change in competition the reason your company left?
18 And I can say that I had the employees insured by your company
19 in the past 20 years, and we were very satisfied with your
20 company. Why they left Florida, other than what you have just
21 mentioned about changes in the atmosphere.

22 A I can't speak to exactly why they left Florida. I
23 know in the mid-eighties there was an issue that there was a
24 difficulty with the insurance commissioner giving the rates
25 that they requested. They left to the extent of physician and

1 surgeon coverage. They did not leave as it pertained to
2 hospital insurance.

3 Q Were they caught in the cycle where you had to have a
4 policy with lower premiums in order to be competitive? Was
5 that part of there problem?

6 A I don't believe so. I was mainly engaged in the
7 hospital, the large account area where we would write large
8 hospitals and work with large hospitals.

9 Q Okay.

10 A St. Paul never left the state until now.

11 Q Okay.

12 SENATOR VILLALOBOS: Any other questions? Thank you
13 very much, ma'am. This completes the list of invitees who
14 confirmed that they would attend the meeting. So I believe
15 we are done.

16 The President has asked me to try and give him a
17 summary of what we have done, and I am going to attempt to
18 do that. I'll prepare a letter and share it with all the
19 members of the Committee for their review, and they can
20 agree or disagree or do whatever it is that they want with
21 it. But I'm going to try and have that ready for the
22 President based on testimony that's been given before the
23 Committee.

24 I would further recommend to the President that a copy
25 of the transcripts be made available to all members so they

1 can -- the members can review the testimony, and they can
2 make up their own mind, one way or the other. It is up to
3 them to read the information and reach their own
4 conclusions. With no other witnesses, Senator Aronberg,
5 will rise.

6 (The meeting adjourned at 3:45 p.m.)
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STATE OF FLORIDA)

COUNTY OF LEON)

CERTIFICATE OF REPORTER

I, SUSAN WILLIS, CCR, RPR-CM, State of Florida; do hereby certify that I reported the foregoing proceedings at the time and place and in the cause indicated in the caption; that I later had the same reduced to written form by means of computer-aided transcription; and that the foregoing pages are the proceedings had before me as I was directed to transcribe.

I FURTHER CERTIFY that I am neither related to nor employed by any party to this litigation, or their counsel, and that I am not financially or otherwise interested in the outcome of this case.

WITNESS MY HAND AND SEAL at Tallahassee, Florida,
this 18th day of July, 2003.





Susan Willis
MY COMMISSION # DD136786 EXPIRES
August 16, 2006
BONDED THRU TROY FAIN INSURANCE, INC.

SUSAN WILLIS
CCR, RPR-CM
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