Prologue: As many states have, Florida found itself facing a crisis in medical malpractice liability in the 1970s and 1980s. Between 1970 and 1975 more than twenty medical malpractice insurers canceled their coverage of Florida physicians, and by the mid-1980s the state’s largest malpractice insurer ceased doing business there altogether. The reasons? Malpractice claims were increasing, particularly for obstetrics; and severity of claims (that is, the amount paid out) also was increasing, again particularly for obstetrical cases. Clearly, a legislative response to the perceived crisis was called for. In 1988 Florida passed a bill transferring liability cases for newborn infants’ neurological injuries from the tort system to a no-fault system. Unlike the tort system, no-fault liability compensates patients who suffer any treatment-induced injury, not just those that can be traced to medical malpractice or negligence. Legislators focused on neonatal neurological injuries for several logical reasons: Neurological injuries accounted for more than 30 percent—the largest single percentage—of all obstetrical claims, and the injuries tended to be severe. In this paper Jill Horwitz and Troyen Brennan use Florida’s program as a case study, to examine the pros and cons of abandoning tort liability in favor of no-fault injury compensation. The results, five years into the program, are mixed. Horwitz is a candidate for the juris doctor degree at Harvard Law School. She holds a master of public policy degree from the Kennedy School of Government at Harvard. Brennan is a professor of law and public health and director of the Program in Law and Public Health at the Harvard School of Public Health. He also is a professor of medicine at Harvard Medical School and is a physician at the Brigham and Women’s Hospital in Boston. He holds medical, public health, and law degrees from Yale University,
Abstract: Changes in malpractice law remain an important goal of health care reform. Many state and federal legislators continue to call for measures that would limit the ability of injured patients to sue. There is also growing interest in alternatives to fault-based litigation. As legislators consider no-fault proposals, they can look to Florida’s experience with the Neurological Injury Compensation Association (NICA), which for the past four years has been providing no-fault compensation for injured newborns. NICA provides some insights into the ways in which claims are generated, the nature of risk spreading, and the financial viability of a no-fault model.

Virtually all of the health care reform proposals debated over the past five years have included modifications in malpractice law. Empirical evidence suggests that malpractice litigation only partially accomplishes its two major societal functions: compensation of medical injury costs and deterrence of substandard practices. Yet the burden of preventable medical injuries is extremely large and calls for immediate attention. The result has been, in most cases, a political stalemate leading to marginal reforms that reduce the filing of claims by patients.

Interest has increased in alternatives to tort litigation, including enterprise liability, administrative-fault models, and Swedish-style no-fault. For example, the American College of Physicians recently advocated broad experimentation with no-fault compensation. Such reforms would partially or completely supplant tort law.

No-fault programs are intended to increase claims by extending compensation to all injuries, not just those caused by fault. Any increase in compensation costs is supposed to be offset by lower administrative costs of the no-fault system compared with traditional tort litigation. Skeptics doubt these benefits and also question whether no-fault mechanisms can spread risk and maintain provider participation. They also assert that no-fault programs are unconstitutional.

Two no-fault programs are operating in the United States: the Florida Birth-Related Neurological Injury Compensation Association (NICA) and the Virginia Birth-Related Neurological Injury Compensation Program. An analysis of Florida’s program, the larger and more successful of the two, offers some lessons to policymakers about the kinds of problems that occur when a no-fault model is implemented.

To understand the operation of NICA, we conducted more than twenty extensive, structured interviews with key policymakers, NICA officials, leaders of organized medicine, and lawyers from both the defense and plaintiff bars. We also took advantage of the relatively generous amount of empirical information on the operation of the tort system with regard to birth-related injuries in Florida in the 1980s. We attempted to understand how well NICA performs with regard to claims generation, risk spreading (the stability of the financing of the system), legality, physician participation, compensation, and administrative costs. In a number of areas the...
evidence is quite thin, and a considered judgment was not possible, but the experience of NICA does offer important guidance.

**Impetus For Reform In Florida**

NICA was enacted under statute in 1988 in response to growing concern regarding the rising cost and shrinking availability of malpractice insurance in Florida. Between 1970 and 1975 more than twenty medical malpractice insurers canceled their coverage of Florida physicians, and in the mid-1980s St. Paul Fire and Marine Insurance Company, which was the largest medical malpractice underwriter in Florida, left the state. The remaining insurers raised premiums substantially, particularly for obstetrician/gynecologists (OB/GYNs). Between 1980 and 1986 premiums for Florida OB/GYNs rose 395 percent. In 1986 OB/GYN premiums in Florida were much higher than those in other states—$59,537 annually in Florida, $9,940 in Arkansas, $36,472 in New York, and $33,632 in California, for example. Dade County, Florida, obstetricians reported that by the late 1980s premiums had reached $174,000 per coverage year.

There are several explanations for the increases in premiums and insurers’ withdrawal. The frequency of claims rose sharply, particularly for obstetrics. Claims rates were two to three times greater for obstetricians than for other specialists (although quite similar to other high-risk specialties such as neurosurgery and orthopedics). Severity—the amount paid out on a claim—also increased for all physicians but increased more markedly for obstetricians. Florida insurers paid out almost twice as much in total for OB/GYN claims than for claims in any other specialty. The costs of these factors had to be passed along as higher premiums. Some observers also believe that contractions in secondary insurance markets, which had nothing to do with medical care, affected malpractice markets because of the particularly risky nature of those markets. Others explain that insurance company policies, such as segmenting physician pools by specialty and concentrating risk, led to higher premiums.

Over the course of the 1980s malpractice claims, jury awards, and obstetrician retirements led not only to disgruntled physicians but also to a widely held, but poorly documented, perception that care was jeopardized. Although there is no evidence that a significant number of Florida patients were unable to obtain obstetrical care, nor that reductions in service at some hospitals resulted in lower-quality care, the mood of crisis prevailed. In at least one Florida county OB/GYNs and emergency room physicians threatened to go on strike, which led the Federal Trade Commission to investigate. Legislators, targeted by well-organized and effective physician lobbying, feared that women in labor would be turned away from delivery...
rooms. Widespread media and constituent attention to large and increasing jury verdicts fueled the perception of a crisis.

To address the perceived crisis, Florida legislators passed a bill, which stated that “it is incumbent upon the Legislature to provide a plan designed to result in the stabilization and reduction of malpractice insurance premiums for providers.” The legislature identified the tort system as the problem, although there was apparently little evidence on the availability of OB/GYNs who were willing to perform deliveries.

The No-Fault Response

To address the Florida insurance problems, the state legislature moved the most expensive cases, those involving infants with birth-related neurological injuries, from the tort system into an administrative, no-fault system. As noted above, tort law is intended to provide compensation to an injured party, place an economic penalty on the negligent party, and deter future negligence. The obligations assigned by tort law are based not on explicit contracts but, instead, on common-law duty to behave carefully when dealing with others. For liability to be found, four conditions must be met: (1) establishment of a duty of care, (2) evidence that the physician’s services did not conform to the appropriate standard of care, (3) a determination that the failure to act in accordance with the duty of care was the cause of the harm, and (4) existence of a physically objective and ascertainable injury. In theory, the threat of economic loss through a lost suit deters physicians from negligence, and harmed patients are compensated for their injuries. Unlike the tort negligence system, no-fault liability compensates patients who suffer any iatrogenic injuries, not just those caused by negligent medical interventions.

Florida applied no-fault concepts solely to the area of birth-related neurological injuries. The statute itself limits compensation to “injury to the brain or spinal cord of a live infant weighing at least 2,500 grams at birth caused by oxygen deprivation or mechanical injury in the case of labor [or] delivery . . . which renders the infant permanently and substantially neonatally and physically impaired.” The majority of these patients will have cerebral palsy.

The statute, however, carefully avoids guaranteeing compensation for all cases of cerebral palsy. The Florida legislature clearly understood that the definition of the compensable event would be critical to the financial viability of the program. Several studies were commissioned to evaluate the number of expected claims given particular definitions. The final legislative compromise excluded preterm infants.

Legislators hoped that if neurologically injured infant cases that were
particularly expensive to resolve were removed from the tort system, rates of claims and levels of awards would stabilize. Targeting neonatal neurological injuries was a rational strategy. From 1986 to 1990 neurologic injuries accounted for the largest percentage—more than 30 percent—of all obstetrical claims. These injuries were also the most severe. Estimates suggest that up to 60 percent of all obstetricians’ malpractice premiums were absorbed by litigation costs (lawyers, witnesses, and other transaction costs) for alleged birth-related cerebral palsy.

The high costs of birth-related neurological injuries can be attributed in part to difficulty in distinguishing the cause of injury. Current studies suggest that many cases of cerebral palsy and other congenital neurological disorders long thought to be the result of birth-related asphyxia actually have genetic causes. The legislature thus appropriately hypothesized that the definition of causation makes such cases especially difficult for the tort system, leading to protracted litigation. However, it failed to see that these problems also trouble a no-fault system.

In any case, the Florida legislature authorized NICA to start compensating patients in 1989. The process has remained much the same since that time. Once an injury has occurred, the patient files a petition for compensation with the Division of Administrative Hearings to initiate a claim. Eligible patients learn about the program through brochures that a statutory notice provision requires participating physicians and the hospitals to which they admit to provide to all obstetrical patients. NICA enforces this requirement. At least one attorney had his case exempted from NICA because the participating physician who delivered the infant had not given notice of the program to the expectant woman.

The claim petition, which costs $15, includes a brief statement of the facts, relevant medical records, and documentation of incurred expenses and services. Patients may file without having representation, but three-quarters have an attorney. NICA must within forty-five days issue a response based on the data received and a medical examination of the child. A hearing officer employed by the Division of Administrative Hearings then decides the case. The hearing officer’s decision usually follows NICA’s affirmative recommendation, but if NICA recommends against compensation, a hearing similar to a bench trial follows. The claimant may appeal negative decisions to the District Court of Appeal.

NICA compensation is the exclusive remedy. There is, however, an exception for civil action in cases involving malicious or purposefully negligent action as long as the case is filed before NICA pays the claimant. Awards, paid periodically, include actual expenses for medically necessary and custodial care costs as determined by the hearing officer and NICA. Compensation presumes exhaustion of nontort collateral sources.
such as expenses patients receive from the state or federal government or a health insurance plan. (This offset raises the possibility that well-insured patients might not apply for compensation.)

Pain-and-suffering awards for the infant’s parents, made at the discretion of the hearing officer, are capped at $100,000 (although there is no general pain-and-suffering cap in Florida tort law). Most parents of surviving, compensated infants receive the maximum amount, which may attract claimants to NICA. (In Virginia, where no such benefit is available, claims have been much less frequent.) In the event that an infant receives compensation, the patient’s attorney is paid based on customary charges, given the locality and difficulty of the case.

Four major sources fund NICA. Participating obstetricians pay a $5,000 premium per year; all other Florida physicians, excluding residents, pay $250 per year as a condition of licensure; nonpublic hospitals pay $50 per live birth (exemptions are available to hospitals that provide a high level of charity care); and the state of Florida granted a one-time, $40 million budget item to fund the program. The statute includes provisions for assessing insurance companies up to an annual amount of 0.25 percent of each entity’s net direct premiums written should the fund become actuarially unsound. NICA also has purchased a reinsurance plan.

Each case is reviewed for substandard medical care by the Division of Medical Quality Assurance (DMQA) of the Department of Business and Professional Regulation. The DMQA can levy penalties ranging from reprimand to loss of license for poor-quality care uncovered in NICA claims.

### Analysis And Evaluation Of NICA

**Claims generation.** Accurate assessment of the proportion of potentially covered injuries now compensated by NICA has proved difficult, for several reasons. First, the statutory language is somewhat unclear. At the program’s outset, actuaries predicted claims rates based on untested interpretations of the statutory language. Even now, after several years of experience, attorneys and administrators debate the meaning of the statutory terms severe mental and physical injury and mechanical injuries as well as the period covered by “course of labor, delivery or resuscitation.” However, NICA has derived a definition of injury, the boundaries of which are fairly widely recognized.

Second and more important, while incidence estimates of cerebral palsy were available and may have provided an upper bound for claims estimates, there were no data regarding iatrogenically injured, neurologically impaired infants. Finally, NICA’s small size and limited nature meant that small errors in estimation yielded large variation in expected loss estimates.
Recognizing these difficulties, NICA planners nonetheless developed a range of estimates based on varying cost estimates, number of claims, and physician participation. The NICA actuaries estimated twenty-eight to fifty-six claims for the first birth year (1989); the estimates climbed to thirty-two to sixty-five claims by birth year 1993.

Experience to date indicates that there are many fewer claims than predicted. From the program’s inception in 1989 through January 1994, NICA had investigated eighty-five claims and compensated only thirty infants. (The major reasons for noncoverage were that the infant’s birth-weight was too low, or that the physician was not covered by NICA.)

By early 1995 thirty-one claimants were being compensated, twelve compensated claimants had died, and twenty-five claims were pending.

Although records of successful negligence-tort suits for injuries that fit under the NICA definition are unavailable, matching Frank Sloan’s sample of obstetrical claims in the fault-based malpractice system that closed between 1986 and 1989 to NICA categories provides some insight. We calculated the number of claimants for birth-related injuries under Florida tort law as follows. The Sloan team identified 613 potential respondents for their study through their search of all claims files from Florida’s Department of Insurance. Approximately two-thirds or 408 of these were birth-related. The claims were obtained from spring 1986 to summer 1989 (thirty-nine months). This means that there were approximately 126 claims per year.

Among the 127 birth-related claims that Sloan and colleagues interviewed, approximately eighteen were compensated out of injury category IV (22 x .818) and eighteen out of category III (26 x .692). These categories correspond to the criteria for NICA. Of this total, 26 percent of the infants weighed less than 2,500 grams and so would not have qualified for NICA coverage. Thus, from Sloan’s work, based on a number of assumptions, it appears that approximately twenty-seven people (36 x .74) per year filing in the malpractice system could expect payment under NICA.

Unless the number of potentially compensable claims changed in the years after NICA was founded, or those compensated under the tort system suffered injuries that were not iatrogenically caused, at least twenty-seven claims should have been compensated annually. Even this estimate may be conservative because many meritorious claims may not have been filed, because of the cumbersome process of finding a lawyer.

Although our calculations are based on a series of assumptions, we conclude that forty-three compensated claims in five years probably represents too few. More claims should be compensated under NICA than under a tort system because there are more iatrogenic injuries than injuries caused by negligence. Yet NICA’s claims rate may be even lower than that under tort law.
One reason there may be so few claims is the method of payment for attorneys. Attorneys are compensated on an hourly basis, determined by the customary charges in a locality. Since fewer hours of preparation are needed than in a tort case, and given the lack of a contingency fee, lawyers may not be interested in bringing no-fault cases. A recent court decision ruled that $400 per hour was too high in the Miami area.\(^{35}\) Also, the difficulties of finding an attorney documented by Sloan and colleagues may be exacerbated by the no-fault system. The other major reason for fewer claims than expected is the definition of compensable injury. According to all the lawyers, risk managers, obstetricians, legislators, and insurers interviewed for this study, the scope of the statute is very narrow. (Before a 1990 amendment, the Virginia statute contained an even narrower definition of neurologic injury.\(^{36}\) Even now it requires that patients be “permanently in need of assistance in all activities of daily living.” The Virginia program has received only six claims and compensated two since 1988.)

We cannot provide information on the accuracy of the no-fault mechanism. We know that malpractice litigation is notoriously inaccurate, but we have no similar information on NICA.

**Compensation awards.** Estimating the efficacy of NICA in covering the losses of patients also has proved difficult. Costs of care might be based on imprecise estimates of medical and general inflation rates, changes in technology and treatment, and collateral sources available to claimants. Thus, any estimates have very broad confidence intervals.

Given these caveats, we believe that compensation for claims brought under NICA appears to be relatively adequate. Using data from Sloan and colleagues, we constructed a simple comparison of mean economic compensation estimates of similarly injured patients under both systems.\(^{37}\) It shows that tort claimants received higher awards for economic damages than claimants under the no-fault system received. Tort claimants received an average of $1.4 to $1.7 million each in 1989 dollars.\(^{38}\) The average amount reserved for each NICA-compensated patient is $1.1 million each in 1993 dollars.

The dollar difference in compensation of patients under tort and no-fault is significant because plaintiffs typically suffer economic consequences greater than the amount of their award. Sloan has concluded that families of neurologically injured infants were only compensated for one-half to two-thirds of their total loss, including medical expenses, lost wages, and nonmarket loss (lost household production).\(^{39}\)

But the simple figures on awards may be deceptive. Attorneys’ fees under NICA, which are quite low, are included as a direct expense in the NICA economic award. If the figures were corrected for attorney fee payments (estimated under tort law to be 33 to 40 percent of fees by Sloan and
In addition, the method of patient management used by NICA allows for cost savings, even though the services ultimately provided to patients under tort and no-fault may be identical. NICA buys medical products through discount suppliers and negotiates rates for therapy and nursing care. Under the tort system, courts award payments based on medical expense estimates known as life care plans or continuum of care plans. These plans, compiled by consulting firms hired by plaintiffs’ attorneys, estimate prices at much higher levels than those paid by NICA for medical services. It is possible that although NICA patients receive less money, they receive comparable care. Some plaintiffs’ attorneys, however, have argued that the goods and services NICA purchases are inferior to those that patients would buy.

**Risk spreading.** One measure of NICA’s success, especially given the predictions of legislators and observers, is that it still exists. NICA is financially stable on a cash basis. Indeed, NICA’s balance sheets show that it is cash rich; in 1992 cash and cash equivalents topped $90 million.

NICA’s long-term financial stability is less certain. NICA has been running an accumulated, accrual deficit based on expected claims. This deficit means that if all expected claims for each birth year up to the present were actually filed and NICA did not make special provisions for those claims, it would be unable to cover its obligations in the late 1990s.

NICA has remained in operation because expected claims have not been filed and payouts on filed claims have been lower than predicted. By the fall of 1993 NICA had paid only $4 million for patient compensation and administrative expenses and estimated a need for $69 million to cover future costs for all claims deemed compensable and likely to be deemed compensable. This total, $73 million for four program years, is much lower than the approximately $120 million predicted in initial actuarial reports. Indeed, with a statute of limitations of five years, the surplus from 1989 and 1990 seems secure.

Recognizing the uncertainty in claim predictions and being perhaps overly cautious, NICA purchased a reinsurance fund that will cover unpredictable losses through 1997. Because claims are being filed more slowly than predicted, however, NICA is cash rich and could probably cover an increase in claims itself if this trend continues. If NICA continues to hold reinsurance, it will not face cash deficits.

NICA’s resources are rather tightly constrained. Operating revenues come from two sources: hospitals (through fees for each birth) and physicians (through assessments and premiums), which provide a relatively flat revenue stream. The risks are well spread in that physicians and hospitals are able to pay this amount, but it is uncertain whether they would be
willing to pay more if claims rates increased.

Revenues from current sources rose by 7.4 percent from fiscal year 1991 to 1992, as more hospitals and doctors elected to participate, but are not likely to continue to rise. Obstetrician dues are not likely to increase, and program participation dropped slightly in the first few months of 1994 because two hospitals ceased paying premiums. (Soon thereafter, most affected physicians purchased coverage themselves.) Although revenues will increase with the Florida birth rate, births have not increased substantially, and more births would lead to more injuries and higher expenses.41

From 1992 to 1993 interest revenue—the major source of nonoperating revenue—decreased by 11.6 percent but has risen more recently with increasing interest rates. NICA’s investment success is directly tied to Florida’s because its funds are invested in the state investment pool; as a result, NICA has little control over returns. To exacerbate the funding problem, the Florida legislature, spotting large cash accounts, has been tempted to use the money for other programs. The enabling statute mandates that if NICA’s solvency is threatened, the program must stop taking new claims, and the tort system would be reinstated.42

NICA’s fiscal position provides important lessons for other programs. If the unique statutory protections are dismissed, NICA’s viability will be driven not only by current cash flow but also by claims rates and its ability to meet those claims. This would be a demanding task because historical loss information with which to determine necessary reserve levels is unavailable. Since physicians are unable to determine whether covered diseases are genetic, congenital, or iatrogenic, it is unlikely that actuaries and program administrators will be able to make such a determination accurately until enough program experience accrues.

Estimates of the program’s fiscal needs are troubled by several other issues as well. The present-value economic costs to severely injured patients are subject to wide variation.43 Finally, fiscal stability depends on the difficult predictions of the life expectancies of injured infants because payments stop when the claimant dies. Although NICA will not become insolvent, because it is required to shut down before doing so, comprehensive programs would not have the option to return cases to a parallel tort system because, presumably, the no-fault program will have replaced the tort system.

Given its limited scope, NICA’s long-term prospects do not necessarily illustrate the potential financial stability of larger-scale no-fault programs. NICA compensates a single, very expensive injury that is difficult to identify and predict, and so does not spread risks among other injuries. Its actuarial base is quite small, and even the relatively stable rate of loss accrual does not guarantee future financial health. Broader no-fault systems would not face the same degree of uncertainty. Nonetheless, the problems
of estimating and spreading risk will be salient for any alternatives to tort law.

Legality. NICA has survived several legal challenges that could have terminated the program. New no-fault programs probably will encounter many of the same legal challenges faced by NICA. The most significant challenge, Coy v. Florida Birth-Related Neurological injury Compensation Plan, was filed by nonparticipating physicians, who argued that the $250 assessments violated a discrimination clause in the Florida Constitution because only physicians and not all Florida residents were required to pay the special tax. According to the plaintiffs, nonparticipating physicians did not benefit from the program any more than did any other Florida resident and, therefore, should not have been assessed unless all residents were assessed. The Florida High Court held, however, that the state had a rational reason for assessing physicians and ruled in favor of NICA.44 NICA also has prevailed in several cases in which the plaintiffs (in some cases, representatives of potentially compensable clients) asserted that NICA denies potentially compensable clients equal protection rights under the Florida Constitution.45

NICA and other programs should expect further legal challenge. Plaintiffs’ attorneys argue that no-fault violates critical constitutional principles. The Florida Constitution’s equal protection clause, for example, allows the legislature to restrict a right—in this case, the right to a jury trial—only if the right is replaced by an equal benefit. Plaintiffs’ attorneys argue that no-fault programs often do not provide an equal benefit and, even if they do when programs are initiated, the benefits are subject to reduction by budget-constrained legislatures.46 Attorneys also argue emphatically that injured patients are harmed by NICA’s limited pain-and-suffering award cap ($100,000), which, they believe, does not reimburse claimants adequately.47 Some Florida attorneys are waiting for a good case with which to challenge NICA on the grounds outlined above.

It seems unlikely to us that NICA will be terminated on the above grounds. The courts were sympathetic to doctors when NICA was implemented and remain so today. According to one judge, there remains a fear that if doctors are not given protection, provider dissatisfaction will mount, leading to unfortunate results (including doctors’ simply walking off the job).48 Nonetheless, as other states implement larger-scale no-fault programs, policymakers should expect sustained legal challenges.

Physician participation. Provider participation is critical for any elective liability system to succeed. Although precise figures are not available, more than 80 percent of the approximately 900 practicing Florida obstetricians were enrolled in NICA by 1994.49 Those who do not participate have presumably made a judgment that the costs in terms of higher premiums for
their insurer are lower than the $5,000 fee they must pay or are among the physicians who have dropped all liability insurance, a growing trend in Florida, where personal bankruptcy laws are favorable. Residents, interns, and nurse-midwives supervised by participating physicians are covered by the plan. Some hospitals condition admitting privileges on obstetrician enrollment in NICA. Jackson Memorial Hospital in Miami, which performs more than 12,000 deliveries per year, buys coverage for all of its physicians. Many insurers also give full premium credit to subscribers.

While participation is broad, physicians interviewed for this study offered only qualified approval of NICA. They believe that the program is conceptually valid but that the narrow statute application of the injury definition has lessened its impact. Since there have been only approximately forty compensated claims, few doctors have any experience with NICA. Physicians advocate expansion of the injury definition to include premature deliveries and other infants.

NICA was also instituted to satisfy physicians’ demands, keep them insured, and encourage them to remain in the practice of obstetrics. We have little evidence on any of these key issues. However, it seems that fewer obstetricians have stopped practicing, and fewer obstetricians report a decrease in the number of deliveries since the inception of NICA, although one must rely wholly on potentially biased survey data on this issue. In surveys conducted by the American College of Obstetrics and Gynecology (ACOG) before and after the implementation of NICA, the gap between U.S. and Florida obstetrician dropout rates narrowed by 50 percent. Similarly, fewer Florida obstetricians indicated that they limited the number of deliveries they performed as a result of malpractice risk (from 14.2 percent before NICA, in 1987, to only 8.6 percent by 1992). Of course, OB-GYNs’ self-reports are not necessarily corroborated by other empirical evidence. A recent report by the U.S. Congress Office of Technology Assessment (OTA) fails to identify any negative defensive medicine among OB-GYNs in New York, even though surveys had widely reported such activity.

**Administrative costs.** NICA’s administrative costs consist primarily of NICA overhead, attorneys’ time, and the costs associated with adjudicating claims before a hearing officer. NICA employs its general counsel only if the patient is represented by an attorney; approximately 75 percent of claimants are so represented. The total cost for administering a claim based on operating costs and including attorneys’ fees for both sides when the patient chose to be represented, but excluding the cost of the hearing officer, was $18,000 per claim in 1989. Subsequent years’ costs are lower, but NICA does not have firm data. The Florida courts have shown a willingness to limit attorneys’ fees to an hourly rate lower than the contin-
gency fee would have been for a similar case and have refused to reimburse attorneys for time spent litigating fees.\textsuperscript{58}

The administrative costs of the tort system are much higher. Because they work on contingency, lawyers must receive enough pay from successful cases to cover all case expenses. Attorneys’ fees and other litigation costs in Florida represented nearly 57 percent of total insurance costs in 1989; claimant payments accounted for only 43.1 percent.\textsuperscript{59}

There is some concern that administrative costs could rise. As noted, the NICA injury definition excludes infants with genetically and congenitally caused neurological impairment. Recent developments in scientific understanding of neurological injuries to infants, however, suggest that it is difficult to differentiate among injuries of iatrogenic, genetic, and congenital causes.\textsuperscript{60} If hearing officers cannot adequately discern the cause, then a no-fault system could become quite inefficient, as a great deal of resources would be absorbed by the attempt to determine the cause.

Yet NICA has seen relatively little inflation in administrative costs. In part, this is due to NICA policies. According to NICA’s executive director, when there is doubt as to the cause of injury, NICA is likely to err on the side of compensating the patient.\textsuperscript{61} But opponents of the program report just the opposite result—that NICA and its doctors take every opportunity to exclude cases. The more open to interpretation the cause of injury is, the more a no-fault program’s administrative costs will grow.

Summary

Our analysis of NICA, a small, five-year-old program, is not intended as a final recommendation or condemnation of the no-fault medical malpractice system. Our aim has been much more modest: to understand how well a new system performs with regard to the critical issues of claims generation, compensation of claims, financial and legal viability, administrative cost, and physician participation.

On all of these issues, NICA receives passing, if not exemplary, marks. Perhaps its worst score is on claims generation. Using Sloan’s work on Florida birth-related injuries, the only evidence of its kind available, we estimate that NICA is not receiving all of the potential claims for its narrow definition of injury. New no-fault programs should be aware of this and should take strong measures to encourage claims. Unlike other tort reforms, no-fault is intended not to reduce insurance premiums paid by providers but rather to channel more money to severely injured persons by reducing administrative costs. Programs will do so only insofar as they publicize the availability of compensation.

Of course, we should not judge NICA too harshly on this account,
Underclaiming is well recognized in other areas of injury compensation.\textsuperscript{62} In medical malpractice, as few as 5 percent of persons negligently injured and thus eligible for compensation file claims.\textsuperscript{63}

On other measures, NICA scores higher. Compensation of injuries is comparable to that under tort law. Administrative costs are much lower. The program has withstood legal challenges and has been self-sufficient and fiscally stable since its inception. More than 80 percent of Florida obstetricians subscribe to NICA despite other Florida regulations that discourage physicians from carrying liability insurance and a widespread perception that the injury definition is too narrow to make the program effective.

A more thorough investigation of NICA would require primary data collection to evaluate more carefully the rate and degree of compensation for birth-related injury. Such an investigation also would have to evaluate deterrence and defensive medicine, issues we cannot address without analysis of medical injury rates and careful surveys of physician behavior.

In sum, NICA demonstrates how a no-fault system can function. It also shows that claims can successfully be administered with relatively low costs. As such, it provides a model for states that would entertain broader no-fault reforms. Yet these reforms will have to be carefully evaluated before one can recommend no-fault as a replacement for fault-based medical malpractice litigation. The evidence from Florida is as yet insufficient for anything other than careful and responsible further experimentation.

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NOTES

8. Ibid., 4.


13. GAO, Medical Malpractice, 24.


15. Interview with Art Simon, Florida State Representative, 14 October 1994.

16. Interview with John Thrasher, Florida State Representative and excounsel to the Florida Medical Association, 3 February 1994.


27. Ibid.


29. Interview with J.A. Lamert, investigative specialist II, Division of Medical Quality Assurance, Department of Business and Professional Regulation, 31 March 1994.

32. Sloan et al., *Suing for Medical Malpractice*, 192; and interview with Dickinson, November 1993.
33. Sloan et al., *Suing for Medical Malpractice*, 212.
34. Ibid., 75.
35. NICA v. Carreras, 622 So. 2d 1103 (Fla. App., 1994).
37. Sloan et al., *Suing for Medical Malpractice*, 129, 192.
38. Ibid., 125.
39. Ibid., 125.
40. Ibid., 189.
41. Interview with Dickinson, 8 March 1994.
45. Interview with Patty Murray, attorney, Fowler and White, counsel to University of Miami, 24 February 1994.
46. Interview with Florida Academy of Trial Lawyers.
47. Ibid.
48. Interview with Wetherington.
50. Tedcastle and Dewar, “Medical Malpractice,” 579.
52. Florida House of Representatives, “Update on the Florida Birth-Related NICA.”
53. Interviews with Paul Gluck, obstetrician and past president, Florida OBGYN Association, Baptist Hospital, 28 January 1994; Bernie Fogel, dean, University of Miami Medical School, 24 February 1994; and Bedell.