WISCONSIN STATE LEGISLATURE COMMITTEE HEARING RECORDS

2005-06
(session year)

Assembly
(Assembly, Senate or Joint)

Committee on Insurance (AC-In)

File Naming Example:

Record of Comm. Proceedings ... RCP

- 05hr_AC-Ed_RCP_pt01a
- 05hr_AC-Ed_RCP_pt01b
- 05hr_AC-Ed_RCP_pt02

COMMITTEE NOTICES ...

- *Committee Hearings ... CH* (Public Hearing Announcements)
- **

- *Committee Reports ... CR*
- **

- *Executive Sessions ... ES*
- **

- *Record of Comm. Proceedings ... RCP*
- **

INFORMATION COLLECTED BY COMMITTEE CLERK FOR AND AGAINST PROPOSAL

- *Appointments ... Appt*
- **

Name:

- *Clearinghouse Rules ... CRule*
- **

- *Hearing Records ... HR* (bills and resolutions)
- **05hr_ab0766_AC-In_pt02**

- *Miscellaneous ... Misc*
- **

CTCW
Civil Trial Counsel of *Wisconsin*
1123 N. Water St. Milwaukee, WI 53202 phone: 414-276-1881 fax: 414-276-7704 www.ctcw.org

TO: Members, Assembly Committee on Insurance

FROM: Jim Hough, Legislative Director

DATE; October 18, 2005

RE: Support for AB 766

On behalf of the Civil Trial Counsel of Wisconsin (CTCW), I commend the excellent work of the Speaker's Task Force on Medical Malpractice, chaired by Rep. Gielow.

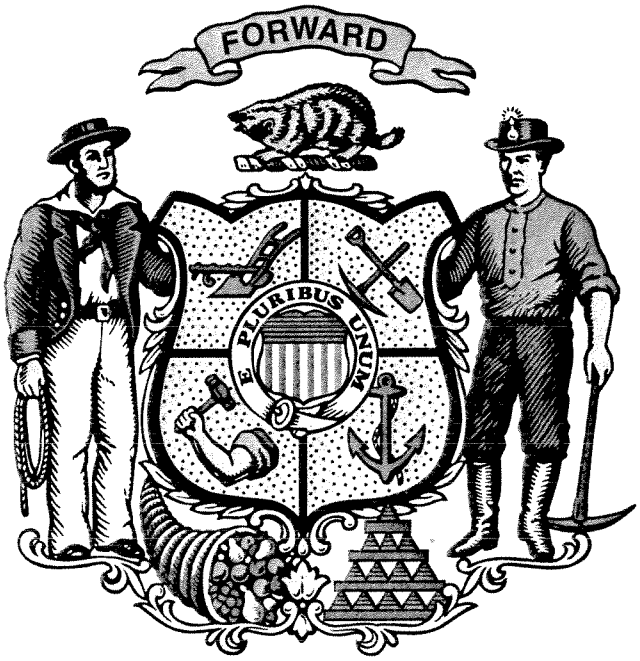
Three recent Wisconsin Supreme Court cases and the fact that Wisconsin law is out of sync with most of the country on expert opinion evidence and the standard for determining strict/product liability, have seen our national ranking for "litigation atmosphere" plummet, creating a true liability crisis in our state. We need a comprehensive response to this crisis to restore a favorable legal environment that impacts on business and personal expansion and location decisions.

Assembly Bill 766 responds to the *Ferdon* decision issued by the Court in July of this year and which struck down the caps on noneceonomic damages in medical malpractice cases which were adopted by the Wisconsin Legislature in 1995. As one who was involved in the 1995 legislation, I can assure you that the Wisconsin Legislature adopted the caps in direct response to legitimate concerns regarding the cost of medical malpractice insurance, availability of medical services, defensive medicine and overall health care costs.

In my personal opinion, the Supreme Court, in the majority opinion in *Ferdon*, demonstrated a blatant desire to legislate and/or a fundamental lack of understanding of how the legislative process operates in establishing public policy.

Assembly Bill 766 is reasonable and rational and we respectfully urge your support.

[CTCW is a statewide organization of trial lawyers engaged primarily in the defense of civil litigation. Past President Mary Wolverton served as a member of the Speaker's Medical Malpractice Task Force.]


FORWARD
PLURIBUS UNUM

Wisconsin Coalition for Civil Justice

TO: Members, Assembly Committee on Insurance

FROM: Jim Hough, Legislative Director &
Bill Smith, President

DATE; October 18, 2005

RE: Support for AB 766

On behalf of the Wisconsin Coalition for Civil Justice (WCCJ), we commend the excellent work of the Speaker's Task Force on Medical Malpractice, chaired by Rep. Gielow.

Three recent Wisconsin Supreme Court cases and the fact that Wisconsin law is out of sync with most of the country on expert opinion evidence and the standard for determining strict/product liability, have seen our national ranking for "litigation atmosphere" plummet, creating a true liability crisis in our state. We need a comprehensive response to this crisis to restore a favorable legal environment that impacts on business and personal expansion and location decisions.

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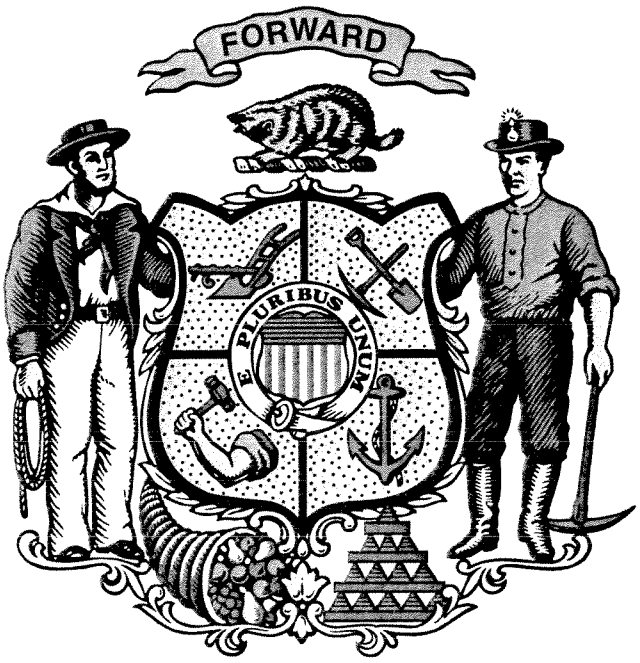
[WCCJ is a statewide coalition of organizations dedicated to fairness and equity in our civil justice system. A list of members is attached.]

Wisconsin Coalition for Civil Justice

WCCJ Members

October 18, 2005

American Council of Engineering
American Insurance Association
Associated Builders & Contractors of Wisconsin
Associated General Contractors of Wisconsin
Building Industry Council
Civil Trial Counsel of Wisconsin
Community Bankers of Wisconsin
National Federation of Independent Business
Petroleum Marketers of Association of Wisconsin
Professional Insurance Agents of Wisconsin
Tavern League of Wisconsin
Wisconsin Asbestos Alliance
Wisconsin Association of Consulting Engineers
Wisconsin Association of Health Underwriters
Wisconsin Auto & Truck Dealers Association
Wisconsin Builders Association
Wisconsin Economic Development Association
Wisconsin Federation of Cooperatives
Wisconsin Grocers Association
Wisconsin Health Care Association
Wisconsin Health & Hospital Association
Wisconsin Institute of CPA's
Wisconsin Insurance Alliance
Wisconsin Manufacturers & Commerce
Wisconsin Medical Society
Wisconsin Merchants Federation
Wisconsin Mortgage Bankers Association
Wisconsin Motor Carriers Association
Wisconsin Paper Council
Wisconsin Petroleum Council
Wisconsin Realtors Association
Wisconsin Restaurant Association
Wisconsin Society of Architects
Wisconsin Society of Land Surveyors
Wisconsin Transportation Builders Association
Wisconsin Utilities Association
Wisconsin Utility Investors


FORWARD
E PLURIBUS UNUM

Wisconsin Economic Development Association Inc.

TO: Members, Assembly Committee on Insurance

FROM: Jim Hough, Legislative Director &
Peter Thillman, President

DATE; October 18, 2005

RE: Support for AB 766

On behalf of the Wisconsin Economic Development Association (WEDA), we commend the excellent work of the Speaker's Task Force on Medical Malpractice, chaired by Rep. Gielow.

Three recent Wisconsin Supreme Court cases and the fact that Wisconsin law is out of sync with most of the country on expert opinion evidence and the standard for determining strict/product liability, have seen our national ranking for "litigation atmosphere" plummet, creating a true liability crisis in our state. We need a comprehensive response to this crisis to restore a favorable legal environment that impacts on business and personal expansion and location decisions.

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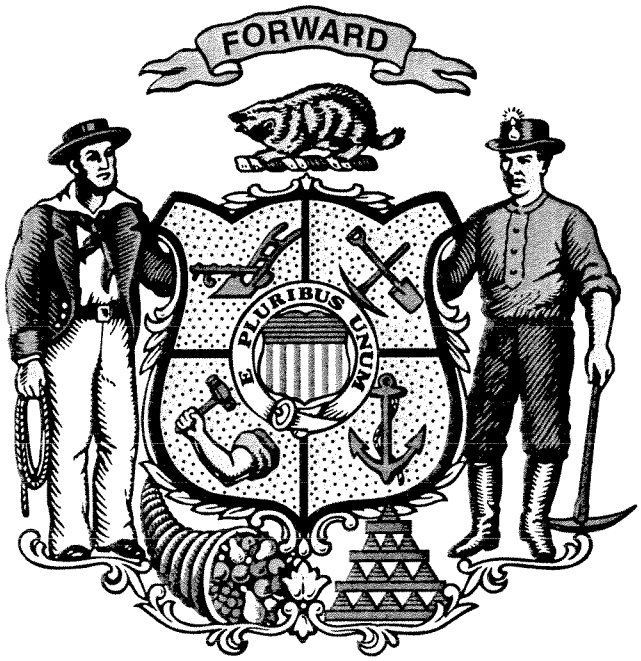
Assembly Bill 766 is reasonable and rational and we respectfully urge your support.

[WEDA is a statewide organization of over 400 economic development professionals who advocate policies beneficial to Wisconsin's economy and that encourage retention expansion and location of businesses within and into our state.]


FORWARD
E PLURIBUS UNUM

Keeping Wisconsin Families Safe
www.watl.org

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Testimony of Daniel A. Rottier

on behalf of the

Wisconsin Academy of Trial Lawyers

before the

Assembly Insurance Committee

Representative Anne Nitschke, Chair

October 18, 2005

Good afternoon, Representative Nitschke and committee members. My name is Daniel A. Rottier. I am the managing partner of Habush, Habush & Rottier, in Madison, WI. I serve as the President-Elect of the Wisconsin Academy of Trial Lawyers (WATL). On behalf of WATL, I thank you for the opportunity to appear to testify today.

Our Wisconsin Constitution grants citizens several rights – the right to trial by jury, the right to remedy, the right to due process and the right to be treated equally under the law. WATL is dedicated to preserving these very important rights for our clients. Every day our members represent people in the state of Wisconsin who need these rights protected. Courts are places where people can go to have these rights vindicated. Not the Legislative or Executive branches. Courts then serve uniquely different functions than the Legislature or Executive branches. As Senator Lindsay Graham recently remarked while discussing judicial independence, courts are places people can go that politics often won't give them access to, where the unpopular can be heard, the poor can take on the rich and the weak can take on the strong. That is why WATL is opposing 2005 AB 766 and 2005 AB 764.

There has been little deliberative process or full participation from all interested parties. Speaker Gard announced he wanted a new cap and appointed a handpicked task force to get it. Consumer groups, injured patients and their families were completely ignored in this process, yet the legislation seeks to take away their very rights. While the legislative process shuts them out, the courts are required to listen to them. They are on equal footing with the special interests. That is not true here.

There has been a rush to judgment. The Supreme Court just threw out the last cap and the Legislature is coming back within 3-4 months with a new one. What has changed to justify it? The legislation was introduced one day and now this hearing is being held and a vote likely on the floor next week. Where is the deliberation? Where is the consideration? It is a sham. We are talking about taking away the constitutional rights of our citizens and you treat it like you're voting for a national appreciation day. The Legislature has not given this issue the weight or depth of analysis it requires.

The Task Force dismissed or did not consider evidence the Supreme Court looked at when deciding the *Ferdon* case.

The Supreme Court gave the Legislature some very clear signals — if they are going to restrict the rights of Wisconsin citizens, it had better show some very good reasons and a rationale that justifies taking this extreme step. The evidence that the Task Force was presented with did not present any clear rationale that justifies a cap, especially one at such a low amount.

The Commissioner of Insurance, Jorge Gomez, testified that, "Wisconsin, … probably has the most sound and functional malpractice environment in the country. … Wisconsin is by far in a much better position than any other state that has a non-problem at the moment with their malpractice environments. … And Wisconsin will not be [in a state in crisis] any time in the future, regardless of what your committee or the legislature decides on the issues of caps…. The reality is that the marketplace is competitive, the Fund is solvent, and we'll likely make adjustments based on the court's decision on assessment in the future."

That hardly appears like justification for a cap.

The testimony from Physicians Insurance Company of Wisconsin (PIC), the state's largest medical malpractice insurer, indicated there was no impending crisis and that the worst-case scenario resulting from the cap's repeal would be "single-digit" premium increases for Wisconsin doctors. In addition, PIC spoke of Wisconsin's "common sense" exercised by juries. Again we had only nine cases that were affected by the cap from 1995-2005, hardly a pressing problem.

Yes, I heard much hand wringing about "potential" problems, particularly access to physicians in rural areas. That problem existed before 1995. If the 1995 cap did not solve this problem, what evidence is there that a new cap will solve it?

The "findings" under Wis. Stat. § 893.55(1d) are merely statements of "hopefulness" and based on partisan studies and which do not reflect other studies that refute them. Whatever the objective is for a cap, the evidence — doctors fleeing or lower malpractice insurance premiums —is merely "speculative," which the Court held could not support the constitutionality of the cap.

How can the cap be justified? It is only $5,000 above the cap that was just determined to be unconstitutional. Where did the numbers come from? It again appears that it was picked out of the air.

The caps continue to discriminate against the most severely injured, the legislature has not remotely considered their rights in this bill and it continues to treat families unfairly, a point that was brought up in the *Ferdon* opinion.

On 2005 AB 764, the language is contradictory. It continues to recognize the right of subrogation and reimbursement, but then it requires the judge to reduce the amount required to be reimbursed and the claimant get the difference. What happens to the amount required to be reimbursed? The language doesn't do away with the requirement to pay those entitled to reimbursement or subrogation.

I, and other members of our firm, represent injured patients and their families. We have represented citizens across the state that suffered severe injuries as a result of medical negligence. For example:

Candace Shepard:

This is a woman in her early twenties who had a relatively minor gynecological problem known as a Bartholin's cyst, which is a cyst that can occur on a woman's perineium. Her doctor advised her that she should have it removed. He told her that it was a routine procedure with minimal complications. The procedure was scheduled on an outpatient basis for a Friday and she was told she would be able to return to work on Monday. In fact, this procedure is very invasive causing significant blood loss and in some cases complications, which are painful and permanent. The doctor did not tell Ms. Shepard about other far less invasive procedures which did not carry the significant risks. Ms. Shepard underwent the removal of the cyst, developed a blood clot which significantly damaged the nerves in her perineal area. She has a permanent injury which necessitates icing on her perineal area every day. She must sit on an inflatable donut to reduce discomfort. She is unable to engage in sexual activity.

A Portage County jury found the doctor who failed to properly advise Ms. Shepard responsible under the informed consent statute and awarded $700,000 for pain and suffering. Because there was little that could be done for Ms. Shepard, her medical expenses were approximately $12,000 and lost wages were $8,000. The jury awarded these amounts in addition to $700,000 in pain and suffering, for a total verdict of $720,000. Due to the operation of the medical malpractice cap, this young unmarried woman who suffers terrible pain daily along with loss of ability to have sexual relations for the rest of her life, was limited to a total recovery of $370,000.

Tanner Noskowiak

Tanner was born on February 13, 1996. Within days of birth he was diagnosed as a hemophiliac. At two months of age a family practitioner who was aware of the hemophilia, performed a lumbar puncture without consulting with a hematologist or administering a clotting factor. As a result, the child bled into the spinal canal and suffered a stroke-like injury to the artery. Resulting injuries are severe deficits of both upper extremities, which reduces them to flipper-like appendages. He will never have normal use of his hands.

Lori Schmitz

This is a 38-year-old married woman and mother of two daughters. She was being treated for neck pain and headache with up to 12,000 mg of morphine on a daily basis in combination with 10 other medications. Finally, when the physician attempted to convert her morphine to methadone, Ms. Schmitz developed nausea, vomiting, anorexia and muscle spasms which caused her to collapse during the conversion process. She subsequently suffered seizure activity and permanent brain damage. Since August of 1998, she has been incapable of caring for herself and/or her family, is a danger to herself and others, and has had to be institutionalized.

Sharon Swatek

A 43-year-old married woman and mother of two children, was having flu-like systems in February 2001. She sought treatment at an urgent care and ER, but was not placed on antibiotics. She continued to be ill and eventually went into septic shock. Subsequent cultures revealed she was infected with Strep A which exacerbated into strep pneumonia. The treatment for septic shock included the use of vasopressors which preserve perfusion to vital organs at the expenses of the periphery. This resulted in a loss of perfusion to her extremities, necrosis and finally amputations of both arms, one above the elbow and one below, and bilateral below the knee amputations of her lower extremities.

These are the Wisconsin citizens trial lawyers all across Wisconsin are representing — real people injured through no fault of their own — who simply want to understand what happened to them and have whoever caused the wrong held responsible. They are not asking for special treatment, but they expect whoever caused the injury should be held financially and legally responsible.

The Ferdons' challenged the cap's reduction because the law did not treat them equally. The Supreme Court took this challenge very seriously. In a scholarly, exhaustive and well-reasoned opinion, the Court reviewed the legislative purpose of the 1995 cap as well as evidence to support and refute it. The Court reviewed over 50 reports and articles.

I would like to highlight the evidence against the caps.

Medical malpractice insurance premiums are an exceedingly small portion of overall health care costs. In Wisconsin, they are now less than 40 cents out of every $100 dollars spent on health care and it is a declining proportion. *Expansion Magazine* has rated Wisconsin's malpractice costs as the lowest in the nation. Meanwhile, Wisconsin health insurance premiums are rated second highest in the nation. There is no correlation between malpractice costs and health care costs.

The Court found that "even if the $350,000 cap on noneconomic damages would reduce medical malpractice insurance premiums, this reduction would have no effect on consumer's health care costs." That certainly proved true under the $350,000 cap. Did anyone experience lower health care costs since 1995? The Court concluded, "Accordingly, there is no objectively reasonable basis to conclude that the $350,000 cap justifies placing such a harsh burden on the most severely injured medical malpractice victims, many of whom are children."

Just nine (9) jury verdicts were impacted by the cap from 1995-2005. Below is a summary of the case and how the cap impacted the injured patients and their families.

Jury Verdict Date, County, Case #	**Injured Patient and Age**	**Nature of injury**	**Noneconomic damages jury awarded, including pain and suffering**	**Final award**	**Percentage Reduced**
April 2005 Milwaukee 2003CV3456	Joseph Richard mid-50's	He underwent an unnecessary removal of his rectum, with a leak of the anastomosis, ten further surgeries, and permanent bowel problems.	$540,000	$432,352	20%
May 2004 Marinette 2002CV60	David Zak mid-30s	Failure to diagnose suspicious infection causing body to shut down resulting in loss of bodily function	$1 million	$422,632	57%
April 2004 Kenosha 2001CV1261	Estate of Helen Bartholomew Early 60s	Failure to diagnose heart attack causing massive heart and brain damage requiring her to live in nursing home and resulting in her death 3 years later	$1.2 million	$350,000	70%

Jury Verdict Date, County, Case #	Injured Patient and Age	Nature of injury	Noneconomic damages jury awarded, including pain and suffering	Final award	Percentage Reduced
Dec. 2003 Ozaukee 1999CV360	Sean Kaul infant	Negligent failure to provide timely and proper treatment for hypoglyceminia and hypovolemia that developed shortly after birth rendered child permanently disabled	$930,000	$422,632	55%
Dec. 2002 Brown 2001CV1897	Matthew Ferdon infant	Negligent delivery resulting in right arm being deformed and partially paralyzed	$700,000	$410,322	40%
June 2002 Dane 2000CV1715	Scott Dickinson mid-30s	Negligent treatment during a psychotic episode and rendered a quadriplegic.	$6.5 million	$410,322	93%
June 2001 Eau Claire 2000CV120	Kristopher Brown 16 years old	Negligent treatment of a broken leg resulting in part of the leg being amputated	$1.35 million	$404,657	67%
March 2000 Eau Claire 1998CV508	Bonnie Richards Early 40s	Common bile duct clipped during laproscopic cholecystectomy resulting in residual hernias requiring additional surgeries and almost dying twice.	$660,000	$381,428	41%
October 1999 Portage 1998CV169	Candice Sheppard mid-20s	Negligent surgery to remove a cyst in the vaginal area resulted in permanent pain and injury	$700,000	$350,000	50%

These nine cases show a reduction of approximately $10.2 million from what the juries determined the damages to be after hearing all the evidence compared to the damages available under the cap enacted in 1995. That's about $1 million per year. That comes to 18 cents per person in Wisconsin per year. Furthermore, because an injured patient shares the cap with family members, the cap has a disparate effect on patients with families. It is these injured patients and their families who are bearing the total burden if medical malpractice occurs and a jury awards more than the cap. Why is it fair to burden the most seriously injured while providing monetary relief to health care providers and their insurers?

The data from the National Practitioner Data Bank, to which all payments to people injured by medical negligence must be reported, show that Wisconsin was the third lowest state for the number of payments per 1,000 doctors in 2003, the same ranking we held in both 1994 and 1995, before the cap on damages took effect.

With a cap, the Fund's enormous assets are denied to patients for whom juries have awarded compensation above the cap. In the last 10 years, the Fund's assets have almost tripled, increasing an average of $47 million a year to almost $750 million. During the same period, the Fund was only drawn upon an average of 19 times per year and payments made to families averaged only $28.5 million per year. *That amounts to $18.5 million less than the average annual increase in Fund assets.* Meanwhile, the Fund's assets, while barely tapped by injured patients, have been utilized to reduce Fund malpractice fees for doctors. Fund fees have been cut six of the last seven years, most recently by 30 percent. *The Fund fees for 2005-2006 are more than 50% lower than fees from 1986-87.*

Injured Patients & Families Compensation Fund

Year	Number of Cases Paid	Losses Paid to Injured Patient & Families
1994-95	25	$24,098,896
1995-96	28	$51,456,670
1996-97	16	$34,679,277
1997-98	24	$18,718,458
1998-99	28	$19,929,978
1999-2000	12	$19,657,326
2000-01	22	$39,636,276
2001-02	14	$35,304,773
2002-03	11	$22,074,552
2003-04	13	$19,496,969
Total	**193**	**$285,053,175.00**
Average	**19.3**	**$28,505,318**

WATL believes that grossly inaccurate actuarial projections have fueled the need for a cap. In 1995, sponsors of the cap legislation used the inaccurate projections by actuaries as a reason to impose the noneconomic damages cap. Legislators were told there was a *$67.9 million projected actuarial deficit* as of June 30, 1994. Instead, the actuaries now estimate there was a *$120 million actuarial surplus*. ***It shows that when the Legislature acted in 1995, it was given estimates that were off by almost $188 million!!*** As the Supreme Court it didn't seem to make any difference if there was or wasn't a cap because the Fund has flourished both with and without a cap.

In Wisconsin, few medical malpractice claims are filed. In a state with 5.5 million people, with millions of doctor-patient contacts yearly, only 240 medical negligence claims were filed in 2004 with the Medical Mediation Panels. That is one claim for every 22,916 Wisconsin citizens. The number has been steadily decreasing since the mid-80s. This pattern suggests that even when there was no cap on damages from 1991-1995, there was no corresponding explosion of claims. In fact, there was a decline in filings. So, the imposition of a cap is simply an additional, but wholly arbitrary, barrier to justice for most families.

Year	Medical Mediation Claims Filed	Amount of Cap*
1986	***	$1,000,000
1987	398	$1,030,000
1988	353	$1,070,170
1989	339	$1,123,678
1990	348	$1,179,862
Total	**1438**	
Average	**359.5**	
1991	338	No Cap
1992	313	No Cap
1993	276	No Cap
1994	292	No Cap
Total	**1219**	
Average	**304.75**	
1995	324	$350,000
1996	244	$359,800
1997	240	$369,874
1998	305	$375,052
1999	309	$381,428
2000	280	$392,871
2001	249	$404,657
2002	264	$410,322
2003	247	$422,632
2004	240	$432,352
Total	**2702**	
Average	**270.2**	

** The $1 million cap went into effect on June 15, 1986 and the cap was indexed on that day each year. The $350,000 cap went into effect on May 25, 1995 an was indexed each year on May 15.*
**** No numbers for that year.*

One of the most persistent assertions about caps is that they would hold down malpractice premiums for doctors. The Court analyzed several studies and found that "according to a General Accounting Office report, differences in both premiums and claims payments are affected by multiple factors in addition to damage caps, including state premium rate regulation, level of competition among insurers, and interest rates and income returns that affect insurers' investment returns. Thus, the General Accounting Office concluded that it could not determine the extent to which differences among states in premium rates and claims payments were attributed to damage caps or to additional factors. For example, Minnesota, which has no caps on damages, has relatively low growth in premium rates and claims payments. "

In fact if you listened to the insurance companies own executives, they would not promise any savings from caps. This was recently highlighted in Illinois. In a recent news article it was reported, "As for caps on awards resulting in reduced rates for malpractice insurance premiums that doctors must pay, supporters of caps say they can't promise the new caps will significantly lower insurance rates.

Ed Murnane, the leading tort reform advocate in Illinois, said at a tort reform summit in mid-May, 'No, we've never promised that caps will lower insurance premiums.'"

Insurance execs speak up

"We wouldn't tell you or anyone that the reason to pass tort reform would be to reduce insurance rates." Sherman Joyce, President of the American Tort Reform Association, (Source: "Study Finds No Link Between Tort Reforms and Insurance Rates," *Liability Week*, July 19, 1999.)

"Insurers never promised that tort reform would achieve specific premium savings . . ." (Source: March 13, 2002 press release by the American Insurance Association (AIA).)

"[A]ny limitations placed on the judicial system will have no immediate effect on the cost of liability insurance for health care providers." (Source: "Final Report of the Insurance Availability and Medical Malpractice Industry Committee," a bi-partisan committee of the West Virginia Legislature, issued January 7, 2003.)

An internal document citing a study written by Florida insurers regarding that state's omnibus tort "reform" law of 1986 said that ***"The conclusion of the study is that the noneconomic cap . . . [and other tort 'reforms'] will produce little or no savings to the tort system as it pertains to medical malpractice."*** (Source: "Medical Professional Liability, State of Florida," St. Paul Fire and Marine Insurance Company, St. Paul Mercury Insurance Company.)

This theme was further bolstered by a recent rate filing by GE Medical Protective, which sought a 19% rate increase just one year after Texas voters narrowly approved a $250,000 cap on non-economic damages in medical malpractice cases. After claiming that caps would reduce malpractice premiums, the insurer admitted in its rate-filing request that "capping non-economic damages will show loss savings of 1%."

Further, we must agree with the Supreme Court that, "Victims of medical malpractice with valid and substantial claims do not seem to be the source of increased premiums for medical malpractice insurance, yet the $350,000 cap on noneconomic damages requires that they bear the burden by being deprived of full tort compensation."

Various new studies have been released to bolster this statement. In Texas, researchers looking at Texas found that soaring malpractice premiums were not correlated with malpractice lawsuits and settlements. A team of legal scholars from the University of Texas, Illinois, and Columbia examined all closed claim cases from 1988 to

2002. The law professors found that claims rates, payments and jury verdicts were roughly constant after adjusting for inflation and concluded that the premium increases starting in 1999 "were not driven primarily by increases in claims, jury verdicts, or payouts. In the future, malpractice reform advocates should consider whether insurance market dynamics are responsible for premium hikes."

A second comprehensive study of medical malpractice claims, this time in Florida, also shows no sharp increase in lawsuits relative to population growth and a modest increase in the size of settlements. "When we compared the number of malpractice cases to the population in Florida," said Neil Vidmar, one of the study's authors and professor at Duke's School of Law, "there has been no (large) increase in medical malpractice lawsuits in Florida." Vidmar said rising health-care costs and more serious injuries resulting in larger claims or litigated payments caused the increase in the claim total. Finally, the report concludes the "vast majority of million-dollar awards were settled around the negotiation table rather than in the jury room." Of the 831 million-dollar awards reported since 1990, 63 were awarded by juries. The rest occurred as settlements.

The National Bureau of Economic Research study reviewed the relationship between the growth of malpractice costs and the delivery of health care in three areas: (1) the effect of malpractice payments on medical malpractice premiums, (2) the effect of increases in malpractice liability to physicians closing their practices or moving and (3) defensive medicine. The study found a weak relationship between medical malpractice payments and malpractice premium increases.

A July 7, 2005, study released by Center for Justice and Democracy finds that net claims for medical malpractice paid by 15 leading insurance companies have remained flat over last five years.

Meanwhile, net premiums have surged ***120 percent.*** During the 2000-04 period, the increase in premiums collected by leading 15 medical malpractice insurance companies was ***21 times*** the increase in claims they paid. The study shows an "overall surge in malpractice premiums with no corresponding surge in claim payments during the last five years."

Other key highlights of the study:

- "Over the last five years, the amount the major medical malpractice insurers have collected in premiums more than doubled, while their claims remained essentially flat."
- "...In 2004, the leading medical malpractice insurers took in approximately three times as much in premiums as they paid out in claims."
- "{T}he surplus the leading insurers now hold is almost double the amount the National Association of Insurance Commissioners deems adequate for those insurers."

Wisconsin Unique System: The Injured Patients and Families Compensation Fund

A short history of the Injured Patients and Families Compensation Fund may be in order since it has figured so prominently in the discussion of Wisconsin's malpractice system. Wisconsin's medical malpractice insurance structure was set up in 1975 to deal with a serious problem in availability of medical malpractice insurance. The Legislature guaranteed the availability of insurance by creating the Wisconsin Health Care Liability Insurance Plan (WHCLIP) as a risk-sharing plan to provide primary insurance coverage and by creating the Patients Compensation Fund (the Fund) to pay claims in excess of primary coverage. (The Legislature changed the Fund's name in 2003 to the Injured Patients and Families Compensation Fund. 2003 WI Act 111.) The same Board of Governors governs both.

The 1975 Statutory Scheme

The statutory scheme is unique: insurance is mandatory for physicians (except government-employed) and hospitals; primary coverage is from WHCLIP or a private company; the Fund fees are also mandatory and provide unlimited coverage over the primary level.

WHCLIP is run like an insurance company; the Fund is not. Fund fees were originally calculated as a percentage, not to exceed 10%, of the WHCLIP rates. Fees were to be reduced if "additional fees would not be necessary to maintain the Fund at $10 million."

The 1975 legislation contained a potential limitation on payouts. Wis. Stat. § 655.27(6) initially provided,

> If, at any time after July 1, 1978 the commissioner finds that the amount of money in the Fund has fallen below $2,500,000 level in any one year or below a $6,000,000 level for any 2 consecutive years, an automatic limitation on awards of $500,000 for any one injury or death on account of malpractice shall take effect. ... This subsection does not apply to any payments for medical expenses.

In March 1980, the law was changed to require an annual report for the Fund, prepared according to generally accepted actuarial principles, that would give the present value of all claims reserves and all

Timeline of the Fund

1975 — Legislature establishes Patients Compensation Fund (Fund) and the Wisconsin Health Care Liability Insurance Plan (WHCLIP). The legislation required that all physicians carry malpractice insurance either from a private insurer or WHCLIP for up to $200,000 and then mandates participation in the Fund, which provides unlimited coverage and pays claims in excess of primary coverage. The same 13-member Board of Governors governs both. WHCLIP is run like an insurance company; the Fund is not. Fund fees were originally calculated as a percentage, not to exceed 10%, of the WHCLIP rates and the Fund was not to have more than $10 million in assets.

1980 —The fiscal nature of the Fund was changed to give the present value of all claims reserves and all incurred but not reported (IBNR) claims. IBNR claims are claims that are not presently known but are presumed to exist. This changed the Fund from a form of "pay as you go" system to a system with a potential surplus or deficit.

1986 — The Legislature adopts an indexed $1 million cap on pain and suffering. The Fund also collapsed the number of Fund classes from 9 to 4 for purposes of calculating fees.

1987 — Doctors' primary coverage increased to $300,000.

1988 — Doctors' primary coverage increased to $400,000

1991 — $1 million indexed cap sunsets.

1995 — $350,000 indexed cap adopted.

1997 — Doctors' primary coverage increased to $1,000,000.

2003 — Fund name changed to Injured Patients and Families Compensation Fund.

incurred but not reported (IBNR) claims. IBNR claims are those claims that are not presently known but are presumed to exist; they have played an important role in the Fund's financial situation ever since 1980.

The net effect of this statutory change was to change the Fund from a form of "pay as you go" system to a system with a potential surplus or deficit based on the annual actuarial reports. The potential surplus or deficit relied heavily on the projected value of claims reserves and IBNR claims.

The Fund was established to pay claims in excess of primary coverage. Health care providers are required to purchase primary coverage — $200,000 in 1975, $300,000 in 1987, $400,000 in 1988, and $1,000,000 in 1997. Fees assessed against all health care providers in the state pay for the Fund. The Fund fees are created by administrative rule, providing the Legislature with oversight authority. The Fund is divided into no more than four

The 1986 Legislative Changes

In the early and mid-80s, was a sudden and dramatic requests for premium and fee increases. This led to a second "crisis" in medical malpractice insurance. Because WHCLIP and the Fund mechanisms worked as intended, Wisconsin did not have problems with *availability* of insurance as it had in 1975. Instead, Wisconsin suffered an "*affordability* crisis," that is; the dramatic price increases made insurance premiums and Fund fees less affordable.

The highest Fund fee increase suggested by the actuaries was a 160% fee increase for 1985-86; more than half of the increase was meant to offset a portion of the actuarial deficit. The Legislature would not go along with that huge increase but did approve a 90% fee increase.

The increased cost of medical malpractice insurance led health care providers to lobby the Legislature for strong tort "reform" measures, including caps on damages, limits on the attorneys fees of injured consumers, and limits on payments for future medical expenses. After much debate, the Legislature made numerous changes to the law in 1986 including a cap of $1 million on all noneconomic damages. The legislation, however, made few changes to directly address the elimination of the Fund's actuarial

deficit. Nevertheless, Fund fees were only moderately increased from 1986 through 1994. There was virtually no impact on fees after the noneconomic damage cap sunset on December 31, 1990 (resulting in no cap being in effect).

In addition, during the 1980s, the Fund collapsed the number of classes from nine to four, thereby moderating costs between general practitioners (Class 1) and neurologists and OB-GYNS (Class 4).

The establishment of the Fund represented an egalitarian reform that involved *sharing of risk* among all providers to hold down malpractice rates. Consequently, the Fund's premium structure divided the medical profession into just four categories, resulting in substantially lower rates for higher-risk specialties and somewhat higher rates for lower-risk categories. This sharing of risk helps Wisconsin to retain doctors in high-risk specialties upon whom general practitioners can rely for referring patients in need of more specialized care.

In sharp contrast, the cap on pain and suffering imposed a *shift of risk* from providers as a whole to patients and the public. Patients could no longer count on the legal system to give them full compensation for the pain and suffering caused by medical negligence. Juries were deprived of the power to fully compensate injured patients.

Moreover, it is precisely the Fund's unique and progressive features—not the cap—that have actually accounted for the decreases in malpractice premiums:

a) **Non-profit:** The Fund is not-for-profit. In contrast to private insurance corporations characterized by huge executive salaries, massive bureaucracies, and wild swings in premium rates contingent on stock and bond

How Wisconsin doctors are insured against malpractice

Nature of malpractice claim	Source of insurance	Premiums
For claims up to $1 million	Private insurers	Set by insurance firms, highly dependent on stock and bond investments
For claims up to $1 million when private insurance is not available	WHCLIP (serves only 2.3% of doctors)	Rates are set by the Board, and are set higher than other private malpractice insurance
For claims above $1 million	Injured Patients and Families Compensation Fund	Set by Fund Board. Fees have been cut to sub-1986 levels.

market investments, the Fund does not subject Wisconsin medical providers to these burdens.

b) **Universal:** The Fund is universal, covering virtually all health care providers in the state. Thus, the Fund draws upon a large pool of doctors to share the risk and hold down costs.

c) **Sharing the risk:** The Fund spreads the cost of insuring against risk across interrelated medical professions, so that high-risk specialties do not bear an inordinately heavy burden.

Because the Fund has been so successful at accumulating assets — almost $750 million assets. As the Supreme Court noted in *Ferdon v. WCFP*, 2005 WI 125, ¶158 "The Fund has flourished both with and without a cap. If the amount of the cap did not impact the Fund's fiscal stability and cash flow in any appreciable manner when no caps existed or when a $1,000,000 cap existed, then the rational basis standard requires more to justify the $350,000 cap as rationally related to the Fund's fiscal condition."

Conclusion

The ominous implications for the Constitutional rights of Wisconsin citizens—particularly injured patients—were minimized during the legislative debate in 1995 that imposed the cap on pain and suffering in medical malpractice cases. Instead, advocates of the cap argued that this loss of legal access for a relative few would be far outweighed through a tradeoff for broader public benefits — lower health care costs, more doctors in underserved areas and a solvent and stabilized Fund for injured patients and their families.

In practice over the past decade, the tradeoff of legal rights for public benefits proved to be disastrous. While our legal rights certainly were diminished, the promised benefits have never appeared. Wisconsin does not have lower health care costs, doctors are still not going to underserved areas and the Fund was never in jeopardy, it had been in surplus since 1990, the year the $1 million cap expired.

The Legislature is following down the same trail again to impose a cap the attempts to ask the most severely injured patients and their families of severely injured patients to bear the burden of "fixing" the legal malpractice system alone. That is neither fair nor just.

Caps are a barrier to the courthouse for injured patients and their families and strike at the very heart of the civil justice system. It deprives juries of their constitutional mandate to do *justice* in individual cases. You are once again tilting the scales of justice in Wisconsin against severely injured patients and their families in favor of health care providers and their insurance companies.

We believe that is not only immoral, but unconstitutional.

Wisconsin's Healthcare Picture by the Numbers

	Medical Malpractice Facts	Healthcare Facts
1	***40 cents out of every $100 dollars*** **spent on healthcare goes for medical malpractice costs — insurance costs and payments to injured patients and families**	***8 of top 10*** **U.S. cities with highest physician fees**
2	**50th and lowest** Wisconsin's rank in terms of medical malpractice costs in U.S.	**2nd highest** Wisconsin's rank in terms of healthcare premiums in U.S.
3	**9 verdicts** Exceeded the cap on noneconomic damages from 1995-2005	**18 cents a year** Average *savings* per Wisconsin resident per year for those cases exceeding the cap
4	**48th lowest** Wisconsin's rank in frequency of paid malpractice claims, 7.9 claims per 1,000 doctors	**+24.3%** Percentage that Wisconsin *exceeds* the national average for health care coverage per worker.
5	**49th lowest** Wisconsin's rank in frequency of jury findings in favor of injured patients per 100,000 Wisconsin residents	**+49.3%** *Rise* in Wisconsin workers' out-of-pocket health costs, 2000-2004, more than 4 times wage increases over the same period of time.
6	**$30,000 lower** Difference in Wisconsin's average paid medical claim compared to the national average	**+27%** Percentage that Milwaukee spending on overall health care *exceeds* the U.S. average.
7	**-16%** Percentage of *decline* in malpractice claims after Wisconsin's cap of $1 million expired in 1991 and there were no limits until 1995.	**+63%** Percentage that Milwaukee hospital costs *exceed* the national average.
8	**4 cases** In 2004, injured patients and their families won just 4 out of 23 cases tried to juries.	**+33%** Percentage that Milwaukee doctor prices *exceed* the national average.
9	**$28.5 million** Average yearly payments by the Injured Patients and Families Compensation Fund from 1994-2004 to injured patients and their families	**$47.0 million** Average yearly increases in Fund assets through investment income and fees collected by the Injured Patients and Families Compensation Fund from 1994-2004.
10	**50th lowest** Wisconsin's ranking of taking serious actions against doctors by the Medical Examining Board in 2003	**195,000** Number of people who die each year in hospitals in the U.S. from medical errors

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Sources:

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2. *Expansion Management* magazine, February 14, 2005.

3. Randy Sproule, Administrator, Medical Mediation Panels.

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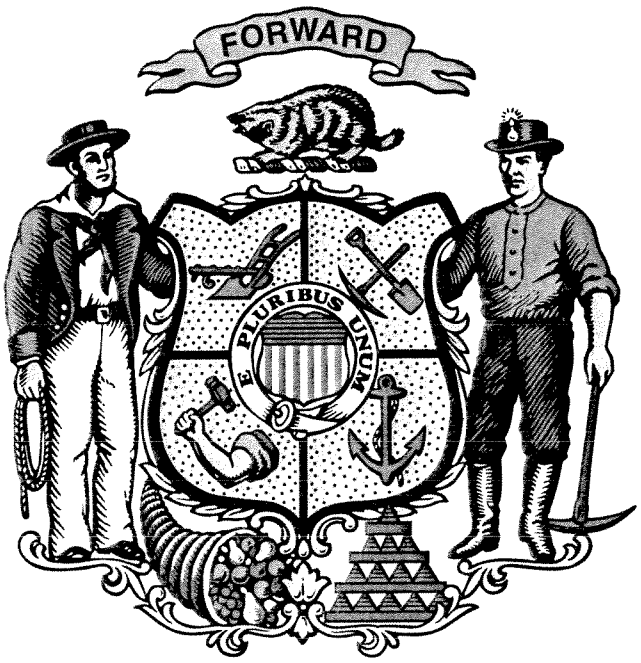
10. "Ranking of the Rate of State Medical Boards' Serious Disciplinary Actions in 2003," Public Citizen, April 2004 and HealthGrades report July 2003. See *Milwaukee-Journal-Sentinel* article, 1A, July 28, 2003.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TO: Assembly Insurance Committee

FROM: Kim and David Zak

DATE: October 18, 2005

RE: Testimony against caps on damages

We are Kim and David Zak from Crivitz, Wisconsin. We are here today to speak against caps on damages because we have been impacted in a very deep and personal way by malpractice. I want to tell our story.

David is an auto mechanic and was at work flushing out a cooling system, when hot anti-freeze burned his right forearm. The burn was cleaned, but unknown to us, the burn drove Group A Strep bacteria, which is on our skin, into David's bloodstream.

That night David woke up in the middle of the night with chills. He took a Benadryl and went back to sleep. Five hours later he awoke with the shakes. He called me at work and asked that I come home and drive him to the hospital. This was a very unusual request.

I came home and we drove to Green Bay, on the way we stopped and grabbed all the bottles that David had used that day and took with us to the ER. It took about an hour and half to drive. We arrived about 9 a.m.

During the next 3 and half hours, they treated David's burn and did blood work-up, including a CBC. His temperature spiked to 103.9 degrees and his blood pressure was low. They said it would take 24-48 hours for the cultures to grow and prescribed Ibuprofen and Tylenol for the pain and fever, alternatively. We were advised that if conditions didn't worsen to come back in two days.

David spent the rest of the day resting and didn't present any new symptoms. He took a cool bath and his temperature went down a bit.

The hospital called back at 10 p.m. and said something was growing in the cultures and to return to the ER that night or in the morning. We decided to return that night. On the way to the hospital, David started experiencing diarrhea. By the time we reached the hospital, his blood pressure was very low and he was already septic. I could see blood coming out of the penis.

David's organs started shut down – liver, kidneys, and bladder. His lungs were bleeding. He spent three weeks in the hospital on antibiotics. Everything came back, but his bladder. He was required to have tubes inserted into his back, so his urine could drain into bags on his legs. They had to be cleaned everyday and bandaged.

We went to an urologist at the Mayo Clinic to have his bladder removed and a new bladder rebuilt. The new bladder is a neobladder made from his appendix, colon and intestines.
What happened? During the course of our trial we learned that the Physicians Assistant (PA) had done an analysis of the blood called a wet analysis. The result said to do it manually, which would have taken an hour. The PA also told the doctor that David was already septic, yet the doctor said it was April and he had the flu and sent him home without any antibiotics.

What is our life like? We are constantly watching for infections. He is required to use a catheter every time he goes to the bathroom and he is very susceptible to infections.

David must take liquid medication and antacids for metabolic acidosis. He is fatigued.

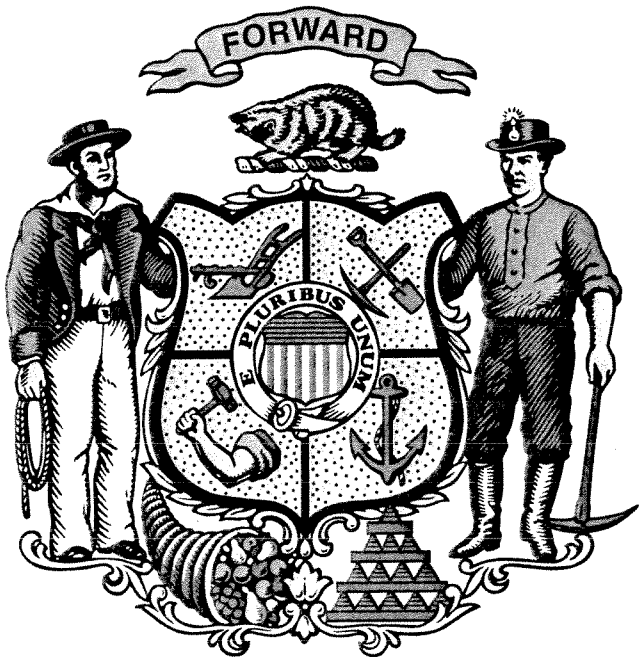
He suffers from erectile dysfunction. To have an erection he must inject himself with Triple agent. If it doesn't work right and the erection doesn't subside, he must go to the hospital and have it cut and drained.

We had an eight-day trial in Marinette County that gave us $1 million for our pain, suffering and disability. David received $750,000 and I received $250,000. The cap cut down our award over 55%. The compensation recognizes what we will have to go through for the rest of our lives.

Also, I want to point out, if David and I hadn't brought this lawsuit, workers' comp would not be repaid. To date, our case is still on appeal and we haven't received any money to date.

I hope that none of you in this room ever have to be sitting in this place that we are today. A mistake was made that changed our lives forever. It could have happened to anyone here... It still could happen to you.

Please don't enact new caps on damages. It only serves to hurt someone like us.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Testimony

Against Legislation for Re-establishment of Caps for Pain and Suffering Resulting from Medical Malpractice [Room 412E]

by
Dr. Eric E. Rice
Wisconsin Family Justice Network
Middleton, WI

18 October 2005

There are many significant medical malpractice issues that need to be resolved to help patients and their families to: gain disclosure of information, have equal rights and legal protection under the law, and seek accountability for medicine that is well below the standard of care. I submit to you that the medical insurance industry is the route of the medical malpractice problems in this country and that is where reform is needed. We should not do more harm to the effected patients by putting caps back. Caps on non-economic damages are a hindrance to finding out the truth and gaining accountability for our citizens.

The Rice Family of Middleton, Wisconsin experienced a medical crisis and loss of our 20-year old daughter, Erin Elisabeth Rice at UW Hospital on April 19, 1999 due to gross misdiagnosis of her illness. This ordeal has identified many significant medical and legal issues that need to be fixed by this legislature. The Wisconsin Family Justice Network, of which I am involved, was formed to fight for all of us, fight for the rights of all patients and our families.

[1] The Network does not support medical malpractice caps and we believe that judges and juries should make those decisions just like in any other civil action.

[2] The Network supports the passage of the Family Justice Bill [sponsored by Senators Plale, Hansen, and Erpenbach, and Representatives Ott, Sheridan, and Zephick] that will put all patients on an equal basis and prevent discrimination based on age and marital status.

[3] The Network supports the Repeal of the 180-day Notice Rule [SB-74 - Sponsored by Senator Risser, and Representatives Jenson, Hines, Pocan, Berceau, and Lehman] that UW physicians and lawyers have used to unfairly discriminate against patients that use UW physicians.

Patients/Families that have suffered or died require the right to litigate against physicians, hospitals, HMOs, insurance companies in a standard equal and fair way. The same standards must be utilized for any medical provider within a given state. No unfair advantage must be afforded to one medical provider over another when it comes to the provision or need for malpractice insurance, limits of liability, and notice of claim rules.

The recent low $350,000/$250,000 [with inflation] cap on malpractice/wrongful death non-economic damages limit (in Wisconsin and elsewhere) is totally unconstitutional should not be approved by our legislature. The Wisconsin Supreme Court will declare its flaw once again, if passed; however, I expect that Governor Doyle will veto it.

Until recently, the State of Illinois had no cap on medical malpractice, as the previous caps were declared unconstitutional by the Illinois Supreme Court. The Judges and Juries made those determinations. With no caps, healthcare in Illinois has improved, physicians practiced better medicine, the cost of medicine only increased by 1%, there is much less indirect pain and

suffering, and there is much less indirect adverse economic cost to the people. The bad doctors moved to states with caps! In states where lower caps exist (like Indiana, for example), the quality of medicine is poor, and the greater is the pain and suffering and greater is the unmeasured economic loss of patients and their families. This lower cap may result in patients not being treated with the smartest or heroic measures because it is cheaper for the medical system to simply go through the motions and let the patient die and pay the limited claim in or out of court.

Any cap - at any level - on medical malpractice provides tremendous advantages to the medical practitioner and the insurance company and does a terrible injustice to a victimized patient in either the negotiation of a fair settlement or trial action, if taken. Reinstatement of Caps will only reduce the quality of healthcare that patients receive in this state. If there are problems of frivolous lawsuits, let the juries and judges make the fair decisions. Provide these institutions the tools they need to foster fairness to both the patients and doctors!

The Patient's Compensation Fund is for Patient Compensation. It has ballooned to a whopping $750M and still the insurance companies complain. Even after significant reductions in physician premiums, the fund still grew by $20M last year. The fund is meant to try to make "whole" the patient and families that have been harmed or killed by medical errors and failures.

For cases, usually involving young or older victims, there may be no likely economic claim, the caps on non-economic damages will prevent an action from making it to the court room. I'll explain why. To gain legal representation, a client's case must make sense, economically. If there is a plaintiff win probability of 25% and there is a cap of $400K, that means that the likely economic win would be 25% of $400K which would be a $100K probable result. However, to put on a trial, the out of pocket costs for depositions, testimony of medical experts, travel, etc., will easily reach $100K. Also, the Wisconsin jury trial plaintiff win probability last year was 17% [4 out of 23] in WI. The Lawyer will not take the case because there is not enough likelihood of getting paid any thing for his or her labor. This means that patients like these will never get to the court room to find out what happened. No accountability will ever be achieved.

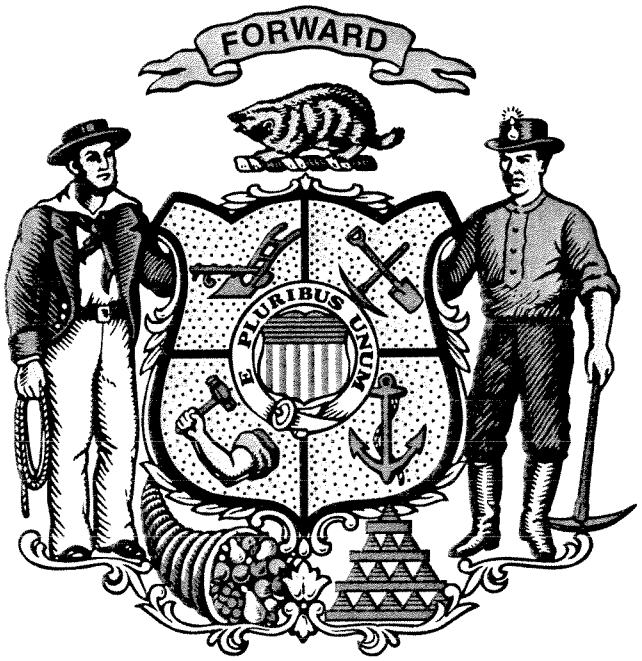
Just think what you would do if your older parent or your young child died of medical malpractice and no attorney could take the case because of caps, and you could never find out what happened. That's why the caps need not be put back. And that is why the Medical Society and Insurance Company Lobbyists support Caps. Medical Malpractice in this country accounts for less than 0.46% of the total cost of the health care delivery system. Wisconsin had the lowest rate in the nation at less than 0.4%. Who has the correct facts here? We do.

Vote No for Caps

Vote Yes for Family Justice

Vote Yes for repeal of the 180-day Notice Rule.

That's my input -- Thanks for listening!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STATEMENT

By

ROBERT E. PHILLIPS, M.D.
GENERAL INTERNAL MEDICINE DEPARTMENT
MEDICAL DIRECTOR, GOVERNMENT RELATIONS
MARSHFIELD CLINIC

BEFORE THE
ASSEMBLY COMMITTEE ON INSURANCE

18 OCTOBER 2005

Chairperson Nischke and members of the Assembly Committee on Insurance, I am Doctor Robert Phillips, a practicing general internist and Medical Director of Government Relations for the Marshfield Clinic. I am here representing the 722 physicians and other healthcare providers in the Marshfield Clinic system. Thank you for the opportunity to testify in support of AB 766.

Marshfield Clinic's mission is to provide accessible high-quality healthcare, research, and education to all who access our system. Marshfield Clinic cares for all who seek our care regardless of their ability to pay. The repeal of caps on non-economic damages by the Wisconsin Supreme Court in the Ferdon vs. Wisconsin Patients Compensation Fund in June of this year has already begun to impact our system of care. Within days after this decision, Marshfield Clinic was notified by a plaintiff's attorney with an open claim against us that he was doubling damages in the case. Because of our self-funded primary medical malpractice insurance program for our physicians and staff, Marshfield Clinic is required by the Office of the Commissioner of Insurance to set aside reserves to cover possible claims. On September 28, 2005, Marshfield Clinic deposited an additional $900,000 into its trust fund to meet its funding requirement. This amount was determined to be necessary by the Clinic's independent actuary.

In 2004, Marshfield Clinic paid $1.8 million as assessments for its physicians and staff to the Injured Patients and Families Compensation Fund (IPFCF). The Fund provides coverage in excess of that provided by the Clinic's self-insurance plan. Although currently unknown, there is speculation that Fund assessments could as much as double over the next couple of years, which could require the Clinic to pay an additional $1.8 million to the IPFCF. The combination of the Clinic's self-insurance plan increased reserves and increased IPFCF assessments represents the amount that could be used to purchase a new $1.6 million linear accelerator for radiation oncology to treat cancer patients, a new $1 million CT scanner which would be used for diagnosing and following response to treatment of cancer patients and for diagnosis of other serious medical conditions, and a $600,000 digital mammogram machine which is used for breast cancer screening and diagnosis of early stages of breast cancer. Patient with cancer are often very ill with limited energy. Marshfield Clinic tries to bring cancer care closer to home for its patients because this facilitates more timely patient-centered healthcare.

In previous testimony, Marshfield Clinic pointed out the challenges of recruiting physicians, primary care and specialty positions, to our northern service areas. Stability of the medical malpractice insurance environment is important to physicians from out-of-state and our own resident physicians who are considering practicing within our system. Access to obstetrician/gynecologists, emergency room physicians, and specialty surgeons is very important to ensure that citizens in rural Wisconsin receive the same high-quality healthcare their urban counterparts do. As of September 30, 2005, the Clinic was recruiting 97 physicians in 43 different specialties. Marshfield Clinic finally recruited a pediatric general surgeon to its Marshfield Center after a 6-year search. On average time to recruit and fill positions in our rural centers is between 3-4 years. Recently, a vascular surgeon and nuclear medicine physician from out of state inquiring about positions in our system asked what impact the loss of caps on non-economic damages would have.

Marshfield cares for all who come to us regardless of their ability to pay, that includes the uninsured, Medicare, Medicaid, and BadgerCare patients on an unlimited basis. In two counties in north central Wisconsin in fiscal year 2004, Marshfield Clinic cared for 82% of the eligible

Medical Assistance patients and in another county 57% of eligible Medical Assistance patients. Because government sponsored healthcare programs cannot pay fully the cost of care, healthcare organizations like Marshfield Clinic will need to prioritize new service development vs. provision of healthcare services.

Because of our not-for-profit tax status, Marshfield Clinic invests net revenues in infrastructure development, new equipment, new clinical services, research, and/or student and resident education. Marshfield Clinic has invested millions of dollars since the early 1990s in an integrated computerized medical record linking all 41 of our centers, which includes physician's notes, consultations, lab, x-ray results, and electrocardiograms (EKG's). A clinical decision support service will link individual providers to the latest standards of medical treatment to ensure that patients receive the most current evidenced-based healthcare. A medication management program is providing a single medication portal with drug interaction and allergy warning software built in to ensure safe drug prescribing. A patient web portal currently allows patient access to immunization records, appointments, and lab results. These initiatives are examples of infrastructure development the Marshfield Clinic has invested in to enhance patient care. Diverting revenues to medical malpractice self-insurance reserves and IPFCF assessments will adversely affect development of new technologies.

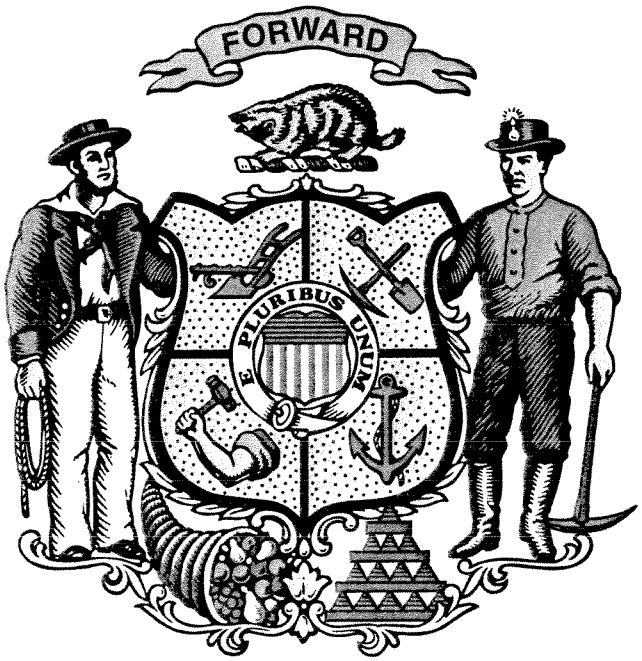
Marshfield Clinic, a founding member of the Wisconsin Collaborative for Health Care Quality, is committed to ongoing public reporting of validated health outcomes, both quality and cost of care, so that government and private purchasers ultimately will pay differentially for quality healthcare and achieve value in services provided. Marshfield Clinic is concerned that the repeal of non-economic caps will impede healthcare organizations' willingness to report publicly quality of care institutionally and even individually. Our commitment to quality is predicated on the Institute of Medicine's six aims, healthcare that is safe, patient centered, timely, effective, efficient, and equitable.

Marshfield Clinic supports AB 766 because it will provide reasonable caps on non-economic damages in medical malpractice judgments based on age. The combination of reasonable caps on non-economic damages and the IPFCF's unlimited coverage for economic damages will ensure that limited healthcare resources can be invested in information technology for quality reporting, new clinical services and access to healthcare for all Wisconsin citizens.

Thank you again for the opportunity to testify.

I will be pleased to address any questions the committee might have.

Robert E. Phillips, M.D.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FILE

Keeping Wisconsin Families Safe
www.watl.org

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Memorandum

TO: Members of the Wisconsin State Assembly

FROM: Wisconsin Academy of Trial Lawyers

DATE: October 25, 2005

RE: Opposition of Assembly Bills 764 and 766

The Wisconsin Academy of Trial Lawyers urges Assembly members to defeat Assembly bills AB 764 and 766. The bills are unfair and discriminatory.

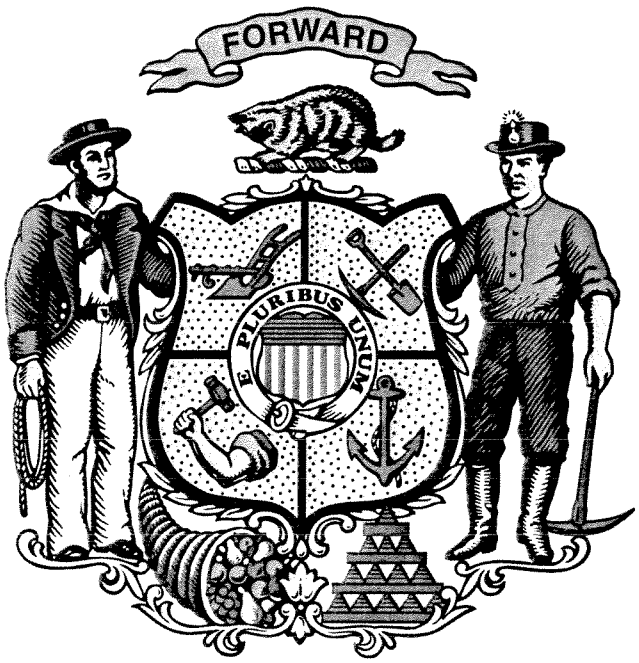
We urge you not to override the constitutional rights of Wisconsin citizens because there is no justification for a new cap that is only 1% more than what the Supreme Court found unconstitutional. Here are the facts:

- *Lowest in nation:* Wisconsin's malpractice costs are ranked very lowest in the US, while its healthcare premiums are ranked 2nd highest.
- *Malpractice costs tiny*: Medical malpractice costs now make up less than 40 cents out of every $100 dollars spent on health care in Wisconsin, lowest in the nation.
- *9 verdicts*: During the decade of 1995-2005 when the previous cap on pain and suffering was in effect in Wisconsin, exactly 9 jury verdicts exceeded the cap in a state of 5.5 million people.
- *Caps lifted, lawsuits dropped*: When Wisconsin's cap of $1 million expired in 1990, the medical industry and allies predicted a vast explosion of medical malpractice lawsuits. So what happened? Malpractice filings actually dropped by 16% from 1991 to 1994.
- *$750 million.* This is how much money is in the Injured Patients and Families Compensation Fund (Fund). A cap prevents the very people the Fund is named for from recovering an amount the jury found fair after hearing all the evidence.

- *$47 million versus $28.5 million.* The first number is the average amount of investment income the Fund earned each of the last 10 years compared to the average amount paid out to injured patients and their families.
- *4 out of 23 jury verdicts last year.* Medical malpractice litigation is actually very rare, with a grand total of 4 verdicts in favor of injured patients of the 23 malpractice cases heard by Wisconsin juries in 2004.
- *No reason for panic.* A top insurance executive testified Sept. 8 that the worst-case scenario from the cap's repeal would be "single-digit" increases in medical premiums, saying, "I don't see any reason for panic."
- *Reimbursement of government health care programs would be denied if AB 764 passes.* If injured people don't recover money for their medical bills, they won't be able to reimburse Medicare, Medicaid or any other government program. This shifts the burden of compensating someone fairly away from the person causing the wrong to the taxpayers who pay for the government programs. That is not fair.

Where is the evidence to support a cap? As Insurance Commissioner Jorge Gomez told the Speaker's task force, "Wisconsin will not be in crisis regardless of what the Legislature does about the caps. Wisconsin does not have runaway juries. Juries are uninformed about the caps. The marketplace is very competitive and the Fund is very solvent."

Wisconsin citizens value the freedom to seek justice when they are wronged by the powerful. Every citizen—no matter how rich or poor—should have an equal shot at justice before a jury. Legislators must demand that solutions involving less drastic alternatives — insurance reform and patient safety — be explored before rushing to re-impose the caps simply to serve the interests of well-heeled special interests. Legislators need to demand proof that there is a problem, which requires our citizens to give up their constitutional rights. If the proof cannot be shown, the Legislature should not deprive the most severely injured citizens of their right to be treated equally under the law.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October 27, 2005

Testimony before the Committee on Agriculture and Insurance
Re: AB 766

My name is Scott Hansfield and I have been practicing obstetrics and gynecology for over 20 years. Two years ago, I relocated to Wisconsin where I have been in practice at Waupun Memorial Hospital. Only months before my move, I envisioned practicing in the state of Illinois for my entire career. I was born and raised in the Chicago area. I graduated from medical school at Northwestern University in 1981 and I did my residency at Rush-Presbyterian-St. Luke's Medical Center in Chicago where I was the chief resident. I went into private practice in Highland Park, a northern suburb of Chicago. I was the managing partner of my practice, and we were the largest and busiest obstetrical group at the hospital. I was chairman of the department of obstetrics and gynecology at Highland Park Hospital where I was on staff for 18 years, and I was vice chairman of the department of obstetrics and gynecology at Evanston Northwestern Healthcare which had over 100 members and spanned 3 campuses.

I lived with my wife and four children in our dream house that we had built a few years earlier. My wife was also born and raised in the area. After serving as president of the PTO and volunteering in the schools while the kids were young, she had returned to work as an R.N. We had a daughter in college, a son in high school, and a daughter and son in middle school. Our entire family was visible and involved, and, as corny as it sounds, we were considered fixtures in the community.

There was one significant problem, though. I was practicing medicine in an environment where both hospitals and physicians feared for their economic survival. In a climate of falling reimbursements and rising costs, everybody was unhappy and the most unpredictable cost, the wild card so to speak, was malpractice insurance. The hospital system I was associated with could not get insurance in the U.S. and went overseas for a policy that covered them only for excessive losses. My colleagues would complain about the cost of liability insurance each spring when they got their bills for their July policy renewals. Every year, there would be a physician march on the state capital. Every year, there would be anger and discontentment, and every year, my colleagues paid their bills on July 1st and were quietly disgruntled until the following spring.

Medical malpractice lawsuits were not a stigma in Illinois, they were the norm. Physicians mistrusted patients, and always advised second opinions. Patients mistrusted doctors, and frequently sought third opinions. A bad outcome meant litigation. I remember one instance where an attorney was snooping around labor and delivery less than 2 hours after an unexpected obstetrical outcome. Keep in mind that physicians are taught to be honest with their patients when the unexpected happens. They're told to take the time to talk to their patients, but most people didn't want to talk to their doctors. When there's money on the line, injured parties would much rather talk to their lawyers.

My most memorable story is that of a colleague who was being sued for a post-operative complication. In the midst of the litigation, the patient suing him called his office to make an appointment for evaluation of an unrelated problem. The receptionist was surprised and asked why the patient would want to be treated by a doctor she was suing. She replied that she had the highest regard for the doctor and thought he was very skilled. The lawsuit was an unrelated issue. You see, when she first immigrated to this country, she was told that the quickest way to financial success in the U.S was to sue a doctor.

Please don't misunderstand me. I think that people should be compensated for losses that result from medical malpractice. When there is negligence, no injured party should go bankrupt due to medical expenses. No injured party should go hungry because they can no longer work. No child should be deprived of specialty care. However, what mystifies physicians is how one person's pain and suffering can be worth more than someone else's. What terrifies physicians is the unknown cost of that pain and suffering.

This was the atmosphere in Illinois when the doctors started to disappear. The first of my colleagues to leave were part of the brain trust, those senior physicians who truly practiced the art of medicine. They had reached a point in their careers where they were working more for pleasure than for the income. For them, the threat of a lawsuit with a limitless award that could wipe out their assets was enough to coax them into retirement. We lost our most senior internists and surgeons as they chose to escape an environment of practice they no longer recognized. I never dreamed that I would be close behind them.

In mid December 2002, my insurance agent called to give me the "heads up" that his January malpractice renewals were going up 40-60% and he expected the same for his clients who renewed in July. At the time, our group was paying over $400,000 a year for insurance. Based on the average reimbursement for delivering babies, every cent we earned on deliveries from January 1st to early June went to pay our insurance premiums. With this new increase, we'd be paying more than $150,000 per physician. After some quick math, I determined that the cost of my insurance would exceed my income.

That evening, I tested the bonds of my marriage. I told my wife that if I remained in my present practice, we would be unable to afford to live in the same neighborhood as my patients. As an alternative, we could uproot our children, leave our families, and move away. When I went to work the next day, I announced that I would not be practicing medicine in the state of Illinois as of July 1st. I had absolutely no idea what I would be doing after that time.

As I look back on that day, I cannot imagine what I was thinking. I remember a great sense of defiance, and also a great sense of resentment. I never envisioned myself as the one to take a stand. I kept thinking "This can't be happening to me." I immediately started looking for a job. On the AMA website, there was a chart indicating those states in a medical liability crisis, those state showing problems, and those states that were OK. In zeroing in on the latter, there were only six states to choose from. I narrowed down the opportunities, and in mid-January, I interviewed in Waupun where the only OB/Gyn

at the hospital had retired several years earlier. The doctors were knowledgeable and happy and the hospital was well-equipped and financially sound, but it was mighty cold outside. The next day, my wife and I interviewed at a hospital in the foothills of the Sierra Nevadas outside of Sacramento. We sat on a bench in the 60 degree breeze beside a stream running gently through the picturesque town. We were horrified to come to the realization that we were Midwesterners through and through. We got out of there as quickly as possible and in July 2003 we moved to Waupun.

The trials and tribulations of a suburban family from Chicago that moves to the country and lives in a 38 foot travel trailer along with their cat, bird and 100# dog while building a house is right out of the movies. I went from being on call every 4 nights to being available 24 hours a day, 7 days a week. There was no other doctor to cover my patients, so for the first 3 months of my new job, I never strayed more than 30 miles from Waupun. I loved it!

Currently, I provide care to women from a vast array of backgrounds who are trusting and appreciative. My patients don't want referrals and they don't want second opinions, so I am able to practice to my full abilities. The physicians I work with came from different areas of the country because they wanted to practice here. They are well-trained, compassionate people who like practicing medicine. Quite frankly, I was never happier in my professional life until July.

In a country moving toward medical malpractice reform state by state, Illinois included, I found myself in the only state moving in the opposite direction. The Supreme Court ruling overturning caps for non-economic damages instantly made Wisconsin the most undesirable state in the country for physicians looking to establish a medical practice. At least with states in crisis, you know where you stand, and there's movement toward malpractice reform. What do you make of a state that was a model for sensible malpractice legislation one day and the next day, overturns the legislation that stabilized the medical malpractice climate?

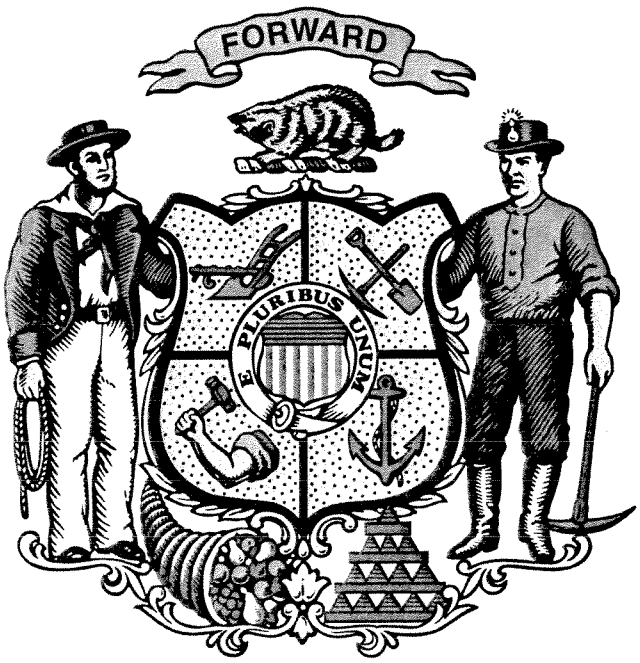
It is amazing how quickly the medical environment can change. It's as if someone turned the lights on at a party. Suddenly, senior physicians who had showed no signs of slowing down earlier in the year started talking about retirement. My colleagues in Waupun did not choose to practice in Wisconsin because of its safe malpractice climate, but they sure sound ready to leave now that things may change. I used to tell people that I enjoyed my new practice so much that I could envision practicing another 20 years. Now, I find myself thinking that being on call 24/7 might get tiring after about 10 years, and if any of my Illinois colleagues asked me about relocating to Wisconsin, I'd have to tell them to stay put for now.

Although most physicians would tell you that placing a cap on non-economic damages is the key to solving the medical malpractice crisis, I cannot prove to you that this would lead to lower healthcare costs and attract physicians. What I can tell you with 100% confidence is that, in today's medical malpractice climate, the loss of a cap on non-

economic damages sends a strong, clear message to doctors. If you don't want caps, you must not want us.

I am here today to tell you that, in no uncertain terms, I would never have moved to this state to practice medicine if I knew that the cap would disappear. I was attracted to Wisconsin because it had the distinction of being one of only six states in the country to have a favorable atmosphere with regard to medical malpractice. Why would a physician be attracted to a state that is heading opposite the direction of the other 49 with regards to solving the medical malpractice crisis? Wisconsin was known as a leader in malpractice reform when establishing the Injured Patients and Families Compensation Fund along with the cap on non-economic damages. It would be tragic for Wisconsin to also be known as the state where a loss of caps lead to instability in the medical malpractice insurance industry and to physician shortages. Do we really want the phrase "Look what happened in Wisconsin" to be the rallying cry for medical malpractice reform across the country?

The people of Wisconsin want good doctors and accessible health care. The death knell is sounding for the days when awards for medical malpractice litigation rival lottery winnings. Here in Wisconsin, we have it easy. We are not trying to pass radical, untested legislation. We're not breaking any new ground. We are simply maintaining the status quo that has made Wisconsin one of the most desirable places in the United States to practice medicine.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CITIZEN ACTION

The State's Largest Public Interest Organization

Wisconsin Citizen Action Testimony before the

Assembly Committee on Insurance

In Opposition to AB766

My name is Darcy Haber and I am the Health Care Campaign Director for Wisconsin Citizen Action. Thank you for the opportunity to testify today in opposition to AB766. Wisconsin Citizen Action believes that putting a cap on the pain and suffering of patients injured by malpractice is simply cruel and immoral – there is perhaps no more appropriate use for the term," adding insult to injury."

Moreover, we have not seen any credible evidence to justify such cruelty in the name of holding down health care costs. I believe the Wisconsin Academy of Trial Lawyers will be testifying further on why this is so, and I don't want to waste your time saying the same thing. I will leave the details of that issue to them. I would like to talk just briefly about the bigger picture. While I understand we are not here to talk about the larger health care crisis in Wisconsin, leaders of this legislation have claimed that somehow adding this insult to injured patients will somehow ease our health crisis.

This is simply untrue. Malpractice costs represent less than .04% of health care costs in Wisconsin. The sponsors of this legislation are simply misguided if they are attempting to ameliorate our health care crisis with this legislation. In the latest ratings by Expansion Management Magazine (2/14/05), the magazine the business executives read when deciding where to locate their business, Wisconsin was rated the best (lowest) in terms of medical malpractice rates and the second worst (highest) in terms of health insurance premiums. But unfortunately we aren't here today to talk about health insurance premiums.

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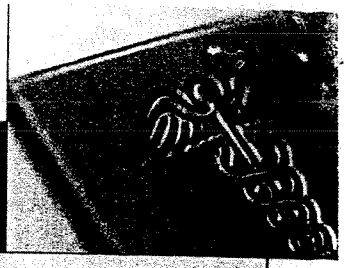
We *are* here today to talk about the unfortunate patients – the real people and families who will testify here today. Can we really look them in the eye and say that we are sorry this terrible thing happened to your family but we do need to make the whole situation even worse for you because we think it might help hold down premiums on malpractice, which represent .04% of Wisconsin health care costs? I know I couldn't do that.

For the reasons mentioned above, the legislation before you will not survive constitutional scrutiny and will be struck down as firmly as the other cap.

The malpractice task force was hoping to find a magic number that would make the caps constitutional but discovered there was no such number.

Because in Wisconsin justice belongs to the people, not insurance companies.

Thank you for your attention today.



EXPANSION MANAGEMENT'S
2005 HEALTH CARE COST QUOTIENT™

All rankings are from 1 (best) to 50 (worst).

2005 HQ Rank	STATE	Health Care Facilities Ranking	Health Care Providers Ranking	Health Insurance Costs Ranking	Health Care Provider Visit Costs Ranking	Malpractice Costs Ranking
1	Kansas	36	19	3	14	13
2	Tennessee	10	26	9	6	32
3	Louisiana	22	33	36	2	3
4	North Dakota	30	11	17	8	24
5	South Dakota	21	16	17	17	18
6	Missouri	7	25	6	8	41
7	Ohio	2	15	16	4	43
8	Iowa	16	13	12	19	28
9	California	16	28	4	44	4
10	Alabama	14	40	13	7	29
11	Pennsylvania	1	8	42	1	31
12	Nebraska	31	9	38	11	10
12	Virginia	24	22	13	27	16
14	Michigan	8	27	26	19	17
15	South Carolina	44	43	2	32	7
16	Rhode Island	40	5	17	31	15
17	Utah	44	36	11	13	22
18	Arkansas	28	43	17	3	36
18	Indiana	18	35	34	29	2
18	Kentucky	14	31	24	5	40
21	Hawaii	42	12	1	47	19
21	Minnesota	6	4	41	40	8
23	Vermont	43	2	17	43	14
24	Montana	24	30	5	36	30
24	Wisconsin	12	10	49	37	1
26	Arizona	27	45	9	22	34
27	New Mexico	50	45	15	34	5
28	Massachusetts	13	1	44	41	11
29	Mississippi	34	48	8	10	47
30	Oklahoma	38	49	40	15	9
31	Colorado	23	34	36	38	6
32	Maryland	26	18	34	41	12
32	Texas	9	47	31	12	38
34	New Hampshire	46	7	39	23	21
35	Oregon	36	24	6	49	26
36	Idaho	48	41	17	30	20
37	North Carolina	19	23	25	32	35
38	Georgia	11	42	26	16	45
39	Delaware	47	29	30	25	23
39	New York	3	13	42	27	39
41	Maine	32	6	50	23	25
42	Illinois	3	19	47	18	44
43	Florida	3	37	32	21	48
44	Washington	29	19	26	48	37
45	Alaska	49	39	17	50	26
46	Connecticut	33	3	45	45	33
47	New Jersey	20	17	48	39	42
48	West Virginia	35	32	45	25	50
49	Wyoming	40	37	32	35	49
50	Nevada	38	50	26	46	46