WISCONSIN STATE LEGISLATURE COMMITTEE HEARING RECORDS

2005-06

(session year)

Assembly

(Assembly, Senate or Joint)

Committee on Insurance (AC-In)

(Form Updated: 11/20/2008)

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Illinois Section
American College of Obstetricians and Gynecologists

May 12, 2005

Access to Obstetric Care Continues to Decline, Survey Finds

Illinois' hostile legal climate is "severely" affecting women's health, doctors say

Chicago – Women are finding it increasingly difficult, if not impossible, to find obstetrical care here in Illinois, according to a survey released today from the Illinois Section of the American College of Obstetricians and Gynecologists (IL ACOG). The reason: Illinois' litigation crisis is forcing doctors to give up high-risk procedures – like delivering babies – or is driving them out of the state entirely.

According to the survey, 22 percent of Illinois obstetricians stopped practicing obstetrics in 2004. This is on top of the 12 percent who stopped delivering babies in 2003. Additionally, another 10 percent of Illinois obstetricians have already announced they will quit by the end of 2005.

"This is bad news for Illinois families," said Denise Elser, M.D., chair, IL ACOG. "Women need to have access to obstetric care near their home and not be forced to drive to Missouri or another state to have a baby. If this downward trend continues, young families will think twice about residing in our state," Dr. Elser said.

The survey polled chairs of the 121 hospitals in Illinois with obstetric departments, representing 49 counties. The return rate was about 67 percent.

A second survey, sent to Illinois' 14 OBGYN residency program directors, found that in 2004, only 24 percent of graduating OBGYN residents stayed to work in Illinois. Traditionally, 80 percent of residents practice in the state where they train, according to the program directors surveyed.

"Not only are we losing doctors, but we're finding it increasingly difficult to recruit new ones or even keep those we train locally. This does not bode well for the future of OB care in Illinois," said Dr. Elser.

Illinois is one of 20 states classified by the American Medical Association as being in "full blown crisis," with access to medical care on the decline due to a hostile litigation system. Unwarranted lawsuits, combined with skyrocketing damage awards, are forcing doctors' liability insurance premiums

through the roof, causing many Illinois doctors to give up high-risk procedures, move to states with legal reforms or get out of medicine entirely.

In 2004, OBGYNs practicing in Illinois paid the second highest liability premiums in the nation, upward of $230,428 annually, according to *Medical Liability Monitor.* This is up an astounding 66 percent from 2003.

Seventy percent of the obstetric department chairs surveyed indicated that our state's liability crisis is "severely" affecting healthcare for Illinois women. Over 20 percent said the crisis is "moderately" affecting women's healthcare, while only about 10 percent said women are being "mildly" affected.

The survey also shows that 25 percent of the OBGYNs who have left Illinois now practice in another state, most going to Wisconsin, Indiana and California, states that have implemented legal reforms.

"Unless Illinois passes meaningful litigation reform *this year*, the decline in our state's obstetric services will soon reach catastrophic proportions," said Dr. Elser. "More and more Illinois families will be issued birth certificates from other states, which is truly sad."

"Illinois OBGYNs have joined 50 other medical organizations in this state in supporting liability reforms endorsed by the Illinois State Medical Society," stressed Dr. Elser. "We need to pass legal reforms – including a cap on non-economic damages – in order to protect medical care for Illinois women and families," urged Dr. Elser.

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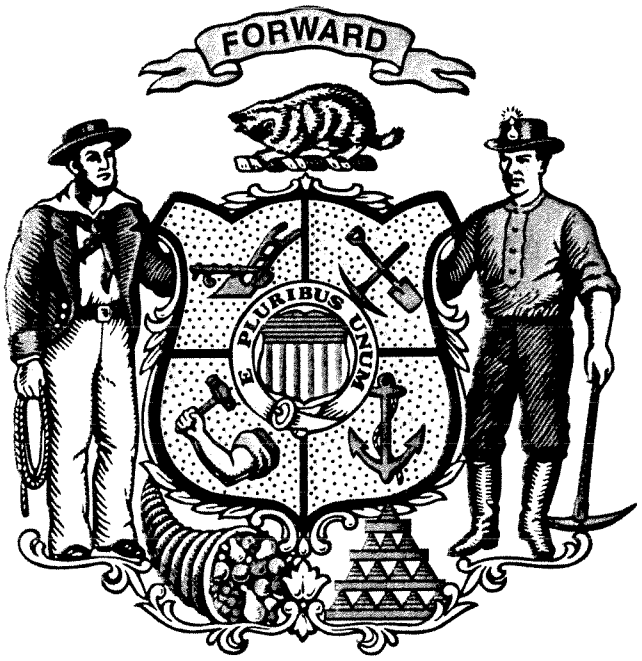
The Illinois Section of the American College of Obstetricians and Gynecologists is the state medical organization representing over 1,100 members who provide health care for women.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State of Wisconsin / OFFICE OF THE COMMISSIONER OF INSURANCE

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May 12, 2005

REPORT ON THE IMPACT OF 1995 WISCONSIN ACT 10

In accordance with s. 601.427 (9), Wis. Stat., I am pleased to submit this report to the Wisconsin State Assembly. The report, to be submitted to the Legislature within two years after the effective date of 1995 Wisconsin Act 10 (May 25, 1995) and within two years thereafter, is to evaluate the impact that Act 10 has had on the following:

(a) The number of health care providers practicing in Wisconsin.
(b) The fees that health care providers pay under s. 655.27 (3) Wis. Stat.
(c) The premiums that health care providers pay for health care liability insurance.

EXPLANATION OF 1995 WISCONSIN ACT 10

Prior to the enactment of Act 10, there existed no cap on noneconomic damages in Wisconsin for medical malpractice claims since January 1, 1991. Previously, a cap of $1,000,000 had been in effect for such claims filed between June 14, 1986 and December 31, 1990, per 1985 Wisconsin Act 340. This Act, however, had a sunset provision which eliminated the noneconomic cap as of January 1, 1991. After the effective date of the sunset provision, members of the Wisconsin Legislature sought to reintroduce noneconomic damages caps to Wisconsin in such bills as 1993 Senate Bill 215 and 1995 Assembly Bill 36. Assembly Bill 36 was passed by the Legislature to become 1995 Wisconsin Act 10.

Among its provisions, Act 10 established a maximum amount that a claimant may recover for noneconomic damages resulting from the negligence of a health care provider. Noneconomic damages are generally defined to include items such as pain and suffering, embarrassment, mental distress, and the loss of companionship and affection. The maximum amount for noneconomic damages was limited to $350,000, and was to be adjusted "by the director of state courts to reflect changes in the consumer price index... with the adjusted limit to apply to awards subsequent to such adjustments." The indexed non-economic damage caps for each of the last four years were as follows:

2001	404,657
2002	410,322
2003	422,632
2004	432,352

IMPACT OF 1995 WISCONSIN ACT 10

Section 3 of Act 10 requires the Commissioner of Insurance to submit to the Legislature a report evaluating the impact that Act 10 has had on the number of health care providers practicing in Wisconsin, the fees that health care providers pay under s. 655.27 (3), Wis. Stat., and the premiums that health care providers pay for health care liability insurance from their primary insurance carriers. To assist the Legislature in its review of Act 10, the Commissioner's report was to include comparative statistics for these three areas for the year prior to enactment (1994) and the year(s) subsequent to enactment.

The required statistics have been compiled and are reported in the three attachments to this report:

Attachment 1 - This attachment displays the number of health care providers practicing in Wisconsin and participating in the Injured Patients & Families Compensation Fund (Fund). There are a certain number of providers who may be practicing in the state but who meet one or more of the criteria allowing them to exempt themselves from Fund participation. The data included in this attachment reflects both the number of health care providers participating in the Fund, and the number of providers who are licensed in Wisconsin, but have claimed exempt status for Fund purposes.

Attachment 2 - This attachment addresses the fees paid by health care providers under s. 655.27 (3), Wis. Stat., for fiscal years 1996-2005, and projected fees for fiscal year 2006. Annual Injured Patients & Families Compensation Fund (Fund) premium rates (fees) are set by the Board of Governors with the approval of the state legislature[1]. The fee-setting process begins with an actuarial assessment of expected loss exposure based on prior years' experience. The other primary factor in determining annual fee adjustments is the overall financial position of the Fund. An actuarial consultant performs analyses of the Fund's loss experience and financial position and submits a report on actuarial indications to the Fund's Actuarial and Underwriting Committee. The Committee then makes a recommendation to the Board.

The actuarial consultants have estimated the expected reduction to the Fund's loss costs due to the cap on non-economic damages. This reduction to the expected loss costs has been incorporated in the funding level indications for the past nine Fund Years. The loss cost reduction imbedded in the funding level indications for the past nine years has resulted in an estimated $180 million reduction in ultimate loss reserves.

The Fund fee changes over the last nine years have ranged from a decrease of 30% to an increase of 10.0%. As discussed above, a primary factor in the determination of rates is the prior years' loss experience. Medical malpractice claims are considered "long tail" due to the fact that losses are not generally realized until at least two to three years after the date of occurrence, and in many cases much longer. Due to this lag in the reporting and subsequent settlement of the claims, the information regarding prior years' experience used in the fee determination would most likely involve claims that occurred two or more years prior to the fee determination.

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[1] The rates for 2005-2006 have been approved by the Injured Patients & Families Compensation Fund Board of Governors and are pending legislative approval.

Attachment 3 - Information regarding the rates health care providers pay for primary coverage is provided in this attachment. To provide the most up-to-date information for Attachment 3, the staff of the Fund has surveyed the five leading carriers of medical malpractice insurance writing primary policies for Fund participants. These five providers account for 81% of all primary level medical malpractice insurance written for Fund participants. The figures obtained are average premiums charged per physician class. Most of these companies classify health care providers into eight categories for the purposes of determining rates, while the Fund utilizes only four classes.

Review of the average premium page for each class noted the fluctuations were very similar to the Fund fee changes, until 1997 when the threshold at which the Fund attached was raised from $400,000 to $1,000,000. Effective July 1, 1997, the primary carrier provides the first $1,000,000 of coverage per occurrence.

In evaluating any effect of Act 10 on the primary insurance premiums, it should be noted that in general, claims in which there are nonecomonic damages awarded tend to be those claims which result in awards which historically have exceeded the primary insurance coverage limit. Any amount of a settlement or judgement in excess of the primary coverage is payable by the Fund. Prior to the increase in the threshold in 1997, the cap on nonecomonic damages would most likely have had more of an impact to the Fund than the primary insurer, and would be reflected more in the Fund fees than in the primary insurance premiums. Since the increase in the threshold to $1,000,000 per incident and $3,000,000 aggregate, in 1997, the primary carriers are subject to more of an impact from the enactment of Wisconsin Act 10.

The primary carriers have reported that projected premiums are expected to remain approximately the same in the next year, with some variation in the different provider classifications. This is after a few years of steady increases which were due to a variety of factors including; reduced returns on investment, strengthening of outstanding loss reserves and the overall condition of the medical malpractice marketplace. No direct correlation can be drawn between the caps enacted in 1995 and current rate changes taking place in the primary market today. However rate stability could be dramatically impacted for both the Fund and primary carriers should the caps be removed and insurers face unlimited non-economic damages.

It is important to note that primary carriers perform actual underwriting of their applicants in rate determination, while the Fund assesses providers based solely upon the class in which their type of practice has been assigned. In performing underwriting, there are multiple factors in rate determination and changes in any of these factors can result in increases or decreases in premium. Therefore, it would be difficult to draw any conclusions from premium numbers based solely on the enactment of Wisconsin Act 10.

In summary, it is important to note that any analysis of the effects of the enactment of Wisconsin act 10 is very difficult due to several factors including:

Many of the payments made on claims are a result of a settlement and not a jury trial. The settlement amount takes into consideration the caps that exist; therefore there is no discernable amount that can be attributed to a reduction due to the caps.

It is not possible to determine the number of the claims that were not filed due to a limited amount of economic damages in addition to the caps.

To conclude, on the contrary, Wisconsin's malpractice marketplace is stable. Insurance is available and affordable, and patients who are harmed by malpractice occurrences are fully compensated for unlimited economic losses. Tort reform of 1995, along with well regulated primary carriers and a well managed and fully funded Patients Compensation Fund has resulted in the stable medical malpractice environment, and the availability of health care in Wisconsin.

Jorge Gomez
Commissioner

Attachment 1

Health Care Providers Licensed in the State of Wisconsin
Five year comparison

Year	Number of providers participating in the Fund	Number of providers claiming an exemption from Fund participation	Total number of Health Care Providers
2000	12,006	9,795	21,801
2001	12,344	9,159	21,503
2002	12,750	9,577	22,327
2003	13,191	9,103	22,294
2004	13,714	10,157	23,871

Active Fund Participants by Provider Type

	Physicians	CRNAs	Hospitals	Hospital Affiliated Nursing Homes	Hospital Controlled Entities	Ambulatory Surgery Centers	Health Care Cooperatives	Partnerships	Corporations
2000	10,088	416	117	32	22	10	2	52	1,267
2001	10,418	434	120	29	19	8	2	47	1,267
2002	10,767	455	122	28	22	10	2	52	1,292
2003	11,145	492	118	27	21	14	1	50	1,323
2004	11,603	490	127	30	23	17	1	53	1,370

Criteria that must be met to claim exemption from Fund participation include the following:

1. The provider practices for no more than 240 hours in Wisconsin in a fiscal year or;
2. The provider is employed by the state, a county or a municipality or;
3. The provider is a federal employee or;
4. The provider's principal place of practice is not in Wisconsin or;
5. The provider is retired or does not practice in Wisconsin but maintains a license.

Attachment 2

Injured Patients & Families Compensation Fund
Annual Fees Health Care Providers Pay Under s.655.27(3)Wis.Stat.

Class	1995-96	1996-97	1997-98	1998-99	1999-00	2000-01	2001-02	2002-03	2003-04	2004-05 Projected	2005-06 Projected
1	2,923	3,215	2,647	2,721	2,531	1,898	1,538	1,461	1,534	1,227	859
2	5,846	6,430	5,294	5,170	4,809	3,606	2,769	2,630	2,761	2,209	1,546
3	12,569	13,825	11,382	11,292	10,504	7,877	6,385	6,063	6,366	5,092	3,565
4	17,538	19,290	15,882	11,292	15,186	11,388	9,231	8,766	9,204	7,362	5,154
Certified Nurse Anesthetist	749	824	678	678	631	475	378	359	377	302	211
Part-time / Retired	731	804	662	680	632	475	385	365	384	307	215
Resident Moonlighter	1,754	1,929	1,588	1,633	1,519	1,139	923	877	920	736	515
Hospital (**) Ins. 17.28(4)(l)and(j)	185	203	167	167	155	116	93	88	92	74	52
Nursing Home (per occupied bed)	35	38	31	31	29	22	17	16	17	14	10
Interest Rate	0.05117	0.05425	0.05201	0.053363	0.04964	0.051428	0.06215	0.02683	0.0155	0.01025	0.01789
Administration Fees (per quarter)	3	3	3	3	3	3	3	3	3	3	3
Mediation Panel Fees	38	38	32	16	16	38	38	19	19	46	34

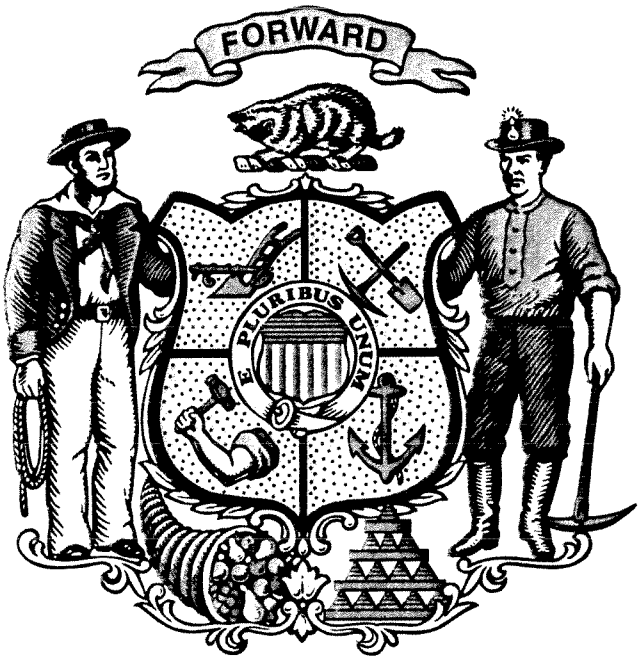
** Hospitals pay an additional amount per 100 outpatient visit assessment

Attachment 3

ACT 10 SURVEY RESULTS
AVERAGE PREMIUM CHARGED FOR PRIMARY COVERAGE*

Class	1996 Average Premium	1997 Average Premium	1998 Average Premium	1999 Average Premium	2000 Average Premium	2001 Average Premium	2002 Average Premium	2003 Premium Written	2003 Number of Providers	2003 Average Premium	2004 Premium Written	2004 Number of Providers	2004 Average Premium	2005 Projected Average Premium
Class 1	2,746	2,243	2,416	2,329	2,236	1,854	2,006	8,219,625	4,046	2,032	10,077,796	4,493	2,243	2,091
Class 2	4,219	4,050	3,946	4,119	3,645	2,208	2,453	8,981,861	2,974	3,020	11,602,556	3,558	3,261	3,368
Class 3	5,888	4,148	4,758	4,669	4,780	3,288	3,119	7,442,126	1,538	4,839	7,978,736	1,624	4,913	4,432
Class 4	6,772	4,716	4,493	7,221	7,199	3,911	4,752	4,093,031	827	4,949	4,771,775	739	6,457	5,592
Class 5	9,020	8,059	8,107	9,531	11,438	5,551	5,618	5,202,778	414	12,567	5,621,030	655	8,582	8,681
Class 6	13,360	11,923	12,637	11,896	14,015	11,233	10,579	2,995,241	312	9,600	3,010,272	319	9,437	11,243
Class 7	14,256	13,016	12,890	14,799	13,247	12,031	12,467	4,976,533	422	11,793	5,278,734	433	12,191	9,356
Class 8	18,187	16,257	21,426	14,615	15,555	18,920	14,748	1,752,403	120	14,603	1,909,009	135	14,141	15,575
Cert. Reg. Nurse Anesthetist	1,674	2,463	2,212	810	798	1,984	2,004	334,855	290	1,155	296,006	293	1,010	1,072
Part-time / Retired	2,332	2,097	1,509	1,760	1,794	1,889	1,832	11,273	2	5,637	6,640	1	6,640	6,640
Resident Moonlighter	1,889	1,442	2,371	988	1,088	1,213	985	27,590	31	890	36,953	30	1,232	1,628
Hospitals	3,630	8,941	9,773	11,057	12,816	53,482	78,015	4,374,307	83	52,702	5,221,402	89	58,667	112,310
TOTAL								48,411,623	11,059		55,810,909	12,369		

*Unaudited numbers provided by insurance carriers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May 17, 2005 Joint Committee on Finance Paper #450

Injured Patients and Families Compensation Fund (Insurance and Health and Family Services)

[LFB 2005-07 Budget Summary: Page 311, #2]

CURRENT LAW

The injured patients and families compensation fund (IPFCF), created in 1975 as the patients compensation fund, provides excess medical malpractice coverage for health care providers. Under current law, health care providers must obtain primary medical malpractice insurance from private insurance companies in the amount of $1 million per occurrence and $3 million per policy year in the aggregate. The IPFCF provides compensation for claimants whose economic damages exceed the negligent health care provider's liability insurance. IPFCF coverage for economic damages is unlimited. Participation in the IPFCF is mandatory, unless the provider qualifies for an exemption. Exemptions include: (a) providers who do not practice in Wisconsin for more than 240 hours in a fiscal year; (b) providers employed by the state, a county, or a municipality who do not expect to practice outside of that employment for more than 240 hours during a fiscal year; (c) providers whose principal place of practice is not in Wisconsin (50 percent of the income from the practice is derived from outside Wisconsin, or more than 50 percent of patients will be attended to outside Wisconsin during the year); (d) federal employees covered under the Federal Tort Claims Act who do not expect to practice outside that employment for more than 240 hours during a fiscal year; (e) retired providers; (f) providers who have never practiced in Wisconsin to date; and (g) corporations and partnerships that cease providing medical services in Wisconsin.

The IPFCF provides coverage on an occurrence basis. Payment of the premium for a given year of practice entitles the provider to coverage for claims filed for any acts of malpractice that occur during that year, including claims that are filed subsequent to the IPFCF coverage cancellation date. If a claim is based on an occurrence during a covered year, the IPFCF is responsible for coverage, regardless of when the claim is filed. Under current law,

claims are paid in the order received within 90 days, unless appealed, and if there are insufficient funds, the claims are immediately payable in the following year in the order in which they were received.

The IPFCF is funded through annual assessments paid by providers and through investment income. There are four fund classes based on provider specialty as identified by applicable insurance services office (ISO) codes. Physicians whose loss exposure is similar are grouped together in one of the four classes. Class 1 includes specialties with the lowest risk and therefore these providers pay the lowest rate. Class 4 represents the highest risk and therefore these providers pay the highest rate. The primary factors influencing annual assessments include an actuarial assessment of expected loss exposure based on prior years' experience and the overall financial position of the fund. Annually, an actuarial consultant analyzes the IPFCF loss experience and financial position and submits assessment fee recommendations to the IPFCF's actuarial and underwriting committee. The committee reviews the recommendations and, in turn, recommends assessment fee levels to the IPFCF Board of Governors. The Board of Governors then submits a fund fee administrative rule to the Legislature for approval.

Under current law, the Wisconsin State Investment Board invests moneys held in the fund in investments with maturities and liquidity that are appropriate for the needs of the fund as reported by the IPFCF Board of Governors. Based on data through September 30, 2004, the IPFCF actuary has estimated IPFCF's balance sheet as of the end of fiscal year 2003-04 to show total investment assets of $741,283,000 total liabilities of $670,773,000, and the fund equity of $70,510,000.

GOVERNOR

Transfer $169,703,400 in 2005-06 and $9,714,000 in 2006-07 from the IPFCF to a new segregated fund, the health care quality improvement fund (HCQIF).

Purpose of the Injured Patients and Families Compensation Fund. Expand the purposes of the IPFCF to include: (a) ensuring the availability of health care providers in the state; (b) enabling the deployment of health care information systems technology for health care quality, safety and efficiency, as referenced in the sections of the bill that would authorize the new Health Care Quality and Patient Safety Board to make grants and loans; and (c) the deployment of health care information systems technology for health care quality, safety and efficiency by the Board.

DISCUSSION POINTS

1. This item would fund a portion of the state's 2005-06 medical assistance (MA) benefits, MA supplemental payments to hospitals, and health care quality grants and loans in 2005-06 and 2006-07 by using assets that have accumulated in the IPFCF. This funding from the IPFCF to support MA benefits and supplemental payments to hospitals would be provided on a one-time

basis, and consequently would not be part of the MA base for the 2007-09 biennium.

Patients Compensation Funds

2. At least eight states other than Wisconsin have patients compensation funds -- South Carolina, Indiana, Kansas, Louisiana, Nebraska, New Mexico, Pennsylvania, and Florida. Other states in the process of establishing a fund include: Ohio, Iowa, Washington, Wyoming, Montana, Colorado, and Nevada. Each state that has a patients compensation fund operates the fund with different requirements. Participation in at least three of the states -- Kansas, Pennsylvania, and Wisconsin -- is mandatory. Coverage in at least two of the states, South Carolina and Wisconsin, is unlimited. Primary insurance coverage that is required for providers varies from state to state. Wisconsin has the highest primary insurance coverage requirement of $1 million per incident and $3 million per policy year. Wisconsin's fund is unique in that it is the only fund to combine mandatory participation with unlimited economic loss coverage.

3. When Wisconsin's patients compensation fund was established in 1975, it operated on a cash basis for the first five years. That is, providers were assessed based on actual payout amounts for claims in a given year. During the 1980s, the fund switched from cash accounting to accrual accounting to improve the integrity of the fund. Under the accrual method, providers are assessed based on estimates of what all claims would total over time for incidents that occurred in any given year, rather than on what the payout amount was for that year. Accrual accounting attempts to ensure that the fund has sufficient assets to pay any outstanding liabilities, including claims incurred but not reported, if the fund were discontinued. The estimates of what claims would total over time are actuarially determined. Wisconsin requires insurers to be financially solvent such that their assets are sufficient to cover any outstanding liabilities. Therefore if an insurer stopped doing business, all outstanding claims would be paid. OCI seeks to administer the IPFCF in a similar manner.

4. During the 1990s, the fund's Board of Governors began to increase reserves to cover any outstanding claims if the fund were eliminated. The amount of the reserves, the assessments and investment income, total the IPFCF's total assets. Any outstanding claims since the inception of the fund, including claims incurred but not reported, compose the fund's outstanding liabilities. The difference between the total assets and the total outstanding liabilities is the fund equity. The IPFCF uses estimated future investment income earnings to discount its total outstanding liabilities.

5. To determine provider assessments for the IPFCF, actuaries attempt to predict how many claims will occur in a given year and how much those claims will cost. By the actuaries' own statements, the process is highly uncertain in an area such as medical malpractice with extended reporting and settlement patterns, and given that the IPFCF provides unlimited excess liability protection over primary insurance. The actuaries indicate that their estimates have been tracking the industry nationally as a whole. However, some have expressed concern that the estimates may be too conservative for Wisconsin.

6. The 13-member IPFCF Board uses the actuarial information to set annual

assessment rates for providers, which are then established by rule. Attachment 1 shows annual provider assessments for each provider classification from fiscal years 2000-01 through 2004-05. The Board has usually set rates that differ from the actuaries' recommendations. The Board attributes the difference to the fact that Wisconsin's medical malpractice environment is much more stable than the rest of the nation and to the fact that, because assessments are mandatory, the IPFCF has a "captured pool" to require additional assessments to make up for any underestimation in assessments from a previous year. Table 1 compares the actuaries' recommended percentage changes to assessments with the percentage changes approved by the Board in each year from 1994-95 through 2005-06.

TABLE 1

Annual Percentage Changes to Assessment Fees
Policy Years 1994-95 through 2002-03

Policy Year	Actuary Recommendation	Board Approved
1994-95	10.8%	7.1%
1995-96	4.9	-11.2
1996-97	17.3	10.0
1997-98	-17.7	-17.7
1998-99	5.9	0.0
1999-00	2.7	-7.0
2000-01	3.7	-25.0
2001-02	-28.6 to 28.2	-20.0
2002-03	N.A.[1]	-5.0
2003-04	N.A.[1]	5.0
2004-05	N.A.[1]	-20.0
2005-06	N.A.[1]	-30.0

[1] Beginning in 2002-03, rather than recommending a specific recommendation for assessment levels, the actuary began offering guidance on a range of assessment levels based on an estimate of the "break even" point for the fund. The break even point is the point at which assessments collected equal all expected claim payments for claims occurring in that particular year, regardless of when the claim is reported or paid.

7. Table 2 lists the number of providers assessed for each of fiscal years 2000-01 through 2004-05 and the assessment revenue for each of those years.

TABLE 2

Number of Providers Assessed and Assessment Revenue
Policy Years 2000-01 through 2004-05

Policy Year	No. of Providers Assessed	Assessment Total
2000-01	11,236	$47,879,300
2001-02	11,253	36,795,100
2002-03	11,552	29,463,700
2003-04	11,902	32,900,629
2004-05	12,093	26,317,000[1]

[1]Estimated.

8. Historically, actual expenditures have been lower than projected expenditures. However, because it is difficult to predict when claims for any specific incident will be paid, expenditures could greatly increase in the future if losses incurred in previous years are finally paid. Through March, 2005, the IPFCF had paid claims totaling approximately $586.3 million, since its inception and 32 claims were outstanding.

9. IPFCF reserves are used to pay claims for incidents that occurred in prior years. For example, a claim may be submitted to the IPFCF for payment several years after the incident occurred. Assessments collected from the year of the incident would have been set-aside in reserves to pay for any claims resulting from that year. Some claims could take up to 20 years after the incident date before they are paid. Although the statute of limitations for filing a medical malpractice claim is, in most cases, three years from the incident date or one year from the discovery date, there is no limit on how long the litigation process will take. Attachment 2 shows for each fiscal year from 1975-76 through 2003-04 assessments collected during that year, claims paid out through September 30th of that year, paid indemnity for incidents that occurred in that year, the number of claims paid for incidents that occurred in that year, and the number of outstanding claims associated with each year. For example, in policy year 1990-91, the fund collected $43,800,000 in assessments and paid claims totaling $41,631,000. However, since 1990-91, the fund has paid a total of $29,455,000 in claims for incidents that occurred during 1990-91. The fund has paid 20 claims since 1990-91 for incidents that occurred during 1990-91, and there remain two claims outstanding.

10. In addition to premiums, the IPFCF invests its reserves, which earn interest. According to a Wisconsin Investment Board annual report, as of June 30, 2004, the fund had total investment assets of $740.7 million. Investment income has accounted for 33 percent of the total IPFCF revenue since 1975. Investment income reduces the provider assessments that fund current and future claim payments. The investments are long-term. These funds are not cash on hand and would have to be liquidated to receive a cash amount. The fund may realize a loss or gain as a result of liquidating assets and the remaining balance would earn less in the future. Table 3 shows

assessments collected, total assets, total liabilities, and the fund equity for fiscal years 1994-95 through 2002-03 as listed in Legislative Audit Bureau reports. Total liability and fund equity estimates for 2003-04 have been revised by the IPFCF actuary based on data through September 30, 2004.

TABLE 3

IPFCF Balances
Fiscal Years 1994-95 through 2003-04

Fiscal Year	Assessments	Total Assets	Total Liabilities	Fund Equity
1994-95	$55,505,700	$310,015,300	$367,738,100	-$57,722,800
1995-96	51,048,900	336,223,000	378,018,500	-41,795,500
1996-97	58,259,200	376,830,700	420,924,900	-44,094,200
1997-98	49,884,800	462,227,500	484,394,300	-22,166,700
1998-99	50,621,700	501,134,200	492,554,400	8,579,800
1999-00	47,879,300	542,613,000	515,383,300	27,229,700
2000-01	36,795,100	576,709,100	548,260,500	28,448,700
2001-02	29,556,000	588,823,400	582,219,300	6,604,100
2002-03	29,463,700	667,448,500	659,513,500	7,935,000
2003-04[1]	31,603,000	741,283,000	670,773,600	70,510,000

[1]Reestimated by the IPFCF actuary based on data through 9/30/04.

11. As shown in Table 3, OCI estimates that, based on data through September 30, 2004, IPFCF's fund equity was approximately $70.5 million.

Legal Issues

12. In 2003 Wisconsin Act 111, subsequent to the 2003-05 budget deliberations, the Legislature: (a) renamed the patients compensation fund the injured patients and families compensation fund; (b) specified that the IPFCF is established to curb the rising costs of health care by financing part of the liability incurred by health care providers as a result of medical malpractice claims and to ensure that proper claims are satisfied; (c) specified that the fund, including any net worth of the fund, is held in irrevocable trust for the sole benefit of health care providers participating in the fund and proper claimants; and (d) specified that moneys in the fund may not be used for any other purpose of the state.

13. In an April, 2005, memorandum, the Wisconsin Legislative Council addressed potential legal issues related to the Governor's proposal to transfer $179.4 million from the IPFCF to the HCQIF created in the bill. In addition to addressing the AB 100 proposal affecting the IPFCF, the attached Legislative Council memorandum provides information on a somewhat similar proposal contained in the Governor's 2003-05 biennial budget bill and 2003 Act 111. The

memorandum summarizes possible legal arguments that could be raised with respect to the Governor's proposal to create additional purposes for the fund and reallocate moneys from the fund for the new purposes. The legal issues include whether the proposed IPFCF transfer represents an unconstitutional taking of property without due process of law, and whether the transfer represents an unconstitutional impairment of contract. While it articulates arguments both for and against the legality of the transfer, the memorandum states that the "taking" claim "is somewhat strengthened" by the fact that AB 100 does not include a sum sufficient appropriation to ensure payment of claims the IPFCF is unable to pay because of insufficient funds. Further, with respect to the impact of Act 111 on a claim of impairment of contract, the memorandum states, " ... it could be questioned whether reserves that were established under current law, especially those that have accrued since the law was changed under 2003 Act 111, may be bound by the new purposes proposed in Assembly Bill 100."

14. The IPFCF Board of Governors indicates that it has a fiduciary responsibility to protect the integrity of the fund and has passed a resolution that indicates that as trustee, the Board opposes any attempt to withdraw funds from the IPFCF that goes beyond the original intent that the fund be held in trust solely for liability claims. In addition, the Board has directed legal counsel for the fund to review the issue.

Medical Malpractice Issues

15. According to various publications such as *Health Affairs* and the *Health Policy Monitor* published by the Council of State Governments, the country is in the midst of a medical malpractice crisis, the third such crisis following the malpractice crises of the 1970s and 1980s. Nationally, over the last several years, malpractice insurance premiums have increased by between 15 and 30 percent, although rate increases in some individual states were much higher. Analysts have attributed the increases to a combination of factors, including the withdrawal of some major malpractice insurers from the market, slow economic growth affecting insurers' investment income, and the severity of malpractice claims.

16. According to a July, 2004, study commissioned by the National Association of Insurance Commissioners (NAIC), the extent of a medical liability insurance crisis varies among the states. Twenty-eight jurisdictions out of 51 surveyed in the NAIC study reported loss ratios in 2002 above 100 percent (that is, for each premium dollar received, more than one dollar is expected to be paid); yet, there were seven jurisdictions with loss ratios below 70 percent, which would be considered relatively favorable. Wisconsin reported the lowest ratio, 61.71 percent, of all reporting jurisdictions. Additionally, medical liability rates are, on average, lower in Wisconsin than in most surrounding states. The NAIC study indicates that underwriting losses have been the primary, although not exclusive, driving factor in rate increases experienced by physicians and other health care providers. Others dispute whether rising insurance premiums have been caused by rising malpractice claims or payouts. The NAIC study also found that much of the medical malpractice data reviewed for the report was "inconsistent, incomplete, difficult to obtain and even more difficult to interpret." The authors of the NAIC study agree with the conclusion in a 2003 GAO study that "a lack of necessary data has hindered and continues to hinder the efforts of Congress,

state regulators, and others to carefully analyze the problem and the effectiveness of the solutions that have been tried."

17. More than two-thirds of medical liability insurers nationwide reported that malpractice premiums seem to be leveling off in 2004, according to survey results from the *Medical Liability Monitor* a publication that has been publishing news about malpractice issues for 30 years. According to the 2004 *Medical Liability Monitor* survey, 15 percent of firms responding to the 2004 rate survey said they expect rates to increase significantly in the next year; whereas in 2003, 83 percent of survey respondents forecast significant increases.

18. However, malpractice rates are not leveling off everywhere, and the *Medical Liability Monitor* survey notes that some carriers are still reporting triple-digit increases. Moreover, some physicians who are experiencing smaller increases are still paying extremely high rates. In states where physicians face sharp increases in their medical liability premiums, some medical facilities have shut down, some physicians are reluctant to perform high-risk procedures, and early physician retirements are on the rise. According to the *Medical Liability Monitor* survey, for the most part, doctors in states with tort reforms tended to fare better with respect to malpractice premium increases than those in states without reforms.

19. Wisconsin has implemented a number of tort reform measures to stabilize the medical malpractice environment, including: (a) a statute of limitations, in most cases, of three years from the incident date or one year from the discovery date; (b) a cap on noneconomic damages of $350,000 plus a cost-of-living increase, currently approximately $432,500; (c) limits on attorney contingency fees; (d) mandatory professional primary liability insurance of $1 million per incident and $3 million per policy year; (e) periodic payment of damages; (f) a mediation system to resolve disputes without litigation; (g) a contributory negligence provision, which allows damages awarded to be diminished in proportion to the amount of negligence attributed to the person recovering; (h) abolition of the collateral source rule, which results in the admission of evidence, in an action to recover damages for medical malpractice, of any compensation for bodily injury received from sources other than the defendant to compensate the claimant for the injury; and (i) the provision of unlimited excess liability coverage through the IPFCF. The other five states that show no problem signs have also implemented a variety of tort reforms.

20. A number of cases have been filed in Wisconsin courts challenging the constitutionality of the cap on noneconomic damages. In 2004, the Wisconsin Supreme Court upheld the cap in a medical malpractice wrongful death case. In early 2005, the Wisconsin Supreme Court agreed to hear another case challenging the cap, this time involving an appeal from a jury verdict that found a physician was negligent in delivering a baby, causing deformities and some paralysis to the boy's arm. The IPFCF actuary has estimated that, if Wisconsin's cap on noneconomic damages were to be declared unconstitutional, the potential fund liabilities may be increased by an estimated $150 million to $200 million.

21. The American Medical Association has listed Wisconsin as one of six states whose medical liability systems are not in crisis or showing problem signs (the other five being California,

Colorado, Indiana, Louisiana, and New Mexico).

22. As noted in an October, 2004, Wisconsin Legislative Audit Bureau (LAB) report, the IPFCF is often cited as an important factor in Wisconsin's relatively stable environment for health care providers, and the fund's solid financial position provides flexibility to readily respond to changes that may occur in the medical malpractice environment in the future. Although the IPFCF contributes to the stable and predictable medical malpractice environment, the extent to which transferring money from the fund on a one-time basis may affect Wisconsin's stable medical malpractice environment is difficult to estimate. The medical malpractice environment would still be predictable because the amount of the transfer is known, and the transfer is on a one-time basis, so the fiscal effects could be calculated. However, if malpractice premiums significantly increase in response, it could contribute to a destabilization of the medical malpractice market in the state.

Fund Integrity and Actuarial Reviews

23. Another issue regarding the proposed transfer of $179.4 million from the fund involves taking a fiscally sound fund and making it less so in order to promote other public policy considerations. The Governor's bill proposes to use $179.4 million from the IPFCF to substitute for GPR funding that would otherwise be needed to support MA-eligible health care costs, and for grants and loans for a variety of health care information technology purposes.

24. According to the actuarial analysis submitted to the IPFCF actuarial committee by Milliman, Inc., as actuary for the fund, transferring $179.4 million would create a substantial fund equity deficit. Additionally, if IPFCF moneys were transferred from the fund, the amount of future investment income earnings available to offset the IPFCF's total estimated outstanding liabilities would have to be reestimated downward. OCI has received an estimate that, when decreased investment earnings are factored in, a transfer of $179.4 million from the fund would equate to an impact on the fund of more than $227 million.

25. Another issue involves the accuracy of actuarial estimates of total outstanding loss liabilities for the IPFCF. The LAB October, 2004, audit of the IPFCF reiterated a suggestion that OCI contract for an independent review of Milliman's methods and assumptions in estimating the IPFCF's loss liabilities. LAB noted that an actuarial audit may be especially useful to the IPFCF because of the long-term nature of medical malpractice claims, increased unpredictability resulting from the fund's coverage, and the significant effect actuarial analyses have on the fund's financial decisions and operations. Additionally, LAB noted that some parties have been critical of the IPFCF actuary for what those parties view as overly conservative estimates of IPFCF loss liabilities. In late February, 2005, OCI contracted with the firm of Tillinghast-Towers Perrin, a consulting actuary with extensive experience in performing actuarial services related to medical malpractice. Tillinghast-Towers Perrin will review the assumptions and methodologies used by Milliman, Inc., in estimating IPFCF loss liabilities. OCI expected to receive a written report from Tillinghast-Towers Perrin by the end of April, 2005, but has yet to receive the report.

26. In the meantime, the administration retained Aon Risk Consultants (Aon) to provide

an independent actuarial opinion of the IPFCF. In a report dated April 4, 2005, Aon recommended a net unpaid loss and loss adjustment expense calculation for the IPFCF from the fund's inception through September 30, 2004 of $387,987,000. Aon compares this with a Milliman recommendation for a net unpaid loss and loss adjustment expense provision through June 30, 2004 of $666,497,000. (Milliman has since revised this estimate downward to $620,603,000, based on data through September, 2004.) Additionally, Aon recommended projected losses and loss adjustment expenses for the 2004-05 fund year of $64,796,000 for the IPFCF, which Aon compares to the Milliman recommendation of $80,111,000. (Milliman has since revised this estimate downward to $72,966,000 based on data through September, 2004).

The net unpaid losses and loss adjustment expenses are part of the total liabilities for the IPFCF. The loss liabilities are the amounts expected to be paid in the future for incidents of malpractice that have already occurred. Loss liabilities increase each year, as another year of activity is added to the ultimate potential losses paid. Estimates of undiscounted losses and loss adjustment expenses are offset by estimates of investment income to arrive at net unpaid losses and loss adjustment expenses. The total liabilities are subtracted from the total assets to arrive at the fund surplus. For example, to reflect the fund balance as of the end of fiscal year 2003-04, based on data through September, 2004, Milliman estimated total IPFCF assets of $741,283,000, reestimated total IPFCF liabilities of $670,773,000, and calculated a fund surplus of $70,510,000. Under Aon's recommendation for estimating net unpaid loss and loss adjustment expenses as of September 30, 2004 of $387,987,000, the fund surplus at the end of fiscal year 2003-04 would be estimated to exceed $303 million.

In arriving at a recommendation estimating net unpaid losses and loss adjustment expenses at a level $232,617,000 below that recommended by Milliman (as revised for data through September, 2004), Aon used an 85 percent confidence percentile. According to the Aon report, this can be interpreted to mean that there is an 85 percent probability that actual liabilities will be below the estimate, and a 15 percent probability that the actual liabilities will ultimately exceed the estimate. Aon estimates that the Milliman recommendation equates to a confidence percentile slightly below 99 percent for its recommendation for net unpaid losses and loss adjustment expenses of $666,496,494 as of June 30, 2004, which would mean that there exists a 99 percent probability that actual liabilities will be below the estimate.

The Aon report states that there are situations where it is appropriate to maintain net unpaid losses and loss adjustment expenses at confidence levels in excess of 90 percent, including: (a) when there is a limited or unreliable loss history; (b) when there is a likelihood of receiving several "mega-million" dollar claims; and (c) where there is an inability to assess for shortfalls. After acknowledging that one or more of these situations may have applied in the early years of the IPFCF's existence, Aon asserts that, given the IPFCF's 30-year loss history, the statutory limit on non-economic damages, and comparatively high mandatory malpractice coverage levels ($1 million per occurrence, $3 million per policy year), it would be reasonable and appropriate to maintain liabilities at a 75 to 85 percent confidence level. Further, Aon notes that "in the unlikely event that actual liability payments exceeded the 75% to 85% percentile, the Fund has the ability to make up any shortfall through the annual assessment determination."

It is presumably on the basis of the Aon report that the administration asserted in documentation accompanying its budget that "independent analysis of the fund reserves indicate that the liabilities have been overestimated and that revenues can be transferred without affecting the financial stability and long-term viability of the fund." Table 4 represents a balance sheet through 2003-04 comparing the IPFCF surplus projected by Milliman in its published report to the IPFCF actuarial committee with its recalculated surplus based on data through September 30, 2004, and the surplus projected by Aon based on data through September 30, 2004.

TABLE 5

IPFCF
Balance Sheet Through Fiscal Year 2003-04

	Fund Financial Statement As Published	Hindsight Restatement Based on Actuarial Studies @ 9/30/04 Milliman	Aon
(1) Total Fund Assets	$741,283,000	$741,283,000	$741,283,000
(2) Fund Undiscounted Unpaid Claim Liabilities	880,445,000	786,030,000	493,625,000*
(3) Offset for Investment Income	-213,948,000	-165,427,000	-105,638,000
(4) Fund Discounted Unpaid Claim Liabilities [(2) + (3)]	666,497,000	620,603,000	387,987,000
(5) Total Fund Liabilities	716,667,000	670,773,000	438,157,000
(6) Fund Surplus [(1) - (5)]	24,616,000	70,510,000	303,126,000

*Unpaid claim liabilities as of 9/30/04 represent estimates at an 85% confidence percentile.

27. Milliman, Inc., an international consulting actuarial firm, has been the IPFCF actuary since the fund's inception. Milliman is one of the two largest actuarial firms in the country in terms of its medical malpractice specialty area.

Milliman has noted factors that make providing actuarial estimates for the IPFCF uniquely challenging, including the fact that: (a) the fund provides coverage on an occurrence basis, entitling a provider to coverage for claims filed for any acts of malpractice that occur during a year in which the provider was assessed a fee, including claims that are filed subsequent to the IPFCF coverage cancellation date; (b) the state capped noneconomic damages in 1995 at $350,000, indexed for inflation; (c) the fund participates in relatively few malpractice cases due to the $1 million primary insurance threshold imposed in 1997, giving the actuary a small statistical sample with which to work; and (d) the fund provides unlimited coverage for economic damages. The statutory cap on noneconomic damages and the $1 million primary insurance threshold each has the effect of reducing the fund's exposure; however, those two changes occurred 20 and 22 years into the fund's history, respectively. Consequently, the current liability parameters have existed for fewer than 10 years, giving an actuary a relatively brief period on which to base estimates of the individual and combined effects of those changes. Milliman acknowledges that, in hindsight, its estimates appear

conservative in the wake of those changes, evidenced by its recommendations each year since 1997 to reduce the recommended reserves based on another year of the fund's development. However, Milliman contends that a conservative approach is warranted, given the relatively brief period in which the current system has existed. Arguably, Milliman's annual suggested changes to its earlier recommendations for the fund's reserves, based on another year's history, correct to some extent any overly conservative prior estimates.

Although Milliman has not issued an official written response to the Aon report, Milliman actuaries have discussed potential reasons for the significant differences in the firms' estimates of the IPFCF surplus as of June 30, 2004. For example, Milliman notes that its projections differ from Aon's related to the number of malpractice claims incurred but not yet reported, the length of time during which those claims may still be reported for any given year, and the average payment per claim. In short, Milliman projects a higher number of claims overall, predicts that claims may be reported for a longer period relating to any particular year, and predicts that the fund will pay more per claim. The firms' estimates for potential future loss and defense costs differ throughout all years of the fund's existence, but differ most significantly for the years 1990-91 through 2001-02, the period during which the noneconomic damages cap was reinstated and the primary insurance threshold was raised to $1 million per occurrence. Milliman projects unpaid claim liabilities of $564,489,000 for those years, but Aon projects unpaid claim liabilities of $312,866,000, accounting for a difference of over $251 million. Although the firms' estimates of total potential loss and defense costs differ significantly for the 12-year period from 1990-91 through 2001-02, their estimates of the number of claims incurred but not reported for any given year do not differ significantly. The significant difference in the total amount of unpaid claim liabilities projected by the firms seems to stem from the fact that Milliman predicts that claims attributable to any given year may be reported for a longer time after that year, and would result in higher payments from the fund.

Additionally, Aon states that the scope of its study did not include an independent analysis of appropriate assessment levels for the 2004-05 fund year. Milliman cautions that reliable assessment revenue estimates are available for 2004-05, in the amount of $26.3 million. In its report, Aon has recommended a projection for losses and loss adjustment expenses for 2004-05 in the amount of nearly $64.8 million (compared to Milliman's estimate of $72,966,000.) Thus, although not necessary for Aon's projection of fund equity as of September 30, 2004, data were available to Aon indicating that fund equity in 2004-05 would be reduced by approximately $38.5 million, or the difference between Aon's projection for losses and the projected assessment revenues. Moreover, in February, 2005, the IPFCF board approved fees at a level estimated to generate $18,400,000 in 2005-06, or 30 percent less than in 2004-05. Thus, by Milliman estimates, when projected assessment revenue is balanced against projected liabilities for fiscal years 2004-05 and 2005-06, the fund balance statement as of June 30, 2006 may show a $30 million deficit.

In the "Conditions and Limitations" section of its report, Aon states that its projections "make no provision for the extraordinary future emergence of losses or types of losses not sufficiently represented in the historical data, or which are not yet quantifiable." Aon has based its estimates and recommendation exclusively on empirical data regarding payments throughout the

fund's history. The largest single award in the fund's payment history has been approximately $18 million. By not providing for the possibility of an extraordinary future loss, Aon may have underrepresented potential fund payments. Milliman, as the actuary hired to advise the IPFCF Board, must attempt to account for extraordinary future emergence of losses in its recommendations. In its November 24, 2004 report to the IPFCF actuarial committee, Milliman notes that a coverage such as medical malpractice, with its extended reporting and settlement patterns is especially difficult to estimate and that fact is "compounded even further for the Fund, given the nature of its coverage -- unlimited excess liability protection over the primary carriers." The fact that catastrophic claims for economic damages have not yet occurred provides no assurance that they will not, given the fund's limitless coverage of economic losses. Additionally, Milliman states that these same factors that make IPFCF coverage difficult to estimate also prevent Milliman from presenting its recommendations to the IPFCF Board in terms of "confidence percentiles" as Aon does in its report. Rather than present a variety of projections at various confidence percentiles, a practice it considers incongruous and inappropriate given the nature of the fund's coverage, Milliman presents its best estimate of liabilities to the IPFCF Board.

Transfer of Funds

28. As noted above, based on the analysis in the attached Legislative Council memorandum, the absence of such a GPR sum sufficient appropriation may make the administration's proposal more vulnerable to a successful legal challenge. If the Committee adopts the Governor's recommendation to transfer funds from the IPFCF to the general fund, it could create a GPR sum sufficient appropriation to pay any portion of a claim for damages arising out of the rendering of health care services that the IPFCF is required to pay but is unable to pay because of insufficient moneys.

29. Also, the majority of the funds in the IPFCF are not cash on hand and would have to be liquidated to receive a cash amount. The fund may realize a loss or gain on the liquidation. The Committee could modify the Governor's proposal by including a provision that would require the state to repay in the 2007-09 biennium, or over a longer period, any amount of funding transferred from the IPFCF in 2005-07, including interest foregone and including losses resulting from liquidation.

30. Finally, the Committee could delete the provision from the bill in order to avoid a potential legal challenge, to avoid any potential adverse effects to the medical malpractice environment in Wisconsin, and to maintain the integrity of IPFCF's fund equity balance.

ALTERNATIVES

1. Adopt the Governor's recommendation to transfer $169,703,400 in 2005-06 and $9,714,000 in 2006-07 from the IPFCF to the health care quality improvement fund.

2. Modify the Governor's recommendation by creating a sum sufficient GPR appropriation to pay any portion of a claim for damages arising out of the rendering of health care

services that the IPFCF is required to pay but is unable to pay because of insufficient moneys.

3. Modify the Governor's recommendation to require that the state repay, from a GPR sum sufficient appropriation, the amount transferred from the IPFCF, including interest foregone and losses resulting from liquidating IPFCF assets, at an interest rate determined by the Wisconsin State Investment Board, over the following number of years:

a. 2 years from the end of the 2005-07 biennium.

b. 4 years from the end of the 2005-07 biennium.

c. 6 years from the end of the 2005-07 biennium.

4. Delete the provision.

Prepared by: Eric Ebersberger
Attachments

ATTACHMENT 1

Annual Provider Assessments[1]

Provider Types	2000-01	2001-02	2002-03	2003-04	2004-05
Physician Class 1[2]	$1,898	$1,538	1,461	1,534	1,227
Physician Class 2[3]	3,606	2,769	2,630	2,276	2,209
Physician Class 3[4]	7,877	6,385	6,063	6,366	5,093
Physician Class 4[5]	11,388	9,231	8,766	9,204	7,363
Nurse Anesthetist	475	378	359	377	302
Hospital -- per Occupied Bed	116	93	88	92	74
Nursing Home -- per Occupied Bed	22	17	16	17	13
Employees of a Partnership or Corporation					
Nurse Practitioner	475	385	365	384	307
Advanced Nurse Practitioner	664	538	511	537	430
Nurse Midwife	4,176	3,385	3,214	3,375	2,700
Advanced Nurse Midwife	4,365	3,538	3,360	3,528	2,822
Advanced Practice Nurse Prescriber	664	538	511	537	430
Chiropractor	759	615	584	614	491
Dentist	380	308	292	307	256
Oral Surgeon	2,847	2,308	2,192	2,301	1,841
Podiatrists -- Surgical	8,067	6,538	6,209	6,520	5,216
Optometrist	380	308	292	307	256
Physician Assistant	380	308	292	307	256

[1] These rates apply to providers having Wisconsin as their primary place of practice. Other rates apply to providers for whom Wisconsin is not their primary place of practice.

[2] Includes family or general practice physicians not performing surgery, and nutritionists.

[3] Includes family or general practice physicians performing minor surgery, and ophthalmologists performing surgery.

[4] Includes most types of surgeons, such as plastic, hand, general, and orthopedic.

[5] Includes obstetric and neurological surgeons.

Note: The listed assessments represent IPFCF assessments only and do not include malpractice insurance rates for coverage with limits of $1 million/$3 million. For example, in 2002 the average malpractice insurance premium for general surgeons in Wisconsin was $17,433.

ATTACHMENT 2

Wisconsin Injured Patients and Families Compensation Fund
Policy Years 1975-76 through 2004-05
as of September 30, 2004

Year	Fund Year* Assessments	Paid Indemnity in Calendar Period	Paid Indemnity Incidents that Occurred in in Fund Year as of 9/30/04	Number of Claims Paid for Incidents that Occurred in the Fund Year as of 9/30/04	Number of Outstanding Claims by Fund Year as of 9/30/04
1975-76	$3,037,000	$0	$5,713,000	16	0
1976-77	3,056,000	0	4,977,000	21	0
1977-78	1,351,000	360,000	9,160,000	24	0
1978-79	1,419,000	2,219,000	11,179,000	23	0
1979-80	2,396,000	1,832,000	21,652,000	37	0
1980-81	4,413,000	3,966,000	16,279,000	34	2
1981-82	4,671,000	3,740,000	22,976,000	45	1
1982-83	7,351,000	8,472,000	19,320,000	32	0
1983-84	10,272,000	13,227,000	19,574,000	34	0
1984-85	17,401,000	12,894,000	11,772,000	26	0
1985-86	32,705,000	7,959,000	54,440,000	42	0
1986-87	30,809,000	18,930,000	23,798,000	37	0
1987-88	33,280,000	25,184,000	41,884,000	23	0
1988-89	37,985,000	18,222,000	23,540,000	18	0
1989-90	43,279,000	22,366,000	25,796,000	24	0
1990-91	43,800,000	41,631,000	29,455,000	20	2
1991-92	42,199,000	26,056,000	38,402,000	19	1
1992-93	46,188,000	44,961,000	30,394,000	21	0
1993-94	51,200,000	18,537,000	51,121,000	21	1
1994-95	55,542,000	48,066,000	31,718,000	32	1
1995-96	50,535,000	40,045,000	15,450,000	13	3
1996-97	58,703,000	23,680,000	16,233,000	14	3
1997-98	50,363,000	25,625,000	8,671,000	5	1
1998-99	50,620,000	16,386,000	22,730,000	6	3
1999-00	47,640,000	48,672,000	10,600,000	4	3
2000-01	36,573,000	30,018,000	519,000	0	6
2001-02	29,750,000	30,361,000	1,250,000	1	4
2002-03	29,319,000	16,315,000	0	0	1
2003-04	31,603,000	18,882,000	0	0	0
2004-05	26,317,000	0	0	0	0
	$883,777,000	$568,606,000	$568,603,000	592	32

* Fund Year is the policy period beginning July 1 and Ending the following June 30

WISCONSIN LEGISLATIVE COUNCIL

Terry C. Anderson, Director
Laura D. Rose, Deputy Director

TO: BOB LANG, DIRECTOR, LEGISLATIVE FISCAL BUREAU

FROM: Laura Rose, Deputy Director

RE: Injured Patients and Families Compensation Fund Issues

DATE: April 26, 2005

This memorandum discusses the following:

- The Governor's budget proposal from the 2003-05 Legislative Session on the Patient Compensation Fund (PCF).
- 2003 Wisconsin Act 111, which relates to the purpose and integrity of the PCF, and changed the name of the PCF to the "Injured Patients and Families Compensation Fund" (IPFCF).
- The Governor's current budget proposal on the IPFCF.
- Issues relating to the Governor's proposal.

2003-05 Budget Proposal on the Patient Compensation Fund

2003 Senate Bill 44, introduced by Governor Doyle on February 20, 2003, proposed the following changes to the PCF:

- Created subch. VIII of ch. 655, the health care provider availability and cost control fund. The purposes of the fund were to assist in the education and training of health care providers; ensure that Medical Assistance (MA) health care providers and providers for other health care programs established by this state receive sufficient reimbursement rates to retain their participation in the programs; and defray the cost of other health-related programs that the Secretary of the Department of Health and Family Services (DHFS) determines are effective in ensuring the availability of health care providers in this state, and controlling the cost of health care services.

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- Funded the health care availability and cost control fund with the transfer of $200,000,000 in fiscal year 2003-04 from the PCF to the health care provider availability and cost control fund.

- Established a sum-sufficient appropriation for the payment of any portion of a claim for damages arising out of the rendering of health care services that the PCF is required to pay under ch. 655 but that the PCF is unable to pay because of insufficient moneys.

- Provided for the administration of the health care availability and cost control fund by the State Investment Board.

The Joint Committee on Finance removed the proposal from the budget bill.

2003-05 Legislation Relating to the Patient Compensation Fund

In the 2003-05 Legislative Session, the Legislature passed Assembly Bill 487, which became 2003 Wisconsin Act 111.

2003 Wisconsin Act 111 does the following:

1. Changed the name of the PCF to the "Injured Patients and Families Compensation Fund (IPFCF)."

2. Specified that the IPFCF is established to curb the rising costs of health care by financing part of the liability incurred by health care providers as a result of medical malpractice claims and to ensure that proper claims are satisfied.

3. Specified that the IPFCF, including any net worth of the IPFCF, is held in "irrevocable trust" for the sole benefit of health care providers "participating in the fund" and proper claimants. The Act specified that any moneys in the IPFCF may not be used for any other purpose of the state.

Act 111 took effect on January 8, 2004.

2005-07 Budget Proposal on the Injured Patients and Families Compensation Fund

In the 2005-07 Budget Bill (2005 Assembly Bill 100), Governor Doyle proposes to transfer $169,703,400 in 2005-06 and $9,714,000 in 2006-07 from the IPFCF to the health care quality improvement fund (HCQIF), which would be created in the bill. The HCQIF would be a separate, nonlapsible trust fund, that would consist of these transferred funds, as well as $130,000,000 from the net proceeds of revenue obligation bonds backed by the state's excise taxes on alcoholic beverage, cigarette, and tobacco products; $250,000 annually from program revenues DHFS collects from health care providers; repayment of loans provided by the Health Care Quality and Patient Safety Board; and unanticipated general fund revenues received in the 2005-07 biennium, in an amount determined by the Department of Administration Secretary, that would otherwise be transferred to the budget stabilization fund.

The Governor's budget also proposes to create three segregated (SEG) revenue appropriations from the HCQIF to support MA benefit costs, as follows:

- Create a continuing appropriation, budgeted with $150,000,000 SEG in 2005-06 and $130,000,000 SEG in 2006-07 to support MA benefit costs.

- Create a sum sufficient appropriation, to which unanticipated general fund revenues received in the 2005-06 biennium, as described above, would be credited.

- Create an annual appropriation, budgeted with $9,703,400 in 2005-06 and $9,714,000 in 2006-07, to provide payments for direct graduate medical education, a major managed care supplement, a pediatric services supplement, rural hospital supplements, and an essential access city hospital supplement.

The bill repeals the sum sufficient appropriation and all of the statutory references to this appropriation on June 30, 2007.

The current purpose of the IPFCF is to curb the rising costs of health care by financing part of the liability incurred by health care providers as a result of medical malpractice claims and to ensure that proper claims are satisfied. The IPFCF provides excess medical malpractice coverage for medical malpractice claims that exceed the provider liability limits of $1,000,000 per claim and $3,000,000 per policy year in the aggregate. Health care providers must obtain primary medical malpractice insurance up to the liability limits. The IPFCF is funded through annual assessments paid by providers and through investment income. Annual assessments are determined based on actuarial estimates of the IPFCF's loss liabilities. The State of Wisconsin Investment Board makes long-term investments for the IPFCF. As of June 30, 2004, the Investment Board reported net assets of the fund to be approximately $695,600,000.

The Governor's budget bill expands the purpose of the IPFCF to include all of the following new purposes:

- Ensuring the availability of health care providers in the state.

- Enabling the deployment of health care information systems technology for health care quality, safety, and efficiency, as referenced in the sections of the bill that would authorize the new Health Care Quality and Patient Safety Board to make grants and loans.

- Deploying health care information systems technology for health care quality, safety, and efficiency by the Board.

Issues Relating to Proposal

The following summarizes some possible issues that could be raised with respect to the Governor's proposal to rename the IPFCF, create additional purposes for the fund, and reallocate moneys from the fund for these new purposes.

1. *Taking of Property Without Due Process of Law.* Because 2003 Wisconsin Act 111 states that the IPFCF, including any net worth of the IPFCF, is held in "irrevocable trust" for the sole benefit of health care providers participating in the fund and proper claimants, and the moneys may not be used for any other purpose of the state, it is possible that the proposal to reallocate moneys from the IPFCF to

the HCQIF created in the Governor's budget bill may be considered to be a taking of property without due process of law.

The U.S. Constitution, Amendment Five, provides in part: "No person shall ... be deprived of life, liberty, or property, without due process of law; nor shall private property be taken for public use, without just compensation." Article I, Section 13 of the Wisconsin Constitution provides: "The property of no person shall be taken for public use without just compensation therefor."

In *Wisconsin Professional Police Association, Inc. v. Lightbourn*, 243 Wis. 2d 512, 627 N.W.2d 807 (S. Ct. Wis. 2001), Justice Prosser set forth the initial steps in analyzing a taking claim: whether a private property interest exists, and whether the private property has been taken. If private property is shown to have been taken, the next steps are to determine whether the property is taken for a valid public use, and whether just compensation is provided therefore. *Wisconsin Retired Teachers Assn. v. Employee Trust Funds Board*, 207 Wis. 2d 1, 558 N.W.2d 83 (1997).

An accrued claim for medical malpractice is a property interest. *Aicher v. Wisconsin Patients Compensation Fund*, 237 Wis. 2d 99, at 143 (S. Ct. 2000). An individual who receives a malpractice award has a property right in having the claim paid by the IPFCF if it exceeds the limits for which the liable health care provider is insured. If the Assembly Bill 100 proposal were to result in jeopardizing the payment of a claimant's award by the IPFCF, it could be seen as a taking of property without due process of law. The "taking" claim is somewhat strengthened by the fact that the sum sufficient appropriation that was included in the 2003-05 budget proposal to ensure payment of claims is not included in Assembly Bill 100.

It might also be possible to assert that participating IPFCF providers, if required to pay higher fees as a result of the Assembly Bill 100 proposal, had their property taken because they did not agree to fund the HCQIF, as created in Assembly Bill 100, with their IPFCF fees.

On the other hand, it could be argued that the cash reserves in the IPFCF are ***not*** private property. In *Great Lakes Higher Education Corporation v. U.S. Department of Education*, 911 F. 2d 10 (7th Cir. 1990), the cash reserves of the Great Lakes Higher Education Corporation (GLHEC), a private, nonprofit, corporation providing student loan guarantees, were found not to be "private property" for the purposes of the Fifth Amendment to the U.S. Constitution. 911 F. 2d 10 at 14. In that case, the U.S. Department of Education (DOE), after amendments to the statutes governing the agreements between student loan guarantee agencies such as GLHEC and DOE, recouped cash reserves from these agencies that it determined were excessive. The court said this recoupment of reserves was not a taking:

> The purpose and legal structure of Great Lakes places it in that borderline between the wholly public and wholly private instrumentality. The extensive federal regulation of the agency suggests its highly public nature .... In essence, Great Lakes is an intermediary between the United States and the lender of the student loan. The United States is the loan guarantor of last resort. Great Lakes assists the United States in performing that function. It cannot be compelled to perform that function, nor can it insist that its compensation for that service be irrevocably fixed. We, therefore, conclude that the reserve fund excess is not "private property" for purposes of the Fifth Amendment. 911 F. 2d 10, at 13-14.

If a court were to determine that private property interests exist in the IPFCF for claimants or payors, the next question is whether: (1) the proposal in Assembly Bill 100 to create a new fund in ch. 655 and transfer approximately $180,000,000 from the IPFCF reserves jeopardizes the payment of any accrued claims under the IPFCF; or (2) the proposal will result in an increase in IPFCF provider fees, and those fees are taken for a use not contemplated by ch. 655.

Several Wisconsin Supreme Court cases examined transfer of funds from state trust funds to other funds. A recent case, *Wisconsin Professional Police Association, supra*, held that legislation which authorized the transfer of funds from the one account in the Wisconsin Retirement System (the transaction amortization account or TAA) to the reserves and accounts in the fixed trust, which resulted in more benefits to some classes of fund participants over others, did not constitute a taking.

Another transfer at issue in *Wisconsin Professional Police Association* involved a distribution of $200,000,000 from the employer reserve to employers as a credit for employers against unfunded liabilities. The court stated that this was not an unconstitutional taking of property, nor was it an unconstitutional impairment of contract:

> The size of the employer reserve balance does not increase or in any way determine the contractual benefit to be received by participants. At best, the balance in the employer reserve may heighten the possibility of an increase in the formula multiplier or the benefit caps in a future vote by the state legislature.... No one in this litigation suggests that Act 11 abrogates the statutory and constitutional obligation of employers to fulfill benefit commitments to participants. These "benefits accrued" for "service rendered" are the essence of the property right enjoyed by participants. There is no taking of property or impairment of contract when everyone concedes that accrued benefits must be paid.... 243 Wis. 2d 512, at 602-603.

Other cases have found an unconstitutional taking upon a transfer from vested retirement funds. In *Association of State Prosecutors v. Milwaukee County*, 199 Wis. 2d 549 (S. Ct. Wis. 1996), the court determined that it was an unconstitutional taking to give retirement service credits to district attorneys transferred from the Milwaukee County system to the state system and fund the transferred credits by transferring moneys out of the county pension fund, instead of paying for the credits with state moneys.

An unconstitutional taking was also found in *Wisconsin Retired Teachers Association, Inc. v. ETF Board*, 207 Wis. 2d 1 (S. Ct. Wis. 1997). In that case, a transfer from the retirement fund was authorized by the passage of a law that superseded the role of the ETF in making such transfers. In that case, 25% of annuitants received a special investment performance dividend as part of a $230 million distribution from the TAA, while 75% of annuitants received no dividend. This distribution violated many of the statutory provisions in ch. 40, and superseded the statutory role of the Employee Trust Fund in making these distributions.

2. *Impairment of Contract.* The proposal to reallocate moneys from the IPFCF to the HCQIF created in the Governor's budget bill may be considered to constitute an impairment of contract. If the IPFCF is contractually limited to paying part of health care provider liability for medical malpractice

claims to further the purpose of curbing the rising costs of health care by financing part of the liability, then using the funds for unrelated purposes could be deemed an impairment of contract.

Article I, Section 10 of the U.S. Constitution provides, in part, as follows: "No state shall...pass any...law impairing the obligations of contracts...." Article I, Section 12 of the Wisconsin Constitution, provides, in part, as follows: "No bill of attainder, ex post facto law, nor any law impairing the obligation of contracts, shall ever be passed...."

The Wisconsin Supreme Court, in *Wisconsin Professional Police Association, supra*, stated that it usually follows a three-step methodology developed by the U.S. Supreme Court in analyzing impairment of contract claims: first, to inquire whether the challenged statute has operated as a substantial impairment of a contractual relationship; second, if the legislation is found to substantially impair a contractual relationship, whether there exists a significant and legitimate public purpose behind the legislation; and third, if such a public purpose exists, whether the challenged legislation is based upon reasonable conditions and is of a character appropriate to the public purpose justifying the legislation's adoption. *Wisconsin Professional Police Association*, 234 Wis. 2d 512, at 593-594.

In this case, health care providers required to participate in the IPFCF could possibly claim a contractual relationship with the state through the IPFCF: in return for payment of the mandated fees, the participating providers receive malpractice coverage for claims which exceed the amounts covered by their private malpractice insurance policies. If the Governor and the Legislature created a new purpose for ch. 655 after the establishment of the initial contractual relationship, these providers could assert that they did not agree to have their fees used for this broader statutory purpose.

If this proposal were to be enacted into law and subsequently challenged in court, the court would first analyze whether this change in the purpose of ch. 655 operated as a significant impairment of contract. In *Great Lakes Higher Education Corporation v. U.S. Department of Education, supra*, the court found no impairment of contract when the agreement between GLHEC and the U.S. DOE was altered by statutory amendments to permit the recoupment of cash reserves. However, in that case, the original enabling legislation specifically stated that GLHEC agreed to conform both to the existing federal statutes and regulations and to new obligations that Congress or the Secretary of Education might impose in the future. GLHEC consented to these terms in the insurance program agreement. 911 F. 2d 10, at 12.

In this case, the statutes governing the IPFCF do not mention that the health care providers participating in the IPFCF agree to be bound by new obligations that the Legislature might impose on the fund in the future. Of course, the Legislature is free to amend the purpose of the IPFCF at any time. However, it could be questioned whether reserves that were established under current law, especially those that have accrued since the law was changed under 2003 Act 111, may be bound by the new purposes proposed in Assembly Bill 100.

If a court found an impairment of contract, a court would then examine whether there is a significant and legitimate public purpose behind the legislation that allegedly gave rise to the impairment. The proponents would likely assert that using IPFCF reserves to supplement Medical Assistance costs essential to maintaining the participation of health care providers in the Medical Assistance program and to ensuring the availability of health care providers to serve low-income persons in this state. Alternatively, if the transfer of funds were to somehow result in an unacceptable fee

increase for participating providers that resulted in lessening the supply of providers, it could be argued that the proposal does not serve a significant and legitimate public purpose. However, it is beyond the scope of this memorandum to speculate on the effect of the proposal on IPFCF fees.

Finally, if an impairment of contract was found, but was justified by a legitimate public purpose, a court would examine whether the legislation is based upon reasonable conditions and is of a character appropriate to the public purpose justifying the legislation's adoption. It might also examine whether it is reasonable and appropriate to require mandatory IPFCF participants to supplement Medical Assistance costs with their fees, as well as funding the other purposes established under the HCQIP.

If you have any questions on the issues raised in this memorandum, please contact me directly at the Legislative Council staff offices. My telephone number is 266-9791.

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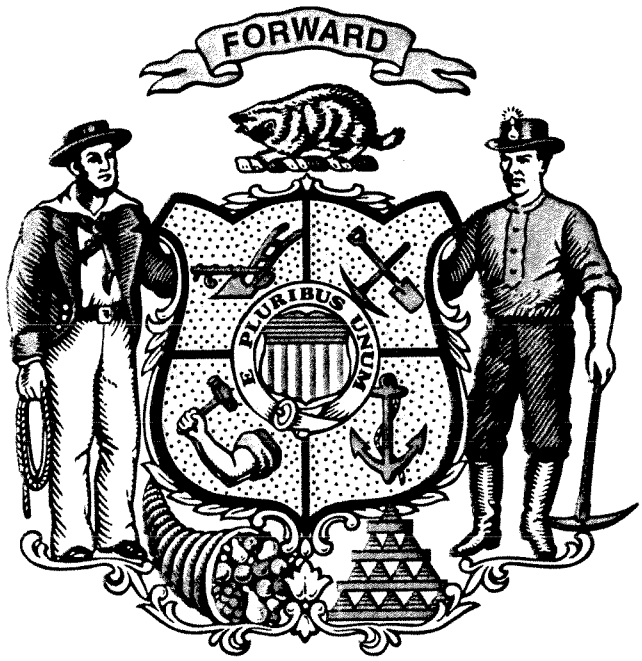
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TRENDS

The Growth Of Physician Medical Malpractice Payments: Evidence From The National Practitioner Data Bank

The growth of malpractice payments is less than previously thought.

by Amitabh Chandra, Shantanu Nundy, and Seth A. Seabury

ABSTRACT: We used data from the National Practitioner Data Bank (NPDB) to study the growth of physician malpractice payments. Judgments at trial account for 4 percent of all malpractice payments; settlements account for the remaining 96 percent. The average payment grew 52 percent between 1991 and 2003 (4 percent per year) and now exceeds $12 per capita each year. These increases are consistent with increases in the cost of health care. A preoccupation with data on judgments, extreme awards, or specific specialties results in an incomplete understanding of the growth of physician malpractice payments.

INFLUENTIAL TRADE associations such as the American Medical Association (AMA) and the Physician Insurers Association of America (PIAA) have attributed the dramatic increase in physician malpractice insurance premiums to the growth in malpractice payments.[1] Other factors such as declines in insurers' investment income are acknowledged to have contributed to the new medical malpractice crisis; however, losses from rising malpractice payments are believed to be the primary contributor to the growth of malpractice premiums.[2] To restrict the growth of payments, both groups advocate a nationwide $250,000 limit (cap) on noneconomic damages, a policy endorsed by President George W. Bush.[3] Support for damages caps is largely driven by the belief that malpractice payment growth has been concentrated in the very largest awards.[4]

Discussions of the malpractice crisis often rely on restrictive subsets of malpractice data, so a precise description of the problem is lacking. The AMA has drawn attention to trends in jury verdicts, even though only a small fraction of malpractice cases are resolved at trial.[5] This restriction overstates the size of payments, and by ignoring information on settlements, it may drastically understate the overall burden of malpractice payment. The PIAA's tabulations, while more complete in principle than those that only rely on jury verdicts, rely on data that are not publicly available. In this paper we establish new facts on the growth in malpractice payments made on behalf of physicians by using a national database of payments from judgments at trial and settlements during 1 January 1991–31 December 2003.

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Study Data And Methods

Data and study sample. All malpractice payments made on behalf of a licensed health care provider must be reported to the National Practitioner Data Bank (NPDB) within thirty days under the Health Care Quality Improvement Act of 1986.[6] Noncompliance is subject to civil penalties codified in 42 USC 11131–11152.[7] The NPDB has information on 250,137 such payments made between 1 September 1990 and 31 December 2003. We restricted our sample to the fifty states and excluded payments made for Washington, D.C.; areas with missing state information; and other U.S. territories (N = 3,200). The NPDB became operational late in 1990, so we deleted observations in this year (N = 2,132). We excluded payments that were linked to dentists, pharmacists, social workers, or nurses (N = 53,538). In a small fraction of payments (n = 10,823), there are multiple physician defendants (and thus multiple reports) but only the total payment by all defendants is reported. In these cases, we averaged the payment by the number of physicians involved.[8]

In the NPDB, 5 percent of payments are made by state funds in addition to other payments made by the primary insurer for the same incident (N = 9,919). We matched such payments based on an algorithm that used physician identifiers, state of work, state of licensure, area of malpractice, type of payment (judgment or settlement), and year of occurrence. We also experimented with using additional data fields to perform this match, but values were missing for many of these fields. Fund payments that could not be matched were retained in the data (N = 3,822). Because these cases were rare, we experimented with deleting them from the analysis. With the exception of Pennsylvania, which had 5,308 state fund payments (53 percent of all fund payments recorded in the NPDB), our results were essentially unchanged.

Our final sample consists of 184,506 payments made between 1 January 1991 and 31 December 2003 in the fifty states. Ninety-four percent of these were for physicians with a medical degree (MDs); the remaining 6 percent were for osteopathic physicians (DOs). Each malpractice payment in the NPDB is classified in ten major categories of liability (such as surgery, diagnostics, obstetrics), which we used for our primary analysis.

Data on health care spending for 1991–2002 are from the National Health Accounts (NHA) published by the Centers for Medicare and Medicaid Services (CMS).[9] We converted all payment amounts into 2000 dollars using the Implicit Gross Domestic Product (GDP) Price Deflator.[10] Finally, data on state and national population levels by year for 1991–2003 come from the U.S. Census Bureau.[11]

Data quality and the role of the "corporate shield." Most previous studies of malpractice awards used data from publications that recorded information on jury verdicts in local jurisdictions, known as "jury verdict reporters." Data from these reporters and the NPDB differ for several reasons, all of which make the NPDB better suited to our analysis. First, the reporters are not meant to cover the universe of awards; information is collected only on jury verdicts in local jurisdictions, and no data on settlements are included. Second, amounts recorded in the NPDB measure the amount of actual payments, not jury awards: If a jury awards a plaintiff $1 million, that figure is recorded by a reporter; however, if a malpractice policyholder has coverage for only a smaller amount (which is what is paid by his or her insurer), if plaintiffs settle for a lower amount (to avoid appeals by the defendant), or if the jury award is reduced to comply with state damages caps, the NPDB will record the lower number—which is the number that is relevant for insurance premiums. Third, data from reporters record awards based on the year of the verdict, while the NPDB reports the year in which payments were made.

The NPDB has been the subject of criticism, from the PIAA in particular, but also from the U.S. Government Accountability Office (GAO).[12] One of the major points of criticism is the "corporate shield." This loophole renders payments made on behalf of a hospital or other corporation exempt from inclusion in the NPDB, as long as any individual practitioner is

dropped as part of a settlement agreement. We assessed the potential importance of this source of bias (which understates the number and severity of payments) by comparing jury verdicts reported in the NPDB with those from a data set compiled by the RAND Institute for Civil Justice (the Jury Verdict Database, or JVDB) for New York and California.[13]

Between 1991 and 1999 the JVDB data showed an average annual growth of awards against physicians of 3.9 percent in New York (an average of forty-two awards) and 4.3 percent in California (an average of thirty-five awards). Over the same time period the NPDB reported average annual growth of 13 percent in New York (an average of fifty-three awards) and 1.6 percent in California (an average of forty-three awards). For both states, the NPDB understates both the number of and growth in awards. The magnitude of underreporting is remarkably consistent (approximately 20 percent in both states). This estimate is best interpreted as an upper bound on the degree of underreporting, because the NPDB reports payments by date of payment, whereas the JVDB records them by date of verdict. The two dates will differ if a verdict occurred in one year but payments began in another year.

Other concerns about the NPDB include potential underreporting of restrictions on clinical privileges and the quality of certain data fields that are not relevant for our study.[14] Despite its limitations, though, the NPDB is the most representative national and publicly available database on physician malpractice payments. Indeed, hospitals are required by law to query the malpractice histories of potential hires; in 2002 the databank was queried 1.12 million times, or more than 3,000 times a day.[15] We emphasize that it would be misleading to infer anything about the occurrence of negligence from data on payments, because past work shows a weak correlation between a malpractice claim and negligence.[16]

Study design. We present trends in the number and average dollar amount of U.S. medical malpractice payments from 1991 to 2003. We report average payments per capita and the constituent components: frequency of payments (number of payments per capita) and average conditional severity (average size of payment for claims where a payment was made); an increase in either component will increase per capita malpractice payments. We focused on these two measures because of the assertion in earlier research that they are the key components of malpractice pressure influencing the practice of defensive medicine.[17]

To explore the claim that growth in payments has been concentrated in the largest awards, we compared the growth of the mean payment to the growth in the top 10 percent of payments. If the distribution of payments has become more skewed, we would expect the observed growth at the top end of the distribution to exceed that of the average payment.

When one is considering the growth in malpractice payments, it is important to account for changes over time in the number of events that are at risk for litigation. The number of physicians or health care workers may seem like a natural proxy for health care use, but it could be affected by medical malpractice liability.[18] We therefore used two different variables to control for use at the national level. The first was population, which is almost certainly exogenous to medical malpractice but ignores trends in the use of care.[19] The second was total health care spending, which might not be exogenous to medical malpractice but should capture trends in the price and quantity of medical services. Note that there are no data in the NPDB that allow us to measure changes in litigiousness (that is, the number of claims—successful or unsuccessful—per capita). We report the number of dollars for payments as a function of total health spending and spending on physician and clinical services (the latter are probably more relevant for our data, given that the NPDB only reports payments on behalf of physicians).

Study Results

Growth of malpractice payments. The number of payments (which comprises the number of judgments and settlements) remained stable over the study period. The average payment amount (severity) grew 52 per-

cent in real dollars (an average annual growth rate of 4 percent) between 1991 and 2003 but only 6 percent between 2000 and 2003 (average, 1.6 percent). The top 10 percent of payments grew only 33 percent (2.6 percent annually) from 1991 to 2003. Thus, the growth in the middle of the malpractice distribution exceeded the growth at the top.

Comparing the numbers of judgments with the full sample of payments, we see that judgments account for less than 4 percent of all payments but are approximately 1.7–2.4 times larger than settlements, on average. The growth in the average payment has been larger for settlements than for judgments (Exhibit 1). However, growth in average payments is larger than growth in the most severe cases for both judgments and settlements; there has been no statistically significant increase in the top 10 percent of judgments.[20]

In real dollars, payments per person grew 41 percent, from $9.2 in 1991 to $13.0 in 2001 (Exhibit 2), an annual rate of thirty-one cents per year (p value for trend < .001). The number of payments per 100,000 people decreased slightly, from 5.2 to 5.0 (p value for trend < .026, data not shown). Exhibits 1 and 2 underscore the importance of including settlements with judgments; if we ignored settlements, per capita payments would be much smaller.

Malpractice payments have grown proportionately with health care spending (Exhibit 3). Payments per $1,000 spent on physician and clinical services grew about 10.6 percent during the decade, compared with 6.8 percent for payments per $1,000 spent on all health care.

Growth by area of alleged malpractice. Exhibit 4 reports the severity of payments for ten broad areas of alleged malpractice. Payments were highest in obstetrics; in fact, the severity of judgments in obstetrics has greatly increased since 1996, with average payments rising 40 percent, from $697,000 to $1,005,000 ($p$ < .01). When obstetrics is excluded, the growth in severity from 1996–98 to 2001–03 is comparable with that from 1991–93 to 1996–98.

EXHIBIT 1
Change In Medical Malpractice Payments Made On Behalf Of Physicians, 1991–2003

	Judgments and settlements		
Year	Number of payments in NPDB	Average payment	Average payment for highest 10% of all payments
1991	13,365	$173,018	$ 867,792
1992	14,119	194,893	972,865
1993	14,151	197,152	955,292
1994	14,568	200,908	995,174
1995	13,511	207,863	999,689
1996	14,240	220,062	913,449
1997	13,845	219,881	973,642
1998	13,305	225,187	985,769
1999	14,175	232,711	1,050,898
2000	14,626	247,651	1,054,807
2001	15,694	258,965	1,130,976
2002	14,539	262,629	1,127,478
2003	14,368	263,101	1,155,031
Test for trend		p < .000	p < .000
1991–2003 growth		52.1% (4.0%)	33.1% (2.5%)
2000–2003 growth		6.2% (1.6%)	9.5% (2.4%)

EXHIBIT 1
Change In Medical Malpractice Payments Made On Behalf Of Physicians, 1991–2003 (cont.)

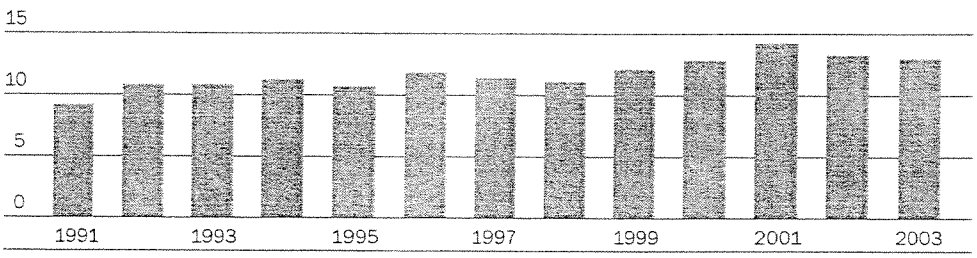
Year	Number of payments in NPDB	Average payment	Average payment for highest 10% of all payments
	Judgments		
1991	459	$320,917	$1,472,779
1992	413	398,890	2,111,009
1993	444	422,652	2,034,162
1994	419	353,326	1,542,976
1995	398	369,793	1,798,806
1996	578	387,264	1,634,023
1997	453	384,905	1,594,561
1998	401	425,663	1,764,773
1999	404	387,782	1,447,200
2000	537	474,821	1,840,507
2001	533	601,155	2,827,785
2002	411	488,020	1,903,668
2003	430	460,736	1,850,294
Test for trend		$p < .006$	$p < .295$
1991–2003 growth		43.6% (3.4%)	25.6% (2.0%)
2000–2003 growth		−3.0% (0.7%)	0.5% (0.1%)
	Settlements		
1991	12,906	$167,758	$ 853,373
1992	13,706	188,746	918,424
1993	13,707	189,847	894,590
1994	14,149	196,395	908,393
1995	13,113	202,948	997,338
1996	13,662	212,988	898,364
1997	13,392	214,298	945,389
1998	12,904	218,958	949,778
1999	13,771	228,162	1,015,759
2000	14,089	238,992	1,023,973
2001	15,161	246,935	1,064,999
2002	14,128	256,072	1,095,691
2003	13,938	257,004	1,080,121
Test for trend		$p < .000$	$p < .000$
1991–2003 growth		53.2% (4.1%)	26.6% (2.0%)
2000–2003 growth		7.5% (1.9%)	5.5% (1.4%)

SOURCE: Authors' tabulations based on data from the National Practitioner Data Bank (NPDB).

NOTES: Data are for all payments (judgments or settlements) involving a physician defendant in the fifty states between 1 January 1991 and 31 December 2003. All dollar values are converted to year 2000 dollars using the implicit Gross Domestic Product (GDP) Price Deflator and are rounded to the nearest dollar. Numbers in parentheses are average annual growth rates.

A focus on severity alone might lead to the spurious conclusion that areas of malpractice with the highest payments also account for the largest share of malpractice dollars. However, an area with high severity might not account for a large portion of liability if the number of

EXHIBIT 2
Growth In Per Capita Medical Malpractice Payments, 1991–2003

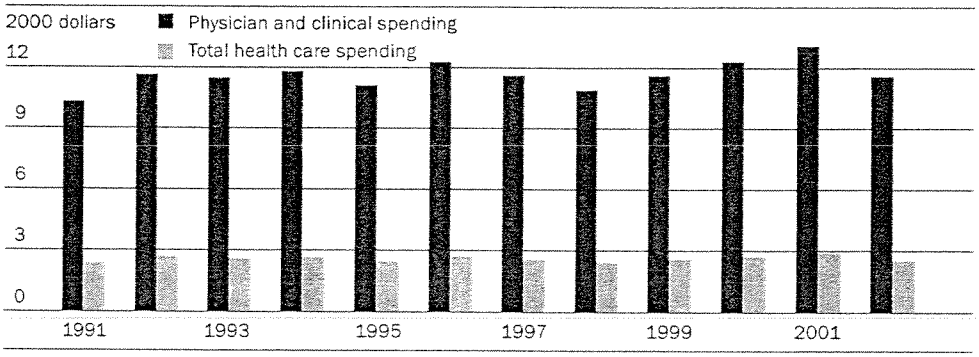


SOURCE: Authors' tabulations based on data from the National Practitioner Data Bank (NPDB).
NOTES: Data are for all payments (judgments or settlements) involving a physician defendant in the fifty states between 1 January 1991 and 31 December 2003. All dollar values are converted to year 2000 dollars using the Implicit Gross Domestic Product (GDP) Price Deflator and are rounded to the nearest dollar. Between 1993 and 2003, per capita malpractice dollars grew $0.31 per year ($p < .001$).

payments for that area is relatively small. Consistent with this hypothesis, Exhibit 5 demonstrates that the largest areas of total malpractice payments between 2001 and 2003 were diagnoses, surgery, and treatment. In this exhibit, payments in obstetrics are the most severe but are the fourth-largest contributor to all malpractice dollars. We have combined data from judgments and settlements but in unpublished work have verified that the two distributions are identical.[21]

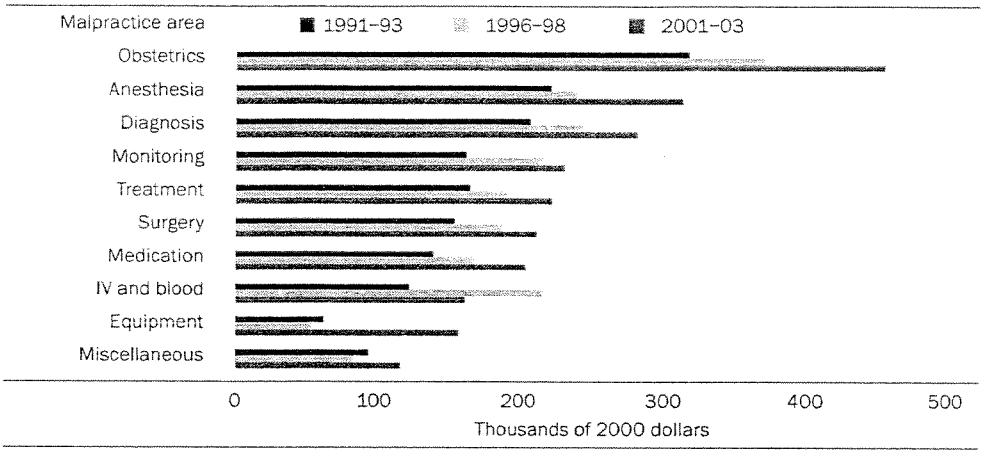
We also examined the detailed distribution of malpractice payments in surgery and obstetrics, because these specialties have high malpractice premiums and receive the most attention (data not shown). Contrary to anecdote, suits stemming from operating on the wrong body part or leaving foreign objects in the wound represent less than 5 percent of surgical payments. Likewise, in obstetrics, abandonment, improperly performed cesarean sections, and retained instruments are not major contributors to malpractice payments. The sum of all payments for these high-profile incidents accounts for less than 2 percent of total malpractice payments.

EXHIBIT 3
Malpractice Payments Per $1,000 In Health Spending, 1991–2002



SOURCE: Authors' tabulations based on data from the National Practitioner Data Bank (NPDB) and data from the National Health Accounts, Centers for Medicare and Medicaid Services.
NOTES: Data are for all payments (judgments or settlements) involving a physician defendant in the fifty states between 1 January 1991 and 31 December 2002; National Health Accounts data are those for total health care spending and spending on physician and clinical services. All dollar values are converted to year 2000 dollars using the Implicit Gross Domestic Product (GDP) Price Deflator and are rounded to the nearest dollar.

EXHIBIT 4
Change In Average Malpractice Payments, By Area Of Alleged Malpractice, 1991–93, 1996–98, And 2001–03



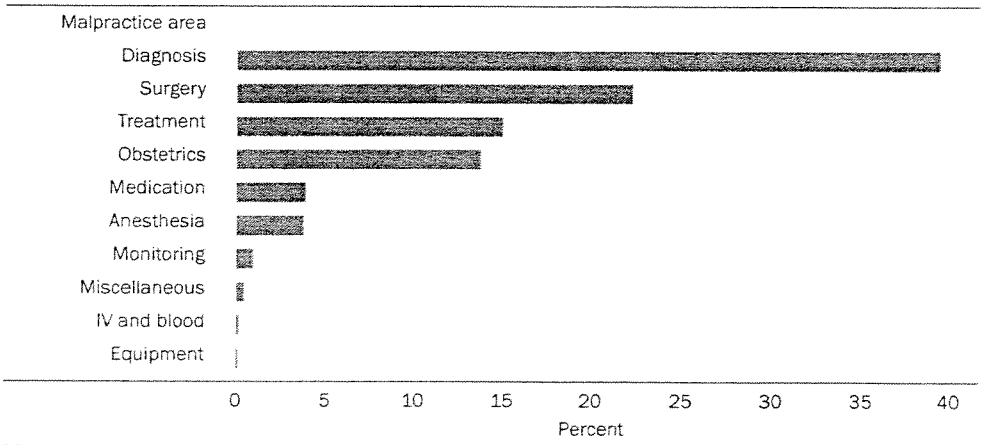
SOURCE: Authors' tabulations based on data from the National Practitioner Data Bank (NPDB).
NOTES: Data are for all payments (judgments or settlements) involving a physician defendant in the fifty states between 1 January 1991 and 31 December 2003. All dollar values are converted to year 2000 dollars using the Implicit Gross Domestic Product (GDP) Price Deflator and are rounded to the nearest dollar.

Discussion

The goal of our analysis was to describe the growth of physician malpractice payments—a factor widely believed to be the principal driver of the growth in malpractice premiums. Our study uncovered several salient findings.

■ **Salient findings.** First, focusing exclusively on judgments provides an incomplete picture of malpractice trends; judgments account for less than 4 percent of all payments

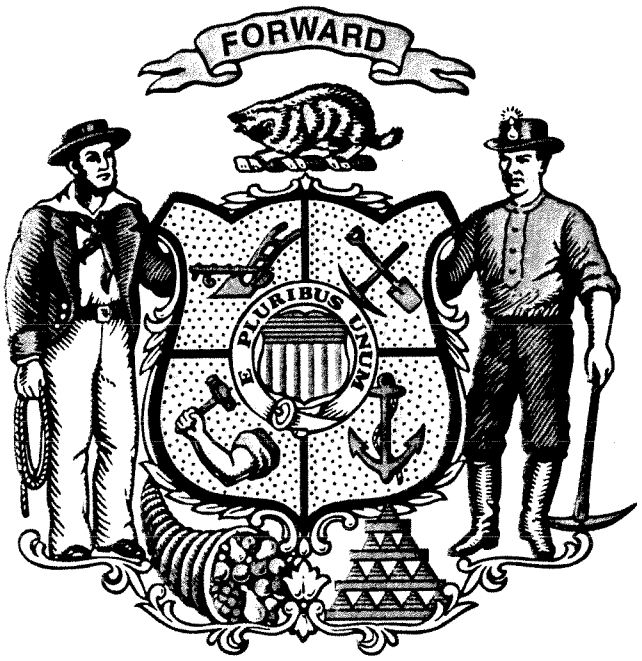
EXHIBIT 5
Distribution Of Medical Malpractice Payments, By Area Of Alleged Malpractice, 2001–2003



SOURCE: Authors' tabulations based on data from the National Practitioner Data Bank (NPDB).
NOTES: Data are for all payments (judgments or settlements) involving a physician defendant in the fifty states between 1 January 2001 and 31 December 2003. All dollar values are converted to year 2000 dollars using the Implicit Gross Domestic Product (GDP) Price Deflator and are rounded to the nearest dollar.

"Health Accounts," 17 March 2005, www.cms.hhs.gov/statistics/nhe/default.asp (6 May 2005).

10. Bureau of Economic Analysis, U.S. Department of Commerce, "Gross Domestic Product: Implicit Price Deflator," 28 April 2005, research.stlouisfed.org/fred2/data/GDPDEF.txt (6 May 2005).
11. U.S. Census Bureau, "U.S. Census 2000, Resident Population," 25 January 2002, www.census.gov/population/www/cen2000/respop.html (6 May 2005).
12. Smarr, "Statement of the Physician Insurers Association of America"; and GAO, *Major Improvements Are Needed to Enhance Data Bank's Reliability*, Pub. no. GAO-01-130 (Washington: GAO, 2000).
13. We labeled the size of a medical malpractice award as "severity." This usage is standard in the economics and public health literatures; see, for example, Mello et al., "The New Medical Malpractice Crisis," and P.M. Danzon, "The Frequency and Severity of Medical Malpractice Claims: New Evidence," *Law and Contemporary Problems* 49, no. 2 (1986): 57–84. Our use of this word should not be seen as implying that there is an association with the severity of the alleged injury. Regarding the JVDB, see M.A. Peterson and G.L. Priest, *The Civil Jury: Trends in Trials and Verdicts, Cook County, Illinois, 1960–1979*, Pub. no. R-2881-ICJ (Santa Monica, Calif.: RAND, 1982).
14. GAO, *Major Improvements Are Needed*.
15. J.T. Hallinan, "Doctor Is Out: Attempt to Track Malpractice Cases Is Often Thwarted," *Wall Street Journal*, 27 August 2004.
16. See, for example, A.R. Localio et al., "Relation between Malpractice Claims and Adverse Events Due to Negligence: Results of the Harvard Medical Practice Study III," *New England Journal of Medicine* 325, no. 5 (1991): 245–251; P.C. Weiler et al., *A Measure of Malpractice: Medical Injury, Malpractice Litigation, and Patient Compensation* (Cambridge, Mass.: Harvard University Press, 1993); and E.J. Thomas et al., "The Reliability of Medical Record Review for Estimating Adverse Event Rates," *Annals of Internal Medicine* 136, no. 11 (2002): 812–816.
17. See, for example, D.P. Kessler and M.B. McClellan, "The Effects of Malpractice Pressure and Liability Reforms on Physicians' Perceptions of Medical Care," *Law and Contemporary Problems* 60, nos. 1–2 (1997): 81–106.
18. D.P Kessler and M.B. McClellan, "How Liability Law Affects Medical Productivity," *Journal of Health Economics* 21, no. 6 (2002): 931–955.
19. We avoided using hospital days or physician visits (in lieu of population) for two reasons. First, the use of these services is affected by the liability climate. See D.P. Kessler and M.B. McClellan, "Do Doctors Practice Defensive Medicine?" *Quarterly Journal of Economics* 111, no. 2 (1996): 353–390. It is also difficult to argue that increases in use of health care services are completely captured by hospital days or physician visits. For example, increases in screening and procedure usage may be only weakly correlated with hospital days or the number of physicians.
20. We have also looked at the presence of million-dollar awards, which increased from 143 awards between 1991 and 1993 to 168 between 2001 and 2003. Between 1991 and 2003, the average payment for a judgment conditional on being over $1 million increased from $1.8 million to $2.0 million. The latter number could be understated because of the corporate shield.
21. These tabulations are available from the authors on request; send e-mail to amitabh.chandra@dartmouth.edu. The tabulations for 1991–1993 are also very similar to those in Exhibit 5.
22. S.A. Seabury, N.M. Pace, and R.T. Reville, "Forty Years of Civil Jury Verdicts," *Journal of Empirical Legal Studies* 1, no. 1 (2004): 1–15.
23. B. Black et al., "Stability, Not Crisis: Medical Malpractice Claim Outcomes in Texas, 1988–2002," *Journal of Empirical Legal Studies* (forthcoming). Black and colleagues note that the number of claims was constant during the 1990s and that there was no statistically significant increase in the number jury awards. There does not appear to be a noticeable increase in the severity of payments, but there was a 4.3 percent (annual) increase in real defense costs associated with a claim.
24. Ibid.
25. K. Baicker and A. Chandra, "The Effect of Malpractice Liability on the Delivery of Health Care," in *Frontiers of Health Policy Research*, vol. 8, ed. D.M. Cutler and A.M. Garber (Cambridge, Mass.: MIT Press, 2005).
26. Black et al., "Stability, Not Crisis."
27. GAO, *Medical Malpractice Insurance*; and Baicker and Chandra, "The Effect of Malpractice Liability."
28. GAO, *Medical Malpractice Insurance*.
29. Baicker and Chandra, "The Effect of Malpractice Liability."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TRENDS

Have State Caps On Malpractice Awards Increased The Supply Of Physicians?

Data from U.S. counties indicate that rural areas feel the effects of caps most acutely and that the amount of the cap matters.

by William E. Encinosa and Fred J. Hellinger

ABSTRACT: Twenty-seven states have laws that cap payments for noneconomic damages in malpractice cases. In this study we examined whether these laws have increased the supply of physicians, using county-level data from all fifty states from 1985 to 2000. Counties in states with a cap had 2.2 percent more physicians per capita because of the cap, and rural counties in states with a cap had 3.2 percent more physicians per capita. Rural counties in states with a $250,000 cap had 5.4 percent more obstetrician-gynecologists and 5.5 percent more surgical specialists per capita than did rural counties in states with a cap above $250,000.

THERE IS MUCH EVIDENCE indicating that a state's legal environment influences the frequency and size of malpractice awards there.[1] Thus, it is reasonable to expect that the supply of physicians per capita and access to care would be greater in states with laws that limit payments in medical malpractice cases. Yet a recent report by the U.S. Government Accountability Office (GAO) did not find this to be the case.[2] However, the GAO report relied heavily on data from a relatively small number of interviews with providers in five states and on Medicare utilization data for only three procedures in these five states.

This study extends the findings of our earlier study examining how state laws that limit damages payments in malpractice cases affect the geographic distribution of physicians.[3] The earlier study was released by the Agency for Healthcare Research and Quality (AHRQ) in July 2003. Using county-specific data from 1996 and 2000 to explain the geographic distribution of physicians across counties, it found that counties in states with caps on damages awards had more physicians per person than counties in states without caps. However, this finding was only a picture of physician supply after caps had been in place for a while (twenty-two states already had caps in place by 1996).

In this study we expanded our county analyses to include data from years both before and after most states had adopted caps (1985–2000). Twenty states introduced caps during this period, so we could conduct a before-and-after analysis of the effects of caps within each county. Moreover, our expanded study examined the impact of the size of the caps on the supply of physicians, the differential impact of caps on physician supply in rural and urban areas, and the impact of caps on the supply of two types of physicians that have been particularly hard hit by the surge in medical mal-

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practice premiums: surgeons and obstetrician-gynecologists (OB-GYNs).

Background On Malpractice Award Caps

Proponents of legislation that caps malpractice damages awards maintain that high malpractice rates are driving physicians out of business or to states where such awards are capped. They also maintain that excessive jury awards for pain and suffering, and for punitive damages, vary widely because there is no accepted process by which juries assign dollar values to these concepts.

Opponents of tort reform legislation that caps damages awards in malpractice cases (principally, trial lawyers and some consumer groups) maintain that poor quality of care and poor investments by insurance companies are to blame for the recent spike in malpractice insurance premiums. Opponents argue that caps will harm those patients who suffer the most harm and who need help the most. Recent evidence suggests that caps may be regressive and hurt low-wage workers, women, and the elderly—those who rely on the noneconomic damages portion of malpractice awards for adequate compensation.[4] Opponents also maintain that medical malpractice claim payments are not the underlying cause of rapidly rising malpractice premiums.[5]

In March 2003 the U.S. House of Representatives passed a bill capping damages awards in medical malpractice cases (the Help Efficient, Accessible, Low-Cost, Timely Healthcare [HEALTH] Act of 2003, H.R. 5). However, on 9 July 2003, efforts to pass similar legislation in the U.S. Senate (the Patients First Act of 2003, S. 11) failed. Although President George W. Bush continues to support proposals that cap noneconomic damages payments at $250,000 in malpractice cases, Congress has not yet passed such legislation.

The effort to adopt a federal cap on malpractice awards is largely a response to recent increases in malpractice premiums.[6] Over the past two years, physicians in New Jersey, West Virginia, and Florida have carried out work stoppages in response to the rapid premium increases and to support state legislation limiting payments for noneconomic damages in malpractice cases.[7] Malpractice premium rates for internists, general surgeons, and OB-GYNs rose, on average, 25 percent, 25 percent, and 20 percent, respectively, in 2002.[8] In some states, a few specialties have seen premium increases of as much as 75 percent.

In response, legislation limiting noneconomic damages awards in malpractice cases was signed into law in Nevada and Mississippi in 2002; in Florida, Ohio, and Texas in 2003; in Oklahoma in 2004; and in South Carolina in 2005.[9] Twenty-seven states now have laws capping noneconomic damages or limiting total damages (Exhibit 1).[10]

Although there is relatively little information in the literature about the impact of caps on access, there are numerous studies of their impact on malpractice premiums. A number of studies based on data from the 1970s and 1980s have shown that tort reform laws that limit payments in malpractice cases result in lower premiums.[11] Moreover, a recent study by Kenneth Thorpe found that malpractice premiums in states with caps on malpractice awards are 17 percent lower on average than in states without caps.[12]

Indeed, malpractice premiums vary considerably across states. For example, in Florida, annual premiums for OB-GYNs ranged from $143,000 to $203,000 in 2001 (a year in which Florida had no cap). In contrast, in California, which has had a cap since 1975, annual premiums for OB-GYNs ranged from only $23,000 to $72,000. Similarly, annual premiums for surgeons in Florida ranged from $63,000 to $159,000, while in California they only ranged from $14,000 to $42,000.[13]

Such wide premium differences may eventually lead to disparities in access to physicians and particularly to surgeons and OB-GYNs.[14] This study examined whether or not state caps enacted during 1985–2000 have increased the supply of physicians, surgeons, and OB-GYNs.

EXHIBIT 1
States With Caps On Malpractice Awards For Noneconomic Damages, 1975–2005

State	Years with any cap	Years with $250,000 cap
Alabama	1987–1991	
Alaska	1986–	
California	1975–	1975–
Colorado	1986–	1988–2003
Florida	1988–1991, 2003–	
Hawaii	1986–	
Idaho	1990–	2003–
Illinois	1995–1997	
Indiana[a]	1975–	
Kansas	1988–	1988–
Louisiana[a]	1975–	
Maryland	1986–	
Massachusetts	1986–	
Michigan	1986–	
Mississippi	2002–	
Missouri	1986–	
Montana	1995–	1995–
Nevada	2002–	
New Hampshire	1977–1980	1977–1980
New Mexico[a]	1976–	
North Dakota	1995–	
Ohio	1975–1994, 1997–1999, 2003–	1975–1994
Oklahoma	2004–	
Oregon	1987–1999	
South Carolina	2005–	
South Dakota	1986–	
Texas	1977–1988, 2003–	
Utah	1986–	1986–2002
Virginia[a]	1976–	
Washington	1986–1988	
West Virginia	1986–	2003–
Wisconsin	1985–	

SOURCES: National Conference of State Legislatures, *State Medical Liability Laws Table* (Washington: NCSL, October 2002 and October 2004); American Tort Reform Association, *State Laws on Medical Liability: Medical Liability Reform* (Washington: American Tort Reform Association, October 2002 and 13 July 2004); and McCullough, Campbell, and Lane, "Summary of Medical Malpractice Law," www.mcandl.com/states.html (18 April 2005).

NOTE: The year 2005 includes only January through April.

[a] Cap on total damages.

Trends In Physician Supply Under Tort Reform

Our data on the supply of physicians in counties in all states from 1970 to 2000 are from the Area Resource Files (ARF). The ARF is maintained by the Health Resources and Services Administration (HRSA). The ARF obtained data on physician supply from the American Medical Association (AMA) Physician Masterfile, AMA distribution-of-physicians data, and the AMA Physician Specialty Microdata File.

Exhibit 2 examines trends in physician supply under the two eras of malpractice award caps. First, from Exhibit 1, there were seven states that enacted legislation capping

EXHIBIT 2
Trends In County Physician Supply For States With Caps On Malpractice Awards, 1970 (1975) And 2000

	Median number of doctors per 100,000 county residents		
All physicians	**1970 (75)**	**2000**	**Percent increase**
No cap before 2000	122.40	224.36	83
Cap adopted in 1975–1977	132.69	246.61	86
Cap adopted in 1985–1987	108.23	218.41	102
Surgical specialists[a]			
No cap before 2000	32.39	41.74	29
Cap adopted in 1975–1977	37.20	43.03	16
Cap adopted in 1985–1987	29.32	42.37	45
OB-GYNs[a,b]			
No cap before 2000	50.25	54.30	8
Cap adopted in 1975–1977	45.57	58.37	28
Cap adopted in 1985–1987	36.94	51.68	40

SOURCE: Area Resource File.

NOTES: Observations are weighted by the county population, except for the obstetrician-gynecologists (OB-GYNs) row, where observations are weighted by the county's female population ages 15–44.

[a] Data in the first column are for 1975.

[b] OB-GYN supply is the number of OB-GYNs per 100,000 female county residents ages 15–44.

awards in 1975, 1976, or 1977 in response to the medical malpractice crisis of the early 1970s (not including the overturned cap in New Hampshire). Second, there were thirteen states that enacted laws implementing damages caps in malpractice cases in 1985, 1986, or 1987 in response to the medical malpractice crisis of the early 1980s (not including the overturned caps in Alabama, Florida, and Washington).

We found that there was an 83 percent increase in the median number of physicians per 100,000 residents from 1970 to 2000 in the states that never had a cap on malpractice awards before 2000. For the states that enacted caps in the 1970s, physician supply grew 86 percent, compared with 102 percent in states that passed caps between 1985 and 1987. Thus, the caps responding to the malpractice crisis of the 1980s appear to have had a much greater effect on physician supply than the caps set in place during the 1970s malpractice crisis.

A similar effect occurred with the supply of surgical specialists and OB-GYNs from 1975 to 2000. The median number of surgical specialists per 100,000 residents rose 45 percent under the 1980 caps, compared with 16 percent under the 1970 caps and 29 percent in states without caps. The median number of OB-GYNs per 100,000 females ages 15–44 grew 40 percent under the 1980 caps, compared with 28 percent under the 1970 caps and 8 percent for states without caps. Thus, caps in both eras had a strong impact on the supply of OB-GYNs.

Exhibit 3 examines the trend in rural physician supply with respect to the monetary size of the cap. Between 1970 and 2005 only nine states had caps set at $250,000; all other caps were above that limit. Moreover, 40 percent of the population in states with caps faced a cap with a limit above $400,000. Between 1975 and 2000 the median number of physicians per 100,000 residents of rural counties rose 48 percent for states with $250,000 caps, compared

EXHIBIT 3
Trends In Rural-County Physician Supply In States With $250,000 Caps On Malpractice Awards, 1975 And 2000

	Median number of rural doctors per 100,000 county residents		
All rural physicians	**1975**	**2000**	**Percent increase**
Cap equals $250,000	60.61	89.65	48
Cap above $250,000	49.34	71.26	44
Rural surgical specialists			
Cap equals $250,000	19.23	27.09	41
Cap above $250,000	16.81	22.00	31
Rural OB-GYNs[a]			
Cap equals $250,000	23.87	38.30	61
Cap above $250,000	24.61	36.57	49

SOURCE: Area Resource File.

NOTE: Observations are weighted by the county population, except for the obstetrician-gynecologists (OB-GYNs) row, where observations are weighted by the county's female population ages 15–44.

[a] OB-GYN supply is the number of OB-GYNs per 100,000 female county residents ages 15–44.

with 44 percent in states with caps above $250,000. For surgical specialists the rates were 41 percent and 31 percent growth, respectively. For OB-GYNs (per 100,000 women ages 15–44), the rates were 61 percent and 49 percent growth, respectively.

Impact Of Malpractice Award Caps On Physician Supply

■ **Data.** We used data on county characteristics from the Area Resource Files. We used 23,593 county-year observations from eight years: 1985, 1986, 1990, 1994, 1995, 1998, 1999, and 2000, accounting for about 99 percent of the U.S. population. We excluded Alaska and the District of Columbia, and we examined three county-fixed-effects models of physician supply under tort reform.

■ **Methods.** First, following the work of Daniel Kessler and Mark McClellan on the effects of tort reform on defensive medicine spending, we used a difference-in-difference model to examine the "before" and "after" effects of state caps on overall physician supply and on rural physician supply.[15] Using county fixed effects, we regressed the log of physician supply on state dummies indicating whether or not the state had a cap during that year. Key results are presented in Exhibit 4. Because our data set began in 1985, we could not examine the impact of reforms adopted before that year. However, only five of the twenty-seven states with caps adopted their cap before 1985. In particular, we were able to examine the effects of the 1985–87 caps (passed during the second malpractice crisis) seen in Exhibit 2.

Second, as did Kessler and McClellan, we also employed a county-fixed-effects, dynamic model based on the time since adoption of the cap. Exhibit 4 shows (1) the effect of the first two years of a cap on the log of physician supply (compared with the omitted reference category—years without caps), and (2) the final effect of the remaining period of three or more years' experience with a cap.

Third, we used a county-fixed-effects difference-in-difference model to examine the effects of caps with a $250,000 limit on damages on the supply of surgical specialists and OB-GYNs. In all three models we also examined the impact of caps in rural counties. About 72 percent of counties were in our rural sample; they accounted for 20 percent of the U.S. population.

EXHIBIT 4
Impact Of Malpractice Award Caps On County Physician Supply, All Counties And Rural Counties, 1985–2000

	Within-county percent increase in physician supply due to cap	
	All counties	**Rural counties**
State has a cap	2.18 ($p < .01$)	3.24 ($p < .01$)
Time since adoption of cap		
Years 1 and 2 of cap	0.50 ($p = .75$)	1.07 ($p = .59$)
Additional effects of years 3+ of cap	2.11 ($p < .01$)	2.94 ($p < .01$)

SOURCE: Area Resource File.
NOTES: Regression results are available at www.ahrq.gov/research/statecaps. Statistical findings denote difference from zero.

In all three models we used the following controls. Since each county has its own idiosyncratic socioeconomic, cultural, and political factors; regulations (other than caps); and tax rates, which might influence the supply of physicians and access to them, we included county dummy variables to capture these factors. This allowed us to identify the within-county effect of introducing a cap in each state. Also, dummy variables for each of the eight years were included to capture time trends.

We also controlled for four other state malpractice reforms: (1) collateral source rule reform—prevents payments for losses that have been compensated from other sources, such as workers' compensation; (2) prejudgment interest reform—limits payments for interest accruing on losses between the time the medical mishap occurred and the time the trial judgment was made; (3) joint and several liability reform—when there are codefendants, this limits each defendant's payments to the percentage of the harm for which the defendant is responsible; and (4) caps on punitive damages—limits payments to punish a defendant for intentional or malicious misconduct.

Finally, we controlled for factors that might affect the demand for physicians: health maintenance organization (HMO) enrollment in the state; whether the county had a medical school; county Medicare enrollment; county unemployment rate; county personal income; percentage of county that is black; county birth rate among women ages 15–44; and county death rate for diseases such as heart disease, liver disease, cancer, influenza and pneumonia, and chronic obstructive pulmonary disease.[16]

Empirical results. Caps were responsible for a 2.18 percent within-county increase in the supply of physicians, or an increase of five physicians per 100,000 people (Exhibit 4). The effect of caps was larger in rural counties (3.24 percent). These effects occurred mainly three or more years after the cap had been in place. Other malpractice reforms, such as collateral source rule reform, prejudgment interest reform, joint and several liability reform, and caps on punitive damages, did not have an impact on the supply of doctors.

Compared with counties without caps, the caps with limits above $250,000 had no significant within-county effect on the overall supply and rural supply of surgical specialists and OB-GYNs (Exhibit 5). The $250,000 caps increased the overall supply of surgical specialists by 4.16 percent but had no effect on the overall supply of OB-GYNs.

The $250,000 caps had a larger impact on rural counties than others. Slightly more than 7 percent of the rural sample was under a $250,000 cap, and 28 percent of the rural sample was under a cap with a limit higher than $250,000. For the rural population in states with caps, nearly half faced caps with limits above $400,000. Caps with a $250,000 limit increased the number of rural surgical special-

EXHIBIT 5
Impact Of $250,000 Malpractice Award Caps On County Supply Of Surgical Specialists And Obstetrician-Gynecologists, 1985–2000

	Within-county percent increase in physician supply due to cap			
	Surgical specialists		OB-GYNs	
	All counties	Rural counties	All counties	Rural counties
Cap above $250,000	NS	NS	NS	NS
Cap equals $250,000	4.16 ($p = .01$)	5.51 ($p < .01$)	NS	5.42 ($p = .05$)

SOURCE: Area Resource File.

NOTES: Regression results are available at www.ahrq.gov/research/statecaps. Statistical findings denote difference from zero. NS is not significantly different from zero.

ists per residents by 5.51 percent compared with states without caps and those with caps above $250,000. Similarly, a $250,000 limit increased the number rural OB-GYN per female resident ages 15–44 by 5.42 percent compared to states without caps and those with caps above $250,000.

Conclusions And Policy Implications

In this study we found that state caps on noneconomic damages awards in malpractice suits between 1985 and 2000 increased the supply of physicians. Moreover, the caps had a larger impact on physician supply in rural counties, and caps limiting malpractice awards to $250,000 had a much larger effect on surgeons and OB-GYNs in rural areas than caps with limits above $250,000. Twenty-seven states have caps on malpractice awards, but only five have caps with a $250,000 limit on awards, and 40 percent of the U.S. population living in a state with a cap has one with a limit above $400,000. Thus, a federal cap set at $250,000 for noneconomic damages could have a beneficial impact on the supply of surgeons and OB-GYNs in rural areas.

How robust are these results? In a recent study of the impact of malpractice caps on physician supply, using state data from 1980–1998, Jonathan Klick and Thomas Stratmann similarly found that states that had adopted a cap had 3 percent more doctors per 100,000 residents than states that did not have caps.[17] However, their state-level analysis did not find any effect of $250,000 caps as our county-level analysis did. In a more recent study, David Matsa found that malpractice liability caps did not increase the overall supply of physicians in all counties with a cap using county data from 1970–2000.[18] However, he did find that malpractice caps increased physician supply by 3–5 percent from 1970 to 2000 for extremely rural areas (25 percent of counties, accounting for 3 percent of the population). We found effects for a much larger rural area (70 percent of counties, accounting for 20 percent of the population). Matsa's definition of *rural* was based on county population density, while ours was based on a U.S. Department of Agriculture measure. It is possible that Matsa found smaller effects of caps because he examined the impact of caps during both malpractice crises of the 1970s and 1980s combined, while we examined the impact of caps during the crisis of the 1980s only. Recall from Exhibit 2 that caps had a much larger effect on physician supply during the 1980s than in the 1970s. This lower impact of the 1970s caps might explain why Matsa found smaller effects than our analysis of 1985–2000.

We also found that other state malpractice laws did not affect physician supply. In particular, we found that the following laws (described earlier) did not have an effect: collateral source rule reform; prejudgment interest reforms; joint and several liability reform; and caps on punitive damages.

Although such laws may be related to physicians' decisions whether or not to practice in a given geographic area, they are not nearly as conspicuous as laws that cap payments. Moreover, three previous studies found laws that indirectly affect the level of malpractice damage awards (for example, laws permitting periodic payments or that abolish the common rule of joint and several liability) have less impact on the costs of defensive medicine and liability premiums than laws that directly limit malpractice damage awards.[19]

Finally, although the increased supply of physicians attributable to caps is likely to increase the availability of care for most residents, it is not clear what effect this has on the cost of care. Kessler and McClellan found that tort reforms such as reasonable limits on noneconomic damages can reduce health care costs by 5–9 percent without substantial effects on mortality or medical complications.[20] However, they examined only a few cardiac procedures for Medicare beneficiaries during three years (1984, 1987, and 1990). Thus, the impact of caps on noneconomic damages on health care costs should be the focus of future research.

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NOTES

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