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)

COMMITTEE NOTICES ...

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(2005 documents)

John Gard
Speaker of the Assembly

August 11, 2005
FOR IMMEDIATE RELEASE

CONTACT: SPEAKER GARD
608-266-2343

SPEAKER GARD NAMES PUBLIC MEMBERS OF MEDICAL-MALPRACTICE REFORM TASK FORCE

MADISON - Five public members will round out the Speaker's Task Force on Medical-Malpractice Reform. Assembly Speaker John Gard (R-Peshtigo) created the task force to find a way to keep Wisconsin an attractive place for doctors to practice medicine after the recent Supreme Court decision which threw out caps on non-economic damages. For a decade, Wisconsin law capped excessive non-economic, pain and suffering awards. The ruling leaves Wisconsin vulnerable to a mass exodus of health care professionals.

"I'm very concerned about how this ruling will affect folks in rural Wisconsin," Gard said, "When the caps were in place, Wisconsin was a destination state for good doctors. In other states that don't have the caps, rural areas are not able to find quality doctors and people are forced to drive hours for health care. That can't be allowed to happen here."

The five public members will be: David Strifling, an attorney with the law firm of Quarles and Brady; Mary Wolverton, an attorney who specializes in health care lawsuits in her practice with Peterson, Johnson and Murray, SC of Milwaukee; Dr. "Bud" Chumbley, an obstetrician and President/CEO of Medical Associates Health Centers in Menominee Falls; David Olson, a hospital CEO, board member and founder of NorthReach; and Ralph Topinka, Vice President and General Counsel of Mercy Alliance in Janesville.

Representative Curt Gielow (R-Mequon) will lead the the task force. Joining Representative Gielow will be; Assembly Majority Leader Mike Huebsch (R-West Salem), Representative Ann Nischke (R-Waukesha), Representative Jason Fields (D-Milwaukee) and Representative Bob Ziegelbauer (D-Manitowoc).

"Fewer quality doctors mean an increased likelihood of malpractice cases and malpractice lawsuits," Gard said, "We need to lower health care costs and keep doctors from fleeing – especially rural parts of the state."

The Supreme Court threw out Wisconsin's ten year old statutes protecting patients and doctors from paying for excessive pain and suffering lawsuits. In 1995, Assembly Republicans led the fight to bring lawsuit reform to Wisconsin. It is worth noting that Wisconsin has no cap for economic damages. Injured patients can be fully compensated for their loss of work and medical costs.

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10 MEMBERS: 5 Representatives and 5 Public Members

LEGISLATIVE COUNCIL STAFF: Richard Sweet, Senior Staff Attorney and Ron Sklansky, Senior Staff Attorney.

August 26, 2005

WISCONSIN HOSPITAL ASSOCIATION, INC.

August 30, 2005

TO: Speaker's Medical Malpractice Task Force

FROM: Eric Borgerding, Senior Vice President

SUBJECT: Medical Liability Reform

Chairman Gielow and members, my name is Eric Borgerding, and I am Senior Vice President for the Wisconsin Hospital Association (WHA). Thank you for this opportunity to speak today, and for this venue – an extraordinarily rapid and high-priority response to the loss of Wisconsin's cap on non-economic damages.

The WHA appreciates your concern and commitment, and we are anxious to work with the Task Force and anyone else seeking reasonable dialogue and reasoned solutions to maintain stability in our medical liability system. Your urgency is warranted, for the consequences of inaction or delay, though dismissed as "anecdotal" by those unfamiliar with health care administration, are of a nature that threaten to undermine Wisconsin's health care delivery system -- a system that is already facing a physician shortage in certain geographic areas and certain specialties.

If you work in the health care system, that is, if you struggle with recruiting physicians to rural or urban areas, if you are a hospital trying to keep the only long-term care facility within miles open, if you are a rural family practice doctor who also delivers babies because there are few, if any, obstetricians in the area, or more importantly, if you are a patient who may not have access to the care you need, you know the consequences of inaction or inadequate action, are far beyond anecdotal.

What has happened in Illinois, Oregon, Washington, Nevada, Ohio, and many other states without caps simply cannot be ignored or minimized:

- In Oregon, liability premiums for family practice physicians that deliver babies have increased 332% since caps on non-economic damages were struck down in 1999. By 2002, 34% of all physicians delivering babies in Oregon had quit performing deliveries.

- In Washington, where their short-lived caps were struck down in 1988, fewer doctors are delivering babies and more women are arriving in Washington hospitals never having received prenatal care.

- In Illinois, where in 2002 uncapped non-economic damages accounted for 91% of the average jury award, OB-GYNs have fled the state, many coming to Wisconsin. Southern Illinois is devoid of neurosurgeons and without head trauma coverage.

- In Ohio, where caps were struck down in 1991 and again in 1995, a 2004 survey of physicians conducted by the Ohio Department of Insurance indicated that nearly 40% of those who responded said they had retired, or planned on retiring in the next three years due to rising insurance costs. Only 9% of the respondents were over age 64.

While the reason we are all here today is the result of action taken by Wisconsin's judicial branch, the remedy, whether it be legislation or amendment of the state constitution, rests squarely with the Legislature and, in the case of legislation, also the Governor.

With that in mind, we understand that the goal of the Task Force is to develop and recommend legislative solutions. It is in the pursuit of that important task that WHA commits to working with you to provide input and information towards this end and throughout the following legislative and/or constitutional process. For act we must.

Until very recently, Wisconsin had one of the most balanced, and frankly envied, medical liability systems in the country -- the sum of an equation that included two key factors – the Wisconsin Injured Patients and Families Compensation Fund (Fund) and a cap, indexed to inflation, on non-economic damages (some would include a third component – unlimited economic damages).

Indeed, on May 12, 2005, just six weeks before the Ferdon ruling, Wisconsin Commissioner of Insurance Jorge Gomez reported on the impact of 1995 Act 10 ($350,000 cap on non-economic damages plus inflation). In his report, the Commissioner described a then favorable medical liability climate, and the impact it has had on access to health care.

> *"To conclude ... 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 Injured Patients & Families Compensation Fund has resulted in the stable medical malpractice environment,* ***and the availability of health care in Wisconsin."*** (emphasis added)

In the same report, again issued roughly two months before the Supreme Court overturned our cap on non-economic damages, Commissioner Gomez indicated that medical liability carriers were predicting premiums would remain roughly the same in Wisconsin over the coming year. However, he also made it very clear that, and again I quote:

> *"... 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."*

Commissioner Gomez must have a crystal ball in his office, for today, just seven weeks since the Ferdon decision, his same concerns are not only being expressed, but predicted by leading actuaries.

Just this month, Pinnacle Actuarial Resources, a respected independent actuary and consulting firm, predicted premiums for Wisconsin doctors and hospitals will increase by a total of 18% to 22% --- 12% to 15% for primary ($1 million/$3 million) coverage, and up to 150% for the Fund, which pays claims in excess of primary coverage. According to Pinnacle, Wisconsin's not-for-profit insurance fund, which interestingly has many newfound advocates these days, will be hit *much harder* than primary insurers because it is now responsible for unlimited non-economic damages.

A fair system, one that balances the rights of injured parties with the basic need for an accessible health care system, is what we had in Wisconsin, and what we must strive to maintain through this process. A system in which liability premiums do not drive out of business, out of the state, or into retirement, the very hospitals and doctors we count on the most when we need them the most.

Finally, I would like to read an excerpt from testimony delivered on April 7, 2005 by my counterpart in Illinois, just one of many states facing a very real, very litigation-driven health care access emergency:

> *"The medical liability crisis in Illinois is causing an unprecedented health care access crisis throughout the state. While some areas of Illinois may be suffering more than others, the systemic problems driving these crises exist all over Illinois and show no signs of abating. In the areas hardest hit, we are finding an absence of obstetricians willing to treat "high risk" babies, emergency care physicians unwilling to provide trauma care, and neurosurgeons refusing to provide complex and high-risk procedures."*
>
> *The commercial insurance market has abandoned hospitals, leaving them to pay the astronomical costs of verdicts and settlements out of their own pockets – money that should be spent on caregivers and new technology and in dozens of other ways that would benefit patients and communities. This crisis is growing. If nothing is done, the health care access barriers may become insurmountable."*

This is not a "hollow anecdote," this is real life, and it is testimony I hope you will never hear in Wisconsin.

On August 25, 2005, after passing the Democrat-controlled house and Democrat-controlled Senate, Illinois Governor Rod Blagojevich, also a Democrat, signed Illinois's new cap on non-economic damages into law.

We must learn from the mistakes of other states, not try to repeat them. We do not need to experience the dismantling of a health care system; we need to prevent it from happening.

WHA believes a balanced and fair system can be preserved in Wisconsin. We also believe that system must have as its foundation a cap on non-economic damages.

Wisconsin Medical Society

Your Doctor. Your Health.

TO: Members, Speaker's Medical Malpractice Task Force

FROM: Mark Grapentine, JD – Senior Vice President, Government Relations

DATE: August 30, 2005

RE: Restoring stability to the medical liability climate

On behalf of more than 10,000 members statewide, the Wisconsin Medical Society thanks you for this opportunity to testify on a matter of critical importance for the state's health care system: restoring a reasonable cap for noneconomic damages.

It is important to note that five out of seven Wisconsin Supreme Court justices believe there can be a constitutional cap on noneconomic damages. While the Court's decision has been jarring, the wide bipartisan call in the Capitol and by the general public to restore the caps provides comfort. This cry for action shows that health care affordability and availability are nonpartisan issues.

Two members of the Supreme Court have specific concerns with how the Legislature decided on the cap figure in the 1995 legislation. The creation of this Task Force has already started to correct that flaw – the Task Force has the opportunity to build a legislative history that most bills do not enjoy. This can only reassure the Court that a coequal branch of government, the State Legislature, has acted far from arbitrarily in setting the new cap. Crafting a solution through fact-finding and data analysis can also reassure the Governor that the Legislature has properly taken the Court's opinions into account.

As this Task Force deliberates toward a recommendation to restore stability to the state's medical liability system, we ask you to keep the following tenets in mind:

I. The Cap Needs to be Reasonable and Effective

Throughout the United States, maintaining or restoring balance and stability to the medical liability system is a primary focus of the medical community. While other states have struggled for years trying to find the right mix of reforms, Wisconsin succeeded in creating a stable medical liability environment. From 1995 until July 13 of this year, two branches of our state government hit upon a system allowing Wisconsin to become one of just six states without a medical liability crisis or near-crisis.

If we assume the Court's concerns must be considered when setting the new cap, that new law must be reasonable – that is, it must not be set arbitrarily and must amply show legislative reasoning for the specific cap figure or solution. It must balance the needs of the injured patient with those of all Wisconsin citizens who desire affordable and available health care – especially high-risk specialty or emergency medicine care.

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The cap must also be effective. This seems obvious on its face, but in implementation it is possible to set a cap too high to achieve the stability of medical liability premiums and access to medical care, particularly specialty care in rural communities. We believe there is a "tipping point" above which a cap does little to prevent physicians from fleeing the area to practice in states with a more favorable medical liability climate, or prevent questionable lawsuits that tend to discourage the efficient, yet effective practice of medicine. Defensive medicine is far from a myth; one study, cited by the U.S. Department of Health and Human Services, suggests that defensive medicine cost the nation as much as $126 billion in health costs in 2003.

Arriving at the eventual dollar amount of the cap or establishing the "tipping point" for effective medical liability reform is not necessarily simple, but we believe it can and must be accomplished.

II. The Cap Needs to be Passed and Enacted as Soon as Possible

While less than seven weeks have passed since the Supreme Court removed the noneconomic damage cap, Wisconsin is already beginning to witness the effects. Physician recruiters are hearing doubts from those physicians who had previously considered Wisconsin a safe haven. Medical students are well aware of the sudden climate change and are asking questions about other state's situations.

Meanwhile, those other states' environments are becoming more, not less, attractive when compared with Wisconsin's medical liability climate. A week ago Illinois' governor signed a cap into law. Alaska, Georgia, Mississippi, Missouri, Nebraska, Nevada, Oklahoma, South Carolina, Texas and West Virginia have all successfully worked to create or strengthen their medical liability environment in just the last two years. The medical liability litigation problem is real across the country, and other states are taking steps to solve it. Meanwhile, Wisconsin is dramatically shifting in the other direction. Our state must quickly reinstate a reasonable noneconomic damage cap or face the real possibility of a physician exodus to these other suddenly more-attractive states.

III. Other Medical Liability-Related Tort Reforms

In addition to removing the cap on noneconomic damages in medical liability cases, the Supreme Court issued other decisions that will likely have an adverse affect on the state's formerly positive medical liability environment. The Court determined that first-year unlicensed medical residents are not "health care providers" under the noneconomic damages statutes (the *Phelps* case); the Legislature could remedy this when creating the new cap, by clearly providing that unlicensed residents are covered by the Injured Patients and Families Compensation Fund and are subject to any statutory cap on damages in medical liability cases.

The Court also nullified another 1995 statute allowing juries to hear evidence of payments injured patients have received due to insurance settlements, etc., before deciding an award amount at trial (the *Lagerstrom* case). The Court's decision in the *Lagerstrom* case prohibits juries from reducing the amount of an award based on evidence of collateral source payments. This "collateral source" decision could also warrant legislative attention to afford juries the opportunity to properly contain the size of awards in medical liability cases based on collateral source evidence, thereby helping to reduce health care costs.

While other tort areas merit fixes, reinstating a reasonable and effective noneconomic damage cap is clearly the top priority, as it has the largest impact on physician access and health care costs. Any bill reinstating the cap should be drafted and passed with the goal of gaining the Governor's approval and withstanding constitutional scrutiny. Adding too much to any one bill decreases the chances of the bill's ultimate success.

Thank you again for this opportunity to provide testimony. If you need more information on this or any other issue, please contact me at markg@wismed.org or by phone at 608.442.3768.

MARSHFIELD CLINIC.
Where the future of medicine lives

DATE: September 7, 2005

TO: Speaker's Medical Malpractice Task Force

FROM: Barbara A. Kuhl

SUBJECT: Medical Liability Climate

Chairman Gielow and members, my name is Barbara Kuhl and I am General Counsel at Marshfield Clinic. It is a privilege to testify before this task force, and I would like to thank you on behalf of Marshfield Clinic for this opportunity.

Marshfield Clinic has several concerns as a result of the elimination of the non-economic damage cap, including the ability to continue to recruit and retain quality physicians to Wisconsin, access to care for all of us who live in Wisconsin, the impact on self-insured organizations and the cost of health care. I will address each of these concerns separately.

Recruitment and Retention of Physicians

Physician recruitment is already difficult and competitive in light of a national shortage of physicians. When I queried the manager of our physician recruitment department in anticipation of testifying here today, she told me: "We have always touted the fact that Wisconsin has a stable malpractice climate, which certainly appeals to physicians in those states in crisis, so I would hate to lose that edge."

The malpractice climate comes up regularly in discussions with candidates who interview for positions at Marshfield Clinic. It also comes up as physicians who are in our residency program decide whether to stay in this state to practice or go elsewhere. Marshfield Clinic co-sponsors graduate residency programs in internal medicine, pediatrics, general surgery, internal medicine/pediatrics (med-peds), dermatology and palliative care. Currently, these residency programs collectively have 56 residents. Medical education is an important part of Marshfield Clinic's mission, but we also hope that these resident physicians will decide to practice in this State as they reach the end of their residencies.

Recruiting physicians to rural areas is particularly challenging. We took note of the Wisconsin Hospital Association's report of a decline in practicing physicians in states which eliminated non-economic damage caps, and we are concerned that the rural areas in these states were the hardest hit. All 28 of the counties in Marshfield Clinic's primary care service area are in total or in part designated as Medically Underserved Areas or Health Professional Shortage Areas or both.

Marshfield Clinic currently has 99 active physician recruiting searches across our system of care. The estimated average time to fill a search depends not only on the location, but on the type of specialty. We have experienced on average 12 months to fill a search from activation to start date for some of our larger sites. Some positions have been open for much more than one year, especially the sub-specialty positions. For our smaller more rural sites we have had much more difficulty; filling positions for these locations takes on average three to four years. If recruiting and retaining physicians becomes more difficult in this State as a result of the elimination of the cap, then the next issue becomes access to health care for all of us who are Wisconsin residents.

Access to Care

Marshfield Clinic's mission statement is "To serve patients through ***accessible***, high quality health care, research and education." The Clinic's 722 physicians represent 83 medical specialties and sub-specialties. Continued access to care is possible only in an environment which allows us to recruit and retain quality physicians.

Marshfield Clinic provides access to care for many patients who already have limited options for health care. We accept patients regardless of the ability to pay. We have a formal charity care program. We accept Medicare, Medicaid and BadgerCare patients on an unlimited basis. Although we have locations in many rural areas, even in the more populated areas we serve, the Clinic does substantially more than its part to ensure that patients are seen who would otherwise have no access or limited access to health care. For example, for the Clinic's fiscal year ended September 30, 2003 –

- In Eau Claire County, Marshfield Clinic physicians represented 19% of the total physicians. However, Marshfield Clinic served approximately 82% of the County's Medicaid population.

- In Marathon County, Marshfield Clinic physicians represented 30% of the total physicians. However, Marshfield Clinic served approximately 57.2% of the County's Medicaid population.

In addition, Marshfield Clinic provides coverage under our Self-Insurance Plan for medical malpractice to those of our physicians and staff who work in neighboring free clinics, again doing our part to provide access to care for Wisconsin residents. We would like to continue to offer our Plan's coverage for this purpose but would be forced to re-think that position if we start to see increased numbers of malpractice claims or increased non-economic damage awards in Wisconsin. We are not sure that our physicians and staff would continue to work in these free clinics if they were without the protection of the Plan's coverage.

Impact on Self-Insured Organizations

Marshfield Clinic has been self-insured for medical malpractice since 1978. The Clinic's self-insurance plan (the "Plan") was created in lieu of purchasing commercial malpractice insurance and provides primary occurrence based coverage for the Clinic and its employed physicians, CRNAs and other patient care staff. Today we insure 722 physicians, 56 residents, 39 CRNAs and over 5,800 additional staff.

The Clinic's Plan is required to maintain a trust fund at an actuarially determined funding level. The Pinnacle News Flash dated August 2005 reported that in addition to increases of between 12% to 15% in commercial insurance premiums, "insurance industry reserves may experience

additional adverse development of $35 - $40 million because of the court's ruling." If the Pinnacle report is accurate, the Clinic will be required to deposit a substantial additional sum in its trust fund this year, regardless of past claim experience which has been very favorable to the Clinic over the 27-year life of the Plan. I have spoken with our Plan's actuary at Towers Perrin, Brian Young. While the actuarial industry struggles to come up with new funding levels in the State of Wisconsin, Mr. Young has told me that creation of caps in other states resulted in funding decreases in insurance reserves. The opposite is true in states which eliminated caps. In states such as Oregon which lost their caps, the frequency of cases also increased. Thus, while commercially insured organizations may see increased premium rates for future years, the financial impact for self-insured health care organizations is more immediate. Self-insured organizations will not only experience annual ongoing premium increases but will also need to increase reserves for the anticipated impact of the elimination of the cap on claims which are currently open and claims which are not yet reported. To illustrate the immediate impact of the elimination of the cap, within days of the *Ferdon* decision, we received a call from an attorney representing a plaintiff who had an open claim against Marshfield Clinic. The attorney informed us that he was doubling the amount of the plaintiff's demand as a result of the *Ferdon* decision.

Increased Cost of Health Care

Without a non-economic damage cap, we believe an increase in the cost of health care in this State is a certainty. Marshfield Clinic is a not-for-profit corporation. Net earnings are re-invested in infrastructure and in new equipment and services. Any required increased funding of our self-insurance trust fund will necessarily displace other needed funding for equipment, services and the like.

I read with interest the testimony on behalf of the Wisconsin Academy of Trial Lawyers. Although eloquent, the testimony fails to disclose an inherent bias. Attorneys who represent plaintiffs in medical malpractice cases generally are paid on a contingency basis and receive up to one-third of any damage award.

Marshfield Clinic believes that it makes more sense to spend health care dollars on initiatives which will improve quality of care and access to care for all Wisconsin residents rather than on unlimited non-economic damage awards, substantial portions of which will go to satisfy contingency fees of attorneys. The Executive Summary of the Institute of Medicine Report, Crossing the Quality Chasm, provides: "The development and application of more sophisticated information systems is essential to enhance quality and improve efficiency." Since the early 1990's, Marshfield Clinic has invested tens of millions of dollars on integrated computer technology for high quality, efficient patient care. We also recently initiated a patient web portal for on-line health management for patients. We have heard a report that, nationwide, half of all adverse drug reactions may be prevented by computer prescribing. Marshfield Clinic recently implemented an electronic prescribing program. These are the types of initiatives which will improve the quality of care for all Wisconsin residents. This is where we should be spending our health care dollars.

Marshfield Clinic is a founding member of the Wisconsin Collaborative for Healthcare Quality. The Collaborative is a voluntary consortium of organizations focused on improving health care in the State of Wisconsin. The members of the Collaborative agree on quality indicators which are then publicly reported. If the medical malpractice climate in Wisconsin deteriorates as a result of the elimination of the non-economic damage cap, this could serve to chill voluntary reporting. It could also cause physicians in this State to practice defensive medicine to avoid medical malpractice claims. Progress toward the Institute of Medicine's goal of evidence-based medicine

could be deterred and defensive medicine instead of evidence-based medicine could increase the cost of care dramatically.

Conclusion

In conclusion, reinstating a non-economic damage cap as soon as possible is necessary to ensure that Wisconsin has an adequate number of physicians for its future to provide access to care for all its residents. Reinstatement of a cap will allow more health care dollars to be spent on quality initiatives that will serve all of us. A stable malpractice climate will provide an environment where physicians and health care providers are more comfortable publicly reporting quality indicators rather than practicing expensive defensive medicine.

Thank you again for the opportunity to provide testimony here today. If you need any additional information, I may be reached at (715)-389-4885 or by e-mail at kuhl.barbara@marshfieldclinic.org

Keeping Wisconsin Families Safe
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Testimony of Christine Bremer Muggli

on behalf of the

Wisconsin Academy of Trial Lawyers

before the

Assembly Medical Malpractice Task Force

Representative Curt Gielow, Chair

August 30, 2005

Good morning, Representative Gielow and members of the Task Force. My name is Christine Bremer Muggli. I am private practitioner in Wausau Wisconsin and I serve as the Secretary of the Wisconsin Academy of Trial Lawyers (WATL). On behalf of WATL, I thank you for the opportunity to appear today to testify today.

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

We have a perfect example with the establishment of this task force. Where are the people who have been injured as a result of malpractice? They do not have a place at this table. While the legislative process shuts them out, the courts are required to listen to them. They are on equal footing with the special interests. Here in the Legislature injured patients are ignored, while the legislative process once again seeks to take away their rights.

Because courts cannot ignore the plight of injured patients, the issues involving medical malpractice are given a full and fair hearing.

Today with me is Tim Kaul from Grafton, Wisconsin. Mr. Kaul is a 5th generation farmer, avid fisherman and sportsman and a taxidermist. He is also the father of a profoundly disabled child as result of medical negligence as determined by a jury in Ozaukee County. Tim's son, Sean Kaul developed hypoglycemia and hypovolemia that developed shortly after his birth and timely and proper treatment was not provided. As a result of this alleged negligence, Sean is catastrophically brain damaged.

Sean is visually impaired, suffers from cerebral palsy, epilepsy, and is developmental delayed. He is 8 ½ years old, but mentally nearer the age of a one-year-old. He is learning to walk and is still being fed through a tube.

For this life-long disability, the jury determined, after listening to all the evidence, he should receive the amount of $930,000. The previous cap reduced the amount the jury determined by 55 percent — a significant reduction. What do we gain in as a society by penalizing the most severely injured citizens, many children like Sean.

What about the case of Kristopher Brown? He was 16-years-old and broke his leg in a moto-cross accident. The break occurred at the tip of the tibia. Early on, his mother noticed no pulse in the leg. However, the leg was put in a cast. Kristopher immediately began experiencing a lot of pain. Despite complaining, the doctor did not respond to their concerns. A few days later the cast was removed and the leg was 4 times the size of a normal leg. There was a blood clot behind the knee cutting off circulation. After many surgeries Kristopher's foot was amputated.

An Eau Claire County jury unanimously found that health care providers were careless in their 1998 treatment of 16-year-old. The jury said Kristopher should receive $1.25 million for past and future pain and suffering, and his parents should receive $100,000 for their noneconomic damages. With the cap, Kristopher and his family received less than a third of what the jury said he deserved.

Finally let's take the case that brought us here today. Matthew Ferdon is a child who was born in Brown County. The doctor who delivered him injured him at birth. He now lives with a deformed and partially paralyzed right arm. His parents brought a case on his behalf against the doctor. A jury composed on average citizens sat through days of testimony. Each side presented its witnesses. The jury then weighed the evidence and it determined that the Ferdons' had met their burden of proof and found the doctor negligent in causing Matthew's injury. The jury then determined the proper measure of damages for Matthew included $700,000 for his pain, suffering and disability. That amounted to about $10,000 a year. After the verdict was entered, the trial court entertained motions after verdict and because of the cap, the amount was reduced over 40 percent.

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

The Ferdons' challenged the cap's reduction because the law did not treat them equally. The Supreme Court took this challenge very seriously. In a scholarly, exhaustive and well-reasoned opinion, the Court reviewed the legislative purpose of the 1995 cap as well as evidence to support and refute it. The Court reviewed over 50 reports and articles. We believe that it is critically important for this task force to have all the information relied on by the Court, so we are providing members of the committees with as many of cited documents as we could obtain. In addition, we have included the brief our organization filed in the case and a few new articles and reports that have come out since the opinion was released.

We hope that once the task force reviews the evidence you will come to the same conclusion as the Supreme Court – caps on noneconomic damages treat the most severely injured patients and their families unfairly and are an arbitrary and irrational way to address problems facing the health care system.

I would like to highlight the evidence against the caps.

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

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

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

Jury Verdict Date, County, Case #	**Injured Patient and Age**	**Nature of injury**	**Noneconomic damages jury awarded, including pain and suffering**	**Final award**	**Percentage Reduced**
April 2005 Milwaukee 2003CV3456	Joseph Richard mid-50's	He underwent an unnecessary removal of his rectum, with a leak of the anastomosis, ten further surgeries, and permanent bowel problems.	$540,000	$432,352	20%
May 2004 Marinette 2002CV60	David Zak mid-30s	Failure to diagnose suspicious infection causing body to shut down resulting in loss of bodily function	$1 million	$422,632	57%

Jury Verdict Date, County, Case #	Injured Patient and Age	Nature of injury	Noneconomic damages jury awarded, including pain and suffering	Final award	Percentage Reduced
April 2004 Kenosha 2001CV1261	Estate of Helen Bartholomew Early 60s	Failure to diagnose heart attack causing massive heart and brain damage requiring her to live in nursing home and resulting in her death 3 years later	$1.2 million	$350,000	70%
Dec. 2003 Ozaukee 1999CV360	Sean Kaul infant	Negligent failure to provide timely and proper treatment for hypoglyceminia and hypovolemia that developed shortly after birth rendered child permanently disabled	$930,000	$422,632	55%
Dec. 2002 Brown 2001CV1897	Matthew Ferdon infant	Negligent delivery resulting in right arm being deformed and partially paralyzed	$700,000	$410,322	40%
June 2002 Dane 2000CV1715	Scott Dickinson mid-30s	Negligent treatment during a psychotic episode and rendered a quadriplegic.	$6.5 million	$410,322	93%
June 2001 Eau Claire 2000CV120	Kristopher Brown 16 years old	Negligent treatment of a broken leg resulting in part of the leg being amputated	$1.35 million	$404,657	67%
March 2000 Eau Claire 1998CV508	Bonnie Richards Early 40s	Common bile duct clipped during laproscopic cholecystectomy resulting in residual hernias requiring additional surgeries and almost dying twice.	$660,000	$381,428	41%
October 1999 Portage 1998CV169	Candice Sheppard mid-20s	Negligent surgery to remove a cyst in the vaginal area resulted in permanent pain and injury	$700,000	$350,000	50%

These nine cases show a reduction of approximately $10.2 million from what the juries determined the damages to be after hearing all the evidence compared to the damages available under the cap enacted in 1995. That's about $1 million per year. That comes to 18 cents per person in Wisconsin per year. Furthermore, because an injured patient shares the cap with family members, the cap has a disparate effect on patients with families. It is these injured patients and their families who are bearing the total

burden if medical malpractice occurs and a jury awards more than the cap. Why is it fair to burden the most seriously injured while providing monetary relief to health care providers and their insurers?

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

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

Injured Patients & Families Compensation Fund

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

WATL believes that grossly inaccurate actuarial projections have fueled the need for a cap. In 1995, sponsors of the cap legislation used the inaccurate projections by actuaries as a reason to impose the noneconomic damages cap. Legislators were told there was a *$67.9 million projected actuarial deficit* as of June 30, 1994. Instead, the actuaries now estimate there was a *$120 million actuarial surplus.* ***It shows that when the Legislature acted in 1995, it was given estimates that were off by almost $188***

million!! As the Supreme Court it didn't seem to make any difference if there was or wasn't cap because the Fund has flourished both with and without a cap.

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

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

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

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

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

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

Insurance execs speak up

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

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

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

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

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

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

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

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

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

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

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

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

Other key highlights of the study:

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

Wisconsin Unique System: The Injured Patients and Families Compensation Fund

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

The 1975 Statutory Scheme

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

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

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

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

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

Timeline of the Fund

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

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

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

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

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

1991 — $1 million indexed cap sunsets.

1995 — $350,000 indexed cap adopted.

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

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

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

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

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

The 1986 Legislative Changes

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

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

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

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

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

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

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

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

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

How Wisconsin doctors are insured against malpractice

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

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

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

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

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

Conclusion

If this task force is serious about tackling the problems with medical malpractice then more than caps must be on the table — it must include insurance regulation, strengthening physician discipline and patient safety concerns.

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

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

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

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

We believe that is not only immoral, but unconstitutional.

WISCONSIN LEGISLATIVE COUNCIL

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

TO: REPRESENTATIVE CURT GIELOW AND MEMBERS OF THE ASSEMBLY MEDICAL MALPRACTICE TASK FORCE

FROM: Richard Sweet and Ronald Sklansky, Senior Staff Attorneys

RE: Possible Recommendations

DATE: September 27, 2005

This memorandum is a brief summary of possible recommendations submitted to staff by members of the Assembly Medical Malpractice Task Force. Additional details and rationale for some of the recommendations are included in attachments to this memorandum.

Noneconomic Damage Cap

The following four recommendations were submitted to address the elimination of the statutory limit on noneconomic damages in medical malpractice cases by the Wisconsin Supreme Court in *Ferdon v. Wisconsin Patients Compensation Fund*, 2005 WI 125 (2005). In discussing any of these four proposed recommendations or any other recommendations regarding noneconomic damage caps, the Task Force may wish to consider the following in order to bolster the constitutionality of the recommendations:

- Make any new noneconomic damage cap prospective only. In other words, the cap would apply only to incidents of malpractice that occur after the bill's effective date.
- Index any dollar amounts for inflation.
- Include a statement of legislative findings that addresses issues such as adequate compensation of victims, and stability of medical malpractice premiums and the Injured Patients and Families Compensation Fund (referred to in this memorandum as "the Fund").

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The following four recommendations were submitted with respect to the noneconomic damage cap:

Option 1

- Establish the cap on noneconomic damages at $500,000, with an increase of $5,000 per year of life expectancy of the injured patient.

- Establish a separate cap for each family member who is entitled to noneconomic damages under current law at 25% of the cap for the injured patient.

Option 2 (see attachment from David Strifling)

- Establish the cap on noneconomic damages at $500,000 or $8,000 times each year of life expectancy of the injured patient, whichever is greater.

- Create a higher cap (e.g., $750,000) for noneconomic damages for the most severely injured patients. Consider not making the higher cap applicable in high-risk medical fields, such as emergency care or obstetrics/gynecology.

- Do not adjust the caps for additional family members who are entitled to noneconomic damages under current law (i.e., one cap would apply to the injured patient and all family members in the case).

Option 3

- Maintain the current cap ($445,755) as the maximum liability on individual health care providers but require the Fund to pay noneconomic damage awards in excess of that amount, subject to the limits established in the next item.

- Limit noneconomic damages for the injured patient to $2 million. The $2 million cap would be reduced by 1% for each year that the patient's age exceeds 20 years at the time the malpractice occurred.

- Limit noneconomic damages for family members who are entitled to noneconomic damages under current law to 10% of the noneconomic damages awarded to the patient or $20,000, whichever is greater, for each family member who suffers noneconomic damages.

- Ensure that insurance premiums and Fund assessments do not increase due solely to inflationary increases in caps.

Option 4 (see attachment from Ralph Topinka)

- Cap noneconomic damages at $550,000 through one of the following mechanisms: (1) provide immunity from liability for health care providers for amounts above this level; (2) provide immunity from liability for health care providers for amounts above this level if the providers participate in Medical Assistance.

- Establish a state fund that is separate from the Injured Patients and Families Compensation Fund to cover noneconomic damages up to the $550,000 cap. The new fund would be financed through assessments on providers and general revenues and be backed by the full faith and credit of the state.

Medical Residents (see attachment from David Strifling)

This item addresses the issue raised by the Wisconsin Supreme Court's decision in *Phelps v. Physicians Insurance Company of Wisconsin, Inc.*, 2005 WI 85 (2005). In that case, the court held that the statutory cap on noneconomic damages did not apply to a person during his or her medical residency who was not yet a physician and, in the circumstances of the particular case, was not an employee of a hospital. However, the Supreme Court sent the case back to a lower court for a determination of whether or not the medical resident can be considered to be a "borrowed employee" of a hospital.

The recommendations in this area are as follows:

- List medical residents as persons who are covered by the cap on noneconomic damages.

- Consider covering medical residents who are not direct employees of a hospital under the Fund and providing for assessments on those residents for Fund coverage.

Collateral Sources

The recommendation in this area relates to the Wisconsin Supreme Court's decision in *Lagerstrom v. Myrtle Werth Hospital-Mayo Health System*, 2005 WI 124 (2005). In that case, the court noted that current statutes provide that a jury may receive information about other sources of payments for the injured patient's injuries, in addition to payments from the defendant, but the statutes are silent on how the jury is to use that information. The court held that the jury may not use the information about collateral sources to reduce the award to the injured patient, but may use the information to determine the value of medical services rendered.

Option 1 (see attachment from David Strifling)

- Require the jury to reduce the injured patient's award by any collateral source payments received. Offset this reduction by the amount of any obligations that the injured patient has to reimburse the collateral sources (e.g., Medicare).

Option 2 (see attachment from Ralph Topinka)

- Allow or require the jury to reduce the injured patient's award by any collateral source payments received. Require a collateral source to seek redress for payments only from the defendant rather than the plaintiff.

Health Courts (see attachments from Reps. Jason Fields and Ann Nischke)

- Create health courts that deal exclusively with medical malpractice cases.

Audits of the Fund (see attachments from Reps. Bob Ziegelbauer and Jason Fields)

- Require a periodic ***actuarial*** audit of the Fund. Current statutes require that the Legislative Audit Bureau perform a ***financial*** audit of the Fund at least once every three years.

Coverage by the Fund

Currently, the Fund provides coverage for awards above $1 million per occurrence and $3 million per calendar year.

- Allow the Fund to provide first dollar coverage for medical malpractice cases through a subsidiary (see attachment from Rep. Bob Ziegelbauer).

- Reduce the coverage levels of the Fund to $500,000 per occurrence and $1.5 million per calendar year (see attachment from Insurance Commissioner Jorge Gomez).

- Allow the Fund to function as a private insurer (see attachment from Rep. Jason Fields).

Medical Malpractice Prevention (see attachment from Rep. Bob Ziegelbauer)

- Review recommendations made by the Joint Legislative Council's Special Committee on Discipline of Health Care Professionals in 1999 Senate Bills 317 and 318. (A copy of a report describing those bills is attached to this memorandum.)

Worker's Compensation Type of Program (see attachment from Rep. Ann Nischke)

- Consider a long-term reform of creating a medical malpractice system that is similar to the Worker's Compensation system.

Attorney Contingency Fees (see attachment from David Olson)

Currently, attorney's contingency fees in medical malpractice cases are limited to 33-1/3% of the first $1 million received (25% if liability is stipulated within 180 days after filing and not later than 60 days before the trial date), and 20% of amounts in excess of $1 million. A court may approve higher amounts for exceptional circumstances, including an appeal.

- Limit contingency fees to 40% of the first $50,000 received, 33.3% of the next $50,000, 25% of the next $500,000, and 15% of amounts recovered above $600,000.

Feel free to contact us if we can be of further assistance.

RNS:RS:jal

Attachments

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A System for Life

September 26, 2005

The Honorable Curt Gielow
State Representative
Room 316 North, State Capitol
Post Office Box 8952
Madison, WI. 53708-8952

Re: Medical Malpractice Task Force Proposals

Dear Representative Gielow:

Thank you for the invitation to submit suggested legislative approaches to enactment of maximum liability limits on non-economic damages in medical malpractice actions in Wisconsin. Before turning to suggested alternatives, I want to express appreciation for the work of the task force and the opportunity to serve on it. The Task Force is playing an important role in helping to restore the careful balance that helps ensure that plaintiffs in medical malpractice actions are able to receive full compensation for economic damages (e.g., lost income, medical expenses) and fair and reasonably predictable compensation for non-economic damages while, among other things, helping to preserve a stabile professional liability insurance market in Wisconsin. As the Task Force has heard, there is ample evidence from which to draw a rational conclusion that maintenance of caps on non-economic damages in medical malpractice actions helps contribute to a stabile, less costly medical malpractice insurance market.

INTRODUCTION

Unlike patients in most states, patients in Wisconsin who make successful claims for medical malpractice can be assured that they will receive financial compensation. That is because in Wisconsin, health care providers by law must obtain medical malpractice insurance, and must participate in the Injured Patients and Families Compensation Fund (the "Fund"). The combination of providers' malpractice insurance and the Fund means that in Wisconsin, successful malpractice claimants will receive their full economic damages, less costs and attorneys fees. Furthermore, plaintiffs in Wisconsin malpractice actions are assured of receiving their full non-economic damages, again, less costs and attorneys fees. As we are aware, until the recent *Ferdon* decision, there was a statutory cap on recovery of non-economic damages. Even with the cap, however, plaintiffs could recover hundreds of thousands of dollars in non-economic damages in addition to unlimited economic damages.

There are a variety of reports and actuarial studies that demonstrate certain basic facts about the Wisconsin medical malpractice marketplace. These facts include:

- Wisconsin's malpractice insurance market compares favorable to other states in terms of affordability or insurance;
- States with caps on non-economic damages generally have more affordable malpractice insurance and loss ratios;
- States with low to medium caps are more likely to have favorable malpractice insurance markets.

Wisconsin's careful legislative balance—mandatory malpractice insurance and participation in the Fund, unlimited Fund protection for malpractice awards and settlements, and reasonable caps on non-economic damages—has contributed to Wisconsin's favorable malpractice insurance market. This is just one of the reasons we believe maintenance of a cap on non-economic damages in medical malpractice actions is critical.

SUGGESTED LEGISLATIVE ALTERNATIVES

There are numerous potential approaches to restoration of caps on non-economic damages. The following are just a few of the approaches that the Task Force and the Wisconsin legislature may want to consider:

(A) Reinstate caps on non-economic damages.

Legitimate Government Purpose:

Improving access to health care in Wisconsin by stabilizing or increasing the supply of physicians in Wisconsin and encouraging physicians and hospitals to provide health care services in rural and urban areas.

Rational Basis:

In his concurring opinion in *Ferdon*, Supreme Court Justice Patrick Crooks emphasized that "statutory caps on noneconomic damages in medical malpractice cases, or statutory caps in general, can be constitutional." While finding the caps created by the Legislature in 1995 unconstitutional, Crooks concluded, "Wisconsin can have a constitutional cap on noneconomic damages in medical malpractice actions, but there must be a rational basis so that the legislative objectives provide legitimate justification, and the cap must not be set so low as to defeat the rights of Wisconsin citizens to jury trials and to legal remedies for wrongs inflicted for which these should be redress."

The majority opinion in *Ferdon* recognized that, according to a study by the U.S. General Accounting Office, a shortage of physicians existed in rural locations in states without limitations on damage awards. Further, the majority recognized that malpractice pressures are among the factors that affect the availability of services. (See *Ferdon* at 92.)

There are a number of reports that outline Wisconsin's current and increasing shortage of physicians. Given Wisconsin's aging population and other changing demographics, the retention and recruitment of physicians are crucial in order to provide sufficient access to health care. In addition, like the report cited by Abrahamson, there are studies that have found that the retention and recruitment of physicians, especially in rural and urban areas, are more successful in states that have stable and affordable medical liability insurance rates.

As recognized by the Court in *Ferdon*, Wisconsin currently enjoys a stable and affordable medical liability environment. The Legislature, therefore, could opt to reinstate the cap or limit liability for non-economic damages in an amount that is known to support Wisconsin's stable and affordable environment, namely approximately $445,000. Based on actuarial analyses of the insurance exposure amount that would provide stable and affordable insurance rates and studies of the caps in other states, one could argue that a cap of up to $550,000 would not significantly disrupt Wisconsin's current positive environment. On the other hand, based on the same and other studies, it is reasonable to conclude that a cap or limitation in an amount above $550,000 would have a negative impact on that environment. The studies and actuarial analyses indicate that a high cap or limitation would not provide the same predictability, stability, or affordability as a low or medium cap.

Based on the above, in order to improve access to health care in Wisconsin by stabilizing or increasing the supply of physicians in Wisconsin and encouraging physicians and hospitals to provide health care services in rural and urban areas, I recommend that the Legislature reinstate a cap or limit liability for non-economic damages to an amount not to exceed $550,000.

(B) Options to implement a cap or to limit liability on non-economic damages in order to improve access to care:

1. Exemption from Liability.

The Legislature has determined that a number of activities and actions, in certain circumstances, should be exempt (immune) from liability. Exemptions from liability preclude recovery of any type of damage – economic and non-economic (in effect, a cap of $0). The Legislature has created the exemptions from liability to encourage or permit certain actions, including: the participation in recreational activities; the use of private land for recreational purposes; the donation of food; the donation of solid waste; sport shooting range activities; equine activities; providing emergency health care; and providing health care at athletic events.

In *Szarzynski v. YMCA, Camp Minikana*, 184 Wis. 2d 875 (1994), a case in which the Wisconsin Supreme Court upheld nonprofit corporations' statutory recreational immunity from liability in the face of a constitutional challenge, the State argued that immunities and other liability limitations do not deny a plaintiff equal protection. In its brief to the Wisconsin Supreme Court, the State maintained, "The question is whether the legislative objective is rationally furthered, not whether some plaintiffs are injured by immune defendants and some by non-immune defendants. Immunities and other liability limitations will be upheld even if some otherwise similarly situated plaintiffs' recoveries are affected or denied altogether. The Good Samaritan law is a classic abrogation of damage liability that will affect some plaintiffs but not others." The State, citing several examples of immunities created to encourage certain activities, concluded, "In each case, the rationality of a permissible governmental objective denies someone an otherwise full recovery" and that there are "many examples of using tort immunities to further a social policy." The Wisconsin Supreme Court agreed with the State's position in this case and, applying a rational basis standard of analysis of the statute in question, held it to be constitutional.

As with the activities listed above, providing a limited exemption from liability would encourage an activity, here the provision of health services. And, like the other exemptions from liability, this exemption from liability is rationally related to the government's legitimate interest, in this case, increasing access to health care in Wisconsin by encouraging the practice of medicine.

The statutory provision could be drafted as follows:

Create:
s. 895. 5X Liability exemption: medical malpractice. (1.) Notwithstanding s. 655.23(5), any mandatory participant in the injured patients and families compensation fund is immune from civil liability for any injury to an individual caused by the medical malpractice of the mandatory participant to the extent the non-economic damages in a medical malpractice action exceed $550,000.

(2.) This section does not apply if the death or injury was caused by intentional criminal acts or omissions.

Amend:
s. 655.27 Injured Patients and Families Compensation Fund. (1) Fund. There is created an injured patients and families compensation fund for the purpose of paying that portion of a medical malpractice claim for which a health care provider is liable which is in excess of the limits expressed in s. 655.23(4) or the maximum liability ~~limit~~ for which the health care provider is insured, whichever ~~limit~~ is greater, paying future medical expense payments under s. 655.015 and paying claims under sub. (1m). [...]

Or

Create:
s. 895. 5X Liability exemption: medical malpractice. (1) Notwithstanding s. 655.23(5), any mandatory participant in the injured patients and families compensation fund is immune from civil liability for any injury to an individual caused by the medical malpractice of the mandatory participant.

(2.) Subsection (1) does not apply to the extent the damages caused by the medical malpractice of the mandatory participant are economic damages or, if non-economic damages, the damages do not exceed $550,000.

(3.) Subsection (1.) does not apply if the death or injury was caused by intentional criminal acts or omissions.

Amend:
s. 655.27 Injured Patients and Families Compensation Fund. (1) Fund. There is created an injured patients and families compensation fund for the purpose of paying that portion of a medical malpractice claim for which a health care provider is liable which is in excess of the limits expressed in s. 655.23(4) or the maximum liability ~~limit~~ for which the health care provider is insured, whichever ~~limit~~ is greater, paying future medical expense payments under s. 655.015 and paying claims under sub. (1m). [...]

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2. Exemption from liability tied to Medicaid.

The Legislature could refine the "legitimate government purpose" by specifically attempting to increase access to health care for the poor, elderly, disabled, children, and pregnant woman by encouraging participation in the Medicaid program. As discussed, the Legislature has determined that exemptions from liability encourage certain actions or activities and the Court has found liability exemptions constitutional. The Legislature could encourage increased participation in the Medicaid program by providing a limited liability exemption for physicians and hospitals that are certified Medicaid providers.

Create:
s. 895. 5X Liability exemption: medical malpractice. (1.) Notwithstanding s. 655.23(5), any mandatory participant in the Injured Patient and Family Compensation Fund that is certified as a Medicaid provider is immune from civil liability for any injury to an individual caused by the medical malpractice of the mandatory participant.

(2.) Subsection (1) does not apply to the extent the damages caused by the medical malpractice of the mandatory participant are economic damages or, if non-economic damages, the damages do not exceed $550,000.

(3.) Subsection (1.) does not apply if the death or injury was caused by intentional criminal acts or omissions.

Amend:
s. 655.27 Injured Patients and Families Compensation Fund. (1) Fund. There is created an injured patients and families compensation fund for the purpose of paying that portion of a medical malpractice claim for which a health care provider is liable which is in excess of the limits expressed in s. 655.23(4) or the maximum liability ~~limit~~ for which the health care provider is insured, whichever ~~limit~~ is greater, paying future medical expense payments under s. 655.015 and paying claims under sub. (1m). [...]

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3. Full faith and credit of the State.

In order to maintain Wisconsin's stable and affordable medical liability environment, the Legislature could eliminate physicians' and hospitals' liability for non-economic damages resulting from medical malpractice. In order to provide reasonable compensation for non-economic damages, the Legislature would create a state program that compensates injured plaintiffs for non-economic damages in medical malpractice cases. This program's liability exposure would be capped at up to $550,000. This new fund would be backed by the full faith and credit of the State.

In *Ferdon*, the Court recognized that it was constitutional to cap municipal governments' liability exposure for injuries caused by road defects because "municipalities were immune from suit at the adoption of the Wisconsin constitution, and concern about public finances . . . justified the cap involved in the statute" and appeared reluctant to do anything that would disturb caps on government liability exposure (this cap would be such a cap). This option would invoke the State's sovereign immunity and, thus should be treated in the same manner as are existing liability caps that our Court has found to be as constitutional.

Under this option, the Fund would continue to exist and would be supported by provider assessments. The primary insurance requirements would not change. This option is outlined below:

- Hospitals and physicians would continue to be required to have $1 million per occurrence and $3 million annual aggregate primary liability insurance coverage and their liability would continue to be limited to the amount of the primary insurance.
- The Fund would continue to exist, but would provide compensation for economic damages only. The Fund's exposure for economic damages would continue to be unlimited.
- A new state program would be established to compensate injured patients for their non-economic damages. The awards provided by this new program would be capped at $550,000. The program would be backed with the full faith and credit

of the State. Funding of the program would, in part, rely on assessments from physicians and hospitals, with any excess assessments lapsing to the general fund and the full faith and credit of the State backing any shortfall.

(C) Abrogation of the Collateral Source Rule

Legitimate Government Purposes:

To curb the rising cost of providing medical services in Wisconsin, while still protecting the "make whole" principle central to tort law.

Background and Rationale:

The unmodified collateral source rule

The unmodified collateral source rule provides that if a plaintiff is injured by a defendant and the plaintiff receives benefits for that injury from a source such as an insurer, then information about those benefits is not admissible as evidence in a suit by the plaintiff for damages against the defendant. Thus, a plaintiff can receive damages from the defendant health care provider in the amount of the charged value of the medical expenses incurred by the plaintiff even though such expenses were not paid by the plaintiff. This windfall to the plaintiff can occur due to i) a collateral source such as an insurer paying for the medical care, or ii) all or part of the charges for the medical care being discounted by law by Medicare or Medicaid or by contract with a private insurer.

Such windfalls in the form of payments for charges incurred but not paid for by the plaintiff provide damages to the plaintiff that are in excess of what would make a plaintiff whole. These windfalls artificially increase the size of medical malpractice claims that, in turn, result in higher claims losses for medical malpractice insurers. Higher claims losses ultimately lead to higher premiums for health care providers. This phenomenon increases the cost of providing health care in Wisconsin.

Abrogation of the collateral source rule in medical malpractice claims

The abrogation of the collateral source rule in medical malpractice claims would prohibit windfall awards to plaintiffs by reducing damages awarded to a successful plaintiff in a medical malpractice action by amounts that a plaintiff has incurred, but has not paid, for health care services.

By prohibiting such windfall awards, overall health care costs in Wisconsin are not artificially increased due to artificially high medical malpractice claims. Furthermore, the abrogation of the collateral source rule would still allow plaintiffs, and those entities subrogated to principle plaintiffs, to be fully compensated for any and all economic losses they actually incur. Thus, abrogating the collateral source rule curbs the rising cost of providing medical services in Wisconsin, while still protecting the "make whole" principle central to tort law.

There are two basic types of collateral source reform throughout the United States. Mandatory abrogation of the collateral source rule requires that damages awarded to a successful plaintiff in a medical malpractice action be reduced by amounts that a plaintiff has incurred, but has not paid, for health care services. Permissive abrogation of the collateral source rule permits, but does not require, a jury to reduce the damages awarded to a successful plaintiff in a medical malpractice action by amounts that a plaintiff has incurred, but has not paid, for health care services.

Any type of collateral source reform would need to ensure that if a plaintiff's award did not include medical charges incurred but not paid by the plaintiff (and instead paid by a collateral source such as an insurer), that such plaintiff would not be required to later reimburse the collateral source. One way to address this issue would require a collateral source to seek redress for payments made on behalf of the patient (plaintiff) only from the defendant rather than the plaintiff.

*****

Thank you for the opportunity to submit these recommendations. I look forward to continuing to work with the Task Force in this important effort.

Sincerely,

Ralph Topinka

BAY AREA MEDICAL CENTER

September 27, 2005

The Honorable Curt Gielow
State Representative
Room 316 North, State Capitol
P.O. Box 8952
Madison, WI 53708-8952

Dear Representative Gielow:

Thank you for the opportunity to suggest a legislative approach that may be considered in helping restore the favorable medical malpractice environment that Wisconsin has enjoyed. The approach I am suggesting is one of many that the task force will consider, and I certainly do not presume that this approach alone would provide a complete fix. That being said, please allow me to outline the following alternative.

LEGISLATIVE ALTERNATIVE

Attorney Fee Reform in Conjunction with Caps on Non-economic Damage Awards.

Replace Wisconsin's statutory limits on attorney contingency fees in medical malpractice actions with California's statutory limits on attorney contingency fees.

Current Wisconsin Contingency Fee Limits
Current Wisconsin law limits contingent fees to 1/3 of the first $1 million recovered, 25% of the first $1 million recovered if liability is stipulated within 180 days of filing of the original complaint and not within 60 days of first day of trial, and 20% for amounts exceeding $1 million recovered. The law allows a judge to exceed these amounts in exceptional circumstances. These contingency fee amounts are in addition to compensation to the attorney for the reasonable costs of prosecution of the claim. Wis. Stat. §655.013

Current California Contingency Fee Limits
Current California law limits contingency fees in medical liability cases to 40% of the first $50,000 recovered, 33.3% of the next $50,000, 25% of the next $500,000, and 15% of any amount on which the recovery exceeds $600,000. The limitations apply regardless of whether the recovery is by settlement, arbitration, or judgment. "Recovered" means the net sum recovered after deducting any disbursements or costs incurred in connection with prosecution or settlement of the claim. Costs of medical care incurred by the claimant and the attorney's office-overhead

costs or charges are not deductible disbursements or costs for such purpose. Cal. Bus. & Prof. Code § 6146(a).

Rationale:

A contingency fee, in conjunction with cap reform, places more money in the hands of injured plaintiffs.

One reality of medical liability cases is that injured plaintiffs pay a significant portion of awards to their attorneys in the form of contingency fees. In general negligence cases, these fees are frequently 33% or more of a jury award or settlement. Wisconsin law places a high upper limit on what an attorney may charge in medical malpractice cases. However, other states such as California have enacted attorney fee reform to place more of an award in the hands of the injured plaintiff.

Under Wisconsin's current contingency fee limits, if an injured plaintiff receives a one million dollar award, the attorney's professional fees may be no more than $333,333. Note that professional fees do not include costs such as for filing fees and expert witnesses. Under California's contingency fee limits, that same plaintiff would pay only $221,667 in attorney professional fees—a difference of $111,666. For a five million dollar award, the Wisconsin attorney fees amount to $1,333,333, while California's attorney fees would be $821,667. This is a difference of $311,666 or over 8% of what the plaintiff would ultimately receive as an award after payment of Wisconsin attorney fees. A $500,000 award yields an additional $30,000 in attorneys fees owed under the Wisconsin system as compared to the California system.

One example of how attorney fee reform would affect an actual plaintiff can be seen in the case of Tim and Sean Kaul. On August 30, 2005, a representative of the Wisconsin Academy of Trial Lawyers testified to the Task Force and referred to the case of the Kauls as an example of why the representative believed there should not be caps on non-economic damages. What was not discussed was the impact of attorney fees on what the Kauls ultimately receive as a successful plaintiff.

When one looks at what the Kauls ultimately receive from a jury award after attorney costs rather than simply at the amount of the jury award, the Kauls would actually receive 0.86% *more* of an award after attorney fees are deducted if their award were subject to California's reasonable attorney fees and a $550,000 cap on non-economic damages rather than Wisconsin's current attorney fee limits and no cap on non-economic damages. Thus, a non-economic damage cap of $550,000 in conjunction with attorney fee reform would put the Kauls in a better position after attorney fees are deducted than they are under Wisconsin's current medical liability status quo.

California's system has not closed the court room doors to injured plaintiffs.

Some argue that reducing contingency fee arrangements will close the courtroom doors to plaintiffs because attorneys will be unwilling to take on cases at lower contingency rates. A 2004 RAND study of California's medical liability reforms speculates that this may be the case, however the study offers no data to support this speculation. Rather, according to data from the National Practitioner Data Bank, when one compares the average number of paid medical malpractice claims per capita in California and Wisconsin from 1991-2004, California with its attorney fee reform has averaged 3.22 more claims per 100,000 population per year than Wisconsin. Clearly, this data shows that California's attorney fee reform has not had the chilling effect on legitimate claims that the RAND study imagines.

California's experience with damage caps, in conjunction with its attorney fee limits, has shown that such reforms produce a stable medical liability system.

Finally, California has a stable medical liability system, as evidenced by the findings of numerous scientific studies.

In addition to this suggested approach, I would also like to lend my support to the alternatives that were recommended by my fellow task force member and colleague Ralph Topinka. I know that Ralph has spent a great deal of time researching and considering a number of different options, and I believe that his suggestions are well thought out and certainly could provide restoration of our previous favorable medical malpractice environment.

Thank you for the opportunity to submit my recommendations. I appreciate being a part of this assembly task force, and I look forward to supporting the recommended solutions.

Sincerely,

BAY AREA MEDICAL CENTER

David A. Olson
President and CEO

dao:kac

WISCONSIN STATE LEGISLATURE

11TH ASSEMBLY DISTRICT

JASON M. FIELDS
STATE REPRESENTATIVE

DATE: September 19, 2005

TO: Representative Curt Gielow, Chair, Medical Malpractice Task Force

FROM: Representative Jason M. Fields

RE: Ideas for Medical Malpractice Task Force

As we continue to deliberate medical malpractice caps in the state of Wisconsin and prepare to submit our final recommendations, I ask that you please consider the following proposals:

Health Courts

I propose that the Task Force look at the feasibility of creating a health court system similar to that of the worker's compensation system. Health courts will be less expensive than the current system. Today, more than 50 percent of court awards go to court costs and lawyer fees. That is nearly twice the overhead of a typical workers' compensation case. Initially, premiums will remain the same. However, over time, medical malpractice premiums should fall as compensation for injured patients becomes more predictable and the new system helps clarify standards of practice to reduce injuries. This will result in malpractice insurers no longer having to pay any of the sizable awards that make headlines in the current system. They will pay limited compensation awards more frequently.

Compensation Fund

The Task Force should explore auditing the Injured Patients and Families Compensation Fund (Fund) on a periodic basis as to determine actuarially the reality of using the fund to pay claims dollar for dollar. In addition, the Task Force should consider authorizing the Fund to function as a private insurer.

Thank you in advance for your consideration.

State Capitol, P.O. Box 8952, Madison, WI 53708 ◆ (608) 266-3756 ◆ Toll-free: 1-888-534-0011
Fax: (608) 282-3611 ◆ E-mail: rep.fields@legis.state.wi.us

Rep.Gielow

From: Peer, Adam
Sent: Friday, September 23, 2005 10:15 AM
To: Rep.Gielow
Subject: Rep Nischke's Med Mal Recommendations

Rep. Gielow: Rep Nischke asked that I forward these recommendations on Medical Malpractice Reform from her constituents. Please let me know if you have any questions. Adam

ADAM PEER, Legislative Assistant
www.RepNischke.com

Contact • Constituent Services • Legislation
Insurance Committee • Insurance Advisory Council

ANN Nischke
www.RepNischke.com

TO: REPRESENTATIVE ANN NISCHKE

From: Adam Peer, Legislative Assistant

Date: September 9, 2005

RE: Recommendations to the Speaker's Taskforce on Medical Malpractice Reform

You have requested a summary of recommendations voiced at the Insurance Advisory Council relating to the Medical Malpractice Reform Taskforce. Here are the following broad suggestions the council talked about that they hoped would be considered in a potential statutory cap on non-economic damages:

1. It *is desirable* the cap consider plaintiff life expectancy.
2. It *is not desirable* that the cap based on economic damage.
3. If persons, e.g. family members, other than the immediate plaintiff are considered for non-economic compensation, very strict standards defining who may be compensated be established.
4. The Legislature considers a long-term reform that creates a complete compensation system that includes non-economic compensation similar to the state Worker's Compensation Systems.
5. The creation of "health courts" (see attached article.).

Please let me know if you have any questions or if you would like more information or additional information about any of these items.

ASP

State Capitol, Room 8 North, PO Box 8953, Madison, WI 53705-8953
Capitol: 608-266-8580, Fax 608-282-3697

The Washington Times
June 09, 2005
Washington D.C. M/
SUNNY 84° F

Health courts could solve malpractice

By Andrew Damstedt
UNITED PRESS INTERNATIONAL

Washington, DC, Jun. 8 (UPI) -- Health courts, along with non-economic judgment caps and tighter regulation of the insurance industry, might constitute an effective approach to solve the problem of how best to reform medical-malpractice litigation, a panel of experts said.

The Progressive Policy Institute, a centrist Democratic think tank, hosted the panel on Capitol Hill this week to discuss how health courts could benefit doctors, lawyers and most of all patients who have been injured in malpractice cases.

Will Marshall, the institute's president, said the current litigation system is "broken and in need of radical reform." He said one current problem is the issue is being debated along political lines, with Republicans arguing that non-economic caps are necessary and Democrats attempting to protect the

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lawyers.

Marshall said the issue is more complicated than merely choosing sides, however. More often than not, the patient loses under the current system and some of the reform proposals offer "false choices between phony solutions."

The PPI's solution, he told reporters, is to establish a system of health courts that would function similar to patent and bankruptcy courts by eliminating juries and maintaining judges with specialized experience.

David Kendall, a senior fellow at the institute, said health courts would allow patients who think they have been wrongfully injured to file claims with a local review board. Each board, which would be set up by a hospital and operated under the jurisdiction of a health-court judge, would then investigate the claim, free of charge to the patient, and would issue one of three rulings:

-- If there is clear evidence of medical malpractice, the patient is compensated immediately.

-- If no malpractice is found, or if the injury is too minor to justify compensation, the case is rejected.

-- If the circumstances of the injury are not clear, the case is sent to the health-court judge for review or trial.

Both sides could be represented by lawyers and the health courts would employ specially qualified judges, who Kendall said did not need to be doctors but would be trained to understand the healthcare system. The courts also would hire neutral experts to review claims. Judges would decide the cases, not juries -- a potential sticking point, because lawyers probably would object to the courts depriving patients of the right to a jury trial.

"Juries are not the problem," Kendall said. "We are asking them to do an impossible job." He explained that in criminal trials juries are given clear definitions of the alleged crimes, but in medical trials juries are basically told to figure things out for themselves.

Carlton Carl, director of media relations at the Association of Trial Lawyers of America, told United Press International the whole idea of health courts could be unconstitutional. If 12 ordinary men and women can decide Enron is guilty of corruption with

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no expertise on corruption, then they can listen to evidence and make intelligent decisions about whether a doctor has committed malpractice, he said.

"This is another effort to stand in the way of patients injured by medical practice to get justice," Carl said.

"These proposals are being sold to the public as good for patients, but in fact they would be devastating for many, especially the most severely injured," Joanne Doroshow, executive director of the Center for Justice & Democracy in New York City, told UPI. "This is yet another attempt by the healthcare industry to limit its liability exposure by proposing to take compensation judgments away from juries, and replacing the jury system with a statutory structure over which their political action committee money can have more control."

Dr. Donald Palmasino, the immediate past president of the American Medical Association, said his organization supports California's Medical Injury Compensation Reform Act of 1975 as a pattern to reform medical-liability laws. It is a proven performer and has seen success in other states, he said. This would include placing a cap on non-economic damages, but not creating a specialized health court.

"We can stop the problem of escalating costs," Palmasino told UPI.

Philip Howard, a New York corporate lawyer and founder of Common Good, a bipartisan coalition dedicated to restoring the foundation of reliable law, said health courts would be able to establish guidelines for the medical profession.

Howard said the current system tends to polarize viewpoints, while a health-court system would allow people to come together and work things out.

"The most important factor is that the judges will make deliberate choices as a matter of law," Howard told reporters at the panel discussion.

At the news conference, Kendall said health-court judges would make awards based on a schedule of benefits, meaning instead of juries awarding similar cases different amounts, there would be similar awards for similar circumstances.

"Scheduled benefits would bring consistency and hold the system accountable for avoidable errors,"

United Press International

the senior citizens' advocacy group, said his organization supports the "experiment" of health courts and a no-fault system of medical malpractice. There is a worry, however, that a loss of unpredictability in damage awards could result in a deterioration of quality of care, he said.

"A hospital administrator could set someone aside and say 'their damages would only be $100,000' because the hospital can afford that," Jackson told reporters.

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Andrew Damstedt is an intern for UPI Science News.
E-mail: sciencemail@upi.com