WISCONSIN STATE LEGISLATURE COMMITTEE HEARING RECORDS

2005-06
(session year)

Assembly
(Assembly, Senate or Joint)

Committee on Insurance (AC-In)

(Form Updated: 11/20/2008)

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INFORMATION COLLECTED BY COMMITTEE FOR AND AGAINST PROPOSAL ...

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(2005 documents)

CURT GIELOW

State Representative

Handout for the Assembly Committee on Insurance

Re: AB 766

October 18, 2005

The data used in these two documents are from the Wisconsin Hospital Association (WHA)

The first two pages of this document offers a "sort" of the 22 states that have a cap on noneconomic damages in medical malpractice cases by the size of the caps. This document takes one number to stand for each state's cap and sorts the states by that number; low-cap states appear first and caps rise as one works down the list. This two-page list DOES NOT offer full detail on the various states' caps; that's in the last three pages.

The last three pages list alphabetically the 22 states that have med-mal caps and offers all the explanatory notes on the caps. In almost no case is the cap a simple number, so numerous notes are offered to explain each cap. There are less than 50 states listed because not all states have caps.

The omission of notes and the use of one number to describe the various levels of cap in the affected states is a concession to the for an easy list. ***Full understanding and comparison of the many caps requires the notes found in the last three pages.***

I hope this information is helpful.

State Capitol: P.O. Box 8952 • Madison, Wisconsin 53708-8952 • (608) 266-0486 • Toll-Free: (888) 534-0023 • Rep.Gielow@legis.state.wi.us
District: P.O. Box 504 • Mequon, Wisconsin 53092 • (262) 242-2728

CURT GIELOW

State Representative

Testimony on AB764, AB 765, and AB 766
To the
AssemblyCommittee on Insurance

October 18, 2005

Madam Chair and Members,

The Speaker's Task Force on Medical Malpractice Reform has completed its work and presents three pieces of legislation for committee consideration - **AB 764**; **AB 765**; and **AB 766** as the work product of our efforts.

We believe these bills recognize and reflect the necessary balance between fairness, affordability and availability in the area of medical malpractice insurance coverage.

The bi-partisan Task Force heard testimony from interested parties for two full meetings and then held two more meetings to debate and consider an appropriate course of action.

AB 766 creates a two-tiered award benefit structure similar to current law in wrongful death cases. The award cap for persons under age18 would be set at $550,000, 23% higher than under the previous cap while the award cap for persons age 18 and over would be set at $450,000, essentially the same as the recent cap. The majority of the Task Force believes this differentiation, with justifications and legislative findings, is therefore responsive to the courts objection to constitutionality under the equal protection clause of our constitution.

AB 765 simply closes a loophole in current law that did not provide coverage under our healthcare liability requirements to individuals that completed medical school and were doctors but had not yet completed the required first year of post-graduate medical residency, commonly called their internship, to become licensed Wisconsin physicians.

AB 764 clarifies current law on the issue of collateral sources of payments to compensate individuals in medical malpractice cases. The bill provides for the reduction of medical malpractice awards by the amount of collateral source payments, offset by any subrogation or reimbursement resulting from those collateral source payments. Earlier today we discovered some drafting errors which have been corrected in a sub amendment I present here today. The corrections preserve our intent and will not alter the legislative analysis. My preference would be that we treat the ASA as the focus of this hearing and proceed, if possible, to exec on it tomorrow.

I would note for the committee that in all of these bills the effective date is prospective and not retroactive.

I urge the committee's support for these critical pieces of legislation.

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District: P.O. Box 504 • Mequon, Wisconsin 53092 • (262) 242-2728

Caps on Damages

All amounts are for noneconomic damages unless otherwise indic
$X/$Y caps represent the factthat there is one cap for "normal" in

Alaska	$250,000	**Alaska**- Provides a $250K/$400K unadjusted cap with no life exp
California	$250,000	**California**-$250,000 cap on noneconomic damages. (1975)
Kansas	$250,000	**Kansas**-$250,000 cap on noneconomic damages. (1988)
Montana	$250,000	**Montana**- $250,000 cap on noneconomic damages per occurrence
Texas	$250,000	**Texas**-$250,000 cap on non-economic damages for claims against
West Virginia	$250,000	**West Virginia**- $250,000 cap on non-economic damages per occu
Michigan	$280,000	**Michigan** – $280,000/$500,000 cap on noneconomic damages est
Oklahoma	$300,000	**Oklahoma**- Two caps, one for obstetric cases and care provided i
Georgia	$350,000	**Georgia** – $350K/$700K cap created in 2005.
Maryland	$350,000	**Maryland** - Maryland originally imposed a $350,000 limit on no
Missouri	$350,000	**Missouri** - Caps non-economic damages at $350,000, regardless o
Nevada	$350,000	**Nevada**-$350,000 cap in 2002 with exceptions including a judicia
Ohio	$350,000	**Ohio**- Establishes a sliding cap on non-economic damages. The c
Hawaii	$375,000	**Hawaii**-$375,000 cap on noneconomic damages, with exceptions
Idaho	$400,000	**Idaho**- $400K cap from 1987-2003. $250,000 cap on non-econon
Maine	$400,000	**Maine**-$400,000 cap on noneconomic damages in *wrongful death*
Utah	$400,000	**Utah** - $400,000 cap on noneconomic damages for causes of actio
Florida	$500,000	**Florida**- For providers, $500,000 cap on non-economic damages f
Illinois	$500,000	**Illinois** - $500K cap for physicians and $1million for hospitals. C
Louisiana	$500,000	**Louisiana** - $500,000 cap on **all damages**, excluding damages rec
Massachusetts	$500,000	**Massachusetts**-$500,000 cap on noneconomic damages, with exc
Mississippi	$500,000	**Mississippi** – $500,000 cap, *except in* cases where patient suffers

North Dakota	$500,000	**North Dakota**-$500,000 cap on noneconomic damages. (1995)
South Dakota	$500,000	**South Dakota** - $500,000 cap on total general (non-economic) dai
New Mexico	$600,000	**New Mexico**-$600,000 cap on **all damages**, excluding punitive da
Colorado	$1,000,000	**Colorado**-$1 million cap on **all damages**, including any derivativ
Indiana	$1,250,000	**Indiana**-$1.25 million cap on **all damages** for any act of malpract
Virginia	$1,500,000	**Virginia** -$1.5 million cap on **all damages** for acts occurring on o
Nebraska	$1,750,000	**Nebraska**-Various limits enacted at various times. $1.75 million

Caps on Damages

All amounts are for noneconomic damages unless otherwise indicated.
$X/$Y caps represent the factthat there is one cap for "normal" injuries and one cap for severe injuries.

Alaska- Provides a $250K/$400K unadjusted cap with no life expectancy multiplier. (2005) Previous law provided a $400K/$1m cap, with an expectancy multiplier used for amounts below those caps. (1997-2005)

California-$250,000 cap on nonecconomic damages. (1975)

Colorado-$1 million cap on **all damages**, including any derivative claim by any other claimant, of which non-economic losses shall not exceed $300,000 (including any derivative claim by any other claimant). (1988, 2003)

Florida- For providers, $500,000 cap on non-economic damages for causes of action for injury or wrongful death due to medical negligence of physicians and other health care providers. Cap applies per claimant regardless of the number of defendants. Cap increases to $1 million for certain exceptions. For non-providers, $750,000 cap on non-economic damages per claimant for causes of action for injury or wrongful death due to the medical negligence of nonpractitioners, regardless of the number of nonpractitioner defendants. Cap increases to $1.5 million for certain exceptions. (2003)

Georgia – $350K/$700K cap created in 2005.

Hawaii-$375,000 cap on noneconomic damages, with exceptions for certain types of damages, ie. mental anguish. (1986)

Idaho- $400K cap from 1987-2003. $250,000 cap on non-economic damages enacted in 2003.

Illinois - $500K cap for physicians and $1million for hospitals. Cap applies per defendant and **not** per occurrence.

Indiana-$1.25 million cap on **all damages** for any act of malpractice that occurs after 6/30/99.

Kansas-$250,000 cap on noneconomic damages. (1988)

Louisiana - $500,000 cap on **all damages**, excluding damages recoverable for medical care. (1992).

Maine-$400,000 cap on noneconomic damages in *wrongful death actions*. (1999)

Maryland - Maryland originally imposed a $350,000 limit on noneconomic damages in 1986. The limit was increased to $500,000 in 1994, and there after that limit was increased by $15,000 each year. By 2004, the cap on noneconomic damages was $650,000 and a separate cap on wrongful death was over $1.6 million. 2005 legislation suspended the $15,000 increases until 2009, and cut the wrongful death damage cap by half from over $1.6 million to 812,500. If there is a wrongful death action in which there is more than one claimant or beneficiary, whether or not there is also a personal injury action, non-economic damages are limited to 125% of the cap.

Massachusetts-$500,000 cap on noneconomic damages, with exceptions for proof of substantial disfigurement or permanent loss or impairment, or other special circumstances which warrant a finding

that imposition of such limitation would deprive the plaintiff of just compensation for the injuries sustained. (1986)

Michigan – $280,000/$500,000 cap on noneconomic damages established in 1993, adjusted annually for inflation ($371,000/$664,000 in 2005).

Mississippi – $500,000 cap, *except in* cases where patient suffers disfigurement or if the judge finds punitive damages are warranted from 2003-2004.

Missouri - Caps non-economic damages at $350,000, regardless of the number of defendants, with no annual inflator. (2005) Previous law was a $350,000 cap with inflation adjustment. By 2005 that adjusted cap was up to $579,000.

Montana- $250,000 cap on noneconomic damages per occurrence. (1995, 1997)

Nebraska-Various limits enacted at various times. $1.75 million cap on **all damages** in 2003. Health care providers who qualify under the Hospital-Medical Liability Act (i.e. carry minimum levels of liability insurance and pay surcharge into excess coverage fund) shall not be liable for more than $500,000 in total damages. Any excess damages shall be paid from the excess coverage fund. (1976, 1984, 1986, 1992, 2003)

Nevada-$350,000 cap in 2002 with exceptions including a judicial override. 2004 law later eliminated those exceptions.

New Mexico-$600,000 cap on **all damages**, excluding punitive damages and past and future medical care. (1992)

North Dakota-$500,000 cap on noneconomic damages. (1995)

Ohio- Establishes a sliding cap on non-economic damages. The cap shall not exceed the greater of $250,000 or three times the plaintiff's economic loss up to a maximum of $350,000 for each plaintiff or $500,000 per occurrence.
The maximum cap will increase to $500,000 per plaintiff or $1,000,000 per occurrence for a claim based on either (A) a permanent and substantial physical deformity, loss of use of a limb, or loss of a bodily organ system, or (B) a permanent physical functional injury that permanently prevents the injured person from being able to independently care for self and person life sustaining activities. (2002)

Oklahoma- Two caps, one for obstetric cases and care provided in an emergency room and a separate cap for all other medical liability causes of action. The amount of both caps is $300,000. These caps have significant exceptions and loopholes. (2003, 2004)
Neither cap applies in wrongful death cases because the Oklahoma Constitution specifically limits damage limitations in those types of cases.

South Dakota - $500,000 cap on total general (non-economic) damages. (1985, revived by 1996 court decision)

Texas-$250,000 cap on non-economic damages for claims against physicians and other health care providers. The cap applies per claimant regardless of the number of defendants. Also provides a $250,000 cap on noneconomic damages in judgment against single health care institution and a $500,000

cap on noneconomic damages if judgment is rendered against two or more health care institutions, with the total amount of noneconomic damages for each individual institution, not exceeding $250,000 per claimant, irrespective of the number defendants, causes of action, or vicarious liability theories involved. The *total* amount of noneconomic damages for health care institutions cannot exceed $500,000. Combining the liability limits for physicians, health care providers, and institutions, the maximum noneconomic damages that a claimant could recover in a health care liability claim is capped at $750,000. (2003)

$500,000 cap on all civil damages for wrongful death, indexed for inflation since 1977. The cap does not apply to medical, hospital, and custodial care received before judgment or required in the future. In 2002, the cap reached approximately $1.4 million. (1977, limited by 1990 court decision)

Utah - $400,000 cap on noneconomic damages for causes of action arising on or after July 1, 2001 but before July 1, 2002. Indexed annually for inflation thereafter. (2001)

Virginia -$1.5 million cap on **all damages** for acts occurring on or after Aug. 1, 1999. This cap is increased by $50,000 annually beginning on or after July 1, 2000 until July 1, 2006. On July 1, 2007 and July 1, 2008 the cap is increased by $75,000. The last increase shall be July 1, 2008. (1976, 1977, 1983, 1999, 2001)

West Virginia- $250,000 cap on non-economic damages per occurrence, regardless of the number of plaintiffs and number of defendants. The cap increases to $500,000 per occurrence, for the following types of injuries; permanent and substantial physical deformity, loss of use of a limb or loss of a bodily organ system; or permanent physical or mental functional injury that permanently prevents the injured person from being able to independently care for himself or herself and perform life sustaining activities. The limits only apply to defendants who have at least $1,000,000 per occurrence in medical liability insurance. The limits will be adjusted annually for inflation up to $375,000 per occurrence or $750,000 for injuries that fall within the exception. (2003)

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Advocacy Resource Center
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Keeping Wisconsin Families Safe
www.watl.org

EXECUTIVE DIRECTOR
Jane E. Garrott
44 E. Mifflin Street, Suite 103
Madison, Wisconsin 53703-2897
Telephone: 608/257-5741
Fax: 608/255-9285
Email: exec@watl.org

Testimony of Daniel A. Rottier

on behalf of the

Wisconsin Academy of Trial Lawyers

before the

Assembly Insurance Committee

Representative Anne Nitschke, Chair

October 18, 2005

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

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

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

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

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

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

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

That hardly appears like justification for a cap.

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

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

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

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

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

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

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

Candace Shepard:

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

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

Tanner Noskowiak

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

Lori Schmitz

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

Sharon Swatek

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

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

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

I would like to highlight the evidence against the caps.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Insurance execs speak up

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

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

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

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

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

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

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

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

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

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

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

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

Other key highlights of the study:

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

Wisconsin Unique System: The Injured Patients and Families Compensation Fund

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

The 1975 Statutory Scheme

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

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

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

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

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

Timeline of the Fund

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

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

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

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

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

1991 — $1 million indexed cap sunsets.

1995 — $350,000 indexed cap adopted.

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

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

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

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

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

The 1986 Legislative Changes

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

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

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

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

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

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

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

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

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

How Wisconsin doctors are insured against malpractice

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

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

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

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

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

Conclusion

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

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

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

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

We believe that is not only immoral, but unconstitutional.

Wisconsin's Healthcare Picture by the Numbers

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

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Sources:

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WISCONSIN HOSPITAL ASSOCIATION, INC.

October 18, 2005

TO: Assembly Committee on Insurance

FROM: Eric Borgerding, Senior Vice President

SUBJECT: Support for AB 766, AB 765 and AB 764

Chairperson Nischke 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 in support of AB 764, AB 765 and AB 766. This hearing, and the Speaker's task force that preceded it, are an extraordinarily rapid and high-priority response to a series of damaging Supreme Court decisions, and our 130 member hospitals appreciate your concern and commitment.

Your urgency is warranted, for the consequences of inaction or delay are of a nature that threatens to undermine Wisconsin's health care delivery system.

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 rural family practice doctor who also delivers babies, or more importantly, if you are a patient who may not have access to the care you need, you know that inaction, or an inadequate response to these recent decisions could be devastating.

Yet, today you will hear all sorts of reasons why Wisconsin should not restore a cap on non-economic damages. Our opponents will tell you that the damage cap made no difference in Wisconsin and that liability insurance premiums will not go up due to its loss. And if premiums do increase, our opponents will attribute it to bad investments made by insurance companies. But today, you will hear compelling evidence to the contrary from Pinnacle Resources, authors of September, 2005 actuarial analysis of Wisconsin's medial malpractice environment.

Our opponents will attempt to distract you by claiming malpractice premiums are a minuscule percentage of overall health care costs. And you know what, I think they are largely correct. But this is not about some misleading comparison to overall health care spending -- it is about the patients put at risk when skyrocketing liability premiums force physicians to leave Wisconsin or retire too soon.

The fact that malpractice premiums amount to a fraction of overall health care spending won't make much difference to the pregnant mother who has to travel 150 miles to deliver her baby because the last OB/GYN left town.

5510 Research Park Drive P.O. Box 259038 Madison, WI 53725-9038 P 608 274 1820 F 608 274 8554 wha.org

Our opponents tell you to ignore the havoc out of control premiums are wreaking in other states -- but 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, were 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.

We cannot dismiss what has happened in these and other states, and we cannot ignore the stories from the dozens and dozens of skilled physicians who have left these states to come practice medicine in Wisconsin. In fact, you will hear from some of them today.

Our opponents will bury you with a two-foot high pile of studies from academia far and wide or from sponsored advocacy groups claiming damage caps have no impact on malpractice premiums. In contrast, today you will be presented with a fresh, Wisconsin focused actuarial analysis that will show what a cap on non-economic damages helped accomplish in Wisconsin, what the absence of a cap will mean in Wisconsin, and, most importantly, what a cap, depending on the amount, can prevent in the future.

But frankly, we don't need to speculate, or wait and see what the impact of loosing the cap will be, because our members are dealing with it right now.

We have received numerous reports of how much more difficult it has already become to recruit physicians to Wisconsin, particularly to rural areas. New physicians considering practicing in Wisconsin, or those thinking of relocating here are very concerned about what has happened here and, more importantly, what will be done about it. They simply aren't buying the notion that without a cap, Wisconsin will be just fine, or that because we have an Injured Patients and Families Compensation Fund there is nothing to worry about. In the real world of 24/7/365 health care, things are quite the opposite. You will hear more about this today from a Wisconsin physician recruiter.

Through our own physician workforce studies (see attached), we know that even with a cap, Wisconsin is facing serious challenges to recruit and retain new physicians. We must to do everything we can to attract and keep the young doctors we will all need to care for us in the future. Frankly, I can think of nothing more damaging to that critical effort than the Ferdon decision. Doing nothing in response is simply not an option.

Our opponents will have you believe that Wisconsin is somehow immune from the escalating damages and increasing out of court settlements that have taken hold in states without caps. They will try to sidetrack this debate by pointing to the few Wisconsin jury verdicts in the last ten years that exceeded the then existing cap. But make no mistake, without a cap on non-economic damages, we will see more lawsuits, higher damages and, more importantly (but less noticed), higher out of court settlements – all of which will drive up liability premiums.

In fact, within days of Ferdon, there were plaintiff's attorneys in Wisconsin doubling their pre-Ferdon settlement demands. We don't need to speculate about the long-term negative impact of Ferdon – it is happening already.

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 and a cap 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, three months since the Ferdon decision, his same concerns are being predicted by leading actuaries.

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 restore through this legislation. A system in which liability premiums do not drive out of business, out of the state, or into retirement, the very doctors we count on the most when we need them the most.

To accomplish this, we must have a well-reasoned and rational cap on non-economic damages – one that is developed through a deliberative process that contemplates both political and judicial realities. A cap that is meaningful, and that is not so high that it essentially does not exist. A cap that accounts for the differing life circumstances of each plaintiff, including their age. And, a cap that does not, nor is it intended to, stand

alone, but rather as the key component of Wisconsin's comprehensive medical liability system – a system that already includes:

- Unlimited economic damages
- Unlimited damage recovery through mandatory provider participation in the IPFCF
- Mandatory periodic payments
- And, unlike any other state, guaranteed recovery of damages through mandatory $1 million/$3 million coverage for physicians and hospitals

Now missing from this system is a cap on non-economic damages and recognition of collateral sources, both of which will be addressed by the legislation before you.

Finally, I would like to quote 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 speculation or exaggeration, this is real life, and it is testimony I hope you will never here 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 equitable system can be preserved in Wisconsin but it will require the Legislature and Governor to act. We believe that system must have as its foundation a cap on non-economic damages and other important reforms, including recognition of collateral sources and IPFCF coverage for medical residents. We urge you to support AB 764, 765 and 766.