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 ...

- *Committee Reports ... CR*

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- *Executive Sessions ... ES*

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- *Public Hearings ... PH*

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

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INFORMATION COLLECTED BY COMMITTEE FOR AND AGAINST PROPOSAL ...

- *Appointments ... Appt*

**

Name:

- *Clearinghouse Rules ... CRule*

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- *Hearing Records ... HR (bills and resolutions)*

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- *Miscellaneous ... Misc*

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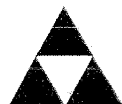
(2005 documents)



AMERICAN ACADEMY *of* ACTUARIES

News Release

FOR IMMEDIATE RELEASE

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202-785-7870 / robichaux@actuary.org

Actuaries Issue Warning About Flawed Report on Medical Malpractice Insurance

The Report *Falling Claims and Rising Premiums in the Medical Malpractice Insurance Industry* cited as "incomplete, actuarially unsound, and misleading"

(October 26, 2005 – Washington, D.C.) The Medical Malpractice subcommittee of the American Academy of Actuaries issued a strongly worded statement today about a July 2005 report that was commissioned by the Center for Justice and Democracy and written by Jay Angoff, an attorney from Jefferson City, Mo. The report, *Falling Claims and Rising Premiums in the Medical Malpractice Insurance Industry*, was characterized as "incomplete, actuarially unsound, and misleading."

The statement noted that, "Historically, the subcommittee has not commented on individual medical liability studies." However the Angoff report, "is an exception because of the public attention it has received, the apparent credibility ascribed to its conclusions and, in our view, the poor quality of the analysis." The statement adds that the subcommittee "believes comments warning readers and potential users of this report are necessary." The subcommittee suggests that, "Before relying on the above report, we recommend that all interested parties seek advice from a qualified actuary. For state legislators and attorneys general, we recommend contacting the qualified actuaries in their state insurance departments."

The actuaries on the subcommittee cite numerous reasons why the report's analysis and conclusions should be questioned, noting that the "report uses improper data comparisons, incomplete information and appears to misuse certain insurance industry benchmarks."

A copy of the statement can be found on the Academy Web site at www.actuary.org. To interview a member of the Medical Malpractice subcommittee about the statement, contact Chris Robichaux at 202-785-7870, or at robichaux@actuary.org

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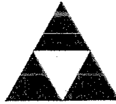
The American Academy of Actuaries is a non-profit, professional membership organization representing actuaries in all areas of practice in the U.S. The Academy's mission is to assist in the formulation of public policy by providing independent and objective information analysis and education, and to help support the establishment, maintenance and enforcement of high standards of actuarial qualification, practice, and conduct. Founded in 1965, the Academy has 15,000 members and is headquartered in Washington, D.C.



AMERICAN ACADEMY *of* ACTUARIES

Statement by the American Academy of Actuaries' Medical Malpractice Subcommittee on the Report by the Center for Justice & Democracy, *Falling Claims and Rising Premiums in the Medical Malpractice Insurance Industry*

Introduction

The American Academy of Actuaries (Academy) is a non-profit, professional membership organization representing actuaries in all areas of practice in the U.S. The Academy's mission is to assist in the formulation of public policy by providing independent and objective information analysis and education, and to support the establishment, maintenance and enforcement high standards of actuarial qualification, practice, and conduct. Founded in 1965, the Academy has 15,000 members and is headquartered in Washington, D.C.

The Academy's Medical Malpractice Subcommittee seeks to provide independent and objective information, analysis and education on medical malpractice issues to legislators, regulators, the actuarial profession and the public, both nationally and internationally, through the use of comment letters, public testimony and educational seminars.

Statement on the Center for Justice & Democracy's report *Falling Claims and Rising Premiums in the Medical Malpractice Insurance Industry*

Consistent with the theme underlying the subcommittee's April 2005 comment letter titled *Important Considerations When Analyzing Medical Malpractice Insurance Closed-Claim Databases*, this subcommittee focuses on providing actuaries and non-actuaries with the foundation necessary to evaluate the critical factors relating to medical liability, to assist in their research, and to form well-reasoned conclusions.

Historically, the subcommittee has not commented on individual medical liability studies. However, the July 2005 study by Jay Angoff commissioned by the Center for Justice & Democracy entitled *Falling Claims and Rising Premiums in the Medical Malpractice Insurance Industry* is an exception because of the public attention it has received, the apparent credibility ascribed to its conclusions and, in our view, the poor quality of the analysis.

The report forms conclusions regarding insurance company financial results and rates, areas in which actuaries have special expertise. In consideration of these circumstances, the American Academy of Actuaries and, in particular, the Medical Malpractice Subcommittee, believes comments warning readers and potential users of this report are necessary.

In our opinion, the report is incomplete, actuarially unsound, and misleading. The report uses improper data comparisons, incomplete information and appears to misuse certain insurance industry benchmarks. Besides reviewing the report, we have reviewed studies commenting on the report and concur with various points made in these studies. Key among these are that the report: contains misleading and inappropriate comparisons of financial data presented in insurance company Annual Financial Statements; does not include all costs associated with providing the insurance product (e.g., costs of defending claims, administrative expenses, etc.); does not adjust for growth in insureds over time; misrepresents and misuses Risk Based Capital (RBC); in addition to other mischaracterizations and misinterpretations.

After the September 28, 2005 press release entitled *Statement by the Center for Justice & Democracy in Response to the Physician Insurance Association of America Critique of "Falling Claims and Rising Premiums in the Medical Malpractice Insurance Industry*," in which the Center for Justice & Democracy stated, "we stand by our Report and our numbers, which insurers themselves filed, under oath, with state insurance departments." It is obvious to us that the report continues to receive unwarranted reliance and credibility.

We believe that the report's data and methodology do not support its conclusions.

In order to constructively move the medical liability debate forward, appropriate data comparisons and complete information must be used so that the public and legislators can properly evaluate the issues. Before relying on the above report, we recommend that all interested parties seek advice from a qualified actuary. For state legislators and attorneys general, we recommend contacting the qualified actuaries in their state insurance departments.

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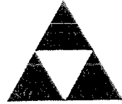
For further information on the Academy go to www.actuary.org, or call Chris Robichaux at 202-223-8196, Robichaux@actuary.org.

For a copy of the subcommittee's comment letter referenced above, *Important Considerations When Analyzing Medical Malpractice Insurance Closed-Claim Databases*, go to http://www.actuary.org/pdf/casualty/medmal_042005.pdf



AMERICAN ACADEMY *of* ACTUARIES

Important Considerations When Analyzing Medical Malpractice Insurance Closed-Claim Databases

Medical Malpractice Subcommittee
American Academy of Actuaries

April 20, 2005

The American Academy of Actuaries is the public policy organization for actuaries practicing in all specialties within the United States. A major purpose of the Academy is to act as the public information organization for the profession. The Academy is non-partisan and assists the public policy process through the presentation of clear and objective actuarial analysis. The Academy regularly prepares testimony for Congress, provides information to federal elected officials, comments on proposed federal regulations, and works closely with state officials on issues related to insurance. The Academy also develops and upholds actuarial standards of conduct, qualification, and practice, and the Code of Professional Conduct for all actuaries practicing in the United States.

1100 Seventeenth Street NW Seventh Floor Washington, DC 20036 Telephone 202 223 8196 Facsimile 202 872 1948

The Medical Malpractice Subcommittee of the American Academy of Actuaries is pleased to offer these comments regarding the use of medical malpractice insurance closed-claim databases (CCDs) for public consumption. The purpose of these comments is to discuss some of the factors that should be considered when working with CCDs.

We at the Academy hope that this comment letter will serve as a foundation for both actuaries and non-actuaries working with CCDs. We believe these comments will help CCD researchers consider and evaluate critical factors involving CCDs before beginning their work and forming conclusions.

Medical Malpractice Insurance Closed-Claim Databases Considerations

1. Exclusion of Claims Closed Without Indemnity Payment

Some CCDs exclude claims that were closed without an indemnity payment. Based on industry information, 70 percent to 80 percent of all medical malpractice insurance claims close without an indemnity payment. Therefore, research performed on any CCD that excludes claims closed without payment does not include a major cost component, namely the cost of investigating and defending these medical malpractice insurance claims. The loss adjustment expense (LAE) for these excluded claims would include items such as claim investigation, medical examination, defense attorney fees, and fees/salaries for claim adjusters and others working on the defense of a claim.

With LAE representing approximately one third of all insured loss and LAE dollars incurred by the insurance industry, any study of medical malpractice insurance loss and LAE leaves a significant component unaddressed if claims closed without an indemnity payment are excluded.

2. Exclusion of Open Claims

CCDs include only those claims that have been closed. Any claims that have not been closed — such as open medical malpractice claims in the discovery stage, undergoing investigation, negotiating a settlement, or progressing through a trial — would not be included in the CCD. Since medical malpractice insurance claims take several years on average from occurrence to closing, with some cases taking in excess of 10 years to close, the use of closed- claim data excludes a significant amount of information on open cases that may be more reflective of the current claim cost environment.

It is important to consider the impact of analyzing data that does not include open claims. This is especially important given the historical volatility of medical malpractice insurance costs (e.g., changes in severity trends) and the impact of recently passed legislated changes or judicial decisions that may be better reflected in open claims.

3. Relationship of Closed Claim Data and Ratemaking

For a number of actuarial reasons, including those noted here, CCDs are generally not used by medical malpractice insurers to produce rate indications. Rates developed by medical malpractice insurers generally use data that includes closed and open claims.

Actuarial Standards of Practice (ASOP) No. 9[1] on ratemaking states, "A rate is reasonable and not excessive, inadequate, or unfairly discriminatory if it is an actuarially sound estimate of the expected value of all future costs associated with an individual risk transfer." In order to produce an actuarially sound estimate, actuaries generally use more information than is available from just-closed claims.

4. Impacts of Tort Reform

It is important that any study reasonably reflect, if possible, the impact of tort reform changes on the CCD. In addition, any assumptions or adjustments to the analysis that reflect the impact of tort reforms should be discussed. Such discussions might include the number of actual post-tort reform claims included in their database, adjustments made to pre-tort reform claims for new caps, ability to properly segment data into the new cap buckets using current CCD identifier fields, ability to analyze economic versus noneconomic damages, etc.

The ability to quantify the true impact of any tort reform is complicated by the uncertainty regarding the constitutionality of reforms passed by each state legislature. Using Texas and Florida, two states with closed-claim databases that recently passed tort reforms including caps on noneconomic damages, we can illustrate the varying degrees of uncertainty. In Florida, the caps are currently being challenged in court to determine whether they will be declared constitutional. This process could take up to five or more years. At the other end of the spectrum, the Texas cap on noneconomic damages should not be subject to constitutional challenge because it was ratified by voters approving Proposition 12.

5. Changes in The Structure of the CCD Over Time

CCDs are commonly developed and maintained by state regulators through data calls to numerous reporting entities over many years. It is important for the user of the CCD to understand any changes that have been made in the CCDs format over time. It is not uncommon for databases and their fields to be periodically reviewed and enhanced. Since previously submitted data are frequently not revised, a researcher should understand the nature and timing of these enhancements, make proper adjustments to ensure consistent treatment of data, and document their handling of these adjustments in their analysis.

For example, the remapping of old fields and the addition of new fields during CCD enhancements may require reformatting older database records into the newer formats, to the extent possible. If historical database changes are not well understood by the researcher, trends developed using pre-enhancement and post-enhancement data could lead to the misinterpretation of results because of improper data comparisons.

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[1] A PDF version of ASOP No. 9 is available from the Academy's web-site www.actuary.org or by directly accessing www.actuarialstandardsboard.org/asops.htm.

6. **Changes in The Entities Reporting to the CCD**

Data may be affected by changes in the entities required to report closed claims. For example, if the CCD historically included only claims reported by insurers and a decision was made to include closed claims reported by captives or self-insureds, it would be important to consider this change in any analysis. If this change was not known or disclosed, a rise in closed-claim payments could be misinterpreted as a large increase in payments, not a change caused by new reporting entities entering the database. The converse could also be true, whereby fewer claims might be caused by fewer reporting entities.

7. **Time Period Considered For Analysis**

It is important to understand the behavior of economic circumstances (e.g., level of general inflation, impact of improving medical technology on costs, etc.) that affect medical malpractice insurance claims over time. When selecting the time period for review, the researcher must consider multi-year changes in factors affecting the frequency and severity of claims that may impact the ultimate conclusions of the analysis.

8. **Integrity of CCDs**

It is important to recognize that CCDs may not be subject to audit for accuracy and consistency. This leaves the interpretation of CCD fields up to each of the reporting entities. For example, there may be inconsistencies in how each reporting entity may itemize total loss dollars (e.g., dollars entered in total, dollars split into economic vs. non-economic damages, lost wages vs. medical costs, etc.) or how multiple plaintiffs/defendants for the same event are entered into the database. In some cases, inconsistent interpretations of data fields may be such that adjustments are necessary to form reasonable conclusions.

9. **Handling of Policy Attributes**

The interaction of deductibles, primary insurance policy claims and excess insurance policy claims that are included in the CCD should be understood. For example, if a large claim is subject to coverage under both a primary insurance policy and an excess insurance policy, it is important that the researcher re-connect the two records in the CCD to properly reflect the full value of the claim. Failure to do so could affect conclusions as to the frequency and severity of claims. Similarly, if the claim record identifies only the portion of loss in excess of a deductible or self-insured retention, the full value of the claim could be understated.

10. **CCD versus Insurer Trends**

It may be important for the user to understand the differences between the loss experience and trends among the various classes of risks in the database. Therefore, it may not be appropriate to infer CCD trends for an individual insurer without comparing the company's mix of business to the mix represented in the CCD. For example, a medical malpractice insurer that writes a heavy concentration of low-risk specialties (e.g., chiropractors, allergists, dermatologists — no surgery) may see trends that are different from those derived from reviewing the entire CCD, which includes all specialties (e.g., chiropractors, neurosurgeons, OB/GYNs), since low-risk specialties typically have minimal exposure to larger jury awards.

11. Consideration of Policy Limits Purchased by Insureds

It is important to understand the trends in policy limits purchased by physicians and hospitals over time. When selecting the time period for review, the researcher must consider multi-year changes in policy limits that may affect the frequency and severity of claims that may impact the ultimate conclusions of the analysis.

12. Adjustments to CCD Data

In general, it is helpful to a reader's understanding of a CCD-based analysis for the report to document any adjustments made to the closed-claim data that could have a significant effect on analysis results. This documentation should also include identification of the potential impacts on the final conclusions made in the analysis. Thorough documentation reduces the likelihood that the conclusions, methodologies, or assumptions of the analysis will be misunderstood by the readers.

The following <u>hypothetical</u> example demonstrates the importance of documenting adjustments.

State X is currently in the midst of a medical malpractice insurance crisis. CCD payments have been increasing at six percent a year and the number of insurers covering physicians has dropped from 20 insurers in 2000 to two insurers in 2002.

State X 2000 CCD payments:	$100 million
State X 2002 CCD payments:	$100 million x (1.06) x (1.06) = $112.5 million
2000 Active writers:	20 insurers
2002 Active writers:	2 insurers
Implied 2000 losses per active writer:	$100 million / 20 = $5 million
Implied 2002 losses per active writer:	$112.4 million / 2 = $56.2 million
Implied annual change:	$(\$56.2 \text{ million} / 5 \text{ million})^{.5} - 1 = 235\%$

The researcher in this example could use two different headlines in the final report:

Headline 1:

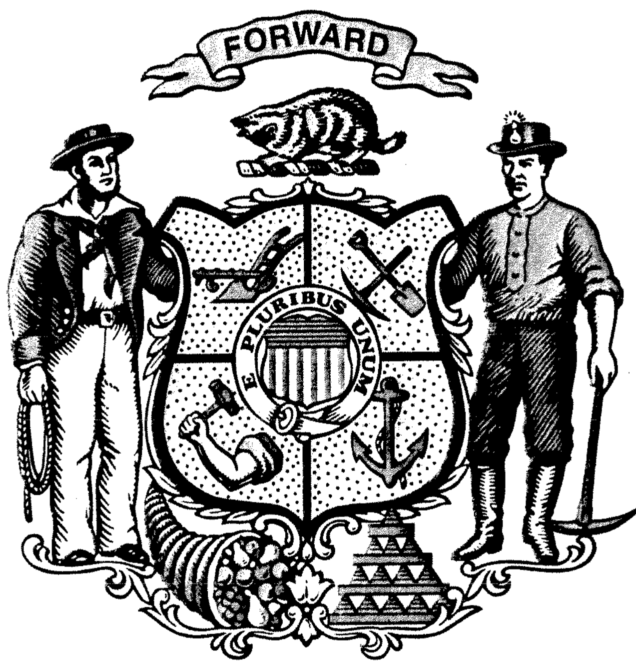
"Medical malpractice insurer severity trends increase six percent per year"

Headline 2:

"Medical malpractice insurer severity trends adjusted for declines in actively writing insurers increase 235 percent per year."

Given the difference in the above severity trends and the potential shock value of headline 2, it is easy to see how important it would be for the researcher in this example to document any adjustments made to the closed-claim data <u>and</u> to discuss the pros and cons of calculating severities adjusted for the number of active writers.

In the end, it is important for the CCD researcher to review publicly available information addressing potential issues and concerns regarding the use of a CCD. Such informational sources could include CCD documentation, discussions with insurance department personnel, special reports mandated by the governor or legislature, and Senate or House testimony. The ability of CCD researchers to discuss any assumptions and adjustments made to the data and disclose important considerations in their reports, ultimately increases the credibility of their analysis and helps to reduce the likelihood that the reports may be misunderstood.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Wisconsin Legislative Hearing

October 27, 2005

Sr. Jomary Trstensky, President
Hospital Sisters Health System

2

HSHS Statistics

- Wisconsin – FYE 6/30/2005

- Salaries	$213,000,000
- Benefits	$ 63,000,000
- Hospital admissions	34,201
- Outpatient visits	456,277

3

Hospital Sisters Health System

- Two-state System
  - Wisconsin – 5 Hospitals
  - Illinois – 8 Hospitals

Provides an opportunity to compare medical malpractice cost and administration between two states.

4

General & Professional Liability Insurance

- Wisconsin hospitals have purchased primary coverage from WHCLIP or from commercial insurance company for the past 20 years. Excess malpractice coverage comes from Patient Compensation Fund.
- In Illinois, unfavorable insurance markets led us to self-insure the primary coverage and then purchase excess coverage for medical malpractice.

5

HSHS Results

- Cost per adjusted occupied bed
  - Illinois $35.63
  - Wisconsin $10.18
  (3.5 to 1)
- Cost adjusted for 2005 WHCLIP Rebates
  - Illinois $35.63
  - Wisconsin $ 8.41
  (4.2 to 1)

Costs are for calendar year 2005. In each state costs include general liability and professional malpractice insurance costs. General liability is a small portion of the total cost.

6

Doctors Have Left Illinois

Belleville – December 2004

Loss of 30 physicians

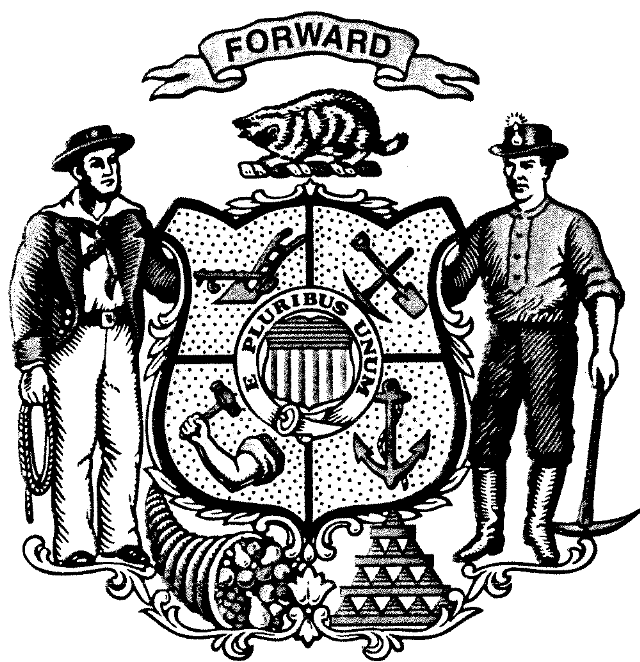
1700 inpatient admissions

12,000 outpatient admissions

4000 surgical procedures

$18 million in revenue

Decreased access to critical services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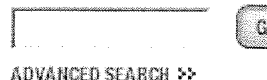

Priority Issues

UIAC Proposed Reform Bill 2005

PLAIN LANGUAGE SUMMARY OF THE UNEMPLOYMENT INSURANCE ADVISORY COUNCIL PROPOSED REFORM BILL, 2005

BENEFIT PROVISIONS

Disqualification for Failure to Give Notice of Absence/Tardiness
This bill creates a specific disqualification from benefits relating to absences and tardiness w
Employers are required to have a written policy that includes what constitutes as incident of
the process for giving notice of an absence or tardiness, verification that the employee recei
policy, one warning before discharge, and the policy is applied uniformly. Six tardies or five a
without notice within a twelve month period will result in benefit disqualification. To requalify,
must wait six weeks and have earned six times the employee's weekly benefit rate. This stat
four year sunset.

Reason: Employers desired an attendance based disqualification with a lower standard of p
standard for misconduct. This change creates a standard for requalification that is less than
misconduct and there is no loss of wage credits. Employers may still seek to establish attenc
related misconduct under the existing higher misconduct standard.

Benefit Rate Increase
The bill provides for an increase in the maximum weekly benefit rate. The increase beginnin
2006 is $12 from the current $329 to $341. The increase beginning January 1, 2007 will be $
$341 to $355.

Reason: The last benefit rate increase was in December 2002.

Benefits for Partial Unemployment
This bill repeals the wage disregard for volunteer firefighters, volunteer emergency medical t
volunteer "first responders."

Reason: Virtually all individuals who provide services to most communities as a volunteer fir
volunteer emergency medical technician or volunteer "first responder" receive compensation
services. This makes it difficult to clearly define the types of services that would be considere
"volunteer." This change would make the treatment of the benefit year and base period wage
performing these services more equitable for both claimants and employers.

Modify Work Search Requirements for Self-Employed
This bill repeals the requirement that a self-employed individual make a bona fide search for
each week to be eligible for benefits regardless of whether the individual is eligible for a waiv
requirement.

Reason: Due to prior law changes, this subsection required any self-employed person, rega
nature or purpose of the business, to search for work each week even if one of the work sea
applies. There are situations where the outside business does not limit the claimant's attachi
work in the labor market and where the individual should be given a waiver, like any other cl
qualified. Likewise, when a self-employed individual is not available for suitable work as a re
self-employment, a disqualification under the able and available provisions would be impose

Employer Fault and Benefit Charging
This bill redefines employer fault to include an employer's failure to respond to an adjudicato for information during a fact-finding interview. Any benefits paid until a new decision is made paid" unless an ALJ finds that the failure is with good cause.

Reason: The department has encountered difficulty with employers who fail to respond to re information at the initial adjudication level but then provide the necessary information at the a This failure to respond has resulted in numerous overpayments if the initial determination is The department then encounters problems and administrative costs when trying to collect th overpayments. Also many of the appeal hearings could be avoided if the employer or their a responded at the adjudication level. The department has tried unsuccessfully to work with th employers/agents to resolve this problem. The law change will provide consequences for the employer/agent's failure to respond. This provision has a two year "sunset."

Revocation of employer agent right to represent employer
This bill allows for revocation of the right of an employer agent to represent employers due to failure to provide information to the Department during a fact finding investigation. If an appe reverses and denies benefits in 5% or more of the cases appealed by an agent within a 12-n and the ALJ finds the agent's failure to provide information is without good cause, the agent' act as an employer agent may be suspended for up to one year.

Reason: The Reason for this change is the same as the employer fault and benefit charging immediately above.

Harmonize "Partial-week" and "Family and Medical Leave" Provisions
This amendment applies the partial-week disqualification to partial weeks of a family and me to partial weeks of a disqualification for a suspension if it affects only a portion of a week anc a termination occurs if it affects only a portion of a week.

Reason: This change creates a consistent and equitable method for determining benefits pa partial weeks under the related statutes.

Technical Correction – Limited Liability Companies
This bill amends the statute to fix conflicting effective dates for benefits and tax issues when department recognizes the federal election of a Limited Liability Company (LLC) to be treate corporation for tax purposes.

Reason: The intent of the department when creating this provision was to avoid payment of benefits and to avoid retroactive adjustment of benefit eligibility when recognizing the federa an LLC. However, the language that was used has led to problems in application the departr anticipate. This change would eliminate the problems while still minimizing the retroactive ac benefit claims.

Technical Correction – Approved Training
This amendment removes references to sections 108.04(2)(a) or (d) to prevent an interpreta would noncharge employers when an able & available disqualification is not imposed becaus claimant is enrolled in approved training.

Reason: Sections 108.04(2)(a) or (d) were included in error during the last bill cycle. The Cc intend to provide a relief of charges to all liable employers for benefits paid while an individu in approved training simply because the individual has restrictions other than the schooling. from charges was only intended for situations involving a separation of employment or job re specific employer.

TAX PROVISIONS

SUTA Dumping
Congress passed and the President signed the Federal State Unemployment Tax Act (SUT Prevention Act of 2004. All states are required to amend their UI laws to remain in complianc federal laws. SUTA dumping is manipulation of business transfers to obtain artificially low UI

Reason: The federal law requires that state laws mandate the transfer of UI account experie the seller and buyer of a business are owned, controlled or managed by the same interests. requires that states prohibit transfer of account experience to a new business where the prim of the purchase is to obtain a lower rate than would otherwise apply. Criminal penalties are a by federal law.

The determination or redetermination of the contribution rate for the successor will be effecti' beginning of the first quarter after the transfer of the business. The department will also have to undo a transfer of UI account experience under certain other circumstances which evince purpose to obtain a lower tax rate.

Expansion of Employer Electronic Reporting
This change would require employer agents who prepare reports for less than 25 employers department's internet reporting application. This change would also require employers repor more employees to use any electronic media to file their wage reports and the internet to file report.

Reason: Currently about 50,000 tax reports and 383,000 wage records are submitted on pa Information received on paper reports has to be manually keyed or scanned into the system savings would be realized if more information was submitted electronically.

Bad Debt Assessment for Reimbursement Employers
This amendment will require all non-profit employers who have elected reimbursement finan an assessment into a newly created account when there is a balance of unpaid and uncollec reimbursements to other non-profit employers. The assessment is equitable to the size of th organization. The maximum total amount assessed in any year is $200,000. If this is not suff reimburse the fund for the outstanding bad debts, the remaining balance will be carried over year.

Reason: Employers who have elected reimbursement financing do not pay state or federal l rather reimburse the fund directly for any benefits paid to their employees. Reimbursement e required to file an assurance of reimbursement to guarantee payment of the required reimbu along with any interest and tardy filing fees. The assurance must be equal to or greater than employer's taxable payroll and when such an employer goes out of existence, the assurance insufficient to cover the benefit charges.

When a reimbursement receivable is declared uncollectible it is charged to the UI fund's bal account which is funded by all taxable employers who pay state UI taxes. The new assessm eliminate the unpaid reimbursement charges to the balancing account.

Individual Liability for Corporate Tax Debt
This amendment allows the department to file a lien against an individual who has been four liable for a corporate tax debt.

Reason: While the statute could have been interpreted to include implicit authority to issue v against individuals held personally liable, this amendment makes that authority specific.

Changes to Levy Fees
This amendment changes the levy statute to provide that the levy fee is in addition to the lev that the fee is not deducted from the amount sent to the Department. It also increases the le for multiple-payment levies.

Reason: This change clarifies that the levy fee that is charged is in addition to the expenses incurred by the department. The change to $15 for multiple levies creates a single fee where law, there could be an unlimited number of $5 levy fees.

ADMINISTRATIVE PROVISIONS

Professional Employer Organization/Client Wage Determination
This amendment changes the definition of professional employer organization (PEO) to thos organizations that are in the business on an ongoing basis of providing staffing services as s professional employer organization statute. It also allows a PEO and its client to share respc setting wages.

Reason: The statute was originally enacted to benefit companies that routinely act as a prof employer organization. The change would still protect the PEO but close the gap that allowe organizations to act as a PEO to one of its subsidiaries. Instances were found where the par organization took part in this activity because the parent organization had a much lower une insurance tax rate or to simplify reporting.

Repeal Food Processing Exclusion
This amendment repeals the exclusion that applies to the employment of certain employees the processing of fresh fruits and vegetables solely during the active processing seasons.

Reason: Currently this statute excludes wages paid to certain individuals who work for empl processing fresh fruits or vegetables. Conditions have changed that now it is not uncommon to work for a single employer or multiple employers in more than one active season which ca The work performed by active processing season employees is basically factory work not ag work. As such, these individuals should not have to meet higher eligibility criteria than other workers.

Admissibility of Labor Market Reports (COED)
This amendment creates a statutory provision that makes the department COED reports adr prima facie evidence in UI hearings without the need for certification by an expert. These rep to determine benefit eligibility when labor market and occupational data is necessary.

Reason: The Reason for the change is to provide for the admissibility of COED reports unde specific to that document rather than under a statute not intended for that purpose and which department to rely on the fiction of "expert" certification.

Reed Act Fund – UI Administration
This amendment permits use of up to $1 million in Reed Act funds for UI administration, if ne 07. The department will consult with the UI Advisory Council before seeking any expenditure

Reason: Reed Act funds are grants to the states by the U.S. Department of Labor that may pay unemployment benefits or for administration of the UI and Employment Service program current knowledge of the funding situation for Wisconsin UI, there is a possibility that the UI need to use such funds for administration during SFY 07.

Eliminate Offset to Collect Imposter Penalties
This amendment removes the department's authority to offset benefit payments in order to r administrative assessments levies against imposters.

Reason: This change is necessary to be in compliance with federal law. Money withdrawn fr unemployment fund is to be used solely for the payment of unemployment compensation an money erroneously paid into the fund. Recovery of administrative assessments against impo unemployment funds, is not allowed under federal law. The U.S. Department of Labor has n DWD that this change is required for Wisconsin's continued conformity with federal law.

Technical Change – Sole Owner/Partner
This amendment defines "employee" as someone who performs services for pay subject to t of 108.02(12)(b). Also clarifies that a sole owner or partner is not an employee only with resp services performed for their own business.

Reason: This change codifies the department's practice to define an employee to mean an i who performs services and to agree with 108.02(15)(a) which defines "employment" as the p of services for pay.

It also clarifies that a sole proprietor or partner who provides services to their own sole propr partnership are not considered employees of that sole proprietorship or partnership. Howeve be considered employees if services are provided for pay to a business that they do not own partner.

NONSTATUTORY PROVISIONS

Study of Unemployment Insurance Fund Solvency and Financing
Under this provision the department and the Unemployment Insurance Advisory Council agr complete a study regarding the future financing and solvency of the Wisconsin unemployme fund.

Reason: This study is to determine the long-term stability of the Wisconsin unemployment r Based on this information the department and the advisory council on unemployment insura determine what measures may be needed to maintain that stability. The findings and recomr from this study will be reported no later than July 1, 2007.

Authorized Position in the Department of Justice
This provision creates and appropriates funding for a half-time position in the Wisconsin Dep Justice.

Reason: The person in this position would be responsible for enforcing those statutes relatir unemployment that provide for criminal penalties. This will allow increased prosecution of bo

and tax fraud.

Benefit Claiming Procedures
This provision directs the department to amend administrative rule DWD 129.01(1). The cha increase the time period in which a claimant can file a timely initial claim application for a giv Currently the claimant has 7 days after the week being claimed to file the application. The pr give the claimant 14 days after the week being claimed to file the application.

Reason: When a claimant files an untimely claim often it is due to a misunderstanding abou claim must be filed. Currently initial claim applications must be filed within 7 days after the w claimed but a claimant is allowed 2 weeks after the close of the week being claimed to timel claim certification. When a claimant files an untimely initial claim application, the claim must adjudicated prior to issuing a monetary computation.

The change would reduce the confusion by making the timeliness requirement for initial clair and weekly claim certifications consistent. It would also avoid the delays involved with adjud issues at the beginning of the claim.

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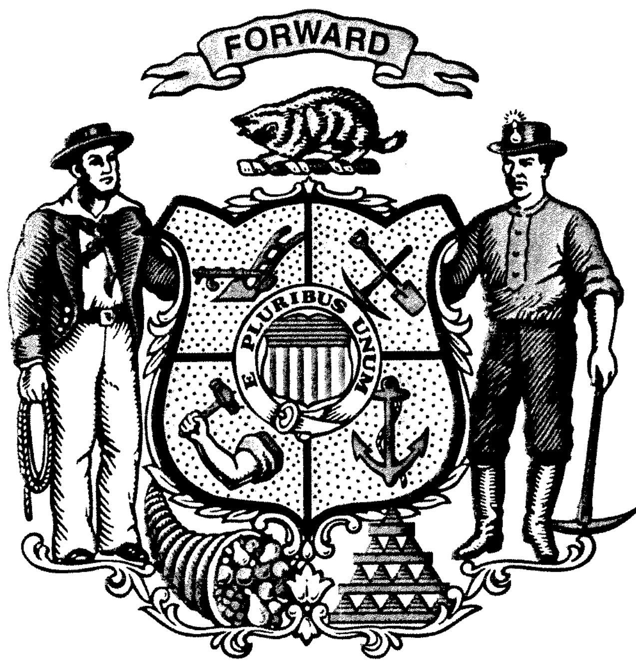
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Yale Journal of Health Policy, Law & Ethics
Winter 2005

Case Study
Question: How can the current state of medical malpractice insurance be improved?
Responses:

*357 **DEBUNKING** MEDICAL MALPRACTICE MYTHS: UNRAVELING THE FALSE PREMISES BEHIND "TORT REFORM"

Geoff Boehm, J.D. [FNa1]

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J.D.

Medical malpractice--negligence and recklessness by hospitals and physicians--injures hundreds of thousands of people each year. In 2000, the Institute of Medicine released a lengthy report, To Err Is Human, revealing that preventable medical errors result in up to 98,000 deaths in hospitals annually. [FN1] Unfortunately, lawmakers and others have focused too much on reducing liability for those preventable errors and too little on reducing their occurrence. As a result, a July 2004 study shows that over a decade in which two-thirds of states passed "tort reform" measures that limit or restrict medical malpractice lawsuits, there was no improvement in safety: The number of avoidable deaths in hospitals alone is now approximately 195,000 per year, not including obstetrics patients. [FN2] Despite these bleak statistics, when organizations like the American Medical Association (AMA) speak about a malpractice "crisis," they are referring not to the people injured or killed by medical errors or the widespread failure to discipline negligent doctors (including repeat offenders), but rather to doctors' increasing malpractice insurance premiums. [FN3]

I. The Unfounded Rhetoric of Tort Reform Lobbyists

Tort reform lobbyists seeking to limit the rights of victims of medical *358 malpractice through

caps on damages often string together various concerns about health care in the United States that are unrelated to, or would not be addressed by, the reforms they seek. In particular, the insurance industry and other tort reform proponents rely on misinformation and largely anecdotal evidence that the civil justice system is "out of control" and needs to be scaled back. [FN4] However, the facts reveal a different picture.

First, the number of medical malpractice cases being filed per capita has dropped over the last ten years, as have tort filings generally. [FN5] Even in the states that the AMA has labeled "crisis states," [FN6] the number of cases per capita has been dropping. [FN7] The vast majority of those injured by malpractice never file a claim seeking to hold the wrongdoers accountable. Even though medical malpractice kills some 195,000 hospital patients every year and injures many more, only about one in eight of those injured files a claim. [FN8]

Second, while the claim that medical malpractice cases tend to be "frivolous" is frequently heard, [FN9] proponents of that claim have failed to ***359** support it with strong empirical support. [FN10] Politicians, insurance industry executives, and medical society lobbyists often support their claim that the system is filled with "frivolous" malpractice lawsuits by citing the statistic that patients only prevail in their medical malpractice lawsuits about twenty-seven percent of the time. [FN11] Yet, a 2004 report from the Federal Trade Commission and the U.S. Department of Justice found that doctors' own lawsuits against employers and hospitals fare even worse: Doctor-plaintiffs win only fourteen percent of those verdicts. [FN12] The fact is that some types of cases are difficult to win, even when they are legitimate-- that they will have low win percentages is not a reflection of frivolity.

Our civil justice system has various checks and balances to discourage frivolous suits and punish those who file them. Not only can sanctions be imposed on the lawyers responsible, [FN13] but the contingency fee arrangement under which plaintiffs' attorneys work--they only get paid and have their expenses reimbursed if they succeed in the case--also screens out baseless lawsuits. As far back as 1986, James Gattuso, then of the conservative Heritage Foundation, wrote an article for the Wall Street Journal entitled Don't Rush To Condemn Contingency Fees. He argued that the contingency fee system ensures that injured persons who could not otherwise afford legal representation obtain access to the legal system and "helps screen [baseless lawsuits] out of the system." [FN14] Even insurance executives, when put under ***360** oath, have admitted that frivolous suits are not a problem. [FN15]

It should also be noted that the issue of "frivolous lawsuits" is a red herring when caps are being considered. By limiting award amounts, caps target the most egregious cases of malpractice and the most severely injured patients--the very opposite of the "frivolous" or "junk" lawsuits that advocates for caps portray when they are trying to rile up the public or lawmakers to limit victims' rights. Two recent studies have confirmed that caps on damages in medical malpractice cases, such as California's draconian $250,000 cap on non-economic damages, are most devastating to those who suffered the most heinous injuries, those killed by the defendants' acts, and those who suffered the greatest loss to their quality of life. [FN16]

In addition to mischaracterizing the quantity and quality of medical malpractice suits,

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supporters of tort reform make unsupported assertions about the impact of medical malpractice litigation on the quality and availability of health care. Despite the claims of the AMA and state medical societies, the number of medical professionals is growing. Moreover, these organizations repeatedly aver that doctors are leaving the twenty "AMA crisis states," and even the twenty-four "AMA problem states," in droves because of litigation concerns, resulting in a lack of access to care. However, investigations of such claims by the U.S. General Accounting Office, various reporters, and state agencies have shown the claims to be false or widely exaggerated. To the extent there are access problems, many ***361** other explanations can be established. [FN17]

For example, it is true that some rural and impoverished urban areas do not have a sufficient supply of health care providers. [FN18] But it is a fiction to tie that lack of access to malpractice litigation or jury awards, or to claim that a cap would make a difference. Such areas often have difficulty attracting or retaining other professionals as well. [FN19] Moreover, this problem has existed for a long time, even before physicians considered malpractice insurance premiums problematic. In fact, the Council on Graduate Medical Education has stated, "The relative shortage of health professionals in rural areas of the United States is one of the few constants in any description of the United States medical care system." [FN20] Rural health ***362** care shortages occur throughout the world, including places where there is nothing like the U.S. civil justice system in place. [FN21]

II. The Truth About Caps and Other Medical Malpractice "Reforms"

The increasing cost of health care in the United States and the high costs of medical malpractice insurance are legitimate and pressing concerns. [FN22] Unfortunately, caps will do little to address these issues.

First and foremost, costs related to litigation are a miniscule portion of health care spending; according to the United States Congressional Budget Office (CBO), these malpractice costs are less than two percent of total spending. [FN23] CBO has, in fact, noted that "a cap on noneconomic damages and a ban on punitive damages . . . would lower health care costs by only about 0.4 percent to 0.5 percent, and the likely effect on health insurance premiums would be comparably small." [FN24]

Tort reform advocates often claim that doctors practice "defensive medicine" because of fears of medical malpractice suits and that this practice, in turn, raises the cost of health care. [FN25] However, in 1994, the ***363** congressional Office of Technology Assessment (OTA) found that less than eight percent of all diagnostic procedures result primarily from liability concerns. [FN26] OTA found that most physicians who "would order aggressive diagnostic procedures . . . would do so primarily because they believe such procedures are medically indicated, not primarily because of concerns about liability." [FN27] Thus, the effects of tort reform on defensive medicine "are likely to be small." [FN28] The CBO has also reported that "some so-called defensive medicine may be motivated less by liability concerns than by the income it generates for physicians or by the positive (albeit small) benefits to patients. . . . CBO believes that savings from reducing defensive medicine would be very small." [FN29]

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The insurance industry, the U.S. Chamber of Commerce, and corporate front groups such as the American Tort Reform Association [FN30] have spent many tens of millions of dollars in pursuit of immunity or limitations on liability from wrongdoing. [FN31] Their efforts include promoting insurance companies' legislative agenda to limit liability for doctors, hospitals, HMOs, nursing homes, and drug companies that cause injury. Moreover, federal and state lawmakers, regulators, doctors, and the general public are being told by medical and insurance lobbyists that doctors' insurance rates are rising due to increasing claims by patients, rising jury verdicts, and exploding tort system costs in general, despite clear evidence to the contrary. [FN32] Just as caps and other tort reforms do not ***364** succeed in significantly reducing aggregate health care costs, they also fail to control individual insurance premiums.

Insurers state that to recoup money paid to patients, they must raise insurance rates or, in some cases, pull out of the market altogether. Since insurers say that jury verdicts are the cause of the current "crisis" in affordable malpractice insurance for doctors, they insist that the only way to bring down insurance rates is to limit an injured consumer's ability to sue in court. [FN33] However, historically, the cause of skyrocketing rates has little to do with the legal system.

Insurance companies make profits primarily from investment income. Insurance companies take in money in the form of premiums paid and then hold it for some length of time until they need to make a payout to, or on behalf of, a policyholder. [FN34] In the interim, the money being held, known as the "float," is invested and earns money for the insurance company. When the investment market is strong and/or interest rates high, the companies make a good profit by investing the float and may under-price policies in an effort to attract more premium dollars to invest--this scenario is termed a "soft market." [FN35] But when investment income falls because of a decline in the markets and/or drops in interest rates, insurance companies will raise their rates or cut back coverage. Such a "hard market" occurred in the mid-1970s, more severely in the mid-1980s, and again between 2002 and 2003. Insurance rates for doctors ***365** skyrocketed in each of the hard markets. [FN36]

Thus, while insurers and other tort reform proponents blame malpractice litigation for the hard market premium increases, they are in fact consistently driven by the insurance companies' response to the broader economic cycle. [FN37] In fact, claims and payouts stayed flat or declined through each of the "crises" or hard markets. [FN38] With payouts flat, rising premiums have caused property-casualty insurers' profits to skyrocket. From 2002 to 2003, profits rose 997% and they continue to soar [FN39]--reportedly doubling between the first quarters of 2003 and 2004. [FN40] Despite these striking statistics, successful lobbying by interest groups in response to increasing insurance rates for doctors has yielded a wave of legislative activity to restrict injured patients' rights to sue for medical malpractice.

Because insurers target the civil justice system, rather than the economic cycle that leads to periodic "crises," "tort reform" remedies--including caps-- pushed by insurance companies and their advocates during each hard market failed to bring down rates. [FN41] When confronted with a report showing that tort reform does not lead to reduced premiums, the American Insurance Association responded, "Insurers never promised that tort reform would achieve specific savings." [FN42] Over the past year and a half, insurers continued to raise premiums,

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even in states where tort reforms were enacted, even though claims and payouts dropped [FN43] and the *366 investment markets began to improve. It appears we are now entering a soft market: Premiums are beginning to drop or increase more slowly in all lines of insurance, including medical malpractice--in states with and without caps or other tort reforms. [FN44] While the soft market will bring some relief as premiums drop, if there is no significant increase in regulation of the insurance industry, we can expect that the next downturn in the economy and the market will bring back rising premiums and, predictably, renewed efforts to blame injured patients and seek ineffective and harmful tort reforms, as insurers once again raise their rates to make up for investment losses.

So if one puts aside the unfounded rhetoric that claims to connect a need for caps to rising insurance premiums and health care costs, to a supposedly growing number of frivolous lawsuits, and to alleged movement of doctors among the states, what then are the true motivators for tort reform proponents? First, tort reform efforts (including caps), are based on a mistrust of, or discomfort with, the American institution of civil trial by jury. This fundamental right of ordinary citizens and consumers to hold accountable those with power--including corporations, large institutions, professionals, and even government--is a fulcrum of our democracy. In fact, one reason that several state courts have struck down tort reform laws as unconstitutional is the way in which the laws limit the power of juries to decide cases. [FN45]

***367** Judges, who have more intimate knowledge of the system than anyone, find such mistrust of juries inappropriate. A 2000 survey sent to one thousand trial judges, including every federal trial judge, revealed that:

- Judges have "a high level of day-to-day confidence in [the jury] system." [FN46]
- "Only 1 percent of the judges who responded gave the jury system low marks." [FN47]
- "[N]ine of every 10 trial judges, those who work closest ***368** with the nation's jury system, think the system needs only minor tinkering, at best." [FN48]
- "Overwhelmingly . . . state and federal judges said they have great faith in juries to solve complicated issues." [FN49]
- "[N]ine of 10 judges responding said jurors show considerable understanding of legal issues involved in the cases they hear." [FN50] Statistics also show that juries are generally conservative and reasonable, and their decisions rarely differ from what a judge would decide. [FN51]

III. Recommendations

Our civil justice system exists to provide those who have been wronged a forum to seek truth and compensation, even to the dismay of those who may have acted negligently, recklessly, or worse. Caps not only limit the liability of wrongdoers, take away the fundamental power of juries to decide adequate compensation, and leave the most severely injured victims without sufficient means of redress, but they do not even address the increasing costs of health care or medical malpractice insurance.

An important solution to avoiding future spikes in premiums is stronger regulation of the insurance industry. Unlike caps and other tort reforms, insurance industry regulation would lower premiums charged to doctors, hospitals, and other policyholders, while protecting the

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rights of patients and consumers. Given the soaring profits of insurance companies, [FN52] such regulation is unlikely to put them in financial harm. *369 State insurance regulators should take the following steps, as suggested by Americans for Insurance Reform--a coalition of over one hundred consumer and public interest groups and a project of the Center for Justice & Democracy--in a recent letter sent to all state insurance commissioners:

(1) Undertake a review of rate levels to determine if rates are excessive in any line of insurance; . . . (2) Initiate an investigation into anti-competitive behavior of insurance companies in making statements and other acts to hold off competition; . . . (3) If any insurer files a rate request in excess of current inflation for that line of insurance, a rate hearing should be called; . . . (4) [B]egin the process of careful analysis as to what led to this most recent cycle, and your department's role in it by allowing rates to fluctuate between excessive (such as now at the end of the hard market) and inadequate (such as right before the turn in the market from soft to hard); . . . (5) Alert your legislature to the end of the hard market and advise them that there is no need to rush into legislative fixes, such as legal limits on victims' rights; . . . (6) Review successes from other states in averting the same sort of price spikes you may have endured over the last two years. Clearly, insurance rate regulation is one thing that has helped tremendously to prevent large rate increases in some states. Nowhere has this been more evident than in California, a state that in 1988 passed the strongest insurance reform law in the country. [FN53]

No one denies that there is a broad array of very serious health care issues facing the United States right now--patient safety, rising costs, availability and affordability of health insurance, and, in some places, rapidly rising malpractice premiums (although they are easing as we enter a soft market). But even with these problems, caps are not a solution. Lawmakers and regulators should stop the insurance industry from price-gouging their policyholders, even while the industry's profits rocket upwards. Moreover, doctors would better serve themselves and their patients by directing their anger and efforts regarding rising premiums toward the questionable practices of the insurance industry and the subset of doctors who repeatedly commit malpractice without facing adequate discipline. [FN54] Seeking to take away patients' rights is not the answer.

[FNa1]. Legal Director, Center for Justice & Democracy.

[FN1]. Inst. of Medicine, To Err Is Human: Building a Safer Health System (2000), http://www.nap.edu/openbook/0309068371/html/ (reporting only on deaths in hospitals, therefore not including those in physicians' offices).

[FN2]. HealthGrades, HealthGrades Quality Study: Patient Safety in American Hospitals 6 (2004), http://www.healthgrades.com/media/english/pdf/HG_Patient_ Safety_Study_Final.pdf ("[E]xcluding obstetric patients, we calculated that ... 575,000 preventable deaths occurred, as a direct result of the 2.5 million patient safety incidents that occurred in U.S. hospitals from 2000 through 2002.").

[FN3]. See, e.g., Donald Palmisano, AMA Past-President, Letter to Editor, N.Y. Times, July 2, 2004, at A18.

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[FN4]. E.g., Texans Against Lawsuit Abuse, Lawsuit Abuse: Patients Are Paying the Price, at http://www.sickoflawsuits.org/news/patients.cfm (last visited Sept. 23, 2004) (referring to "increasing number of lawsuits in the healthcare industry," "runaway tort system," and "lawsuit abuse").

[FN5]. Nat'l Ctr. for State Courts, Examining the Work of State Courts, 2002, at 28 (2003) [hereinafter NCSC, Examining State Courts, 2002]; Nat'l Ctr. for State Courts, Medical Malpractice Filings per 100,000 Population in 11 and 17 States, 1993-2002 (July 19, 2004) (unpublished manuscript, on file with author) [hereinafter NCSC, Medical Malpractice Filings].

[FN6]. Am. Med. Ass'n, America's Medical Liability Crisis: A National View (2004), at http://www.ama-assn.org/ama/noindex/category/11871.html.

[FN7]. See NCSC, Examining State Courts, 2002, supra note 5, at 28; NCSC, Medical Malpractice Filings, supra note 5. Ironically, the type of cases being filed ever more frequently are contract cases, which are much more likely to be filed by a business and are not affected by caps or any other "tort reforms." See Thomas H. Cohen et al., U.S. Dep't of Justice, Civil Trial Cases and Verdicts in Large Counties, 2001, at 3 (2004); Nat'l Ctr. For State Courts, Examining the Work of State Courts, 2003, at 23 (2004).

[FN8]. Harvard Med. Practice Study, Patients, Doctors and Lawyers: Medical Injury, Malpractice Litigation, and Patient Compensation in New York (1990).

[FN9]. See, e.g., Elizabeth Zuckerman, Doctors Protest Rising Medical Liability Insurance Rates, Associated Press, Sept. 23, 2004 ("[T]he immediate past president of the AMA... faults what he said is a higher number of frivolous lawsuits."). President George W. Bush apparently referred to "junk" or "frivolous" lawsuits in 224 different speeches between January 1 and November 8, 2004, and in 86 speeches in 2003. Search on Nexis, Public Papers of the Presidents Database (Nov. 8, 2004).

[FN10]. See, e.g., Alisa Ulferts, Hitch in Malpractice Deal? Bush, St. Petersburg Times, July 16, 2003, at 1B ("Florida Medical Association CEO Sandy Mortham said she wasn't in a position to say whether frivolous lawsuits caused higher insurance rates, even though the FMA has blamed such lawsuits in news releases and statements on its Web site.").

[FN11]. Lawrence Smarr, President of the Physician Insurers Association of America, has stated that a properly functioning system "would be a system where only cases with merit would be brought forward, where the trial lawyers would triage the cases so that they don't lose 80 percent of the time when they go to court.... We have a legal system that encourages the filing of frivolous lawsuits." Thomas H. Cohen, U.S. Dep't of Justice, Medical Malpractice Trials and Verdicts in Large Counties, 2001, at 1 (2004); see also, e.g., Donald J. Palmisano, President, AMA, Speech at National Press Club (July 9, 2003), http://www.npr.org/programs/npc/2003/030709.dpalmisano.html; NewsHour with Jim Lehrer (PBS television broadcast, Jan. 16, 2003).

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[FN12]. Fed. Trade Comm'n & U.S. Dep't of Justice, Improving Health Care: A Dose of Competition 38 (2004), http://www.usdoj.gov/atr/public/health_ care/204694.htm (describing antitrust health care litigation).

[FN13]. See, e.g., Fed. R. Civ. P. 11. State corollaries also provide for such sanctions.

[FN14]. James Gattuso, Don't Rush To Condemn Contingency Fees, Wall St. J., May 15, 1986, at 28.

[FN15]. E.g., Hearing To Receive Testimony from Invited Parties Regarding Medical Malpractice Before the Fla. Senate Comm. on Judiciary, 2003 Leg., C Sess. 56 (Fl. 2003) (testimony of Robert White, President, First Professional Ins. Co.) ("I don't feel you can have a frivolous lawsuit in the State of Florida."); see also Paige St. John, Testimony Reveals Malpractice Myths, Fla. Today, July 15, 2003, at 1; Ulferts, supra note 10.

[FN16]. Nicholas M. Pace et al., Rand Inst. for Civil Justice, Capping Non-Economic Awards in Medical Malpractice Trials: California Jury Verdicts Under MICRA 32-33, 47, 48 (2004) [hereinafter Rand Inst.]; David M. Studdert et al., Are Damage Caps Regressive? A Study of Malpractice Jury Verdicts in California, 23 Health Aff. 54 (2004). California's cap also has a disproportionate impact on children under a year old and females who are injured by medical malpractice. Rand Inst., supra, at 32 (female); id. at 48 (infant). Victims of medical malpractice with the severest injuries--"brain damage, paralysis, or a variety of catastrophic losses"--had their recoveries capped most often. Id. at 47. Patients who suffered "a great loss to their quality of life" but who had smaller economic damages lost the highest percentage of their total awards. Id. Death cases, where the malpractice resulted in the patient's death, are capped more frequently and have higher percentage reductions than injury cases. Id.

[FN17]. E.g., Public Citizen & Ore. State Pub. Int. Res. Group, Oregon's Increased Number of Doctors: Government Data Refutes Medical Lobby Claims 1-11 (2004), http://ospirg.org/reports/ORIncreasedNumberDoctors8_04.pdf; U.S. Gen. Accounting Office, Medical Malpractice: Implications of Rising Premiums on Access to Health Care 16-19 (2003), http://www.gao.gov/new.items/d03836.pdf; John M.R. Bull, Doctors Can't Prove Thinning Ranks: Medical Society Chief Admits Group Lacks Statistics To Show Physicians Are Leaving, Morning Call (Allentown, Pa.), Apr. 23, 2004, at A1; Diane Hirth & Bill Cotterell, Senate Experts Dispute "Myths"; Malpractice Debate, Bradenton Herald (Fla.), July 15, 2003, at A11.

[FN18]. See, e.g., U.S. Dep't of Health & Human Servs., Medically Underserved Areas/Medically Underserved Populations, at http:// bphc.hrsa.gov/databases/newmua/ (last visited Sept. 28, 2004).

[FN19]. See, e.g., S. Res. 22, 108th Cong. (2003) ("[R]ural school districts will have difficulty competing with large school districts in recruiting and retaining quality teachers."); Saving America's Great Places: The Role of Tax Incentives in Preserving Rural Communities: Hearing Before the Senate Comm. on Fin., 108th Cong. 1, 5 (2004) (testimony of Peter K. Froelich, Coordinator, Great Plains Population Symposium Project) (noting that "rural communities are

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being silently destroyed by the out-migration of young people" and that out-migration is causing "[t]he loss of our highly educated young people"); Georgeanne Artz, Rural Brain Drain: Is It Reality?, Choices, Dec. 2003, http:// www.choicesmagazine.org/2003-4/2003-4-03.htm; see also Jim Damicis, Growing the Information Technology Sector in Rural Areas, Maine Is Technology, Nov. 2003, at http://www.state.me.us/newsletter/nov2003/growing_the_information_technolo.htm (noting this difficulty as it pertains to information technology professionals); Clayton W. Faubion et al., Rural/Urban Differences in Counselor Satisfaction and Extrinsic Job Factors, J. Rehabilitation, Oct./Nov./Dec. 2001, at 1, http://www.findarticles.com/p/articles/mi_m0825/is_4_67/ai_81759712/pg_1 (noting this difficulty as it pertains to rehabilitation counselors); Nat'l Teacher Recruitment Clearinghouse, Teacher Shortage Areas, at http:// www.rnt.org/channels/clearinghouse/becometeacher/121_teachershort.htm (last visited Sept. 28, 2004) (noting that the need for teachers is "greatest in urban and rural communities").

[FN20]. Council on Graduate Med. Educ., U.S. Dep't of Health & Human Servs., Physician Distribution and Health Care Challenges in Rural and Inner-City Areas 11 (Feb. 1998), http://www.cogme.gov/10.pdf; see also, e.g., Gregg Broffman, How Can Pediatric Care Be Provided in Underserved Areas? A View of Rural Pediatric Care, 96 Pediatrics 816, 818 (Supp. 1995); Am. Acad. of Family Physicians, Rural Practice, Keeping Physicians In (2002), at http:// www.aafp.org/x16635.xml; Am. Med. Student Ass'n, Health Care Delivery: Rural vs. Urban Communities, at http://www.amsa.org/programs/gpit/ruralurban.cfm (last visited Sept. 28, 2004).

[FN21]. See, e.g., Ctr. for Justice & Democracy (CJ&D), Rural Access to Health Care-A Global Problem, Not a Lawsuit Problem (2004), at http:// centerjd.org/free/mythbusters-free/MB_Rural-International.pdf.

[FN22]. See, e.g., U.S. Cong. Budget Office, Limiting Tort Liability for Medical Malpractice 1 (2004) ("On average, premiums for all physicians nationwide rose by 15 percent between 2000 and 2002--nearly twice as fast as total health care spending per person.").

[FN23]. Id. at 6. CBO's "malpractice costs" are based on premiums paid, which is presumably the cost passed on to health care spenders (patients, health insurers, etc.). Such premiums cover all damages paid, the costs of litigation, insurance overhead, and other related expenses. See id. at 1 n.3, 6; Tillinghast Towers-Perrin, U.S. Tort Costs: 2003 Update 16-17, app. 5 (2003), at http://www.towersperrin.com/tillinghast/publications/reports/2003_Tort_Costs_Update/Tort_Costs_Trends_2003_Update.pdf; Ams. for Ins. Reform, Tillinghast's "Tort Cost" Figures Vastly Overstate the Cost of the American Legal System (Jan. 6, 2004), at http://centerjd.org/air/pr/Tillinghast_ Overstates.pdf.

[FN24]. Id. at 5-6.

[FN25]. E.g., President George W. Bush's Remarks in a Discussion on Health Care in Muskegon, Michigan, 40 Weekly Comp. Pres. Doc. 1958 (Sept. 13, 2004) ("[T]he cost of health care is skyrocketing because of the defensive medicine being practiced by docs.").

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[FN26]. Id.

[FN27]. Office of Tech. Assessment, U.S. Cong., Defensive Medicine and Medical Malpractice 1 (1994), http://www.wws.princeton.edu/cgi-bin/byteserv.prl/~ota/disk1/1994/9405/9405.PDF.

[FN28]. Id. at 18.

[FN29]. CBO, supra note 22, at 6.

[FN30]. ATRA is funded by the AMA, the tobacco industry, gun makers, and the insurance industry. See, e.g., Carl Deal & Joanne Doroshow, CJ&D & Public Citizen, The CALA Files: The Secret Campaign of Big Tobacco and Other Major Industries To Take Away Your Rights (2000).

[FN31]. Id.; David C. Johnson, Commonweal Inst., The Attack on Trial Lawyers and Tort Law 1-20, 26-51 (2003), http:// www.commonwealinstitute.org/reports/tort/tortreport.html; Am. Tort Reform Ass'n, 50 Representative Members, at http://atra.org/about/members.php (last visited Aug. 12, 2004).

[FN32]. See, e.g., Ams. for Ins. Reform, Medical Malpractice Insurance: Stable Losses/Unstable Rates 2003 (2003), http://insurance-reform.org/StableLosses2003F.pdf [hereinafter AIR, Stable Losses/Unstable Rates]; NCSC, Examining State Courts 2002, supra note 5, at 23-24, 28; NCSC, Medical Malpractice Filings, supra note 5; U.S. Dep't of Justice, Civil Trial Cases and Verdicts in Large Counties, 2001, at 9 (Apr. 2004); Press Release, Jury Verdict Research, Jury Verdict Research Releases Verdict Survey (Apr. 1, 2004), http://www.juryverdictresearch.com/Press_Room/Press_releases/Verdict_study/verdict_study8.html; Press Release, Public Citizen, New 2002 Government Data Dispute Malpractice Lawsuit "Crisis" (July 7, 2003), http:// www.citizen.org/pressroom/release.cfm?ID=1480 [hereinafter Press Release, Public Citizen] (reporting that malpractice payouts declined as insurance premiums spiked and that 5.2% of doctors are responsible for 55% of malpractice payouts). But see Press Release, Ctr. for Justice & Democracy, Flawed Jury Data Masks Trends (2002), http://centerjd.org/press/release/020322.pdf (regarding Jury Verdict Research's over-inflation of award figures).

[FN33]. See, e.g., Patient Access Crisis: The Role of Medical Litigation: Joint Hearing Before the Senate Comm. on the Judiciary and the Senate Comm. on Health, Educ., Labor & Pensions, 108th Cong. (2003) (statement of Lawrence Smarr, President, Physician Ins. Ass'n of Am.), http:// judiciary.senate.gov/testimony.cfm?id=600&wit_id=1594.

[FN34]. See AIR, Stable Losses/Unstable Rates, supra note 32, at 4-6.

[FN35]. Id. at 1-2, 4-6.

[FN36]. Id. at 4-6.

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[FN37]. See, e.g., Ralph Nader, The Assault on Injured Victims' Rights, 64 Denv. U. L. Rev. 625, 628 (1988).

[FN38]. See AIR, Stable Losses/Unstable Rates, supra note 32, at 5.

[FN39]. See Press Release, Ins. Servs. Office, Inc., & Prop. Cas. Insurers Ass'n of Am., Sharp Increase in P/C Industry's Net Income Propels Surplus Upward in 2003 (Apr. 14, 2004), http://www.iso.com/press_releases/2004/04_14_ 04.html ("The property/casualty insurance industry's net income after taxes rose to $29.9 billion in 2003--nearly ten times the industry's $3 billion in net income in 2002.").

[FN40]. See P/C Industry's Q1 Net Income Doubles, Ins. J., June 29, 2004, http://www.insurancejournal.com/news/national/2004/06/29/43661.htm.

[FN41]. See J. Robert Hunter & Joanne Doroshow, CJ&D, Premium Deceit: The Failure of "Tort Reform" To Cut Insurance Prices (2002), http://insurance-reform.org/PremiumDeceit.pdf.

[FN42]. Press Release, Am. Ins. Ass'n, AIA Cites Fatal Flaws in Critic's Report on Tort Reform (Mar. 13, 2002), http://www.aiadc.org/DocFrame.asp? DocID=7027; see also Press Release, Ams. for Ins. Reform, Industry Insiders Admit - And History Shows: Tort Reform Will Not Lower Insurance Rates (June 2, 2003), http://centerjd.org/air/pr/Quotes.pdf.

[FN43]. A.M. Best, Medical Malpractice Total Industry (Premiums and Losses), 2002 & 2003 (data set) (copy on file with author).

[FN44]. E-mail from J. Robert Hunter, Director of Insurance, Consumer Federation of America, to Joanne Doroshow, Executive Director, Center for Justice & Democracy (July 25, 2004) (on file with author) (reporting this finding based upon Council of Insurance Agents and Brokers' Commercial Property-Casualty Market Surveys); Letter from J. Robert Hunter, Director of Insurance, Consumer Federation of America, & Birny Birnbaum, Executive Director, Center for Economic Justice, on behalf of Americans for Insurance Reform (AIR), to Insurance Commissioners of fifty states and D.C. (May 11, 2004), http://insurance-reform.org/AIR_Ins_Comm_04.pdf [hereinafter Letter to Insurance Commissioners]; Press Release, Consumer Fed. of Am., Insurer Profits Shoot Up As "Hard Market" of Soaring Commercial Insurance Rates Comes to an End (Nov. 3, 2003), http://www.consumerfed.org/110303hardmarket.pdf.

[FN45]. E.g., Mahomes-Vinson v. United States, 751 F. Supp. 913 (D. Kan. 1990) (holding that a $1,000,000 overall damage cap and $250,000 non-economic damage cap violated jury trial right); Waggoner v. Presbyterian Med. Ctr., 647 F. Supp. 1102 (N.D. Tex. 1986) (holding that a $500,000 cap on medical malpractice recoveries violates equal protection and open courts guarantees); Smith v. Schulte, 671 So. 2d 1334 (Ala. 1995) (per curiam) (holding that a $1 million cap in wrongful death cases against health care providers violates both equal protection and the right to jury trial); Henderson v. Ala. Power Co., 627 So. 2d 878 (Ala. 1993) (holding

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that a $250,000 punitive-damage cap violates the right to jury trial); Moore v. Mobile Infirmary Ass'n, 592 So. 2d 156, 158 (Ala. 1991) (holding that a $400,000 economic damage cap in medical malpractice cases violates jury trial and equal protection guarantees); Smith v. Dep't of Ins., 507 So. 2d 1080, 1089 (Fla. 1987) (per curiam) (holding that a $450,000 cap on non-economic damages recoverable in actions for personal injury violates open courts provision); Best v. Taylor Machine Works, 689 N.E.2d 1057 (Ill. 1997) (holding that a $500,000 cap on non-economic damages was a legislative remittitur, in violation of the separation of powers doctrine, and constituted impermissible special legislation as did abolition of joint and several liability and discovery statutes which mandate the unlimited disclosure of plaintiffs' medical information and records); Wright v. Cent. Du Page Hosp. Ass'n, 347 N.E.2d 736 (Ill. 1976) (holding a $500,000 cap unconstitutional as a denial of equal protection); Brannigan v. Usitalo, 587 A.2d 1232, 1237 (N.H. 1991) (holding that a $875,000 limitation on non-economic damages recoverable in actions for personal injury violates equal protection); Carson v. Mauer, 424 A.2d 825, 836-38 (N.H. 1980) (holding that abrogation of the collateral source rule and the $250,000 non-economic damage cap in medical malpractice cases violate equal protection); Arneson v. Olson, 270 N.W.2d 125, 135-36 (N.D. 1979) (holding that the $300,000 limit on damages recoverable in medical malpractice actions violates state and federal equal protection guarantees); State ex rel. Ohio Acad. of Trial Lawyers v. Sheward, 715 N.E.2d 1062 (Ohio 1999) (holding that a $250,000 non-economic damages cap, a $250,000 punitive damages cap, a certificate of merit, and modification of the collateral source rule violate separation of powers); Lakin v. Senco Prods., Inc., 987 P.2d 463 (Ore. 1999) (holding that a $500,000 cap on non-economic damages in personal injury and wrongful death actions violates the right to a jury trial); Knowles v. United States, 544 N.W.2d 183 (S.D. 1996) (holding that a $1 million medical malpractice compensatory damage cap violates substantive due process); Lucas v. United States, 757 S.W.2d 687, 690-92 (Tex. 1988) (holding that a $500,000 cap for damages in medical malpractice actions violates the open courts guarantee); Condemarin v. Univ. Hosp., 775 P.2d 349, 364, 366 (Utah 1989) (holding that a $100,000 medical malpractice liability limit for state hospitals violates the right to jury trial).

[FN46]. Allen Pusey, Judges Rule in Favor of Juries: Surveys by Morning News, SMU Law School Find Overwhelming Support for Citizens' Role in Court System, Dallas Morning News, May 7, 2000, at 1J.

[FN47]. Id.

[FN48]. Id.

[FN49]. Id.

[FN50]. Id.; see also CJ&D, Judges Show Extraordinary Support for the Civil Jury System, at http://centerjd.org/private/mythbuster/JudgeSurvey.pdf.

[FN51]. E.g., Marc Galanter, Real World Torts: An Antidote to Anecdote, 55 Md. L. Rev. 1093, 1110-12 & tbl.2 (1996) (citing Mark I. Taragin et al., The Influence of Standard of Care and Severity of Injury on the Resolution of Medical Malpractice Claims, 117 Annals Internal Med.

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780, 782 (1992)).

[FN52]. Profits Are the Highest Ever, at http:// centerjd.org/free/mythbusters-free/InsProfitsHighestEver.pdf (last visited Nov. 29, 2004); Press Release, Ins. Servs. Office, Inc. & Property Cas. Ins. Ass'n of Am., Property/Casualty First-Half Income and Surplus Rose on Strong Underwriting Results and Investment Gains (Oct. 18, 2004), http:// www.iso.com/press_releases/2004/10_18_04.html; Press Release, Ins. Servs. Office, Inc. & Property Cas. Ins. Ass'n of Am., supra note 39.

[FN53]. Letter to Insurance Commissioners, supra note 44.

[FN54]. See, e.g., Press Release, Public Citizen, supra note 32 (noting that 5.2% of doctors are responsible for 55% of malpractice payouts).

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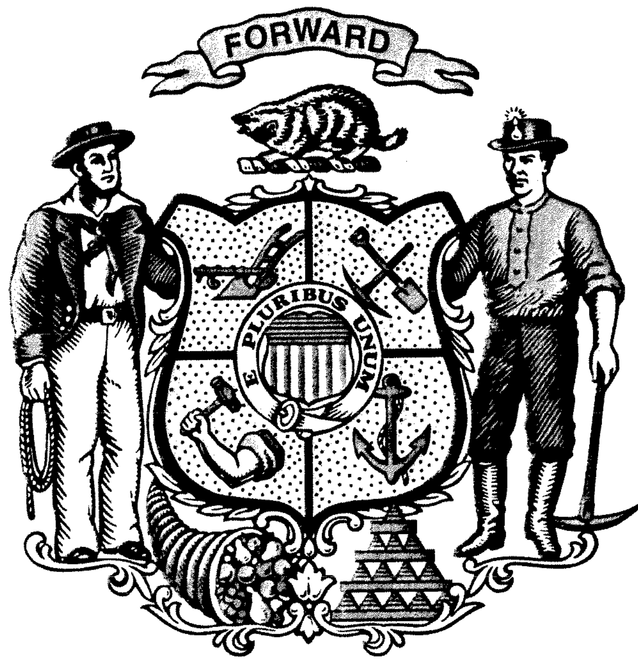
FORWARD
E PLURIBUS UNUM

2005-06 COMMITTEE HEARING INFORMATION SHEET

Welcome to the 2005-06 biennial session of the Wisconsin Legislature! We have many returning committee clerks as well as a number of individuals who will be a committee clerk for the first time. As a result, for some of you this information is a review, and for others it is new information.

I. WHERE & WHEN TO MEET

Hearing room and meeting day assignments for committees for this session have been established. The Assembly Sergeant-at-Arms memo that was previously distributed to you provides a list of the room and day assignments, the list of "even" and "odd" weeks for the biennium, and an explanation of how the even/odd week system works. If you need another copy, please contact the Assembly Sergeant-at-Arms.

All committees have been assigned a hearing day. Approval by the Speaker is required before a meeting on a non-assigned day is noticed. If for example, your committee has been assigned "Tuesday-even," the committee may only meet on Tuesdays in an even week, unless prior approval by the Speaker is obtained.

How to request permission for a hearing on a non-assigned day

In order to help avoid committee scheduling conflicts for members, please adhere to the following procedures when requesting a hearing for a non-assigned day:

- The committee chair must submit a request to the Speaker at least **two weeks** in advance of a proposed hearing on a non-assigned day. Please allow at least **three business days** for the Speaker to consider the request.

- All requests shall include: (a) the purpose for which the hearing will be held; (b) the reason(s) why it is necessary to hold the hearing in advance of a regularly-scheduled meeting day; and (c) whether an executive session will be held.

- Requests may be sent via e-mail or by letter to Ellen Nowak in the Speaker's office.

- In the event that a request is made in order to expedite legislation for floor action, please contact Bob Karius in Majority Leader Huebsch's office to coordinate timing regarding scheduling requirements for the Rules Committee and floor scheduling.

- Committee chairs are responsible for determining if committee members will be attending other committee meetings previously scheduled for the date and time in question. This verification process requires the

committee chair to first determine on which other committees the members serve.

- Committee chairs must also contact the committee chairs of potentially affected committees to determine if a committee meeting is scheduled for the date in question. Any potential scheduling conflicts must be included in the written request submitted to the Speaker.

- As a general rule, **holding a committee meeting on a session day is strongly discouraged**. Please verify the floor period schedule with Majority Leader Huebsch's office if the desired committee date falls within a scheduled floor period. This must be done before submitting the written request to the Speaker. If the committee chair determines it is absolutely necessary to hold a hearing on a scheduled floor session day, the chair must request a hearing time which would conclude before the time that the Assembly is called to the floor or request that the hearing be commenced upon adjournment of the day's floor period.

II. NOTICE FOR PUBLIC HEARINGS

Subject to some exceptions, Wisconsin law requires that government officials conduct hearings that are open to the public and that the public receives advance notice of a meeting. The relevant Wisconsin statutes are sections 19.83-19.85, 19.87-19.88. The following is a summary of the requirements set forth in the law as well as the procedures that the Assembly has established.

What Information Should a Notice Contain?
All notices must provide the date, time, place and agenda for the hearing. When possible, it is best to notice hearings on properly introduced bills. However, if an LRB draft is included on the agenda and it is introduced before the hearing, an amended notice should be sent with the number of the properly introduced bill.

If an executive session may be held on any of the items on the agenda, it should be noted on the notice.

Who Should Be Notified?
Committee chairs are responsible for notifying all committee members and the Legislative Council Attorney assigned to their committee of the hearing. It is also customary for the chair to notify the authors of the bills included on the agenda.

Copies of a hearing notice are required to be posted on the Assembly and Senate Bulleting Boards and filed with the Assembly Chief Clerk for their records and publication in the *Weekly Schedule of Committee Activities*. To be included in the *Weekly Schedule of Committee Activities*, the notice has to be filed with Jody Nussbaum of the Chief Clerk's office before Monday noon for hearings to be held the

following week. It is important for committees to have their hearing notice published in the in the *Weekly Schedule of Committee Activities*.

If a notice cannot be included in the *Weekly Schedule of Committee Activities*, it must be provided at least 24 hours before the committee meets. If the chair determines, with good cause, that the 24 hour notice requirement cannot be met, the law allows shorter notice, but not less than 2 hours under any circumstances. In such cases, the hearing notice is required to be posted as follows:

- If the notice is ready at least 26 hours before the hearing, it is required to be posted on the Assembly and Senate Bulletin Boards and sent to the Chief Clerk. It is also a good idea to send a copy to the media. The Capitol Press Room is located at 235 SW.

- If the notice is ready less than 26 hours before the hearing, it is required to be posted on the Assembly and Senate Bulletin Boards, sent to the Chief Clerk, sent to the official state newspaper, *The Wisconsin State Journal*, and the news media that have specifically requested that they be given such notice (check with the Chief Clerk's office for a list.) Again, it is also a good idea to provide a copy of the notice to the Capitol Press Room.

What if Information Changes After I send a notice?
In general, the same requirements that apply to hearing notices that are described in this memo apply to amended notices. Remember, you must prepare an Amended Notice and post in on the Assembly and Senate Bulletin Boards, send it to the Assembly Chief Clerk and send a copy to committee members. Again, it is a good idea to provide a copy of the amended notice to the Capitol Press Room.

Important Things to Remember

- Committees should always try to have their public hearing printed in the *Weekly Schedule of Committee Activities*.

- Committees should meet on their regularly scheduled hearing day. A written request to do otherwise must be approved by the Speaker.

- Amended Notices should be posted and distributed in the manner explained above.

- If you have any questions about committee procedures, please contact the Legislative Council Attorney assigned to your committee, the Chief Clerk, or the Speaker's office.