WISCONSIN STATE LEGISLATURE COMMITTEE HEARING RECORDS

2005-06
(session year)

Senate
(Assembly, Senate or Joint)

Committee on Agriculture and Insurance (SC-AI)

File Naming Example:

Record of Comm. Proceedings ... RCP

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

COMMITTEE NOTICES ...

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

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

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

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

INFORMATION COLLECTED BY COMMITTEE CLERK FOR AND AGAINST PROPOSAL

- *Appointments ... Appt*
- **

Name:

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

- *Hearing Records ... HR* (bills and resolutions)
- **05hr_ab0766_SC-AI_pt03**

- *Miscellaneous ... Misc*
- **

Wisconsin Medical Society

Your Doctor. Your Health.

TO: Members, Senate Committee on Agriculture and Insurance
Senator Dan Kapanke, Chair

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

DATE: October 27, 2005

RE: **Support** for Assembly Bill 766/Senate Bill 393

On behalf of the more than 10,000 members of the Wisconsin Medical Society, thank you for this opportunity to testify in favor of Assembly Bill 766 and Senate Bill 393. We urge the Legislature to join together and support this effort to maintain Wisconsin's status as a place where physicians can practice medicine in a stable medical liability environment. That stability means patients can have access to quality health care no matter where they live.

Wisconsin Has Avoided the National Medical Liability Crisis

The American Medical Association lists Wisconsin as one of just six states in the nation not experiencing a medical liability crisis or near-crisis (see Tab 1 for latest AMA map). Patients in those red and yellow states lose access to critical care as physicians are forced to retire early, limit their practices or move to another state. Rural areas are hit particularly hard, often with obstetricians and family practice physicians unable to deliver babies. Faced with skyrocketing insurance premiums, high-risk specialists can no longer provide trauma care or perform complicated surgeries.

Of the six AMA "currently OK" states, only Wisconsin and California do not have an absolute cap on all damages, both economic and noneconomic. The envy of physicians across the nation, Wisconsin had found the path to a stable medical liability system resulting in good patient access to care. For years, Wisconsin was a magnet for high-quality physicians.

While Other States' Patients Suffer, Wisconsin Patients Enjoy Readily-Available Care

In large part due to our stable environment for providing care, physicians were attracted to Wisconsin. Part of the attraction clearly lies in the financial ability to practice; but perhaps just as important was an environment, for the most part, free of a constant fear of lawsuits.

When reading the real experiences of what physicians endured in other states (see Tab 2), one realizes not just that other states' medical litigation environments are shockingly toxic, but that in comparison physicians see Wisconsin as an oasis. This attracts physicians here, helping at least to delay an inevitable physician shortage in our state due to an aging population, placing increasing demands on health care system.

The Caps' Removal Has Already Negatively Impacted Wisconsin's Attractiveness

The dramatic upheaval due to the Supreme Court's decision is now getting national attention. Recent headlines like the one atop a recent editorial in the *American Medical News*, the newspaper of the American Medical Association (Tab 3), hardly trumpet Wisconsin as a destination for those choosing to practice medicine. Even medical students, just beginning their decades-long careers in treating patients, express their concerns to this committee today (Tab 3). The editorial and the letter show that Wisconsin's reputation as a "safe" state and a stable place to work is in grave jeopardy.

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Facts and Data Point to "Effective Cap" Target

One of the most difficult variables stemming from the Supreme Court's decision is crafting legislation that is both reasonable and effective in restoring stability to the system. Reasonable in that it responds to the Court's concerns and finds a path to constitutionality; effective in that a cap is not set so high as to fail to provide predictability to the liability insurance system. Because both goals must be met for a cap's success, finding the "tipping point" above which stability fails has been difficult to assess.

We believe the Pinnacle actuarial report (Tab 4) commissioned by the Wisconsin Hospital Association and the Society helps guide the state to that target figure using data that shows what's happening right now across the country. When sorting the states into cap level tiers, a range for achieving maximum stability appears. The award figures in AB 766/SB 393 fall within the range Pinnacle identifies as most effective for a state's medical liability stability. Wisconsin's physicians believe it is no coincidence that an effective cap level is a critical component in a state's liability environment.

AB 766/SB 393 Show Legislature's Response to Supreme Court's Concerns

We believe the Legislature has crafted a bill responsive to a majority of the Supreme Court. Physicians and legislative leaders agree that the medical liability system needs a balance – as the *AMA* editorial puts it, "that plaintiffs aren't paid too little and doctors don't pay too much."

While other states have responded to their liability crises by capping economic damages as well as noneconomic damages, Wisconsin struck a better balance: unlimited economic damages, allowing plaintiffs to be made whole in quantifiable areas like lost wages and medical costs. In attempting to restore that balance, the Speaker's Task Force examined the issues at hand while keeping in mind that the legislative branch is not the judicial branch. A co-equal branch of government can disagree with another branch, but at the same time it must respect the duties of that branch.

The two-tiered proposal acknowledges a difference between minors and adults, much like the wrongful death statute, recently upheld as constitutional. The cap amounts fall in a range the Pinnacle study shows are likely to help stabilize the liability insurance market.

Government Often Creates Caps to Help Balance the System for All Citizens

Constitutional caps on damages are peppered throughout the state's statutes: wrongful death ($500,000 for minors, $350,000 for adults), state-employed physicians ($250,000), actions by government officials in their capacity ($50,000), volunteer fire companies ($25,000), highway defects, the no-fault worker's compensation system, etc. When government has weighed the need to cap damages for the few in order to promote stability for Wisconsin's citizens overall, limits have been ruled constitutional.

Thank you again for this opportunity to register the Society's strong support for AB 766 and SB 393. Please feel free to contact the Society on this or any other issue.

America's Medical Liability Crisis: A National View

States in crisis

States showing problem signs

Effective reforms halting crisis*

States currently OK

May 2005

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* In addition to a cap on non-economic damages, Texas voters passed a constitutional amendment.

AMERICAN MEDICAL ASSOCIATION

Together we are stronger.

Real Stories – Physicians Choosing Wisconsin

Dear Sir/Madam:

My experience as a general surgeon in Ohio is relevant to the current dilemma facing the Wisconsin legislature, regarding legislation to cap medical malpractice damage awards. The absence of tort reform in Ohio caused medical malpractice premiums to rise to a level that made practicing surgery there unaffordable. One of the major reasons for rising rates was because there were no caps on awards for "pain and suffering," hence liability exposure was unpredictable. The situation in Ohio prompted a move to Wisconsin in 2003. Wisconsin was selected solely because it was only one of six states with stable medical malpractice premiums, as rated by the American Medical Association.

I do not wish to dwell on the issue of medical malpractice premium rates, however, as I'm sure this issue has been addressed by other physicians and in other testimony. I would like to address the issue of the drain that is placed on physicians by practicing in litigious areas, and by defending medical malpractice suits. The absence of caps gives attorneys a tremendous financial incentive to file suits, as each suit essentially becomes a lottery. In Ohio, a large part of my practice consisted of consults to evaluate women for the possible diagnosis of breast cancer. As "delay of diagnosis" of breast cancer is one of the commonest excuses for litigation against surgeons, every patient presented as a potential adversary. My practice was the definition of "defensive medicine," which occurred at great expense to the patients and myself. Defending a medical malpractice suit is a tremendous drain on a physician's time and energy. Just as rising premiums restrict patient access to care by causing physicians to close practices, restrict their scope of practice or to retire, so does the threat of frequent lawsuits. After a while it is no longer worth practicing, and retirement becomes an enticing option.

The legislature has a responsibility to the citizens of Wisconsin to preserve access to care by returning the state to its former status as a model of medical malpractice stability, in order to continue to attract physicians to the state. As other states such as Mississippi and Texas are enacting effective tort reform, Wisconsin has lost its competitive edge in that regard.

Thank you for considering this information.

Sincerely,

Pamela G. Galloway, MD
Ministry Medical Group-Northern Region
Rhinelander, Wisconsin 54501

We moved to Wisconsin in March 2003. After 22 years in Cleveland, we had to leave. My premiums had gone up 500% in the last 16 years. Pam's was even more, and literally was so high as to make take home profit in jeopardy. Worse than the premiums was the psychological aspect of constant lawsuits. I did not know anyone who did not have one or more suits pending! The trial lawyers had convinced the populace that doctors were simply part of a lottery system.

Of course, the real tragedy was the negative effect on patients. We knew 14 other doctors leaving Ohio that year alone. And, that was just from 3 hospitals. My wife was head of a breast cancer program, and no replacement was found. The Cleveland clinic told me that they could not absorb my caseload. One hospital had to run operating rooms at only 50% because of anesthesiologists shortage. Two GYN docs left, and women were inconvenienced. Family practitioners had to stop delivering babies and doing minor surgeries, reducing them to mere paper pushers signing referrals to shortage prone, high cost specialists.

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The group of which I was a part quit going to the urban hospital that cared for the poor, because of liability concerns. What good is Badgercare, Medicaid, Medicare if there are no physicians to deliver it? Our lawyers state that it would take 20 or more years to undo the damage caused by the unrestrained plaintiff's attorneys for all those years in Ohio.

Christopher Magiera, MD
Wausau

Dr. Magiera later shared another story – this time about his mother:
My mother, who suffers from spinal stenosis, a very painful condition, lives outside of Rockford, IL (a state with no, until recently, tort reform). She was being treated by a member of a group of neurosurgeons from Rockford. Because of the Illinois med mal crisis, the entire group disbanded. Her doctor moved to Madison because of our favorable med mal atmosphere. The other two doctors retired.

Rockford now only has two neurosurgeons, and they are too busy to see my mother. She will most likely have to drive to Madison. However, (her doctor) will most likely not want to remain in Wisconsin.

Wisconsin must respond with ever-stronger tort reform, including reinstituting the noneconomic damage cap.

One year ago, I left beautiful Seattle to move to Green Bay. I had been in Seattle for over 10 years and never anticipated I would ever leave.

When I made the decision to leave, I was Chief of Emergency Medicine and Chief of Staff at a major downtown Seattle Hospital. I was President-elect of the Washington Chapter of the American College of Emergency Physicians and Assistant Clinical Professor at the University of Washington. So why would I give all this up to move to Wisconsin of all places?

The answer is two fold. First of all, in 15 years of practice, I have never been sued, yet I saw my malpractice premiums increase 400% over a 4-year period. This may seem insignificant, but for a hospital that had a high percentage of Medicaid and charity care, it made continuing practicing economically unrealistic.

Second, and perhaps more important, was the indirect effect of rising malpractice premiums on the ability to practice medicine. Specialists no longer wanted to take emergency call, because it meant providing very high-risk care, often for free. Obstetricians closed practices. An entire group of very good neurosurgeons had their malpractice insurance cancelled, not because of claim history, but simply because they took care of patients with broken necks and brain tumors, and these types of patients often had bad outcomes, despite the best of care.

A year ago, Wisconsin was one of only 6 states considered "safe" to practice medicine. The cap on non-economic damages and the excess compensation fund are precisely the elements needed to keep premiums stable. Not only have I seen that first hand in the year I have been here, but the joy has returned to the practice of medicine. I have all the specialists I need available when I call and they don't argue about taking a patient.

Physicians are not opposed to fairly compensating truly injured patients quickly and equitably. However, the current system is broken in most states. The lottery mentality, in which attorneys are rewarded with 40% of whatever outrageous verdict they can achieve, provides a tremendous incentive to sue and convince a jury that someone deserves $17 million over an adverse outcome. Who wouldn't pull out all stops for 40% of $17 million?

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Personal injury attorneys somehow have the ill-conceived notion that the threat of litigation serves as a deterrent to bad medical care. This could not be farther from the truth. I, and most other physicians I know, practice good medicine because of something called integrity, not because of a threat of a lawsuit. We follow a principle outlined thousands of years ago by Hippocrates called "Primum non nocere" or "first, do no harm." We are the ones who have to look the patient or his family in the eye and explain why something went wrong should an adverse event occur.

The threat of litigation has precisely the wrong effect: it makes me not want to practice medicine at all. I do the best I can for each and every patient in each and every circumstance. I make critical decisions in split second timelines. I often have to act with little or no information about a patient. Sometimes I save lives, sometimes despite my best efforts (and those of my team) some patients do not have an optimum outcome.

I would pose the following question to malpractice attorneys: would you do a job that required split second, life or death decision making if the consequence of making an unintentional error in judgment is losing your entire livelihood and everything you have worked for? This is precisely the situation in states without caps on non-economic damages.

Do not let Wisconsin become one of the states most of us left to come here. A way must be found to restore the caps!

Paul D. Casey, MD, FACEP
Medical Director
Emergency Department
Bellin Health

I have some perspectives on the liability situation that may be helpful.

I am the medical director for the emergency department at Aurora Medical Center in Kenosha as well as the President-elect of the medical staff. I am a partner in Midwest Emergency Associates, which staffs the emergency department in Kenosha as well as Aurora Lakeland Medical Center in Elkhorn, WI and staffs 4 emergency departments in Illinois and 1 emergency department in Missouri. In addition, I helped to found and currently sit on the claims committee and finance committee for EMRRG, a risk retention group domiciled in South Carolina to provide malpractice insurance for emergency medicine physicians.

Up until this point, the favorable liability climate in Wisconsin has made the daily practice of emergency medicine radically different for us than my partners practicing in Illinois. My patients in Wisconsin, at a small community hospital, have access to specialists that patients in Illinois at much larger facilities do not. We are fortunate to have a sufficient number of neurosurgeons, obstetricians, and orthopedic surgeons to provide excellent care in emergency situations. I regularly hear stories from my partners in Illinois of patients in their ERs with life-threatening neurosurgical emergencies and long delays and hassles in finding a facility willing to accept the patient.

Our group is able to attract high-quality board-certified emergency physicians because our cost for liability insurance is reasonable in Wisconsin. In Illinois our costs were rising so dramatically that if we did not take the extraordinary step of forming an RRG we would have had to leave at least one of our ERs.

I hope this has been helpful. I am available if my experience can help the cause to help maintain quality care for our patients.

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For the most part it seems that if doctors up here don't think something needs to be done, they don't do it (what a concept!) - whereas in Illinois everyone is playing the double think game of 'what if this, what if that,' ordering tests and procedures just to look good in case the absolute worst happens.

How many high dollar amount settlements will it take to make doctors in Wisconsin start practicing more defensive medicine? Probably only one or two.

Now of course I know that our medical system (and doctors, to be sure!) are not perfect, and when something happens that should not have there needs to some kind of compensation. But there has to be some kind of balance in place. The cap on noneconomic damages certainly seemed to be working – why the court struck it down while all other states are struggling to put caps in place is simply beyond my comprehension.

Jay S. Harms, MD
Random Lake

My name is Dr. Michael Didinsky D.O. I am a spine surgeon and my wife Dr. Eleanor Figuerres D.O. is an OB/GYN.

We moved to Wisconsin one month ago to join practices in Kenosha. We both trained in Chicago and have families in that area. However, because of exorbitant malpractice rates in Illinois and several other states that we were considering, we decided to move to Wisconsin. Our specialties carry the highest malpractice premiums. The thought of paying a combined total of up to 400-500 thousand dollars per year turned us to look to Wisconsin.

As reimbursement rates decrease, work hours increase, patient volume increases, stress increases, and quality of life suffers, this all begs the question "Is this worth my commitment?" I believe it is "worth it" in Wisconsin. I moved to this state because it was committed to keeping its physicians here. This is through malpractice reform among other things. If the cap is lifted, and malpractice rates increase, I have no doubt that physicians will leave, I know we would, and physicians will begin to select out patients that they deem to risky to treat. This is not the environment I would want to work or be treated as a patient.

Michael Didinsky, DO
Kenosha

I am an independent family physician in a rural area. It has become difficult enough to practice medicine in this complicated system. Although I have never had any problems with malpractice so far aside from the cost of insurance, I will have to stop clinical practice if malpractice becomes a bigger issue.
Barbara Weber, MD
Random Lake

My name is Rod Sathoff and I work as a locum tenens anesthesiologist. This means that I basically travel to work wherever they need me.

I was called to work in Madison County, Illinois because the anesthesiologists there could no longer find an insurance company to provide malpractice insurance for them and they were departing. Thinking that this

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may be about quality of care, I did go to work at the hospital there and soon realized the scope of the problem. There I discovered that it was about a crisis in insurance and not about quality of care.

Placing and keeping a cap on non-economic damages is only a start to the necessary reform.

Rod Sathoff, MD
Green Bay, WI

I trained at Cook County Hospital in Chicago, Illinois. As you are aware, that county is noted for its high malpractice awards. After graduation, I joined a private practice, Healthcare for Women. My tail coverage for working there for 20 months was around $92,000. One of the reasons that I left Chicago was the lack of tort reform.

I moved to Thomaston, Georgia and joined a group of 4 OB/GYNs. My first year in Georgia, my malpractice insurance premium was $27,000. In 3 years it grew to $54,000. My last year there, we were told that our insurance was expected to increase another $23,000. It should be noted that I have never been found liable or EVER been turned into the National Practitioner Data Bank. Because of these problems, Georgia now has tort reform.

I moved to Wisconsin 2 years ago. One of the things that made Wisconsin attractive was the caps. I have seen how without caps, the cost of health care goes up.

Curt Cornella-Carlson, DO, FACOG
Fellow American College of Obstetricians and Gynecologists
Diplomate American Board of Obstetrics and Gynecology

I am a foreign medical graduate that found home in Wisconsin. I have been practicing in Wisconsin for the last 5 years. As a minority, Wisconsin does not seem to be an ideal place to practice but after enjoying the non-economic caps for quite some time, it became practical for me to work and live in Wisconsin. When I was a resident in Illinois, I had personal experience being involved in litigation but fortunately got dropped from the case; however I have seen how settlements were unfairly handled. A patient's sister, which we had not seen, sued the group/hospital for the patient's death from ruptured aortic aneurysm. Although my name is cleared from the national database, this case haunts me every day.

Right now, if the noneconomic cap is not restored, there is no reason for me to stay in Wisconsin. My immediate family resides in Pennsylvania and my husband's family in Chicago. Both states have already tort reforms pending and approved, respectively.

My family's future depends greatly on this matter.

Ana Dimalaluan, MD
Monroe Clinic

In 1990 I moved with my family to Wisconsin to begin a career as a surgeon. I feel relatively fortunate to have had only one lawsuit brought against me since that time. However, if the cap on non-economic damages is not once again restored, my practice may have to be significantly curtailed or moved elsewhere.

Please let me know how I can contribute in this regard, as I feel this is vital to maintaining a safe environment in which to practice and to do what we all know is right for doctors and patients alike. To do otherwise would be unconscionable. Thank you.

Thomas Houting, MD, DDS
Stevens Point

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may be about quality of care, I did go to work at the hospital there and soon realized the scope of the problem. There I discovered that it was about a crisis in insurance and not about quality of care.

Placing and keeping a cap on non-economic damages is only a start to the necessary reform.

Rod Sathoff, MD
Green Bay, WI

I trained at Cook County Hospital in Chicago, Illinois. As you are aware, that county is noted for its high malpractice awards. After graduation, I joined a private practice, Healthcare for Women. My tail coverage for working there for 20 months was around $92,000. One of the reasons that I left Chicago was the lack of tort reform.

I moved to Thomaston, Georgia and joined a group of 4 OB/GYNs. My first year in Georgia, my malpractice insurance premium was $27,000. In 3 years it grew to $54,000. My last year there, we were told that our insurance was expected to increase another $23,000. It should be noted that I have never been found liable or EVER been turned into the National Practitioner Data Bank. Because of these problems, Georgia now has tort reform.

I moved to Wisconsin 2 years ago. One of the things that made Wisconsin attractive was the caps. I have seen how without caps, the cost of health care goes up.

Curt Cornella-Carlson, DO, FACOG
Fellow American College of Obstetricians and Gynecologists
Diplomate American Board of Obstetrics and Gynecology

I am a foreign medical graduate that found home in Wisconsin. I have been practicing in Wisconsin for the last 5 years. As a minority, Wisconsin does not seem to be an ideal place to practice but after enjoying the non-economic caps for quite some time, it became practical for me to work and live in Wisconsin. When I was a resident in Illinois, I had personal experience being involved in litigation but fortunately got dropped from the case; however I have seen how settlements were unfairly handled. A patient's sister, which we had not seen, sued the group/hospital for the patient's death from ruptured aortic aneurysm. Although my name is cleared from the national database, this case haunts me every day.

Right now, if the noneconomic cap is not restored, there is no reason for me to stay in Wisconsin. My immediate family resides in Pennsylvania and my husband's family in Chicago. Both states have already tort reforms pending and approved, respectively.

My family's future depends greatly on this matter.

Ana Dimalaluan, MD
Monroe Clinic

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Thomas Houting, MD, DDS
Stevens Point

I left my practice in the Western Suburbs of Chicago after 28 years in practice because I could not afford to practice. I was in the solo practice of OB-GYN and my income was negative for the last two years I practiced. I had to leave when I did because of the tail (insurance). My tail was $138,000. If I had waited until my policy renewal date, my liability tail would have been $200,000. I had a policy that covered me for 0-49 deliveries a year (low volume obstetrics and gynecology). If I had stayed, I would have had to do all 49 deliveries and the amount I made would not have covered my insurance costs, much less my other overhead.

I am now practicing part-time in Richland Center. We have had a vacation home in rural Richland County for many years, and my husband and I have chosen to make it our home. I feel that I am providing a needed service to this community doing gynecology, cesarean section call, some back-up obstetrics and obstetric ultrasound and consultations for our fine family practice physicians. However, I am now close to 60; though I enjoy what I do and would like to continue to practice medicine, I will not jeopardize my retirement security to continue to practice if the liability climate here comes anywhere near that of Illinois.

Nancy Ellen Rich, MD
Richland Center

I am a 43-year-old OB/GYN physician practicing in Green Bay since February 2003. I moved here from Pennsylvania where I had been practicing for 6 years but could no longer afford malpractice insurance. I had never been sued, yet I couldn't afford the astronomical insurance premiums.

The state of Pennsylvania was in such a crisis that many physicians were leaving or retiring prematurely. Patients were having trouble finding OB/GYNs, orthopedic surgeons and neurosurgeons. I researched the problem and found that Wisconsin was one of perhaps 5 or 6 states with the situation under good control. One of the few things these "good states" all had in common was the presence of the noneconomic cap on malpractice claims.

I was fortunate to find an excellent group of doctors to join in Prevea Clinic located in Green Bay. Now I'm in shock. I can't believe Wisconsin is taking a giant step back – in the wrong direction – after having things well controlled.

Erich Metzler, MD
Green Bay

I must state that (noneconomic damage caps) definitely was one of the reasons that I chose to contract with an associate in Wisconsin. I was shocked and appalled to hear from said associate, only weeks after accepting her offer as well as beginning my state license application, that this cap was being removed – going totally backwards!

In California (I practiced there since 1992), the cap was the single biggest advantage (amongst so few!) to staying put there, and was eventually overridden mostly keeping in mind each offer's state malpractice situation. I almost felt "used" to have signed up and then have this happen (and was told by my attorney that I'd have a legit "out" of my contract if I so decided. The fact I'm now in-state is testimony to how much I enjoyed the people I met at my April site-visit as well as the level of decisiveness of my new associate!

A "close-call" if there ever was one, and I'm hoping this will, indeed, have a happy ending – and soon!

Jeffrey W. Glassheim, DO
Oshkosh

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Jeffrey W. Glassheim, DO
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I'm a dermatologist practicing in Waukesha County, Wisconsin.

I relocated to Wisconsin from the state of Iowa 1 1/2 years ago, after having explored numerous outstanding practice opportunities from around the USA. One of the deciding factors that weighed heavily in my decision was the more favorable professional liability laws in the state of Wisconsin.

I'm certain that I would not have moved to the state of Wisconsin had I known then the action of the Supreme Court this summer. I'm certainly not encouraging my colleagues to move to Wisconsin since the Supreme Court decision.

Thorsteinn Skulason, MD
Waukesha

I came to Waupun in July 2003 from Illinois after learning that my insurance premiums were going to exceed my take-home pay. I decided to leave Illinois in December 2002 and the only states I looked for positions were those that the AMA labeled "safe": Indiana, Wisconsin, Colorado, California, New Mexico, and Louisiana. The fact that Wisconsin will drop off this list will be a great loss to residents of this state.

The practice of medicine is very different here when compared to Illinois. For the most part, the doctors here are happy. They enjoy their job and they do not live under the constant threat of litigation. Here in Waupun, it is a pleasure to be the only obstetrician at Waupun Memorial Hospital. Despite the fact that I am on call 24/7, I enjoy providing service to a population that would undoubtedly be without an ob/gyn in a high risk liability environment where, quite frankly, it wouldn't be worth the hassle to practice here.

When I came to this state, I referred to it as "enlightened." The people here solved issues with access to medical care years ago with the establishment of caps on non-economic damages. I strongly doubt the doctors in this state would find a work environment similar to that which exists in Illinois acceptable. If insurance premiums rise and lawsuits escalate, early retirements and difficulty with recruitment will quickly limit access to medical care in the rural communities.

Scott Hansfield, MD
Waupun, WI

I am an obstetrician-gynecologist who moved here from Pennsylvania in June 2002. I have a wife and five children. We left all of our family and friends in Pennsylvania solely to escape the liability crisis in that state. My main goal in life is to be able to put my children through college. I don't desire fancy cars or expensive vacations. Unfortunately, the liability crisis in Pennsylvania made it impossible for me to put money into my children's college funds.

My partner and I in Pennsylvania were never involved in a lawsuit during the six years that I practiced there. That did not prevent our malpractice insurance rates from skyrocketing. Over my last three years there, our rates went up 60%, then doubled, then went up another 40%. We were traveling to other towns and taking call every other night and every other weekend, but our income continued to decline sharply. We could not even consider getting a third partner. To be honest, there are few good obstetrician-gynecologists available in a state like Pennsylvania at this point, anyway. Again, this is due to the liability crisis. (My ex-partner found a new partner, but he is leaving Pennsylvania in November of this year.)

When I talk to people in Wisconsin, it blows their minds that I would leave the state in which I was raised because of the liability crisis there. I explain that it was not economically feasible to continue practicing there. Actually, my family and I love Wisconsin, so I looked at it as a blessing in disguise. That was until the caps were removed here.
I am now seriously concerned that Wisconsin will become like Pennsylvania (and like so many other states). I see no way that this will not happen unless the caps are re-instated. It is not a coincidence that the few states in the nation not in crisis all have caps on non-economic damages. There is very good reason that so

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many other states are trying to institute such caps. I find it hard to believe that our caps have been removed. It seems that our state supreme court doesn't truly grasp the severity of the crisis in states like Pennsylvania.

Please, re-instate the caps on Wisconsin's non-economic damages. This has been a wonderful state in which to live, and in which to practice medicine over the past three years. I know several other doctors who have moved here from Pennsylvania and who feel the same way. I have been able to start making contributions to my children's college funds, my children are happy, and my wife and I would like to live here for the rest of our lives. We learned a valuable lesson in Pennsylvania, though. It won't take us six years to figure out that obstetrics and gynecology is no longer a viable profession here when the malpractice rates begin to skyrocket. I am absolutely convinced that re-instating the caps is the most important step to prevent this from happening.

Robert D. Moyer, Jr., M.D., F.A.C.O.G.
Green Bay

I am quite interested in seeing the caps on medical liability restored in Wisconsin. I taught Family Medicine for 3 years in Kentucky and also worked in a busy ER there for 3 years. The public is generally unaware of how badly medical liability concerns erode their access to quality healthcare.

For example, a patient might show up with chest pain and in most States this forces a huge and mostly unnecessary evaluation to protect the physician from liability. When the workup is done the patient is sent home with a 4-5 thousand dollar medical bill and having had nothing done to help with their symptoms.

Further and most importantly to Wisconsin is the easy and local access to obstetric care that families here enjoy. In Kentucky it is now typical for many counties to have no way to deliver babies and for women to have to drive 60 to 90 miles for obstetric care. I last heard there were only 223 OB providers left in all of Kentucky and that these numbers were declining.

There is no reason left in much of medicine and medical care costs due to medical liability concerns. I came to Wisconsin specifically because of the favorable medical liability climate. In the relocation process I was hounded by recruiters from Illinois. I have no plans to ever practice Medicine in a high liability area again. I hope you understand my feelings about how important Medical Liability reform is.

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Opinion

Wisconsin opens door to liability crisis

Some physicians in states recently ravaged by soaring medical liability insurance rates have been picking up and moving their practices to Wisconsin, a safe haven for two decades as a state with caps on noneconomic damages awarded in malpractice lawsuits. At least it was — until two months ago, when the Wisconsin Supreme Court stripped the state's doctors of that protection.

In a 4-3 decision, the court said it didn't see a connection between the adjustable cap — which stood at $445,775 at the time of the ruling — and the legislative intent of "compensating victims of medical malpractice fairly." But a fair law would ensure that plaintiffs aren't paid too little and doctors don't pay too much. Without caps, though, the system goes off kilter, with plaintiffs' lawyers aiming to lead juries to return irrationally large verdicts.

And the majority of justices said they didn't see a specific connection between the cap and the idea that it keeps liability insurance premiums low.

They didn't see a connection? The AMA lists 20 states in the midst of a medical liability insurance crisis, with rates that have doctors retiring early, discontinuing high-risk procedures or fleeing to another state with a better insurance climate. Only six states make the AMA's "OK" list. The thing those states have — or should we say *had* — in common was a cap on noneconomic damages.

Wisconsin has been "OK" since the list's inception in June 2002. The question now is whether it can remain OK.

It can. But lawmakers at the state and federal level need to act quickly. They need to pass noneconomic damages caps.

At the state level, doctors and some politicians are doing their part to bring back the cap.

The Wisconsin Medical Society created a Web site *(http://www.keepdoctorsinwisconsin.org/)* that informs residents what could happen if the state goes without a cap for too long. In addition, State Assembly Speaker John Gard formed a task force to study the issue. Already citizens are behind the cap, with a medical society and Wisconsin Hospital Assn. poll showing that 66% of 500 likely Wisconsin voters agreed that the state should cap noneconomic damages "to prevent both higher health care costs associated with frivolous lawsuits and unnecessary medical testing."

Legislation is expected to pass the Republican-dominated Legislature by Thanksgiving. But it is unclear whether the state's governor, a Democrat, would sign a bill. If he does, doctors want to prevent the court from tossing out the cap again, so WMS is pursuing a constitutional amendment that would deem the cap legal.

Of course, if Congress would pass national tort reform, it would stop this state patchwork of laws that are a determining factor of where some doctors set up practice. The House repeatedly has passed legislation with a $250,000 noneconomic damages cap, most recently approving a bill in July. But proposals have stalled in the Senate again and again, and it looks like the latest effort is going nowhere again this year.

Insurance rates didn't go up in Wisconsin overnight. But settlements are already up.

There's one report of a plaintiff lawyer who had reached a settlement agreement a week before the state Supreme Court decision now calling the defendants back and saying he would settle only if the agreed-on amount was doubled. Also, those seeking to recruit doctors already are reporting that they're getting questions from physicians concerned about what insurance rates will do in the coming years without caps.

Before Wisconsin becomes the liability wasteland that 20 other states are, it's time for the state government again to pass tort reform that includes a cap that will be held constitutional and keep Wisconsin as a place physicians can go for shelter from high medical liability premiums.

Better yet, Congress should pass tort reform so doctors can practice where they want, not just where the insurance rates are affordable because a state has a noneconomic damages cap. ◆

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TO: Members, Senate Committee Agriculture and Insurance
Senator Dan Kapanke, Chair

FROM: Jaime Hook – Student and President, Medical Student Association
Nick Maassen – Student and Board Member, Dane County Medical Society
University of Wisconsin Medical School

DATE: October 27, 2005

RE: **Support** for Assembly Bill 766 / Senate Bill 393

Thank you for this opportunity to testify in support of Assembly Bill 766 / Senate Bill 393. As future physicians, we care about restoring caps on noneconomic damages in Wisconsin because we understand that caps are an integral component of a stable medical liability system – a system that unavoidably will be part of our careers.

About three-fourths of the Class of 2008 is from Wisconsin, and history shows that a large number of UW medical students will one day be practicing Wisconsin physicians. Our medical students are a diverse group with an assortment of political ideologies. However, issues surrounding medical liability affect all future physicians.

Although it is unlikely to be the ultimate determinant, medical liability will be a factor in deciding where we live and work. It is true that we are concerned about the impact on medical malpractice insurance rates for both general and specialty care. Substantially more significant, however, is our apprehension of practicing medicine in a litigious environment. We fear such conditions will stand in the way of providing quality patient care by limiting physician access, increasing the frequency of malpractice suits, and changing the dynamics of the patient-physician relationship. Ultimately, a poor liability climate negatively impacts Wisconsin residents seeking affordable and reliable healthcare.

We realize that, as medical students, we cannot report statistics and research to convince you that the medical liability climate is an important factor in the future of medicine. We can, however, offer our feelings and our insight into the challenges that await medical students, as well as express hope that you will consider the impact of this issue on future Wisconsin physicians.

Thank you, again, for your time and consideration.

The Potential Impacts of Caps on Non-Economic Damages in Medical Malpractice Insurance in Wisconsin

September 2005

Pinnacle Actuarial Resources, Inc.
2817 Reed Road, Suite 2
Bloomington, Illinois 61704
(309) 665-5010

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EXHIBITS

The Potential Impacts of Caps on Non-Economic Damages in Medical Malpractice Insurance in Wisconsin

Executive Summary

For states struggling with medical malpractice insurance affordability and availability crises, the state of Wisconsin has long been viewed as a model state. This is due to the ability of the state's broad set of legislative reforms to provide stable and affordable premiums for healthcare providers and a stable environment for insurers. One of the foundational elements of Wisconsin's reforms, the cap on non-economic damages, was recently found to be unconstitutional. The Wisconsin Supreme Court in *Ferdon vs. Wisconsin Patients Compensation Fund* found that the cap violates the state's equal protection guarantees. The court also stated that the ruling does not impact the state's damage cap in wrongful death cases. This decision has led to questions regarding the impact the elimination of the caps may have on coverage availability, affordability and market stability.

Through a review of both publicly available and proprietary data sources, Pinnacle Actuarial Resources, Inc. (Pinnacle) has come to a number of key conclusions regarding the impact of the presence or absence of caps on non-economic damages on the Wisconsin medical malpractice liability environment. The highlights of our findings as regard the various issues include:

- While all caps on non-economic damages reduce losses, the impact diminishes as the size of the cap increases. A cap of $250,000 eliminates approximately 25% of unlimited losses, a $550,000 cap eliminates about 15% and a $1 million cap eliminates about 7%.

- States that have predominantly operated over the last decade with either low ($250K) or medium ($250K-$550K) caps on non-economic damages overall have significantly better insurance company loss ratios and combined operating ratios.

- States that have predominantly operated over the last decade with either low ($250K) or medium ($250K-$550K) caps on non-economic damages overall have more competitive

insurance markets as measured by the number of insurance companies providing coverage in the state.

- States that have predominantly operated over the last decade with either low ($250K) or medium ($250K-$550K) caps on non-economic damages overall have medical malpractice insurance premiums that are much lower than the premiums in states that do not have effective caps.

- The Wisconsin medical malpractice insurance market has significantly outperformed most states in terms of both the affordability of medical malpractice rates and insurance company operating results.

In summary, states with damage caps are more attractive to both current and prospective insurers. This is due in part to the cap on one of the least predictable and most volatile elements of medical malpractice claim costs (i.e. the non-economic portion of high severity, permanent disability claims). This makes losses and therefore rates more predictable.

Similarly, states with damage caps are more attractive to current and prospective health care providers. This is because providers in states with effective caps:

1. have current rates lower than providers in states without effective caps,
2. have had more stable rate levels over the last several years, and
3. more insurance carriers competing for their business

This suggests that healthcare providers find medical malpractice insurance costs more affordable and coverage more available in states with effective caps.

Background

Pinnacle Actuarial Resources, Inc. (Pinnacle) has been retained by the Wisconsin Hospital Association (WHA) and the Wisconsin Medical Society (WMS) to perform analyses of the impact of the presence or absence of caps on non-economic damages at various levels. Specifically, they would like assistance evaluating the impact of:

1. Caps on non-economic damages on claims data from states without caps, and
2. Experience of other states based on the type of cap applicable in the state.

Pinnacle is an Illinois corporation that has been in property and casualty actuarial consulting since 1984. Our 14 consultants make Pinnacle one of the 10 largest property/casualty actuarial consulting firms in the U.S. We specialize in insurance pricing, loss reserving, alternative markets, legislative costing and market analysis and financial risk modeling. Our headquarters are located in Bloomington, IL.

Pinnacle has established a reputation as a provider of unbiased, independent, actuarially sound analyses and reports. This reputation is demonstrated in the variety of clients that have engaged us for projects similar to this one. Clients that have engaged Pinnacle in legislative costing and market evaluation assignments have included insurance industry associations (e.g. NAII, AIA), insurance departments and governmental panels (e.g. Connecticut, Maine, Ohio, Oregon), government insurance programs, (e.g. Virginia), trade associations (e.g. Oregon Medical Association, Illinois Hospital Association) and insurance companies. Pinnacle may be unique in the breadth of parties involved in the medical malpractice insurance system that have engaged us. A list of relevant research and client-related publications follows.

Relevant Pinnacle Reports and Research

- "A Report on Factors Impacting Medical Malpractice Insurance Availability and Affordability", Oregon Professional Panel for Analysis of Medical Professional Liability Insurance, October 2004 (www.pinnacleactuaries.com/pages/publications/files/saiffinalreport.pdf)

- "Final Report on the Feasibility of an Ohio Patients Compensation Fund", Ohio Department of Insurance, May 2003 (www.ohioinsurance.gov/Legal/REPORTS/FinalReportOhioPatientComp.pdf)
- "Preliminary Report on the Feasibility of an Ohio Patients Compensation Fund", Ohio Department of Insurance, February 2003 (www.ohioinsurance.gov/Legal/Reports/Prelim_Patient_Compensation_Report_03-03-03.pdf)
- "The Case of the Medical Malpractice Crisis: A Classic Who Dunnit", Casualty Actuarial Society Discussion Paper Program, Spring 2004 (http://casact.org/pubs/dpp/dpp04/04dpp393.pdf)
- "The Impact of Medical Malpractice Litigation On the Health Care Consumer", A Report to The PLUS Foundation, Summer 2004

Data Sources

A number of data sources were used in the development of this analysis. The data sources relied upon included the following categories:

1. Oregon, Maine, and Florida Closed Claims Database
2. Medical Malpractice Rates and Rate Filings
3. Insurance Company Financial Statements
4. State Statutory and Regulatory Provisions for Medical Malpractice

A brief description of the data sources utilized in each area along with a description of the key data elements and potential limitations of the data follows for each category.

Closed Claims Databases

Statewide closed claim databases are valuable resources for the development of legislative costing estimates in medical malpractice. For this analysis, Pinnacle has relied on databases from the states of Oregon, Maine, and Florida. These databases were selected because the data was readily available, easily accessible and robust in the sense that several years of data for the vast majority of a state's medical malpractice claims experience was available. The use of these databases has enabled us to develop a range of estimated impacts of caps on non-economic damages at various levels which reflect some differing judicial systems and at the same time demonstrate a significant consistency in the estimated reductions in expected losses created by the caps.

In a previous study on behalf of the Oregon Professional Panel for Analysis of Medical Professional Liability Insurance, Pinnacle worked with a number of medical malpractice insurance companies in the state and the Oregon Medical Association to develop an independent, Oregon medical malpractice closed claims database. With these parties' permission Pinnacle has used this database to evaluate the impact of several of the proposed legislative changes. For more information on the specifics of this database, please refer to Pinnacle's earlier report for the Oregon Professional Panel. (www.pinnacleactuaries.com/pages/publications/files/saiffinalreport.pdf)

As a result of the 1977 Maine Health Security Act, "Every insurer providing professional liability insurance in this State to a person licensed by the Board of Licensure in Medicine or the Board of Osteopathic Licensure or to any health care provider shall make a periodic report of claims made under the insurance to the department or board that regulates the insured." This data has been compiled and provided in an electronic format for Pinnacle's analysis by the Maine Bureau of Insurance. For more information on the specifics of this database, please refer to Pinnacle's earlier report for the Maine Bureau of Insurance.

The Florida Department of Insurance has been collecting data on individual medical malpractice claims since 1975. This data contains tremendous descriptive detail about the claim damage amounts, but also about the characteristics of the claim itself. We have chosen to examine claims in the state of Florida that closed during the period from January 1, 1993 through March 1, 2003. This produced 21,639 individual claim records. For more information on the specifics of this database, please refer to Pinnacle's earlier report for the Ohio Department of Insurance.

In all three cases, losses were trended at an annual rate of 7%. The trend factor was selected after a review of recent rate filings from a variety of leading insurers in a variety of jurisdictions, including Wisconsin. In many cases, medical malpractice closed claim data does not contain a split between economic and non-economic damages. We reviewed the closed claim information that is publicly available from the Texas Department of Insurance which does contain the split between economic and non-economic. Based on this data approximately 65% of the total claim amount is due to non-economic damages for claims that closed for amounts between $250,000 and $2 million. For claims greater than $2 million the portion of the claim representing non-economic damages was 50%. Additional data sources such as the Florida Closed Claim database and other industry studies indicate that non-economic damages range from 50% to nearly 70% of the total claim amounts. Unless specific claims detail was available, we have assumed that 60% of claims values, excluding allocated loss adjustment expenses are non-economic damages.

The American Academy of Actuaries has provided guidance on the limitations of using closed claims databases. This guidance can be found at www.actuary.org/pdf/casualty/medmal_042005.pdf. Readers of this report are advised to be aware of these limitations. In spite of these cautions,

closed claim databases such as those used in this analysis remain the most readily available source of large volumes of medical malpractice claims applicable for evaluating the impact of caps on non-economic damages and other legislative changes and are widely used and accepted. These data sources represent states with a variety of different approaches to medical malpractice liability law. While none of the states have a current medical malpractice environment perfectly identical to the climate that exists in Wisconsin subsequent to the *Ferdon* decision, the consistency of the analysis results between the various states suggests that closed claim data are valid for the purpose of estimating the impact of non-economic damage caps. One example of the differences between the states is Maine's mandatory medical review panels. Another is Florida's judicial system which has created a very difficult climate for medical malpractice liability claims that has resulted in a large number of high severity claims. Overall, it appears that the information available in Oregon is most suited to estimating the impact of caps on non-economic damages in Wisconsin. The Florida data may slightly overstate the impact of the damage caps due to the greater frequency and severity of large losses.

Coincidentally, Oregon is another state that has experienced a Supreme Court ruling finding that non-economic damage caps are unconstitutional. The significant rate increases, reduced coverage availability, deteriorating industry operating results and reduced competition in Oregon are troubling evidence of the impact removing damage caps can have on a stable medical malpractice insurance market.

Medical Malpractice Rates and Rate Filings

A tremendous resource for historical rate levels of key insurers in all states is the Medical Liability Monitor. This publication conducts an annual survey of the leading medical malpractice insurers in all 50 states. The information that is requested is mature claims-made rates with limits of $1 million/$3 million (occurrence/aggregate). The Medical Liability Monitor provides rate level information by state for three large physician specialties (internists, general surgeons, and OB/GYNs). Typically data from several insurers is available in a given state. This information is a widely recognized and accepted resource.

Pinnacle has performed an internal analysis of the last nine years of Medical Liability Monitor

data to create an assessment of current insurance industry rate levels by specialty and state as well as average annual rate changes over the period. We attempted to track the rate changes of the largest insurer in state that provided data to the Medical Liability Monitor over the entire nine year period as a measure of rate level changes over the period. Generally, this was the largest or second largest insurer by market share. In a few states, data for a single insurer was not available for the entire period and a judgmental adjustment to reflect the change in leading carriers was necessary. In states where the limits were not typically provided due to coverage from a patient compensation fund or other factors, an estimated adjustment to get the rates to a more "apples to apples" basis was made using available PCF rates and other information. This was used to evaluate the current affordability of medical malpractice coverage by state.

A couple of caveats about this approach to industry rate levels are necessary. First, the current rates for one leading writer of medical malpractice for three specialties in each state are not a precise measure of overall rate levels for the entire industry. Medical malpractice insurers do not move in concert with one another and a leading insurer may have rates that differ materially from other insurers in the state. However, the rate levels of one of the two largest insurers in the state does serve as a reasonable proxy for industry rate levels which are impractical to measure. One complicating factor in this assessment is that other rating factors, including limits purchased and self-insured retentions selected, movement from traditional insurance to self-insurance, and the impact of claims-free credits and experience rating changes are not measured in manual rate changes. Still, the most significant factor influencing health care provider premiums are manual rate level changes.

Insurance Company Financial Statements

In evaluating the relative profitability of both individual medical malpractice insurers and the medical malpractice insurance industry in various states, Pinnacle relied heavily on insurance company annual financial statement data compiled by the A.M. Best Company. Pinnacle examined premiums, losses, loss adjustment expenses and underwriting expenses by line and state. This information was aggregated across all insurers to produce industry composites.

One of the complications of using this data source is that it is limited to carriers that have an

A.M. Best rating. Several writers of medical malpractice insurance, including leading writers such as Northwest Physicians Mutual Insurance Company in Oregon, are no longer in the annual statement databases. For some significant insurers, Pinnacle added data directly from company annual statements to the A.M Best data to produce more accurate industry composite results.

State Statutory and Regulatory Provisions for Medical Malpractice

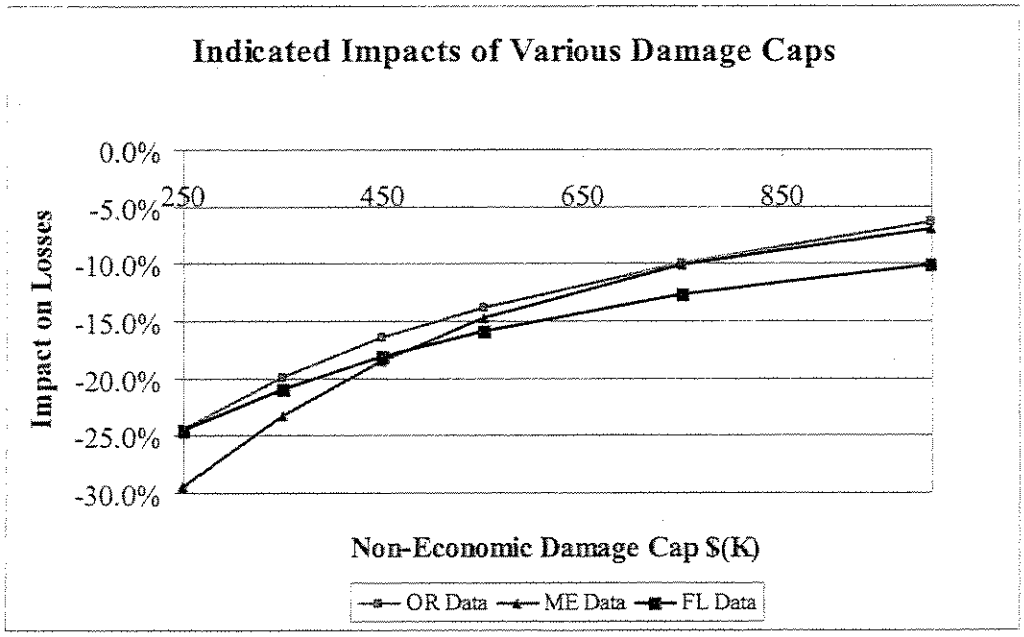
A thorough understanding of the current statutory caps on non-economic damages and any significant changes in these caps over the last decade by state was viewed as essential to providing a meaningful summary of both the presence or absence of damages caps in other states and also the impact these caps have had on the availability and affordability of premiums and insurer loss ratios and combined operating ratios. States with both non-economic damage caps and total caps, e.g. Colorado, were assigned to the state to which their non-economic cap belongs. States with only total damage caps, e.g. Indiana, were given judgmental assignments to the group that their caps most appropriately matched. Reassigning or removing the states with total caps did not materially impact the overall findings of the analysis.

We relied primarily on two resources in compiling information on applicable caps in each state over the last decade. One resource is the website of the law firm of McCullough, Campbell & Lane (www.mcandl.com) which provides a concise summary of many medical malpractice statutory features by state along with the relevant legal citations. The other resource is the website of the American Tort Reform Association (ATRA) which provides a detailed summary of Civil Justice Reforms by State. This information includes both currently active legislation and historical changes. We have followed categorizations of states by non-economic damage caps as Low ($250,000), Medium (between $250,000 and $550,000) and High (greater than $550,000) as they appear to provide reasonable groupings of states with comparable industry conditions. These groupings were recently published in an article in the September 2005 Best Review entitled, "Doctors' Orders", which utilized ATRA data. Pinnacle has used information from both of these resources as a reference in several previous projects and found them to be reliable and accurate.

Discussion and Analysis

While all caps on non-economic damages reduce losses, the impact diminishes as the size of the cap increases. A cap of $250,000 eliminates approximately 25% of unlimited losses, a $550,000 cap eliminates about 15% and a $1 million cap eliminates about 7%. In order to estimate the impact of a cap on non-economic damages, Pinnacle's analysis started by trending the closed claims in the Oregon, Maine and Florida closed claims data set by an annual rate of 7% for indemnity payments and ALAE payments. As noted above, the trend factor was selected based on a review of recent rate filings from leading insurers in a variety of jurisdictions, including Wisconsin. Losses were trended assuming that the non-economic damage caps would begin to apply on January 1, 2006. Exhibit 1 summarizes the results of this analysis.

The results of applying non-economic damage caps ranging from $250,000 to $1,000,000 are remarkably similar for all three databases. A cap on non-economic damages of $250,000 results in an estimated reduction in losses and allocated loss adjustment expenses (ALAE) of between 24.5% and 29.5%. This steadily decreases as the cap increases until the $1 million cap only eliminates 6.3% to 10.1% of total loss and ALAE. We also believe the results in Florida may overstate the likely impact of this high of a cap in Wisconsin due to significant differences in the judicial systems in the two states. The results of this analysis are shown graphically below.



The reverse of this finding is also true. That is we expect that the removal of the Wisconsin caps on non-economic damages which were at approximately $450,000 are likely to increase expected losses by between 18% and 22%. Because of the role played by the Wisconsin Injured Patients and Families Compensation Fund (IPFCF) as the excess coverage provider in the state we expect it will bear a significant portion of the increase losses created by the elimination of the caps. Our analysis suggests that insurance company rates will need to increase by between 12% and 15% while IPFCF assessments may need to more than double. Note that this will reduce the impact on primary insurance company rates but not on health care provider costs as they are responsible for IPFCF assessments as well as their insurance premiums.

This increase in medical malpractice insurance costs will likely involve a single rate correction or potentially a single rate change followed by additional adjustments as the impact is better understood and more data is collected. However, the potential for increased variability in insurance company loss results and increases in loss severity inflationary trends also present the risk of additional rate increases and deterioration of industry loss results. This behavior has been manifested in a number of states without effective caps on non-economic damages and will be discussed later in the report.

The extent to which these estimated cost reductions will be realized depends on a number of issues. The cost reductions do not reflect the potential impact of judicial challenges of damage caps which could delay or reduce the realization of the potential savings. In addition, there is a potential for the migration of some non-economic damages to economic damages. For example, damages paid to the family of a deceased mother who had no outside income can be broadly awarded as pain and suffering, or non-economic damages. If caps are put in place, the costs of the services that can be replaced may be more fully itemized and listed as economic damages. Furthermore, there is no consideration in this analysis of indirect effects such as reductions in claim frequencies due to the cap or reductions in ALAE due to reduced settlement delays created by the caps. These indirect effects are quite difficult to quantify and generally would lead to our estimates being somewhat conservative, i.e. potentially understating the impact of the caps.

This inability to quantify indirect effects of non-economic damage caps based on closed claims data suggests that an additional approach is also needed. Therefore, Pinnacle has compiled industry rate, premium and loss data by state so that state experience by different categories of damage caps can be compared.

States that have predominantly operated over the last decade with either low ($250K) or medium ($250K-$550K) caps on non-economic damages overall have significantly better insurance company loss ratios and combined operating ratios. Exhibits 2 through 4 summarize three important measures of the health of an insurance market: loss and defense and cost containment expense (DCC) ratios, combined ratios and market concentrations by the type of damage cap that exists in a state. Loss and DCC ratios are the ratio of losses and defense and cost containment expenses as a percentage of premium earned. The combined ratio starts with the loss and DCC ratio and adds ratios of both other loss adjustment expenses and underwriting expenses to premium. When these ratios are above 100% an insurance company or state insurance market is paying out more than they are collecting in premiums and can signal a need for rate increases or the potential for reduced access to coverage. Note that this metric does not reflect the investment income that insurers can earn between the time premiums are collected and losses and other expenses are paid.

As shown on Exhibit 2, Wisconsin's five year loss and DCC ratio is lower than even the average for states with low noon-economic damage caps. In fact, it is one of the lowest of any state. The statewide combined ratio is also one of the lowest in the nation. As you can see in Exhibits 2 and 3, the states with low or medium caps demonstrate loss and DCC ratios and combined ratios that are much lower than states with high caps or no caps. The five year average combined ratios of over 135% shown by the states without effective caps have led to voluntary company exits from the marketplace, company liquidations and dramatic rate increases by insurers remaining in these states.

States that have predominantly operated over the last decade with either low ($250K) or medium ($250K-$550K) caps on non-economic damages overall have more competitive insurance markets as measured by the number of insurance companies providing coverage

in the state. An important measure of the availability of insurance coverage is the degree of competition between insurers to provide coverage in a state. One way to measure the degree of competition is the level of market concentration. A more competitive market will tend to be less concentrated. We have examined medical malpractice market concentrations over time and by state. This type of analysis is widely used in insurance and many other markets to measure the competitiveness of a market.

The metric we used to measure market concentration is the Herfindahl-Hirschman Index (HHI). HHI is computed as the sum of the squares of the market shares of the firms competing in a market. The HHI can range from a minimum of close to 0 to a maximum of 10,000. The U.S. Department of Justice considers a result of less than 1,000 to be a competitive marketplace, a result of 1,000 - 1,800 to be a moderately concentrated marketplace, and a result of 1,800 or greater to be a highly concentrated marketplace. In insurance, it is common to sum the data for statutory insurance companies that operate within a single group in terms of their ownership structure and pooling of financial results. Exhibit 4 shows the HHI results by the state categories by damage cap type for 2004 and a five year average (2000-2004) for the medical malpractice market in total.

Wisconsin's marketplace, which ranked 27th in total premium volume, is slightly less concentrated (HHI=1,656) than most states. Generally, states with caps are much more competitive as reflected in significantly lower HHI statistics. The high average HHI for states with medium caps is heavily influenced by a few states with dominant domestic mutual insurers founded by state physicians groups.

States that have predominantly operated over the last decade with either low ($250K) or medium ($250K-$550K) caps on non-economic damages overall have medical malpractice insurance premiums that are much lower than the premiums in states that do not have effective caps. It is noteworthy that not only are loss ratios lower in states with effective damage caps ($250K to $550K), signifying better insurance company results and thus the potential for a more competitive market and greater availability of coverage; but, these states also have significantly lower premiums on average suggesting more affordable coverage. The

results of this rate comparison are summarized in Exhibits 5 through 7. States with small ($250K) and medium caps on non-economic damages have average rates of $11,600 to $13,800 for the internal medicine specialty while state with no caps or caps that were found to be unconstitutional have average rates in excess of $18,000. Similar differences of 25% to 35% exist for the General Surgery and OB/GYN specialties. This results in average OB/GYN rates in states with effective caps being over $25,000 lower than rates in states without caps. Wisconsin rates are among the lowest in the nation in all three specialties.

Similarly, average rate levels over the last six years in states with effective caps have increased between 8% and 12% while rates in states without caps have increased between 14% and 19% annually. This means that for states without caps, many medical malpractice premiums have more than doubled in six years. Wisconsin annual rate increases over the period have been less than 5%.

The Wisconsin medical malpractice insurance market has significantly outperformed most states in terms of both the affordability of medical malpractice rates and insurance company operating results. Exhibits 2 through 7 show that the state of Wisconsin has significantly outperformed most states in all of the categories presented. Market concentration is lower than average suggesting better than average insurer competition. Industry loss and ALAE ratios and combined operating ratios are much lower than national averages. Leading company rate levels and average annual rate changes over the last six years have typically been among the ten best states in the country. These metrics suggest that the state of Wisconsin's broad approach to medical malpractice reform which includes the IPFCF, caps on attorney contingency fees, recognition of collateral sources, mandatory periodic payments, and damage caps, have led to a market with better than average availability and affordability of coverage for health care providers and an environment that encourages competition for insurers while still offering an opportunity to generate reasonable operating results in a stable loss environment.

It appears based on both the expected impact of the removal of the state of Wisconsin's previous non-economic damage cap and the current conditions in other states that Wisconsin's balanced environment is now in jeopardy without meaningful caps. It appears that either a low cap such

as California's $250,000 cap or a medium cap of less that $550,000 are essential to maintaining the current availability, affordability and stability of medical malpractice coverage in the state of Wisconsin.

Disclosures

Distribution and Use

This report is being provided for the use of the Wisconsin Hospital Association and the Wisconsin Medical Society who commissioned the study. It is understood that this report may also be distributed to makers of public policy and various stakeholders in the healthcare industry in the State of Wisconsin. Distribution to these parties is granted on the conditions that the entire report be distributed rather than any excerpts and that all recipients are made aware that Pinnacle is available to answer any questions regarding the report.

These third parties should recognize that the furnishing of this report is not a substitute for their own due diligence and should place no reliance on this report or the data, computations, interpretations contained herein that would result in the creation of any duty or liability by Pinnacle to the third party.

Reliances and Limitations

Judgments as to conclusions, recommendations, methods, and data contained in this report should be made only after studying the report in its entirety. Furthermore, Pinnacle is available to explain any matter presented herein, and it is assumed that the user of this report will seek such explanation as to any matter in question. It should be understood that the exhibits, graphs and figures are integral elements of the report.

We have relied upon a great deal of publicly available data and information, without audit or verification. Pinnacle reviewed as many elements of this data and information as practical for reasonableness and consistency with our knowledge of the insurance industry. As regards the legislative costing elements of this report, it is possible that the historical data used to make our estimates may not be predictive of future experience in Wisconsin. We have not anticipated any extraordinary changes to the legal, social or economic environment which might affect the size or frequency of medical malpractice claims beyond those contemplated in the proposed legislative changes.

Loss and loss adjustment expense estimates are subject to potential errors of estimation due to the fact that the ultimate liability for claims is subject to the outcome of events yet to occur, e.g., jury decisions, judicial interpretations of statutory changes and attitudes of claimants with respect to settlements. Pinnacle has employed techniques and assumptions that we believe are appropriate, and we believe the conclusions presented herein are reasonable, given the information currently available. It should be recognized that future losses will likely deviate, perhaps substantially, from our estimates.

Pinnacle is not qualified to provide formal legal interpretations of state legislation. The elements of this report that require legal interpretation should be recognized as reasonable interpretations of the available statutes, regulations, and administrative rules. State governments and courts are also constantly in the process of changing and reinterpreting these statutes.

Exhibits

Exhibit 1. Impacts of Various Caps on Non-Economic Damages

Exhibit 2. Rate and Loss Experience by Predominant State Damage Caps

Exhibit 3. Premium and Loss Experience by State

Exhibit 4. State Rate Histories

Wisconsin Hospital Association/Wisconsin Medical Society

Exhibit 1

Impact of Various Caps on Non-Economic Damages

I. Indicated Impact Based On Oregon Closed Claim data

Trended Size of Loss	Trended Loss & ALAE Uncapped	Indicated Reduction in Overall Loss and ALAE					
		$250K Cap	$350K Cap	$450K Cap	$550K Cap	$750K Cap	$1M Cap
0-25	15,882,386	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
25-50	16,393,941	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
50-100	26,406,073	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
100-150	19,480,715	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
150-200	19,237,755	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
200-250	14,575,199	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
250-350	27,434,350	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
350-500	38,874,756	-2.2%	0.0%	0.0%	0.0%	0.0%	0.0%
500-1000	101,772,269	-22.8%	-10.0%	-2.5%	-0.3%	0.0%	0.0%
1m-2m	123,309,631	-42.2%	-35.4%	-28.6%	-21.8%	-10.3%	-1.9%
2m+	177,954,398	-37.3%	-34.9%	-32.4%	-30.0%	-25.2%	-19.2%
Overall	581,321,472	-24.5%	-19.9%	-16.4%	-13.9%	-9.9%	-6.3%

II. Indicated Impact Based On Maine Closed Claim data

Trended Size of Loss	Trended Loss & ALAE Uncapped	Indicated Reduction in Overall Loss and ALAE					
		$250K Cap	$350K Cap	$450K Cap	$550K Cap	$750K Cap	$1M Cap
Overall	199,784,402	-29.5%	-23.3%	-18.6%	-14.8%	-10.1%	-7.0%

III. Indicated Impact Based On Florida Closed Claim data

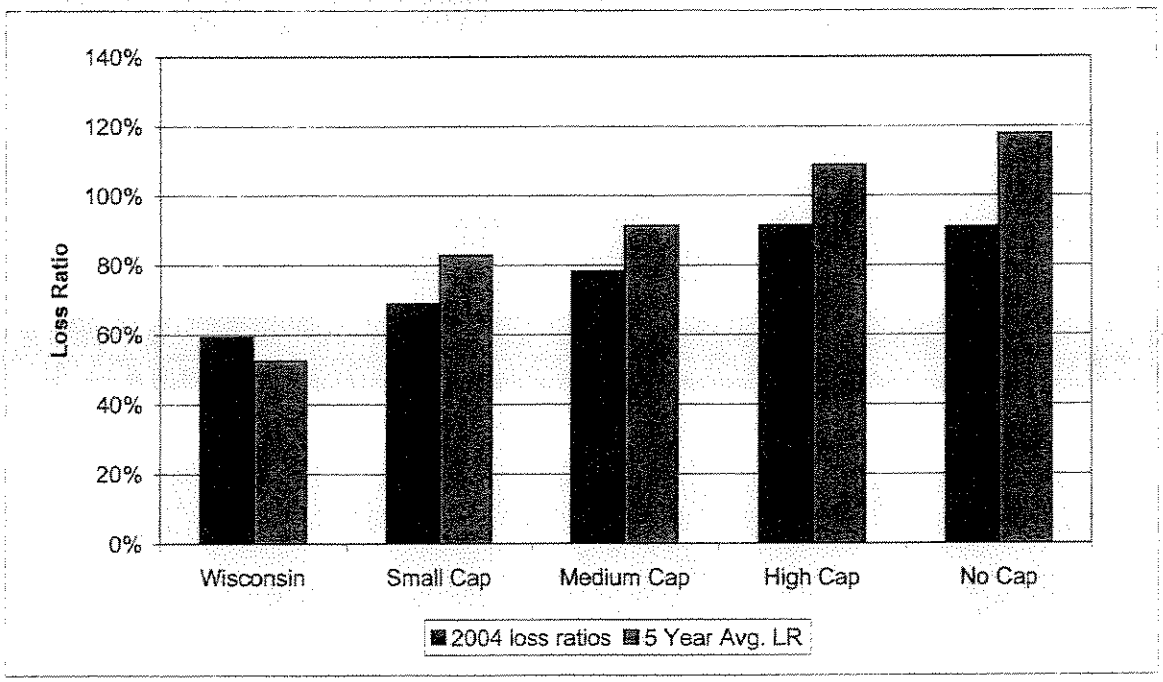
Trended Size of Loss	Trended Loss & ALAE Uncapped	Indicated Reduction in Overall Loss and ALAE					
		$250K Cap	$350K Cap	$450K Cap	$550K Cap	$750K Cap	$1M Cap
Overall	11,219,742,990	-24.6%	-21.0%	-18.1%	-15.8%	-12.7%	-10.1%

Assumes Medical Malpractice Loss Inflation of 7.0% for Indemnity and ALAE.

Wisconsin Hospital Association/Wisconsin Medical Society
Loss Ratios

Industry Experience by State Predominant Damage Cap

Category	2004 Loss Ratio	5 Yr. Average Loss Ratio
Wisconsin	**59.32%**	**52.53%**
Small Cap	68.91%	82.75%
Medium Cap	78.14%	91.32%
High Cap	91.50%	108.69%
No Cap	90.94%	117.72%
Premium Weighted Average	87.40%	110.82%



Source: AM Bests' Aggregates and Averages

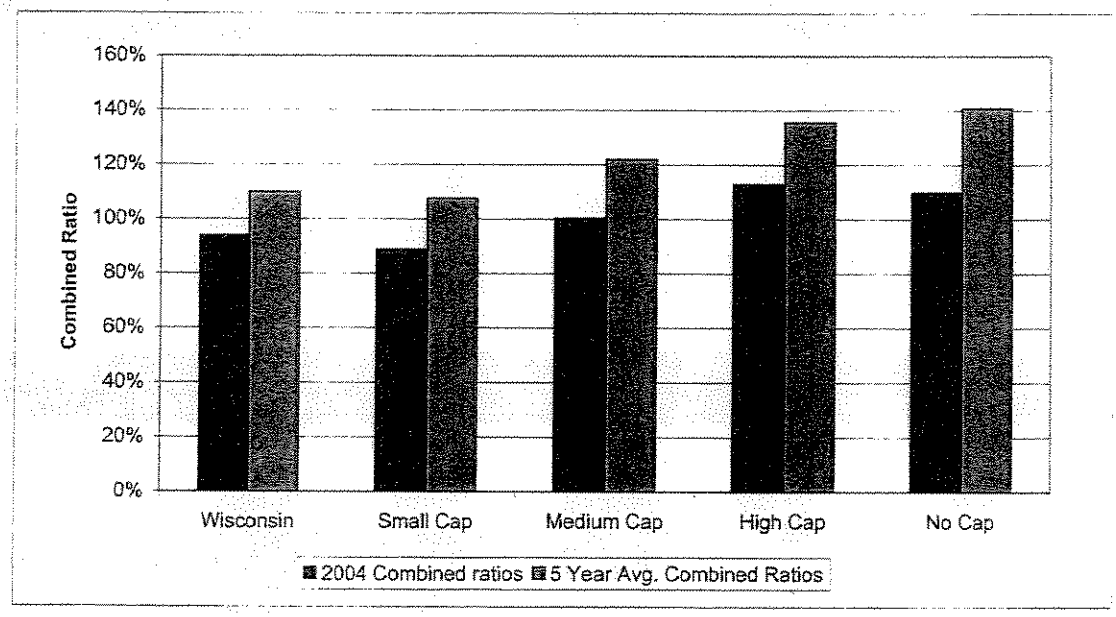
Predominant State Groups are:

Small Cap -	CA,CO, KS, MT, UT
Medium Cap -	AK, HI, ID, IN, MA, MI, ND, OK, SD, WI
High Cap -	MD, MO, NM, VA
No Cap -	AL, AZ, AR, CT, DE, DC, FL, GA, IA, IL, KY, LA, ME, MN, MS, NE, NH, NV, NJ, NY, NC, OH, OR, PA, RI, SC, TN, TX, VT, WA, WV, WY

Wisconsin Hospital Association/Wisconsin Medical Society
Combined Ratios

Industry Experience by State Predominant Damage Cap

Category	2004 Comb. Ratio	5 Yr. Average Comb. Ratio
Wisconsin	**93.89%**	**109.86%**
Small Cap	88.92%	107.65%
Medium Cap	100.34%	121.93%
High Cap	112.89%	135.64%
No Cap	109.84%	140.77%
Premium Weighted Average	106.90%	135.04%



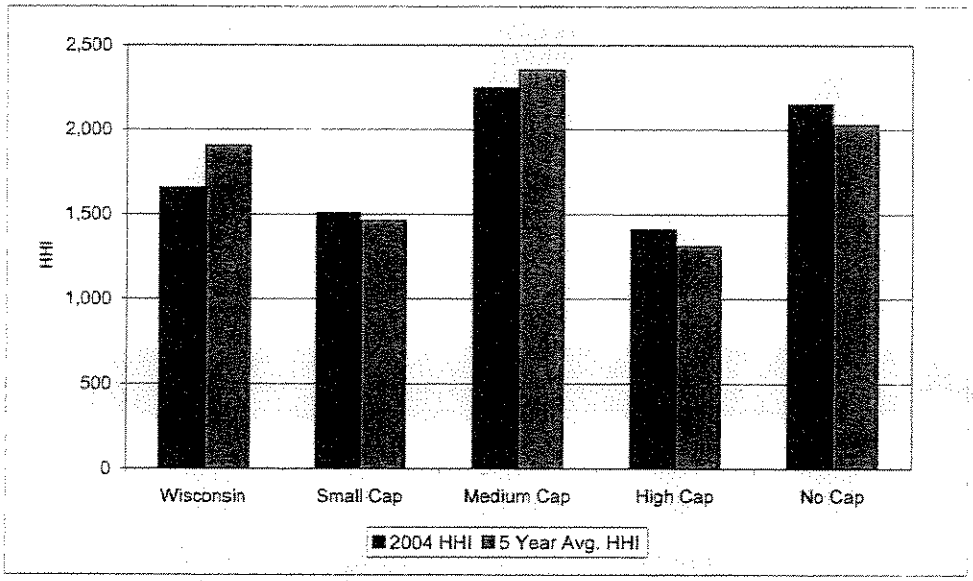
Source: AM Bests' Aggregates and Averages

Small Cap -	CA,CO, KS, MT, UT
Medium Cap -	AK, HI, ID, IN, MA, MI, ND, OK, SD, WI
High Cap -	MD, MO, NM, VA
No Cap -	AL, AZ, AR, CT, DE, DC, FL, GA, IA, IL, KY, LA, ME, MN, MS, NE, NH, NV, NJ, NY, NC, OH, OR, PA, RI, SC, TN, TX, VT, WA, WV, WY

Wisconsin Hospital Association/Wisconsin Medical Society
Market Concentration by State by Year

Comparison by Damage Cap

Category	2004 HHI	5 Year Avg. HHI
Wisconsin	**1,656**	**1,904**
Small Cap	1,507	1,459
Medium Cap	2,246	2,353
High Cap	1,409	1,312
No Cap	2,150	2,028
Written Premium Weighted Average	2,033	1,941



Data Sources: 2004 Direct Written Premium: A.M. Best Page 15 data.

Comments: HHI (Herfindahl-Hirschman Index) is calculated by squaring the market share of each firm competing in a market, and then summing the resulting numbers. The index can range from 0 to 10,000. The U.S. Department of Justice considers a result of less than 1,000 to be a competitive marketplace, a result of 1,000-1,800 to be a moderately concentrated marketplace and a result of 1,800 or greater to be a highly concentrated marketplace.

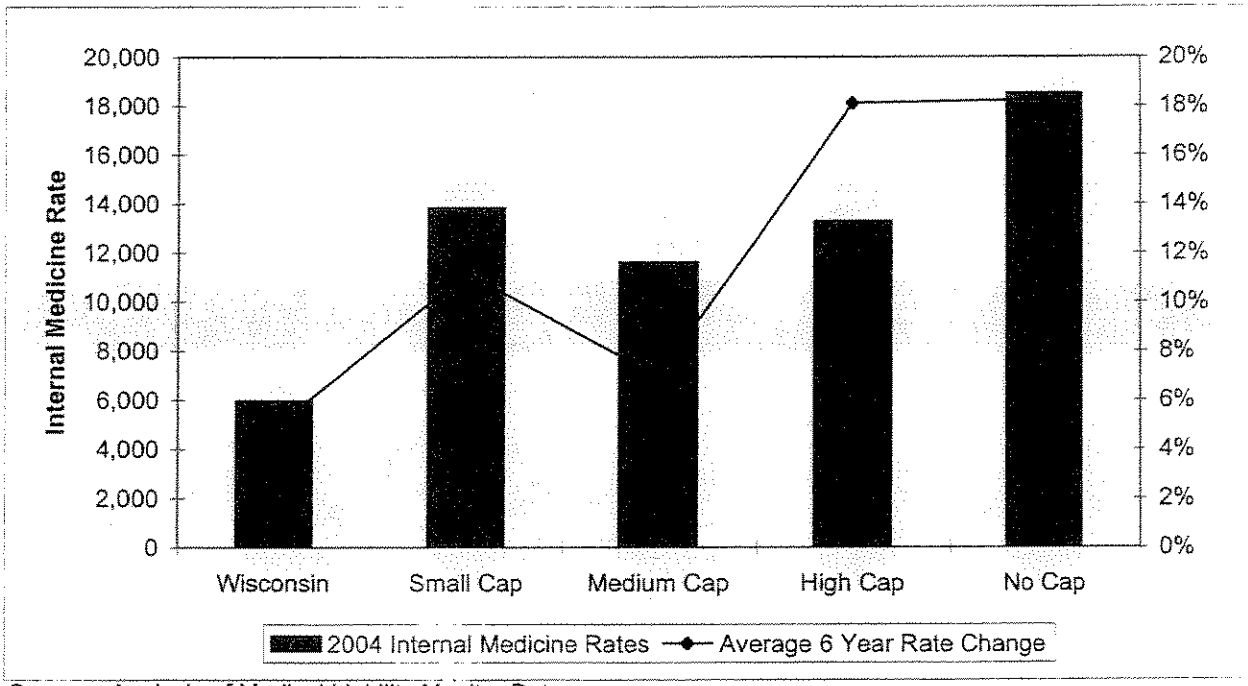
Predominant State Groups are:

Small Cap -	CA,CO, KS, MT, UT
Medium Cap -	AK, HI, ID, IN, MA, MI, ND, OK, SD, WI
High Cap -	MD, MO, NM, VA
No Cap -	AL, AZ, AR, CT, DE, DC, FL, GA, IA, IL, KY, LA, ME, MN, MS, NE, NH, NV, NJ, NY, NC, OH, OR, PA, RI, SC, TN, TX, VT, WA, WV, WY

Wisconsin Hospital Association/Wisconsin Medical Society
Internal Medicine Rates and Rate Levels

Comparison by Damage Cap

Category	2004 Rate	Average 6 year Rate Change
Wisconsin	**5,973**	**4.85%**
Small Cap	13,834	11.17%
Medium Cap	11,615	6.98%
High Cap	13,292	18.11%
No Cap	18,514	18.24%
Physician Weighted Average	16,587	15.78%



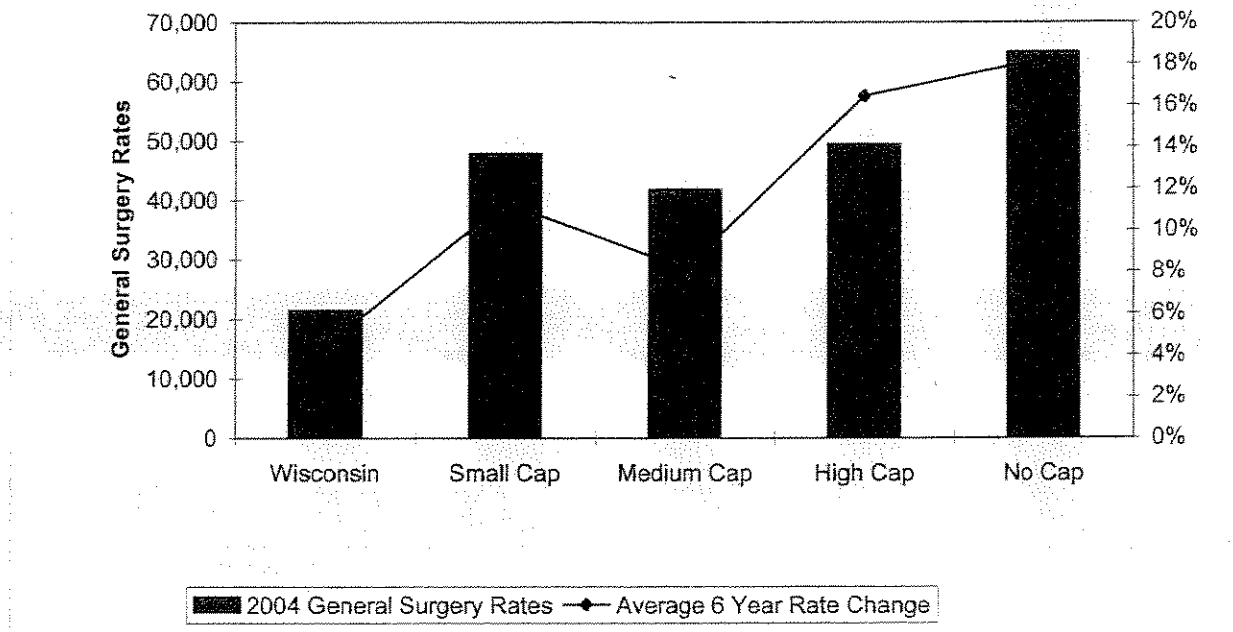
Source: Analysis of Medical Liability Monitor Data

Small Cap -	CA, ID, KS, MT, UT
Medium Cap -	AK, CO, HI, IN, LA, MA, MI, MS, ND, OK, SD, WI
High Cap -	MD, MO, NM, VA
No Cap -	AL, AZ, AR, CT, DE, DC, FL, GA, IA, IL, KY, LA, ME, MN, MS, NE, NH, NV, NJ, NY, NC, OH, OR, PA, RI, SC, TN, TX, VT, WA, WV, WY

Wisconsin Hospital Association/Wisconsin Medical Society
General Surgery Rates and Rate Levels

Comparison by Damage Cap

Category	2004 Rate	Average 6 year Rate Change
Wisconsin	**21,504**	**4.44%**
Small Cap	47,862	11.33%
Medium Cap	41,819	8.13%
High Cap	49,446	16.45%
No Cap	64,974	18.21%
Physician Weighted Average	58,470	15.81%



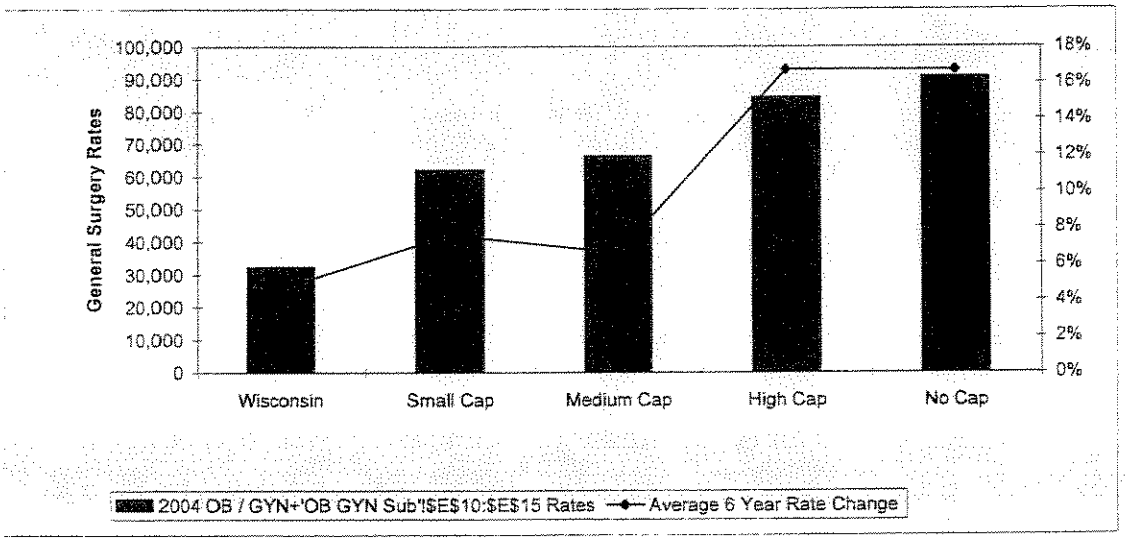
Source: Analysis of Medical Liability Monitor Data

Small Cap -	CA, ID, KS, MT, UT
Medium Cap -	AK, CO, HI, IN, LA, MA, MI, MS, ND, OK, SD, WI
High Cap -	MD, MO, NM, VA
No Cap -	AL, AZ, AR, CT, DE, DC, FL, GA, IA, IL, KY, LA, ME, MN, MS, NE, NH, NV, NJ, NY, NC, OH, OR, PA, RI, SC, TN, TX, VT, WA, WV, WY

Wisconsin Hospital Association/Wisconsin Medical Society
OB / GYN Rates and Rate Levels

Comparison by Damage Cap

Category	2004 Rate	Average 6 year Rate Change
Wisconsin	**32,255**	**4.61%**
Small Cap	61,999	7.58%
Medium Cap	66,241	6.59%
High Cap	84,354	16.72%
No Cap	90,753	16.72%
Physician Weighted Average	83,223	14.15%



Source: Analysis of Medical Liability Monitor Data

Small Cap -	CA, ID, KS, MT, UT
Medium Cap -	AK, CO, HI, IN, LA, MA, MI, MS, ND, OK, SD, WI
High Cap -	MD, MO, NM, VA
No Cap -	AL, AZ, AR, CT, DE, DC, FL, GA, IA, IL, KY, LA, ME, MN, MS, NE, NH, NV, NJ, NY, NC, OH, OR, PA, RI, SC, TN, TX, VT, WA, WV, WY