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Injured Patients and Families Compensation Fund

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Introduction

The injured patients and families compensation fund ("the fund") was created in 1975 to pay medical malpractice claims that exceed the primary layer of malpractice insurance coverage Wisconsin health care providers are required to maintain by law. Initially named the patients compensation fund, the fund was renamed in 2003 as one of several changes enacted that year to Chapter 655 of the Wisconsin Statutes.

Most physicians practicing full-time in Wisconsin, as well as many other health care providers and organizations, are required to participate in the fund. To participate, health care providers must have their own primary layer of medical malpractice insurance coverage in an amount at least equal to the minimum set by law, and they must pay an annual assessment to the fund. If they satisfy these requirements, the fund provides the health care provider unlimited medical malpractice insurance for claims in excess of their own primary layer of coverage. The fund is financed through the assessments paid by participating health care providers and by the investment returns generated by the assets in the fund.

This paper provides an overview of the fund's management, participation, and financing provisions. The paper also summarizes the process injured patients and their families use to recover money from the fund. Included within that discussion is an analysis of the damages medical malpractice victims can recover under Wisconsin law, and how recent legal developments have affected those amounts. The paper concludes by providing information about the fund's finances.

Management of the Fund

The fund is governed by a 13-member Board of Governors comprised of three representatives of the insurance industry appointed by the Commissioner of Insurance, a person named by the State Bar Association, a person named by the Wisconsin Academy of Trial Lawyers, two people named by the Wisconsin Medical Society, a person named by the Wisconsin Hospital Association, the Commissioner of Insurance or his delegate who serves as Chairperson of the Board, and four members of the public, appointed by the Governor, at least two of which are not lawyers or doctors and who are not professionally associated with any hospital or insurance company. The Board of Governors is responsible for the fund's management. Those responsibilities include approving the annual fees assessed against participating health care providers and approving contracts with entities that provide services to the fund, such as the fund's actuary. The Board is assisted in its management responsibilities by staff provided by the Commissioner of Insurance, various Board committees such as its Actuarial and Underwriting Committee, and outside service providers. By May 1 of each year, the Board is required to produce a report to fund members and the standing committees on insurance in each house of the Legislature that summarizes the activities of the fund in the proceeding calendar year.

The investments in the fund are managed by the State of Wisconsin Investment Board. As of June 30, 2006, the fund had total assets of $746,398,200.

Health Care Provider Participation in the Fund

The following list identifies the major categories of health care providers for whom participation in the fund is mandatory.

- Physicians and nurse anesthetists for whom Wisconsin is a "principal place of practice" and who practice their profession in Wisconsin more than 240 hours in a fiscal year. The term "principal place of practice" means either the state in which the provider furnishes health care services to more than 50% of their patients, or the state in which they derive more than 50% of their income in a fiscal year from the practice of their profession.

- Corporations, or any other organization or enterprise, organized and operated in Wisconsin for the primary purpose of providing the medical services of physicians or nurse anesthetists.

- Partnerships comprised of physicians or nurse anesthetists and organized and operated in Wisconsin for the primary purpose of providing the medical services of physicians or nurse anesthetists.

- Hospitals that operate in Wisconsin and entities that operate in Wisconsin that are affiliates of a hospital and provide diagnosis or treatment of, or care for, patients of the hospital.

- Ambulatory surgery centers that operate in Wisconsin.

- Nursing homes whose operations are combined as a single entity with a hospital, whether or not the nursing home operations are physically separate from the hospital operations.

Chapter 655 also identifies several groups of health care providers who have the option of either participating or not participating in the fund. These providers include physicians or nurse anesthetists for whom Wisconsin is a principal place of practice but who practice less than 241 hours a year, other physicians or nurse anesthetists who practice in Wisconsin but for whom Wisconsin is not their principal place of practice, and graduate or medical education programs operating in Wisconsin. As these descriptions suggest, most of the health care providers who have the option of participating in the fund are either part-time practitioners or providers whose practices are not based in Wisconsin. For these providers, as well as providers that are required to participate in the fund, the fund's excess medical malpractice insurance covers not only the health care provider, but also (with some exceptions) their employees, provided the employees were acting within the scope of their employment and were providing health care services.

Table 1 summarizes the number of health care providers, by type, who were actively participating in the fund as of December 31, 2005.

Table 1: Participating Providers by Type as of December 31, 2005

Provider Category	Number	% of Total Participants
Physicians	11,802	84.5%
Nurse Anesthetists	523	3.7
Corporations	1,383	9.9
Partnerships	54	0.4
Hospitals	128	0.9
Hospital-affiliated Nursing Homes	32	0.2
Hospital-owned or -controlled Entities	24	0.2
Ambulatory Surgery Centers	22	0.2
Cooperatives	1	<0.1
Total	13,969	100.0%

With the exception of the year 2000, which experienced a slight decline, the number of health care providers participating in the fund has steadily increased over the past decade, growing from 11,485 participants on December 31, 1996, to 13,969 participants as of December 31, 2005.

Finally, Chapter 655 exempts several categories

of health care providers from participating in the fund. As the following list indicates, most of these statutory exemptions relate to the public sector nature of the health care provider's practice.

- A physician or nurse anesthetist who is a state, county or municipal employee, or federal employee or contractor covered under the federal tort claims act, as amended, and who is acting within the scope of his or her employment or contractual duties.

- Facilities such as county hospitals, juvenile correctional facilities, county homes and infirmaries, and public health dispensaries that are exempted from certain hospital regulations under s. 50.39(3) of the statutes or operated by any governmental agency.

- Physicians or nurse anesthetists who provide professional health care services under the state's volunteer health care provider program described in s. 146.89 of the statutes, with respect to those professional services they provide for which they are covered by s. 165.25 of the statutes and considered an agent of the Department of Health and Family Services.

These exemptions apply only to professional activities covered by the exemption. Thus, if a health care provider whose employment otherwise makes the provider ineligible for fund participation decides to practice outside the scope of that employment (for example, a physician employed by a county hospital who decides to also practice in a private clinic), fund participation is required if their non-exempt activities meet the mandatory participation criteria. In such cases, the fund's insurance coverage applies only to malpractice claims arising from the provider's non-exempt activities.

As of December 31, 2005, 9,596 health care providers had been granted exemptions from participating in the fund. As Table 2 indicates, most of those exemptions arose either because Wisconsin was not the provider's principal place of practice, or because the provider, for a variety of reasons (including retirement, professional inactivity, or the temporary cessation of their practice), practiced less than 240 hours during the fiscal year.

Table 2: Providers Exempted from Participating in the Fund As of December 31, 2005

Basis For Exemption	Number	% of Total Exemptions
Practicing less than 240 hours	2,392	24.9%
Practicing Outside of Wisconsin	2,412	25.1
Retired Providers	1,329	13.9
Not Yet Practicing or Never Practiced	1,538	16.0
State, County, or Municipal Employees	1,308	13.6
Federal Employees	457	4.8
Temporarily Ceased Practice	160	1.7
Total	9,596	100.0%

Prerequisites to Obtaining Insurance Coverage from the Fund

Maintaining Their Own Primary Layer of Medical Malpractice Insurance. To participate in the fund, and to benefit from the excess medical malpractice insurance it offers, health care providers must satisfy two primary obligations. First, they must maintain their own primary layer of medical malpractice insurance in an amount at least equal to the minimum coverage required by statute. Currently, those minimum coverage amounts are $1,000,000 per occurrence and $3,000,000 for all occurrences in any one policy year (for occurrence coverage), or $1,000,000 for each claim arising from an occurrence and $3,000,000 for all claims in any one reporting year (for claims-made coverage). The health care provider can, of course, maintain higher levels of primary coverage than the statutory minimums, in which case the fund's excess coverage is not triggered until the provider's primary layer of coverage is exceeded.

While Chapter 655 allows health care providers to obtain either occurrence coverage or claims-made coverage to satisfy their statutory obliga-

tions, the fund itself provides occurrence coverage. That means the fund offers excess medical malpractice insurance coverage for incidents of medical malpractice that occur during a year in which the participating health care provider has coverage under the fund, regardless of when a claim relating to that incident is actually made.

A health care provider can satisfy the primary insurance requirement by purchasing coverage under a policy issued by an insurer licensed to do business in Wisconsin, or by qualifying as a self-insurer. Rules adopted by the Commissioner of Insurance specify a number of provisions an insurance policy must contain in order to satisfy a provider's insurance obligations under Chapter 655. While most providers buy primary coverage from a private insurer, some purchase the requisite coverage from the Wisconsin health care liability plan, a separately-licensed health care liability insurer created by statute and governed by the same thirteen-member Board of Governors that manages the fund. As of March 31, 2006, the plan provided primary medical malpractice coverage to 335 insureds.

Paying the Fund's Annual Assessment. The second primary obligation health care providers must satisfy to participate is to pay an annual assessment to the fund. The amount of that assessment is established each year by the Commissioner of Insurance by administrative rule, after approval by the fund's Board of Governors, and is based on such factors as the risk level of a participating physician's area of practice, the past and prospective loss and expense experience of the fund, and the provider's own loss and expense experience (subject to peer review as described below). To a significant degree, the Board of Governors is assisted in these calculations by the fund's actuary (currently, Milliman, Inc.) and its analysis of the fund's estimated liabilities and financial position. Additional discussion of the fees assessed by the fund over time, as well as the actuary's estimates of the fund's liabilities and financial position, is provided later in this paper.

As noted, one factor used to set a health care provider's assessment is the provider's own medical malpractice loss and expense experience. Under the statute, every insurer that writes medical malpractice insurance in Wisconsin, as well as every self-insurer, must file reports with the fund's Board of Governors identifying each claim paid for damages arising out of the rendering of health care services. The Board, along with a peer review council, (a five-member committee appointed by the Board), reviews those claims to determine if a surcharge should be added to that provider's annual fund assessment. Since the peer review council was established in 1986, through December 31, 2005, two providers have been assessed a surcharge under these provisions.

With respect to the fees assessed against physicians, Chapter 655 states that not more than four payment categories can exist based on the amount of surgery performed and the risk of diagnostic and therapeutic services provided or performed by the physician. This is reflected in the fund's fee schedule, which establishes four payment classes for physicians, grouped by specialties or types of practice that are similar in their degree of exposure to loss. For example, physicians who practice in the areas of pediatrics (no surgery), or family or general practice, are in Class 1, while OB/GYN surgerons are in Class 4. Within these four payment classes, fees can vary based on factors such as the number of hours the physician practices during the fiscal year. Table 3 identifies the annual fees, by class, for physicians for whom Wisconsin was a principal place of practice, and the fees for certified nurse anesthetists for whom Wisconsin was a principal place of practice, for fiscal years 1997-98 through 2006-07. As Table 3 indicates, the annual fees assessed to individual health care providers have decreased dramatically since 1997-98. This decrease was a product of the fund's positive overall financial performance during that period. These financial trends are discussed in more detail later in this paper.

The Board of Governors also sets fees for par-

Table 3: Annual Fees for Physicians and Certified Nurse Anesthetists (Fiscal Years 1997-98 through 2006-07)

	Physicians				Certified Registered Nurse
Year	Class 1	Class 2	Class 3	Class 4	Anesthetist
1997-98	$2,647	$5,294	$11,392	$15,882	$678
1998-99	2,721	5,170	11,292	16,326	678
1999-00	2,531	4,809	10,504	15,186	631
2000-01	1,898	3,606	7,877	11,388	475
2001-02	1,538	2,769	6,384	9,231	378
2002-03	1,461	2,630	6,063	8,766	359
2003-04	1,534	2,761	6,366	9,204	377
2004-05	1,217	2,209	5,092	7,362	302
2005-06	859	1,546	3,565	5,154	211
2006-07	1,074	1,933	4,457	6,444	264

ticipating organizations. Those fees vary with the size of the organization and the types of health care professionals it employs. For example, under the fund's 2006-07 fee schedule, a participating corporation with a total number of shareholders and employed physicians or nurse anesthetists greater than 100 is subject to an assessment of $923 plus the fees listed in Table 4 for each of the following types of health care providers employed by the corporation.

Table 4: 2006-07 Annual Fees for Participating Corporations, by Type of Health Care Professional Employed

Type of Employee	Annual Fee to Employer Corporation
Nurse Practitioners	$269
Advanced Nurse Practitioners	376
Nurse Midwives	2,363
Advanced Nurse Midwives	2,470
Advanced Practice Nurse Prescribers	376
Chiropractors	430
Dentists	215
Oral Surgeons	1,611
Podiatrists-Surgical	4,565
Optometrists	215
Physician Assistants	215

As with the assessments to individual health care providers, the fund's annual assessments to organizations, based on the types of health care professions they employ, have also decreased dramatically since 1997-98.

How Injured Patients and Families Recover Money from the Fund

Chapter 655 establishes the process individuals must follow to assert medical malpractice claims in Wisconsin, including claims against the fund. Under the statute, patients, their representatives, and health care providers are conclusively presumed to have accepted to be bound by its provisions. Furthermore, any patient, patient's representative, or spouse, parent, minor sibling or child of a patient having a derivative claim for injury or death on account of medical malpractice is subject to Chapter 655.

Mandatory Mediation. Before commencing any court action seeking damages for medical malpractice, claimants must first participate in the mandatory mediation system created in Chapter 655. The stated legislative intent behind this mediation requirement is to provide an informal, inexpensive, and expedient means for resolving disputes without litigation.

To initiate a Chapter 655 mediation, the claimant must submit a written request for mediation to the Director of State Courts that contains identifying information about the claimant, the patient (if different), and the allegedly negligent health care provider. The mediation request also must describe the condition or disease that was being treated and the injury alleged to have been caused by the health care provider's negligence. The Director of State Courts sends a copy of the mediation request to all health care providers identified in the request, and to the fund. The Director of State Courts then appoints a three-person mediation panel comprised of a health care provider, a lawyer, and member of the public who is neither a health care provider nor a lawyer, to hear the dispute.

Chapter 655's mediation process is designed to

be relatively informal and inexpensive. For example, the mediations are conducted without a stenographic record or any other transcript, and without the administration of any oaths. The statute also prohibits the ordering of physical examinations, the production of records, the subpoenaing of witnesses, and the parties' use of expert witnesses, their opinions or reports. Mediation participants, must, however, make available to each other and to the mediation panel all patient health records of the claimant. The statute also allows participants, including the fund, to be represented by a lawyer.

The mediation period expires 90 days after the Director of State Courts receives the request for mediation if the request is delivered in person, or 93 days if the request is sent by registered mail, unless these periods are extended by the parties. The mediation period is significant because claimants cannot commence a court action until the mediation period expires. The one exception to that requirement allows claimants to commence an action in court if they also file a request for mediation within 15 days after filing the action. Even in those circumstances, however, no discovery can be made and no trial, pretrial conference, or scheduling conference can be held until after the mediation period expires.

Legal Representation. The fund retains its own legal counsel to appear and actively defend the fund on each claim. The costs and fees associated with that legal representation are paid from the fund.

As for the claimant's legal counsel, Chapter 655 limits the amount of contingency fees they can collect to not more than one-third of the first $1,000,000 recovered, unless liability is stipulated to within 180 days after the filing of the original complaint and not later than 60 days before the first day of trial, in which case the fee cannot exceed 25% of the first $1,000,000 recovered. The contingency fee on any portion of a recovery that exceeds $1,000,000 is limited to 20%. A court may, upon a showing of exceptional circumstances, approve contingency fees in excess of these amounts. In addition, an attorney can offer to charge the client on an hourly or per diem basis, in which case the fees are not subject to the previously-stated limitations.

Court Actions. After the mediation period expires, and assuming the dispute remains unresolved, claimants can proceed in court with their medical malpractice claim. A person filing such an action can recover from the fund only if the allegedly negligent health care provider has coverage under the fund, the fund is named as a party in the court action, and the action against the fund is commenced within the same time limitation within which the action against the health care provider must be commenced.

Damages Available to the Plaintiff. Plaintiffs in medical malpractice cases often seek both economic damages and noneconomic damages. Economic damages can consist of such damages as past and future medical costs and past and future lost income. Chapter 655 does not place any explicit statutory limits on the amount of economic damages plaintiffs can recover in a medical malpractice case. As a result, there is no statutory limit to the liability the fund may incur for economic damages if a participating health care provider commits medical malpractice.

As for noneconomic damages, the analysis is more complicated. For purposes of Chapter 655, noneconomic damages are defined as moneys intended to compensate for pain and suffering; humiliation; embarrassment; worry; mental distress; noneconomic effects of disability, including loss of enjoyment of the normal activities, benefits and pleasures of life and loss of mental or physical health, well-being, or bodily functions; loss of consortium, society and companionship; or loss of love and affection.

Prior to 2005, Wisconsin law limited the recovery of noneconomic damages for certain types of claims in medical malpractice cases to $350,000, adjusted annually for inflation. In 2005, however, the Wisconsin Supreme Court struck down that

limit in Ferdon v. Wisconsin Patients Compensation Fund, 284 Wisconsin Reports 2d 573 (2005), holding that it violated the equal protection guarantees of the Wisconsin Constitution. Note that Wisconsin law also limits noneconomic damages for wrongful death claims in cases of medical malpractice. Those limits, $500,000 per occurrence in the case of a deceased minor and $350,000 per occurrence in the case of a deceased adult, were not, however, addressed in Ferdon and remain in effect.

In response to Ferdon, the Legislature enacted 2005 Wisconsin Act 183, which raised the limit on noneconomic damages for medical malpractice claims to $750,000 for occurrences on or after April 6, 2006. As a result of Ferdon and the subsequent legislative response to that decision, there are currently no statutory limits on the recovery of noneconomic damages for medical malpractice claims arising from occurrences prior to April 6, 2006, but there is a $750,000 limit on such damages for medical malpractice claims arising from occurrences after that date. Once again, the limits referenced in this paragraph are not the limits Wisconsin law places on the recovery of noneconomic damages for wrongful death claims, limits that were not affected by Ferdon or the legislative response thereto.

Chapter 655 also includes several provisions that can affect the manner and timing in which certain claimants receive money from the fund. First, if a settlement or judgment provides for more than $100,000 in future medical expenses, the portion of such damages in excess of $100,000 is paid into the fund and disbursed for those expenses until the money is exhausted or the patient dies. Second, if a settlement or judgment causes the fund to incur liability for future payments in excess of $1,000,000 to any person under a single claim, the fund pays the full medical expenses each year, plus an amount not to exceed $500,000 per year that will pay the remaining liability over the person's anticipated lifetime, or until the liability is paid in full.

Financial Operations of the Fund

This section of the paper reviews the fund's recent financial operations and financial position. For additional information regarding these topics, readers may wish to review two other reports. The first is the October, 2004, audit report of the fund prepared by the Wisconsin Legislative Audit Bureau that is available on the Legislative Audit Bureau's website. By law, the Legislative Audit Bureau is required to audit the fund at least once every three years. The second is the 2005 Functional and Progress Report prepared by the fund's Board of Governors, which is available on the website of the Office of the Commissioner of Insurance.

According to the fund's 2005 Functional and Progress Report, from July 1, 1975, through December 31, 2005, 5,227 claims were filed in which the fund was named a party. Of that total, the fund paid 627 claims totaling $596,253,376. Of the remaining claims, 4,373 were closed with no indemnity payment, and 227 remained open.

With respect to the fund's recent financial results, Table 5 provides a cash-flow analysis for each fiscal year from 2000-01 through 2005-06. As reflected in Table 5, the fund's primary sources of cash are the fees it collects from participating health care providers and the returns generated by its investments. The primary uses of the fund's cash are its indemnity losses and operating expenses. As Table 5 indicates, the fund's operations generated significant positive net cash flow each of the six most recent fiscal years.

An aspect of the fund's finances not captured by this cash-flow analysis is the fact that each year, the fund incurs liabilities that do not result in actual indemnity losses until some time in the future. For example, during 2004-05, the fund paid $24,341,000 in indemnity losses and loss adjusted expenses (LAE, which are estimates of the future costs to settle claims). That same year, however, incidents of medical malpractice occurred that will not result in

Table 5: Injured Patients and Families Compensation Fund -- Cash Flow (Fiscal Years 2000-01 through 2005-06)

	2000-01	2001-02	2002-03	2003-04	2004-05	2005-06
Fees Collected	$37,134,000	$31,663,000	$30,051,000	$33,290,000	$29,782,000	$15,422,000
Losses and LAE * Paid	-42,436,000	-45,769,000	-26,300,000	-24,756,000	-24,341,000	-37,125,000
Underwriting Expenses	-716,000	-764,000	-940,000	-876,000	-896,000	-972,000
Other Expenses Paid	-64,000	-56,000	-24,000	-44,000	-40,000	-84,000
Cash from Underwriting	-$6,078,000	-$14,929,000	$2,783,000	$7,618,000	$4,503,000	-$22,760,000
Cash Income from Investments	$33,823,000	$32,600,000	$31,594,000	$30,473,000	$32,644,000	$33,459,000
Realized Capital Gains	-180,000	-12,905,000	5,261,000	2,285,000	1,635,000	-1,604,000
Other Income (Expenses)	82,000	4,327,000	1,956,000	3,250,000	242,000	7,754,000
Net Cash from Operations	$27,646,000	$9,093,000	$41,595,000	$43,625,000	$39,024,000	$16,848,000

*Loss adjusted expenses.

cash losses to the fund until the malpractice is discovered, a claim is filed, and the case is resolved, either voluntarily or through litigation.

An annual report prepared by the fund's Board of Governors addresses this and other aspects of the fund's financial position. That report is the "Statement of Net Equity," which estimates the fund's total assets, total liabilities, and total net equity as of the end of each fiscal year. Table 6 summarizes the fund's Statement of Net Equity as of June 30, 2006. According to this Statement of Net Equity, the fund had total assets on June 30, 2006, of $746,398,200, total liabilities of $686,538,100, and a resulting total net equity (total assets minus total liabilities) of $59,860,100. A positive total net equity such as was reported for June 30, 2006, is also referred to as the fund's "surplus." A negative total net equity position is referred to as the fund's "deficit." The fund has reported a year-end surplus every year since 1998-99.

As Table 6 indicates, the fund held nearly three quarters of a billion dollars in assets as of June 30, 2006. Those assets accumulated over time as a result of the positive cash flows generated by the fund's operations. The assets themselves are invested in a range of asset classes, the management of which is overseen by the State of Wisconsin Investment Board pursuant to guidelines established by the fund's Board of Governors. Most of the fund's assets are invested in fixed-income securities. A substantially smaller percentage is invested in equities, which the fund's current investment guidelines limit to 20% of the total portfolio. As the cash-flow analysis shown in Table 5 demonstrates, returns generated by the fund's investment portfolio have significantly contributed to the fund's positive net cash flow in recent years.

The Statement of Net Equity in Table 6 also quantifies the fund's total liabilities. Those liabilities, reported on a present value basis, include not only liabilities associated with claims against the fund that have already been reported, but also liabilities related to medical malpractice occurrences that have been incurred but not reported (IBNR). In fact, the vast majority of the total liabilities stated in the fund's June 30, 2006 Statement of Net Equity

Table 6: Statement of Net Equity as of June 30, 2006

Assets	
Total Current Assets	$92,628,100
Total Non-Current Assets	653,770,100
Total Assets	$746,398,200
Liabilities:	
Total Current Liabilities	$84,778,800
Total Noncurrent Liabilities	601,759,300
Total Liabilities	$686,538,100
Total Net Equity	$59,860,100

reflect an actuarial estimate of these IBNR liabilities.

Estimating the fund's total liabilities is an important function, not only for financial reporting purposes, but also because those liability estimates are one of the factors the fund's Board of Governors considers when establishing the level of annual assessments to be paid by participating health care providers. Accurately estimating those liabilities is difficult. As the fund's Board of Governors acknowledged in the 2005 Functional and Progress Report, the actual amounts paid to satisfy the fund's liabilities will differ from the actuary's estimates because of "the uncertainties inherent in projecting the frequency and severity of claims, the fund's unlimited liability coverage, and extended reporting and settlement periods." Given these inherent difficulties, the fund's estimated liabilities are continually reviewed and adjusted based on a number of factors such as the fund's evolving loss experience, changes in interest rates, and other changes to the economic and legal context within which the fund operates.

The fluid nature of the fund's actuarial estimate of liabilities is illustrated in part by the fact that the actuary's original estimates of fund losses have been consistently adjusted downward after one year, following actuarial review of the fund's subsequent experience. In addition, and as noted above, the fund's assets have steadily grown since 1975 as a result of the positive net cash flows its operations have generated. These and other factors led the Legislative Audit Bureau's October 2004 audit report to observe that, "Some interested parties continue to be concerned that the actuary may be overly conservative in estimating the fund's loss liabilities." Actuarial reports by firms other than Milliman, Inc. during this period also concluded that Milliman, Inc.'s actuarial estimates appeared conservative. In fact, Milliman, Inc. submitted its own analysis dated November 22, 2005, that, among other things, included a "Hindsight Restatement of Fund Surplus" that reflected a greater total net equity position for each of the past 20 years than what the fund had originally reported.

This paper's purpose in mentioning the concerns raised about Milliman, Inc.'s actuarial estimates is not to express an opinion about the accuracy of those estimates, but instead, to bring to the reader's attention the fact that these concerns have been expressed and have been part of the dialogue surrounding the fund.

Several recent proposals by Governor Doyle brought some of these issues to the fore. In his 2003-05 biennial budget recommendations, Governor Doyle proposed transferring $200,000,000 in 2003-04 out of the fund and into what was to be a newly-created health care provider availability and cost control fund to support medical assistance (MA) benefits costs. The Legislature deleted that proposal from the budget, and subsequently enacted 2003 Wisconsin Act 111, which renamed the fund the "injured patients and families compensation fund" from the "patients compensation fund" and added language to Chapter 655 stating that the fund was held in "irrevocable trust for the sole benefit of health care providers participating in the fund and proper claimants." Two years later, in his 2005-07 biennial budget recommendations, Governor Doyle again proposed transferring money out of the fund, this time into what was to be a newly-created health care quality improvement fund, to support MA benefits costs and to support a new program to provide grants and loans for health care quality improvement activities. The amounts of those proposed transfers were $169,703,400 in 2005-06 and $9,714,000 in 2006-07. The Legislature again deleted those proposed transfers from the enacted budget.

Ferdon's Estimated Impact on the Fund. The complexity of estimating the fund's liabilities, and the sensitivity of those estimates to changed assumptions, was demonstrated in the aftermath of Ferdon. As indicated previously, that decision struck down the then-existing limitation Wisconsin law placed on the recovery of non-economic damages for medical malpractice claims. In its 2005 Functional and Progress Report, the fund's Board of Governors stated that the estimated impact of Ferdon was to increase the fund's undiscounted,

unpaid liabilities by approximately $173 million, which when discounted, would result in a $140 million decrease in the fund's surplus position. The Board of Governors also stated that as a result of this increase in the fund's estimated liabilities, the fund's future financial statements would reflect a negative, rather than a positive, net equity position. Following, and in part because of these actuarial estimates, the fund's Board of Governor's approved a 25% increase in the fund's provider assessments for 2006-07 as compared to the 2005-06 assessment levels.

The actuarial estimates cited in the fund's 2005 Functional and Progress Report, were prepared after Ferdon, but before the Legislature responded by enacting a $750,000 limit on noneconomic damages for medical malpractice claims arising from occurrences after April 6, 2006. As the Statement of Net Equity reflected in Table 6 indicates, the fund reported a surplus of $59,860,100 as of June 30, 2006, rather than the deficit that was initially forecast in the 2005 Functional and Progress Report. These, and other aspects of the fund's financial condition, will be addressed in the fund's 2006 Functional and Progress Report, scheduled to be released in early 2007.