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☞ Details: Wisconsin Patients Compensation Fund (PCF)

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WISCONSIN STATE LEGISLATURE ...
PUBLIC HEARING - COMMITTEE RECORDS

1995-96

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Assembly

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Committee on Insurance, Securities and Corporate Policy...

COMMITTEE NOTICES ...

- Committee Reports ... **CR**
- Executive Sessions ... **ES**
- Public Hearings ... **PH**

INFORMATION COLLECTED BY COMMITTEE FOR AND AGAINST PROPOSAL

- Appointments ... **Appt** (w/Record of Comm. Proceedings)
- Clearinghouse Rules ... **CRule** (w/Record of Comm. Proceedings)
- Hearing Records ... bills and resolutions (w/Record of Comm. Proceedings)
  - (**ab** = Assembly Bill) (**ar** = Assembly Resolution) (**ajr** = Assembly Joint Resolution)
  - (**sb** = Senate Bill) (**sr** = Senate Resolution) (**sjr** = Senate Joint Resolution)
- Miscellaneous ... **Misc**

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Wisconsin Hospital Association and State Medical Society of Wisconsin

Joint Task Force on the Wisconsin Patients Compensation Fund

Report and Identification of Issues for Study

The State Medical Society of Wisconsin (SMS) and the Wisconsin Hospital Association (WHA) jointly formed the Task Force on the Patients Compensation Fund in early 1991. (Attachment A) The task force was broadly charged to examine all aspects of the purpose and operation of the Fund. Over the course of the task force's meetings invited experts offered a variety of perspectives on the function and operation of the Fund. This summary provides a review of the information received by and the deliberations of the task force. It also contains the task force's recommendations on the future of the Fund and its identification of issues deserving of further study.

DELIBERATIONS

State Patients Compensation Funds:

Patient compensation funds (PCFs) are state-operated funds that provide excess insurance coverage for health care providers. The statutes which create such funds generally define "health care providers" broadly to include physicians, hospitals and other health care entities and professions. PCFs are typically funded through an annual surcharge against health care providers. States that have such funds generally require fund participants either to maintain primary medical liability insurance in an amount not less than the level at which the fund makes payments or otherwise demonstrate financial responsibility in such amount.

During the 1970s, 17 states enacted PCFs however, only 10 of those states ever activated their funds. Today, six states maintain such state-operated funds. Wisconsin is among those and is unique because it has the only fund which provides unlimited excess medical liability insurance coverage.

The Task Force learned that there is little empirical research to date comparing the effectiveness of compensation systems and their affect on access to care and quality of care. PCFs have generally been developed for two primary purposes: to make excess coverage available and to provide compensation to injured patients. Early studies have indicated that severely injured patients benefit the most in terms of compensation and timing of settlement under such funds.

The Patients Compensation Fund in Wisconsin

The Wisconsin Fund was established in 1975, by Wisconsin Statute 655.[1] It mandated excess professional medical liability insurance coverage for certain health care providers permanently practicing in Wisconsin. The Fund currently provides unlimited coverage in excess of $400,000 for each occurrence and $1 million for all occurrences in any one policy year for each covered health care provider. Participation in the Fund is a condition of licensure for physicians, CRNA's and hospitals in the state.[2]

The Fund is managed by a 13-member Board of Governors composed of:

- Three representatives of the insurance industry appointed by and serving at the pleasure of the Insurance Commissioner;
- Two appointees of the State Medical Society of Wisconsin;
- An appointee of the Wisconsin Hospital Association;
- An appointee of the State Bar Association;
- An appointee of the Wisconsin Academy of Trial Lawyers;
- The Insurance Commissioner or his/her designated representative (who serves as chair); and
- Four public members, at least two of whom are not attorneys or physicians and are not professionally affiliated with any hospital or insurance company.

The Board of Governors also oversees the operation of the Wisconsin Health Care Liability Insurance Plan (WHCLIP), a state-run joint underwriting primary insurance plan association simultaneously created by statute in 1975 to write primary coverage to the Fund threshold. WHCLIP was created to be an insurer of last resort, under which any providers applying would be accepted for coverage.

The Board of Governors is assisted in its duties by the following committees: Underwriting and Actuarial, Legal, Claims, Investment, Risk Management and the Peer Review Council.

Premiums for WHCLIP and Fund fee assessments are annually set by rule of the Insurance Commissioner after approval by the Board of Governors and Fund fees are subject to certain statutory limitations.[3] The Board considers the recommendation of the Underwriting and Actuarial Committee with the advice of a retained consulting actuary -- currently, Milliman & Robertson of Brookfield, Wisconsin.

Legislative Background:

Gordon Anderson, senior staff attorney, Wisconsin Legislative Council, and Mary Alice Coan, legal counsel, Office of the Commissioner of Insurance, described for the task force the legislative history of the Fund.

A legislative study committee on professional medical liability was convened in 1974, to address emerging problems with availability of coverage.[4] By the time the committee had completed its work, the medical liability insurance crisis was well underway. Certain private insurance companies incurred major losses on medical liability claims and premiums for coverage were rising sharply. As a result, medical liability insurance coverage was neither affordable nor available on the private market during the mid-1970s.

In that restricted private market environment, the state Legislature enacted legislation creating the first state risk sharing plan for medical liability.[5] Creation of the risk sharing plan ensured the availability of medical liability coverage for certain categories of health care providers including physicians and hospitals. It also ensured compensation to injured patients in the state. However the Commissioner of Insurance proposed that the coverage should be "claims-made", which drew strong opposition from physicians and,

thus, continued the crisis. Two risk sharing vehicles were created: the Wisconsin Health Care Liability Insurance Plan (WHCLIP) to provide primary liability coverage and the Fund to provide excess liability coverage.

The legislation was motivated in part to protect health care providers from catastrophic judgments which could jeopardize the assets of individual physicians or organizations. It was also intended to stabilize medical liability premium rates. Overall, the main goal was to assure continued access to health care in the state.

The legislation was drafted in conference committee subsequent to the introduction of competing bills in the Senate and Assembly. In signing the 1975 legislation, then Governor Patrick Lucey referred to it as, "a delicate balancing act among the conflicting interests of health care providers, their patients, the legal profession and the insurance industry. . .The conference report is indisputably a product of the process of representative government, and it embodies both the strengths and weaknesses of that process."[6]

The major provisions of Chapter 655 included:

1. The requirement that all physicians, hospitals and nurse anesthetists obtain primary insurance cover age in the amount of at least $100,000 per claim and $300,000 per year in total claims and limited the maximum liability per insured for the primary carrier to $200,000 per claim and $600,000 in aggregate per year in total claims;

2. Creation of the Patients Compensation Fund to pay any medical liability settlement or award which exceeded $200,000 or which, when added to previous claims paid during the year by the health care provider's insurer, caused the total of such claims against the provider to exceed $600,000 in aggregate;

3. Establishment of "informal" patients compensation panels to review malpractice claims for $10,000 or less and "formal" patients compensation panels to review claims for more than $10,000; and

4. Enactment of certain restrictions on attorneys' contingency fees.

The establishment of WHCLIP and Fund in 1975 provided a number of benefits to the various affected interest groups. The Fund assured unlimited medical liability coverage to certain Wisconsin health care providers and defined the limits of liability for primary insurance carriers thereby encouraging private insurance companies to write primary coverage in the state.

Injured patients benefited from the mandatory requirement that health care providers have primary and unlimited excess coverage, which ensured that all claims with merit would be paid. Attorneys also benefitted from a guaranteed method of payment of claims and fees. The constitutionality of the law was upheld in 1978.[7]

A subsequent legislative study committee was convened to consider changes to the patients compensation panel system. It also recommended a change to the statute of limitations for minors.[8] Thereafter, a major legislative revision occurred in 1979.[9] It specified that the Fund would provide "occurrence coverage" rather than "claims-made" coverage.

However, the law did not require that a health care provider's primary insurance also be occurrence coverage, allowing it to be either occurrence or claims-made at the option of the individual health care provider. That option has caused Fund administrators to monitor enforcement requirements so that health care providers who purchase primary claims-made coverage also purchase tail coverage or extended reporting endorsements.

The funding mechanism for the Fund was also altered in 1979. Initially, it had been financed through statutorily set annual fees of $200 plus an amount equal to 10% of the WHCLIP premium for the provider's class. The Fund was a "pay-as-you-go" system not to accumulate more than $10 million in assets. It was not set up as an actuarially based insurance-like program. In time, however, there was concern that the Fund would be unable to meet its future financial obligations.

A proposal was drafted which would have addressed the Fund's actuarial obligations. However, there was debate within the legislature over whether or not reserving was contemplated by the statute. A bill was subsequently enacted

that required the Commissioner of Insurance to set the fees by rule and which specifically required an annual accounting of the present value of all claim reserves by accepted actuarial principles. The change clearly signalled a shift to more of an insurance approach to the fund.[10]

Another significant change occurred in 1983 when the legislature enabled OCI to contract for all or part of the services necessary for the operation of the Fund.[11] By the following year, OCI had contracted with Wausau Insurance Company, already operating WHCLIP, for claims handling. OCI retained administrative, billing, data collection and enforcement functions for the Fund. That year the threshold dollar amount, which determined whether a formal or informal panel proceeding was convened, was increased from $10,000 to $25,000.

In May, 1984, the Legislative Council established the Special Committee on Medical Malpractice to study health care providers' professional liability and patients compensation.[12] Areas for study included the operation and solvency of the Fund and WHCLIP, legal doctrines of liability and the effectiveness of the patients compensation panels. The following year legislation was introduced which eventually resulted in the introduction and passage of a compromise proposal.[13] Highlights of this legislation include:

1. A limit on total recovery for non-economic dam ages, for any single occurrence of medical mal practice to $1 million for claims filed in court beginning June 14, 1986, through December 31, 1990;

2. An increased threshold for penetration of the Fund from $200,000 per occurrence and $600,000 in aggregate claims per year to $300,000/$900,000 effective July 1, 1987 and to $400,000/$1 million effective July 1, 1988;

3. A prohibition of the Fund covering intentional criminal acts of health care providers, regardless of whether those acts may also form the basis for a malpractice claim;

4. A requirement of lump sum rather than periodic payment for liability incurred in excess of $1 million to any one person for one claim and for future medical expenses in excess of $25,000 in all settlements, awards and judgments made after June 14, 1986;

5. Specific limits on attorneys' contingency fees in malpractice actions;

6. The abolition of the patients compensation panels and the requirement of a mediation process;

7. A requirement that, when assessing premiums for health care providers, the Board of Governors for WHCLIP and Fund consider the loss and expense experience of the individual health care provider;

8. The creation of a Patients Compensation Fund Peer Review Council to advise the Board of Governors regarding adjustment of individual health care providers' Fund fees based on individual loss and expense experience;

9. Increased liability protection for persons participat ing on peer review committees;

10. A reduction of the number of fee categories for physicians from nine to four and limitations on the total amount raised by fee assessments to the greatest of:

    a. The estimated total dollar amount of claims to be paid during the fiscal year for which fees are being assessed,

    b. Fees assessed for the fiscal year preceding the fiscal year for which new fees are being established, as adjusted by the Commissioner to reflect changes in the Consumer Price Index, or

    c. 200% of the total dollar amount disbursed for claims during the calendar year preceding the fiscal year for which fees are being set.

11. An expansion of Fund coverage to all corporations organized and operated in the state for the purpose of providing medical services of physicians or nurse anesthetists and to all facilities operated in conjunction with a hospital(s) in the state;

12. The modification of the membership of the Board of Governors from 11 to 13 by deleting two of the five insurance company representatives and adding a representative of the Wisconsin Academy of Trial Lawyers, the State Medical Society and two additional public members; and

13. A requirement that private medical liability insurers file annual reports with the Commissioner.

Since 1986 there have been relatively few changes in the law governing the Fund. However, in 1989 the law was amended to enable the Fund to invest in longer term instruments.[14] The change in investment strategy has reduced the Fund's projected deficit and has helped stabilize Fund assessments. In addition, immunity provisions for Board and committee members were strengthened, professions covered by the Fund were clarified and public employees and facilities were specifically excluded from coverage. The authority to provide a surety bond in lieu of insurance and to use surplus lines of coverage was repealed.

The Experience of the Fund

Peter Wick, a consulting actuary for the Fund, addressed the financial condition and claims trends of the Fund for the task force.[15] From its inception through June 30, 1991, the Fund had paid out approximately $160 million on 289 claims. Twenty-seven of those claims have resulted in awards in excess of $1 million; an additional 18 of such claims are still open. The Fund deficit as of June 30, 1991, was approximately $70 million. Assessment income for 1990-91 was approximately $43 million while investment income was approximately $16 million. Since 1985, claim frequency for the Fund has decreased, however, average claim size has increased dramatically.

Because the Fund was initially established so that statutory assessments were capped and few claims made their way through the system for several years, the Fund assessments remained low through the early 1980s. Since 1980, however, Fund assessments have risen steadily. In 1981, a family practitioner who performed no surgery paid $194 for Fund coverage. In 1991, Fund coverage for that physician cost $2,571. An obstetrician paid $1,600 in Fund assessments in 1981 and $15,425 in 1991.

Richard Roberts, M.D., a member of the Board of Governors and chair of the Claims Committee, reviewed the purposes of the Fund and medical liability trends in general. Ten years ago, medical liability insurance lines were sustaining major losses. By 1989, however, these lines were recovering and some insurers were showing profits. Although severity was up, frequency was down and rates had largely stabilized. That experience has been attributed to improved claims experience, tort reform and other cost containment measures. Recent reports, however, indicate a reversal of that five year trend. According to The St. Paul Companies, the medical liability frequency trend is upward again for the first time since 1985 while the cost of reported claims also continues to rise.[16]

OPTIONS

The Task Force identified two major options for the future of the fund - elimination or continuation. Under each option the group identified factors developed from information and perceptions that were identified by guest presenters, from written information or from the respective memberships, which supported the respective options.

Factors Supporting Continuation of the Fund

Based on comments presented by invited guests and written material provided by SMS and WHA staff, the task force identified the following factors as supporting the continuation of the Fund:

1. Guaranteed compensation for injured patients and protection from physicians who might forego excess liability coverage and risk "going bare."

2. Guaranteed financial protection for the personal/ corporate assets of physicians, hospitals and other health care providers named in medical liability proceedings for instances not excluded by statute.
3. Assured availability of long-term, excess medical liability insurance coverage which may or may not be available on the private market.
4. Availability of unlimited medical liability coverage.
5. The mandatory nature of the Fund spreads the cost of the system across the largest possible statutorily defined risk pool.
6. The existence of Fund coverage encourages maintenance of a stable market for primary liability insurance coverage in the state.
7. The existence of the Fund helps assure Wisconsin citizens of the availability of high risk medical specialties.
8. The existence of the Fund assures coverage to health care providers unable to obtain coverage under private market underwriting standards.
9. An unlimited state-run excess liability fund reduces the concern over joint and several liability and the issue of "deep pockets."
10. The Fund facilitates primary self-insurance for clinics and hospitals. The Fund serves as excess coverage for those organizations wishing to self-insure for their primary liability.
11. As a state-run excess liability insurance mechanism, the Fund has no profit motive, pays no federal or state income taxes and has low operating costs.
12. Arguably, the Fund may have improved access to health care for state citizens as many border physicians have opted into the Wisconsin system.

13. If the Fund were to be eliminated, the current sizable deficit would have to be administered and paid off.

14. The mandatory nature of the Fund affords an opportunity to improve the quality of care through risk management in the state.

15. The existence of the Fund for excess coverage keeps questionable insurance products out of the state.

16. In comparison with the private market, the Fund compares favorably in affordability and availability of coverage.

17. The existence of the Fund retains high public visibility for the medical liability issue.

18. The existence of the Fund forces providers to have a strong interest and knowledge level in the medical liability area.

Factors Supporting Discontinuation of the Fund

1. Fund assessments are stretching the ability of health care providers to absorb the costs of coverage.

2. The mandatory nature of the system precludes individual physicians and organizations from going "partially bare" if they are willing to assume some level of risk.

3. Lower risk specialties, which include the majority of practitioners in the state, partially subsidize Fund coverage for higher risk specialties.

4. There appears to be increased interest within the private insurance market to offer excess coverage in the state.

5. Only six other states have patient compensation funds and none of those provide unlimited excess liability coverage.[17]

6. Because the Fund currently carries a deficit, future physicians and health care providers will wind up paying the cost of the current system.

7. There are perceived problems in the Fund's operation. These relate to issues of accountability, claims management, defense coordination between the primary carrier and the Fund, and structure of the mediation system and fund administration.

8. There is concern that an uncapped fund encourages runaway jury verdicts.

9. The increased cost of medical liability coverage associated with the Fund may decrease access to care by discouraging certain types of physicians from practicing, particularly in rural or underserved areas of the state.

10. The Fund requires continuing commitment of resources from providers to remain responsive.

11. Providing excess coverage through the private market will weed out the poor quality providers who cannot get coverage because of underwriting concerns.

FUND IMPROVEMENT

The Task Force then listed the following potential areas for study and change to improve the Fund if it continues to exist:

1. Pursue tort reform, specifically a cap on non-economic damages, as a key system modification essential to stabilize medical liability premiums and awards. A shortened enforced statute of limitations (2 years) and the institution of periodic payments would also be beneficial.

2. Delineate in statute the obligations of the primary carrier, definitions of coverage and exclusions so as to facilitate a better fit between primary and fund coverage.

3. Correct inequities in participating and paying into the Fund. Examples: health care providers currently not paying individually into Fund (e.g., oral surgeon on hospital staff, psychologists, social workers) but covered by blanket corporate coverage; MCOW physicians paying a reduced rate. Also, health care providers not eligible for fund coverage.

4. Institute better claims coordination between primary carriers and Fund.

5. Make claim management less political.

6. Revise the mediation system; institute binding arbitration system for smaller claims.

7. Limit amount of Fund coverage.

8. Restructure classes for Fund coverage (i.e., more classes.)

9. Implement more consistent coding of physician specialty by primary carrier.

10. Expedite claims processing where Fund's liability is evident.

11. Establish proper long-term and short-term approaches to reserving the Fund.

12. Evaluate trip insurance where patients would buy protection for a given procedure.

13. Evaluate tiered limits for Fund coverage.

14. Evaluate addition of coverage for punitive damages.

15. Evaluate Fund premium structure and how it impacts on the supply of primary care and OB practitioners.

16. Raise base coverage limits to $1 million.

17. Adequately address administrative resource needs of Fund staff so Fund can be more responsive to providers.

RECOMMENDATION TO CONTINUE THE FUND

As noted earlier in this report, when the PCF legislation was signed in 1975, Governor Patrick Lucey referred to the legislation as

> "a delicate balancing act among the conflicting interests of health care providers, their patients, the legal profession, and the insurance industry. . . The conference report is indisputably a product of the process of representative government, and it embodies both the strengths and weaknesses of that process."

Today, as then, depending on one's self interests, various recommendations have been made for the continuation, elimination or modification of the PCF.

This Task Force, also reflecting various interest groups, has attempted to fairly consider the strengths and weaknesses of the PCF as it functions today. Should the PCF continue in existence? Against what criteria should this decision be made?

We believe the criteria for review today are similar to the criteria used in 1975. While today's insurance environment may be more favorable to health care providers, the issues are the same -- availability, affordability, acceptability and the process for amendment.

Availability: In 1975, the issue of availability was critical, as there were few, if any, competing insurance carriers willing to provide excess insurance. Today, as then, the PCF fulfills the excess insurance needs for all health care providers in the state on a consistent and coordinated basis.

Since most malpractice claims involve multiple defendants, the coordination of excess insurance is important to reduce the overall costs and improve the efficiency of the administrative process. While some would suggest that there

are other excess insurance markets available today, they should keep in mind that none of the competing markets provide unlimited excess occurrence coverage which is easily coordinated between all defendant health care providers and which can be relied upon to be there through hard and soft markets.

The PCF continues to meet the issue of availability and goes beyond any competing market by guaranteeing coverage availability and defense coordination to hospitals and physicians in the State of Wisconsin.

Affordability: If a health care provider was able to find excess coverage in 1975, it was likely that the coverage was price prohibitive and not reasonably affordable. Within the classification boundaries established by the legislature (the people), the PCFund addresses affordability more efficiently than any competing system available in 1975 or today.

Since the PCF is mandatory for almost all hospitals and physicians practicing in the state, it spreads the cost over the largest possible base to stabilize and minimize any long-term price increases. No other medical malpractice insurance company has this large a Wisconsin base.

Equally, if not more important, the PCF has no profit motive, pays no federal or state income taxes and has proven low operating expenses. No competing carrier has all these benefits with which to stabilize and minimize their long-term price increases.

Acceptability: In 1975, the PCF was immediately acceptable since for the most part it was the "only game in town". Today, 17 years later, we believe it is still acceptable to the majority of the health care providers in Wisconsin as evidenced by the people that addressed this Task Force, continuing interest from physicians in neighboring states, its adaptability to changing conditions and the unlimited financial security it provides to all covered health care providers. Other than specific recommendations to correct problem areas, there has not been a major movement to eliminate the Fund. Finally, although the Task Force provided an opportunity to physicians and hospitals to express their concerns about the Fund, a handful of providers took the time to respond, further indicating the current lack of major concerns with the Fund.

Process for Amendment: As originally conceived, the PCF reflected the input and compromise of all interest groups. That diversity of input continues today as evidenced by the membership on the various committees and Board of Governors and oversight from the Commissioner of Insurance and the legislature. Numerous avenues are available and have been used since the inception of the Fund to modify and update the PCF in response to the changing needs of health care providers.

Our Task force recommends that in today's environment, considering the Fund's deficit and the status of tort reform efforts, the existing basic structure of the Patients Compensation Fund be continued. While it is not our recommendation to discontinue the fund, we did discuss the implications of doing so. (Attachment B) We believe the benefits of the Fund currently outweigh the deficiencies. We believe that the deficiencies can and should be addressed within the Fund structure as it exists today. We also recognize that enactment of meaningful tort reform could impact on the need for the fund or allow significant changes to be made to it at some time in the future.

Identification of Issues For Study to Improve the Compensation Fund: We believe there are four major areas of concern within the existing structure that need to be reviewed and modified for improved efficiency and to stabilize long-term costs. These issues are:

Issue 1. ***Recommendation*: Tort reform is a key system modification essential to stabilize medical liability premiums and awards and should be strongly supported.** Specifically, a cap on non-economic damages, a shortened statute of limitations to two years, and a system of periodic payments should be pursued. In addition, the PCF Board should re-evaluate the value and acceptability of some form of panel system for resolution of disputes.

Discussion: Actuarial evidence suggests that changes in these areas will have a positive impact on exposure and translate into a stabilization of fees. The Task Force received information that the current media-

tion system is viewed as ineffective by many providers and that, while the previous panel system had its problems, it may have been more effective in resolving disputes, particularly smaller ones, short of the formal trial process.

Issue 2. ***Recommendation:*** **The PCF Board should address inequities and inconsistencies in fund cost and access to fund coverage.** Specifically, the Board should examine the following areas from the perspective of fairness, social impact and actuarial soundness:

a) the availability and cost of fund coverage to part time and temporary practitioners

b) the discount provided to certain classes of providers (example: MCOW physicians)

c) the applicability of mandatory fund coverage to currently ineligible classes of providers

d) the availability and cost of fund coverage for governmental entities or their employees

e) the justification for four versus more fee categories for physician providers

f) the availability and cost of fund coverage for those providers covered by fund corporate coverage but who are not individually assessed.

Discussion: One task force member commented that the surest way to bring the Fund to an end was to create a widespread perception that the fund is not administered fairly. Study of each of the above areas resulting in well-reasoned and well-communicated conclusions will go a long way

toward increasing provider comfort levels on this issue.

Issue 3. ***Recommendation:*** **The Board should study the benefits and adverse implications of making changes to the fund structure, specifically;**

a) moving the primary coverage levels from $400,000 to $1 million

b) imposing caps on fund coverage.

Discussion: The Task Force feels that it is appropriate for the Board to evaluate the structure issue on a continual basis to address changing factors in the liability arena. Primary coverage levels have been raised gradually in the past. There may be some rationale for this practice because of inflationary trends and as a way to concen trate claims handling in the primary lines. The Board should evaluate the impact on the primary coverage market in terms of pricing and underwriting and impact on surplus and accessibility to coverage. While some benefits may be achieved from moving the limits upward, a competitive responsive primary coverage market must be maintained. The Board should also consider any shift in provider exposure which could result from these changes.

Imposing limits on fund coverage might be a way to address fund cost concerns and some perceptions that the unlimited coverage provided actually encourages higher awards. However, it also raises some serious questions about the shifting of liability to "deep pocket" providers and the availability of excess coverage to those providers who want or need it. The Task Force realizes that this is a potentially, sensitive issue which should be examined very carefully by the Board.

Issue 4. ***Recommendation:*** **The Board should <u>seek regular customer input about the administrative effectiveness and responsiveness of the Fund</u>.** Sufficient financial and support resources should be provided to enable the Fund to meet and anticipate its customer needs and expectations.

<u>Discussion</u>: For this to be successful, an ongoing mechanism of communication with Fund "customers" needs to be established and utilized. "Customers" certainly includes those health care providers covered by the Fund, but probably goes beyond that group.

Specific areas of need identified by the task force as potential areas for improving responsiveness were billing practices, availability and analysis of data, ability to respond to customer questions, and clear explanations of exemptions. Two rather large areas of need were improvement in claims coordination and related communications, and strengthening risk management activities. The Task Force noted that, quite recently, additional resources had been allocated in this area. It noted that these efforts need to be monitored for effective ness and value.

The Task Force feels strongly that existing commitments of resources to the administrative functions of the Fund may be insufficient and needed to be examined more closely.

FOOTNOTES

1. Chapter 37, Laws of 1975

2. Wisconsin Statutes 655.23(7)

3. Wisconsin Statutes 655.27(3)

4. Wisconsin Legislative Councils - Special Committee on Liability of Health Professionals

5. Chapter 2, Laws of 1975

6. Governor's Veto Message, July 21, 1975

7. State ex rel. Strykowski v. Wilkie, 81 Wis. 2d 491 (1978).

8. Malpractice Committee Report to the 1977 Legislature dated May 5, 1977. Chapters 131 and 390, Laws of 1977

9. Chapter 194, Laws of 1979

10. Chapter 194, Laws of 1979

11. 1983 Wisconsin Act 27

12. Wisconsin Legislative Council Report dated November 14 to the 1985 Legislature Legislation Relating to Medical Malpractice dated October 1, 1985.

13. 1985 Wisconsin Act 340

14. 1989 Wisconsin Act 187

15. Milliman & Robertson "Actuarial Analysis" dated January 27, 1992

16. Medical Liability Monitor, Sept. 28, 1990 and July 29, 1991

17. The states are Indiana, Kansas, Louisiana, Nebraska, New Mexico, Pennsylvania, AHA Tort Reform Compendium

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Attachment B

STATE MEDICAL SOCIETY OF WISCONSIN

OFFICE MEMORANDUM

TO: Joint Task Force on Patients Compensation Fund

FROM: Mark L. Adams, Corporate Counsel

DATE: January 9, 1992

RE: Proposed Appendix to Task Force Report

Elimination of Wisconsin PCF Coverage

Several fundamental elements incorporated by statute in the Wisconsin Patients Compensation Fund have raised concerns, currently voiced by a small number of physicians and others, regarding the possible negative impact on access to health care for Wisconsin citizens because of increasing PCF fees assessed against a limited number and type of Wisconsin licensed health care professionals.

Those fundamental elements include: 1) direct mandatory participation in PCF by a limited number and type of health care professionals; 2) unlimited coverage for covered claims which exceed the primary insurance limits; 3) limited number of PCF fee classifications with little or no flexibility based upon a) numbers or types of procedures performed or hours/days worked, b) claims experience, c) geographic location, or d) voluntary purchase of higher than currently required primary insurance limits; and 4) problems in coordination of claims defense between PCF and primary insurance company for various reasons including a) an increasing number of cases involving claims greater than the primary limits, b) potential coverage differences between the primary policy and statutory PCF coverage...(examples include defense/indemnity of alleged sexual professional misconduct and alleged punitive damages).

One possible solution to address these problems is to totally eliminate the statutory WI PCF and, in effect, place Wisconsin health care patients, professionals and organizations in a professional liability insurance environment more like the substantial majority of states, including all of our border states, which do not have a Patients Compensation Fund for professional medical liability. No other state in the nation has a PCF like ours in Wisconsin which is mandatory in nature for a limited number and type of provider and which provides potentially unlimited coverage for covered claims.

The method to be used to eliminate the WI PCF should be as simple and easy to implement and administer as possible, especially considering the long "tail" or time period in which PCF claims would need to be defended and paid. The minimum action required to eliminate the PCF would include but would not be limited to the enactment of legislation to: 1) eliminate PCF coverage for any act occurring on or after July 1 following passage; 2) eliminate all future PCF fees and assessments; 3) OCI and WHCLIP/FUND Board of Governors continue to provide or contract for appropriate staff to administer the run-off of claims; 4) all costs of administration and payment of run-off claims to come from the balance of the current PCF funds plus future investment income and, if necessary, state general purpose revenues; 5) WHCLIP to continue operating an occurrence insurance plan to meet possible primary insurance coverage needs of health care providers and institutions not available in the private market.