WISCONSIN STATE LEGISLATURE COMMITTEE HEARING RECORDS

2005-06

(session year)

Assembly

(Assembly, Senate or Joint)

Committee on Insurance (AC-In)

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_ab0765_AC-In_pt01**

- Miscellaneous ... Misc
- **

Vote Record
Committee on Insurance

Date: October 19, 2005

Moved by: Gielow Seconded by: Underheim

AB 765 SB_____ Clearinghouse Rule_____

AJR_____ SJR_____ Appointment_____

AR_____ SR_____ Other_____

A/S Amdt _____

A/S Amdt _____ to A/S Amdt _____

A/S Sub Amdt _____

A/S Amdt _____ to A/S Sub Amdt _____

A/S Amdt _____ to A/S Amdt _____ to A/S Sub Amdt _____

Be recommended for:

X Passage ☐ Adoption ☐ Confirmation ☐ Concurrence ☐ Indefinite Postponement

☐ Introduction ☐ Rejection ☐ Tabling ☐ Nonconcurrence

Committee Member	Aye	No	Absent	Not Voting
Representative Ann Nischke, Chair	☒	☐	☐	☐
Representative Steve Wieckert	☒	☐	☐	☐
Representative Gregg Underheim	☒	☐	☐	☐
Representative Phil Montgomery	☒	☐	☐	☐
Representative Terri McCormick	☒	☐	☐	☐
Representative Curtis Gielow	☒	☐	☐	☐
Representative Karl Van Roy	☒	☐	☐	☐
Representative Joan Ballweg	☒	☐	☐	☐
Representative Terry Moulton	☒	☐	☐	☐
Representative David Cullen	☐	☒	☐	☐
Representative John Lehman	☒	☐	☐	☐
Representative Tony Staskunas	☒	☐	☐	☐
Representative Terese Berceau	☒	☐	☐	☐
Representative Thomas Nelson	☒	☐	☐	☐
Representative Michael Sheridan	☐	☒	☐	☐
Totals:	13	2	0	0

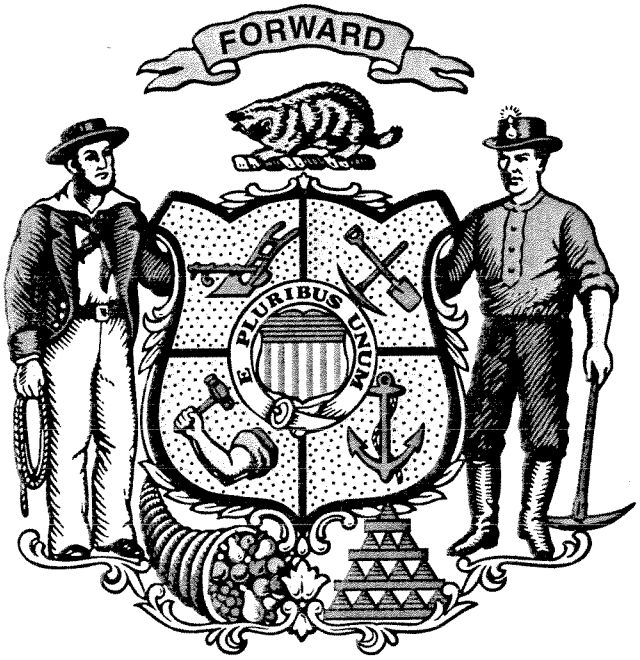
☒ Motion Carried ☐ Motion Failed

AB 769
Amend 15-0
Recc 15-0

AB 765
Recc 13-2

AB 766
Amend 6-9
Recc 9-6

AB 764
Amend (LRB s0261)


FORWARD
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Assembly

Record of Committee Proceedings

Committee on Insurance

Assembly Bill 765

Relating to: coverage under the injured patients and families compensation fund of medical school graduates engaged in postgraduate training.

By Representatives Gielow, Huebsch, Nischke and Gard; cosponsored by Senators S. Fitzgerald and Kapanke.

October 17, 2005 Referred to Committee on Insurance.

October 18, 2005 **PUBLIC HEARING HELD**

Present: (0) None.
Absent: (0) None.

Appearances For

- Barbara Connelly, Brookfield — Ms., Medical College of Wisconsin, Affilliated Hospitals

Appearances Against

- None.

Appearances for Information Only

- None.

Registrations For

- Nick George, Madison — Mr., Wisconsin Manufacturing & Commerce
- Kathryn Kuhn, Milwaukee — Ms., Medical College of Wisconsin
- Jim Hough, Madison — Mr., WCCI, CTCY, WEDA
- Mark Adams, Verona — Mr.
- Elizebeth Schumacher, Madison — Ms., Meriter Health Services
- Mark Grapentine — Mr., Wisconsin Medical Society
- Eric Borgerding — Mr., Wisconsin Hospital Association
- Maureen McNally, Milwaukee — Ms., Froedtert & Community Health
- Ralph Topinka, Janesville — Mr., Mercy Health Systems

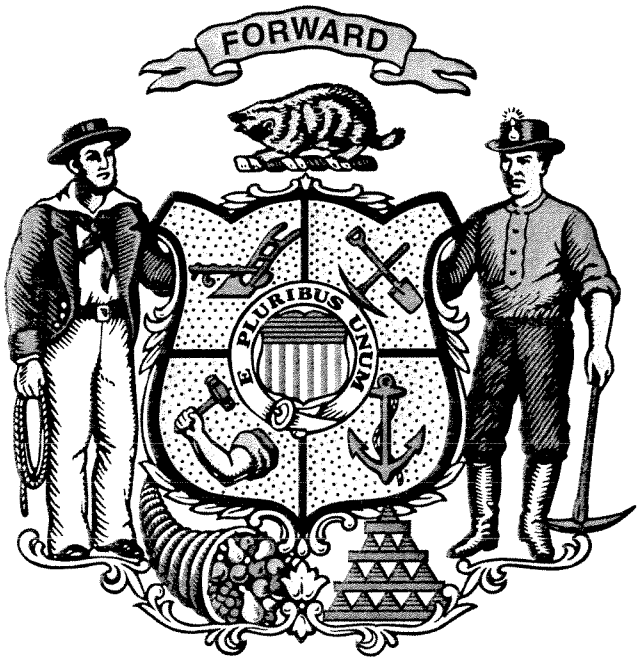
Registrations Against

- Don Garner-Gerhardt, Wausau — Mr., Teamsters Union

October 19, 2005 **EXECUTIVE SESSION HELD**

Present: (0) None.
Absent: (0) None.

Adam Peer
Committee Clerk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Wisconsin Medical Society

Your Doctor. Your Health.

TO: Members, Speaker's Task Force on Medical Malpractice
Representative Curt Gielow, Chairman

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

DATE: September 28, 2005

RE: Wisconsin's Medical Liability Stability Attracts Physicians

On behalf of the 10,000 members of the Wisconsin Medical Society, thank you for this opportunity to share information we believe is important to the Task Force's deliberations on restoring a reasonable and effective cap on noneconomic damages: **Wisconsin's stable medical liability environment made our state a magnet for physicians**. The Supreme Court's decision to remove noneconomic damage caps in medical liability cases dramatically threatens that stable environment, and thus our status as a magnet state.

Following this cover page are accounts of physicians choosing Wisconsin as a place to work and live. They are but a sample of a common theme heard throughout our state: Wisconsin is physician-friendly, free from threats of questionable lawsuits and career-ending "jackpot justice" awards. Within these narratives you will understand the impact the Supreme Court's decision has had on our physician community; there now is an undercurrent of uncertainty and fear.

The opening example comes from Rhinelander and is written directly to the Task Force members. Pamela Galloway, MD and her husband, Christopher Magiera, MD, left a well-established practice in Cleveland, Ohio. They call themselves "medical liability refugees" who chose Wisconsin specifically because it was one of just six states in the nation considered not in the throes of a liability crisis or near-crisis. They desperately want to avoid having Wisconsin go through what Ohio did – increased health care costs and decreased access to specialty care due to a liability environment crisis.

Other accounts follow; all share a similar theme. We have not edited content – the words and emotions are solely the physicians'.

We applaud the Task Force for its commitment to recreating what Wisconsin once had: medical liability reforms making our state the envy of the nation and a destination for high quality physicians willing to practice specialty care. We believe these experiences amply prove to the State Legislature what the medical community has known for the past 10 years: a reasonable cap on noneconomic damages is a major reform bringing physicians to the state and increasing patient access to care.

Thank you for taking the time to read these accounts. If you have any questions, please feel free to contact me at 608.442.3800.

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.

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?

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.

David Farkas, MD, FACEP
Lake Forest, IL

I am a Family Practitioner formerly from Illinois - I practiced there for several years in an emergency department and then in an urgent care. One of the main reasons I left was that I was just sick and tired of the lawsuit paranoia that is rampant there – and I mean paranoia in the fullest sense of the term. Most doctors there are just plain scared, even if they won't admit it – you can see it in their practice style. When I moved to Wisconsin (just last year) I noticed a significant difference in the way medicine was practiced. It seemed like doctors up here use their own common sense a lot more and they don't reflexively order tests just to 'cover their hind end'!

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

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

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

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

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

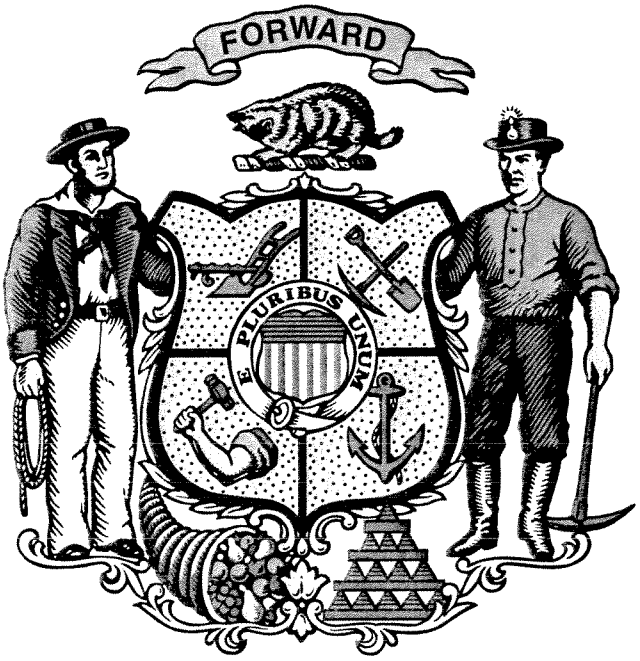
I am quite interested in seeing the caps on medical liability restored in Wisconsin. I taught Family Medicine for 3 years in Kentucky and also worked in a busy ER there for 3 years. The public is generally unaware of how badly medical liability concerns erode their access to quality healthcare.

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.

John R. Ewing, MD
Lake Delton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9200 West Wisconsin Avenue
Milwaukee, WI 53226

Catherine Mode Eastham, Esq.
Vice President & General Counsel

Froedtert & Community Health

414/805-2994 Tel
414/805-5283 Fax
ceastham@fmlh.edu

October 17, 2005

Representative Ann Nischke
Chair, Assembly Committee on Insurance
Wisconsin State Assembly

Ms. Nischke:

I am writing in support of 2005 Assembly Bill 765, which makes changes to the statutes covering the Injured Patients and Families Compensation Fund. The proposed changes directly affect the many residents who participate in training programs at Froedtert Hospital and who are employed by the Medical College of Wisconsin Affiliated Hospitals ("MCWAH"), of which Froedtert is a member. Assembly Bill 765 fills a gap in the Patient Compensation Fund statutory structure and the licensure structure for certain residents. The legislation will codify current practice used by the Fund and continue to support the excellent training we have for medical professionals in Wisconsin.

Background

As Chapter 655 is currently written, there is an ambiguity as to whether the Injured Patients and Families Compensation Fund ("Fund") covers medical residents before they have been licensed by the Medical Examining Board. This ambiguity was an issue in the recent Wisconsin Supreme Court ruling in *Phelps v. Physicians Insurance Co,* 2005 WI 85. The Fund currently covers certain identified health care providers, primarily licensed professionals such as physicians and registered nurses. It also provides coverage for employees of hospitals and other health care providers. In *Phelps,* the Court concluded that these residents who are not yet licensed physicians are not health care providers covered by the Fund. The Court did not determine whether these residents could be considered employees of a hospital, however, which would have given them Fund coverage.

Residents involved in the programs of The Medical College of Wisconsin and MCWAH are not a traditional employee of any hospital. These residents are employed by MCWAH, which has employment contracts with the residents and provides the payroll, benefits, and liability insurance for the residents.

The Fund recently issued an administrative determination that these residents can be considered employees of an affiliate of a hospital providing health care services to the patients of that affiliated hospital. The determination has never been tested in court, however, and we feel a statutory clarification would be better protection for these physicians-in-training.

There is also a gap in the statute as to the granting of temporary educational permits for first year residents. The statutes provide that the permit can be obtained only after completion of 12 months of training in an accredited medical education program. During that 12-month period, it is not clear what status that resident has.

Also, it is after 12 months of training when a resident may apply and take the examinations to obtain a license to practice medicine. Residents who follow this approach may never hold a temporary educational permit.

Proposed Change

The change to Chapter 655 contained in Assembly Bill 765 adds another entity that can be covered by the Fund: a "graduate medical education program." MCWAH would qualify as such a program and as such could *statutorily* obtain coverage under the Fund for its employees. Even if a court were to over turn the administrative decision of the Fund to cover the MCWAH residents, the statute would provide coverage.

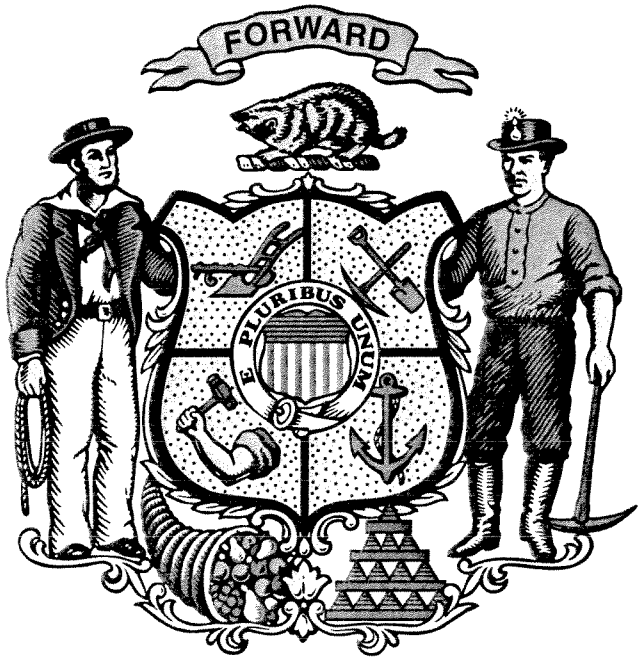
In addition, the Bill changes the rules to require that a temporary educational permit be obtained before a medical school graduate can participate in a residency program.

We support 2005 Assembly Bill 765 because it codifies current practice with respect to Fund coverage and will protect Wisconsin as a good location for residency programs. These benefits will help the state continue to attract quality residents to train here and eventually provide care to Wisconsin residents.

Thank you for your consideration.

Sincerely,

Catherine Mode Eastham
Vice President and General Counsel


FORWARD
PLURIBUS UNUM

Testimony

Against Legislation for Re-establishment of Caps for Pain and Suffering Resulting from Medical Malpractice [Room 412E]

by
Dr. Eric E. Rice
Wisconsin Family Justice Network
Middleton, WI

18 October 2005

There are many significant medical malpractice issues that need to be resolved to help patients and their families to: gain disclosure of information, have equal rights and legal protection under the law, and seek accountability for medicine that is well below the standard of care. I submit to you that the medical insurance industry is the route of the medical malpractice problems in this country and that is where reform is needed. We should not do more harm to the effected patients by putting caps back. Caps on non-economic damages are a hindrance to finding out the truth and gaining accountability for our citizens.

The Rice Family of Middleton, Wisconsin experienced a medical crisis and loss of our 20-year old daughter, Erin Elisabeth Rice at UW Hospital on April 19, 1999 due to gross misdiagnosis of her illness. This ordeal has identified many significant medical and legal issues that need to be fixed by this legislature. The Wisconsin Family Justice Network, of which I am involved, was formed to fight for all of us, fight for the rights of all patients and our families.

[1] The Network does not support medical malpractice caps and we believe that judges and juries should make those decisions just like in any other civil action.

[2] The Network supports the passage of the Family Justice Bill [sponsored by Senators Plale, Hansen, and Erpenbach, and Representatives Ott, Sheridan, and Zephick] that will put all patients on an equal basis and prevent discrimination based on age and marital status.

[3] The Network supports the Repeal of the 180-day Notice Rule [SB-74 - Sponsored by Senator Risser, and Representatives Jenson, Hines, Pocan, Berceau, and Lehman] that UW physicians and lawyers have used to unfairly discriminate against patients that use UW physicians.

Patients/Families that have suffered or died require the right to litigate against physicians, hospitals, HMOs, insurance companies in a standard equal and fair way. The same standards must be utilized for any medical provider within a given state. No unfair advantage must be afforded to one medical provider over another when it comes to the provision or need for malpractice insurance, limits of liability, and notice of claim rules.

The recent low $350,000/$250,000 [with inflation] cap on malpractice/wrongful death non-economic damages limit (in Wisconsin and elsewhere) is totally unconstitutional should not be approved by our legislature. The Wisconsin Supreme Court will declare its flaw once again, if passed; however, I expect that Governor Doyle will veto it.

Until recently, the State of Illinois had no cap on medical malpractice, as the previous caps were declared unconstitutional by the Illinois Supreme Court. The Judges and Juries made those determinations. With no caps, healthcare in Illinois has improved, physicians practiced better medicine, the cost of medicine only increased by 1%, there is much less indirect pain and

suffering, and there is much less indirect adverse economic cost to the people. The bad doctors moved to states with caps! In states where lower caps exist (like Indiana, for example), the quality of medicine is poor, and the greater is the pain and suffering and greater is the unmeasured economic loss of patients and their families. This lower cap may result in patients not being treated with the smartest or heroic measures because it is cheaper for the medical system to simply go through the motions and let the patient die and pay the limited claim in or out of court.

Any cap - at any level - on medical malpractice provides tremendous advantages to the medical practitioner and the insurance company and does a terrible injustice to a victimized patient in either the negotiation of a fair settlement or trial action, if taken. Reinstatement of Caps will only reduce the quality of healthcare that patients receive in this state. If there are problems of frivolous lawsuits, let the juries and judges make the fair decisions. Provide these institutions the tools they need to foster fairness to both the patients and doctors!

The Patient's Compensation Fund is for Patient Compensation. It has ballooned to a whopping $750M and still the insurance companies complain. Even after significant reductions in physician premiums, the fund still grew by $20M last year. The fund is meant to try to make "whole" the patient and families that have been harmed or killed by medical errors and failures.

For cases, usually involving young or older victims, there may be no likely economic claim, the caps on non-economic damages will prevent an action from making it to the court room. I'll explain why. To gain legal representation, a client's case must make sense, economically. If there is a plaintiff win probability of 25% and there is a cap of $400K, that means that the likely economic win would be 25% of $400K which would be a $100K probable result. However, to put on a trial, the out of pocket costs for depositions, testimony of medical experts, travel, etc., will easily reach $100K. Also, the Wisconsin jury trial plaintiff win probability last year was 17% [4 out of 23] in WI. The Lawyer will not take the case because there is not enough likelihood of getting paid any thing for his or her labor. This means that patients like these will never get to the court room to find out what happened. No accountability will ever be achieved.

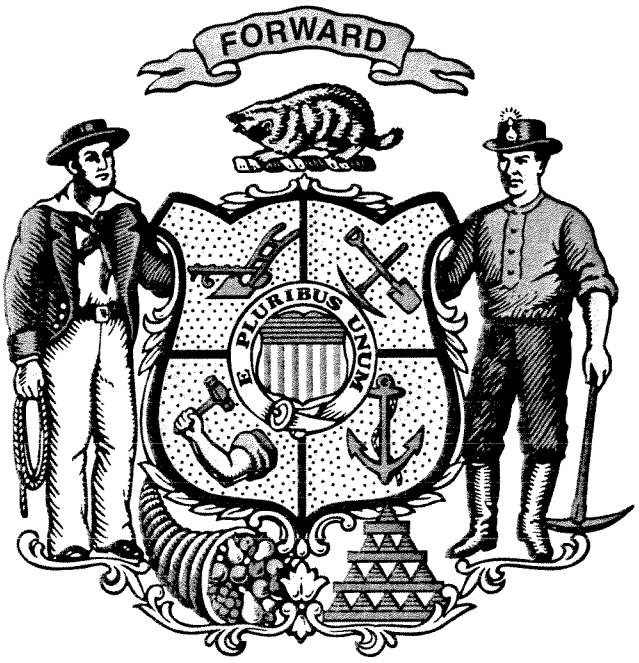
Just think what you would do if your older parent or your young child died of medical malpractice and no attorney could take the case because of caps, and you could never find out what happened. That's why the caps need not be put back. And that is why the Medical Society and Insurance Company Lobbyists support Caps. Medical Malpractice in this country accounts for less than 0.46% of the total cost of the health care delivery system. Wisconsin had the lowest rate in the nation at less than 0.4%. Who has the correct facts here? We do.

Vote No for Caps

Vote Yes for Family Justice

Vote Yes for repeal of the 180-day Notice Rule.

That's my input -- Thanks for listening!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TO: Assembly Insurance Committee

FROM: Kim and David Zak

DATE: October 18, 2005

RE: Testimony against caps on damages

We are Kim and David Zak from Crivitz, Wisconsin. We are here today to speak against caps on damages because we have been impacted in a very deep and personal way by malpractice. I want to tell our story.

David is an auto mechanic and was at work flushing out a cooling system, when hot anti-freeze burned his right forearm. The burn was cleaned, but unknown to us, the burn drove Group A Strep bacteria, which is on our skin, into David's bloodstream.

That night David woke up in the middle of the night with chills. He took a Benadryl and went back to sleep. Five hours later he awoke with the shakes. He called me at work and asked that I come home and drive him to the hospital. This was a very unusual request.

I came home and we drove to Green Bay, on the way we stopped and grabbed all the bottles that David had used that day and took with us to the ER. It took about an hour and half to drive. We arrived about 9 a.m.

During the next 3 and half hours, they treated David's burn and did blood work-up, including a CBC. His temperature spiked to 103.9 degrees and his blood pressure was low. They said it would take 24-48 hours for the cultures to grow and prescribed Ibuprofen and Tylenol for the pain and fever, alternatively. We were advised that if conditions didn't worsen to come back in two days.

David spent the rest of the day resting and didn't present any new symptoms. He took a cool bath and his temperature went down a bit.

The hospital called back at 10 p.m. and said something was growing in the cultures and to return to the ER that night or in the morning. We decided to return that night. On the way to the hospital, David started experiencing diarrhea. By the time we reached the hospital, his blood pressure was very low and he was already septic. I could see blood coming out of the penis.

David's organs started shut down – liver, kidneys, and bladder. His lungs were bleeding. He spent three weeks in the hospital on antibiotics. Everything came back, but his bladder. He was required to have tubes inserted into his back, so his urine could drain into bags on his legs. They had to be cleaned everyday and bandaged.

We went to an urologist at the Mayo Clinic to have his bladder removed and a new bladder rebuilt. The new bladder is a neobladder made from his appendix, colon and intestines.
What happened? During the course of our trial we learned that the Physicians Assistant (PA) had done an analysis of the blood called a wet analysis. The result said to do it manually, which would have taken an hour. The PA also told the doctor that David was already septic, yet the doctor said it was April and he had the flu and sent him home without any antibiotics.

What is our life like? We are constantly watching for infections. He is required to use a catheter every time he goes to the bathroom and he is very susceptible to infections.

David must take liquid medication and antacids for metabolic acidosis. He is fatigued.

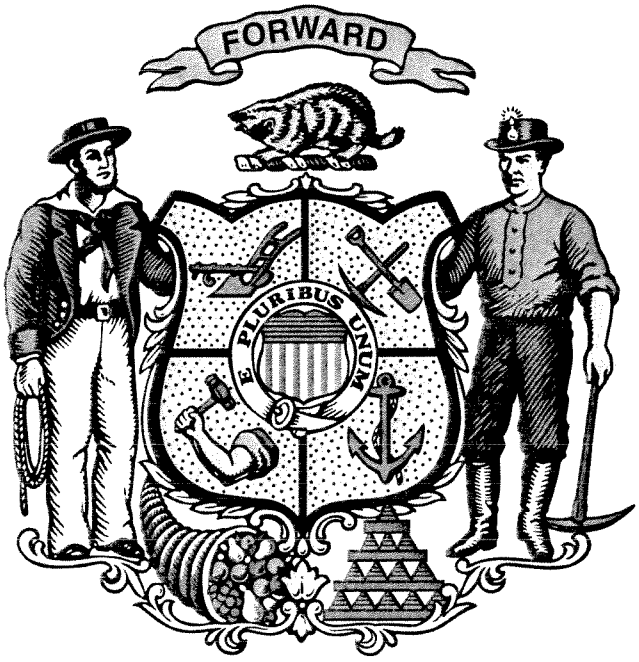
He suffers from erectile dysfunction. To have an erection he must inject himself with Triple agent. If it doesn't work right and the erection doesn't subside, he must go to the hospital and have it cut and drained.

We had an eight-day trial in Marinette County that gave us $1 million for our pain, suffering and disability. David received $750,000 and I received $250,000. The cap cut down our award over 55%. The compensation recognizes what we will have to go through for the rest of our lives.

Also, I want to point out, if David and I hadn't brought this lawsuit, workers' comp would not be repaid. To date, our case is still on appeal and we haven't received any money to date.

I hope that none of you in this room ever have to be sitting in this place that we are today. A mistake was made that changed our lives forever. It could have happened to anyone here... It still could happen to you.

Please don't enact new caps on damages. It only serves to hurt someone like us.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MERCY HEALTH SYSTEM
1000 MINERAL POINT AVE.
P.O. BOX 5003
JANESVILLE, WI 53547-5003
608•756•6000
www.mercyhealthsystem.org

A System for Life

TO: Assembly Committee on Insurance

FROM: Ralph V. Topinka, Vice President & General Counsel
Mercy Health System
Janesville, Wisconsin

DATE: October 18, 2005

SUBJECT: Testimony Regarding - AB764 (Collateral Source) AB765 (Medical Residents) AB766 (Medical Malpractice Caps)

INTRODUCTION

Mercy Health System is an integrated health care delivery system that provides physician, hospital, nursing and other health care services to residents in Southern Wisconsin and Northeastern Illinois. Mercy employs more than 3,300 individuals, including approximately 1,250 persons who are licensed or certified health care professionals, more than 250 physicians and more than 650 registered nurses. We provide clinic-based services in 39 community clinics located in six counties in Wisconsin and Illinois. Our clinics range from single physician practices to large multi-specialty centers with ambulatory surgery, urgent care services and various diagnostic services.

Please accept our strong support for Assembly Bills 764, 765 and in particular, 766. Assembly Bill 764 modifies the collateral source rule to reflect a common sense approach to awarding damages in medical malpractice actions, that is, making sure that claimants recover only once for the same item of damages. Similarly, AB 765 is a sound approach to making sure that residents in training, and their employers, may participate in the Injured Patients and Families Fund and may have the protection of caps on non-economic damages that apply to other health care providers.

CAPS ON NON-ECONOMIC DAMAGES

The main focus of my testimony today is Assembly Bill 766. This bill restores caps on non-economic damages in medical malpractice cases.

Unlike patients in most states, patients in Wisconsin who make successful claims for medical malpractice can be assured that they will receive financial compensation. That is because in Wisconsin, health care providers by law must obtain medical malpractice

insurance, and must participate in the Injured Patients and Families Compensation Fund (the "Fund"). The combination of providers' malpractice insurance and the Fund means that in Wisconsin, successful malpractice claimants will receive their full economic damages, less costs and attorneys fees. As we are aware, until the recent *Ferdon* decision, there was a statutory cap on recovery of non-economic damages. Even with the cap, however, plaintiffs could recover hundreds of thousands of dollars in non-economic damages in addition to unlimited economic damages.

There are a variety of reports and actuarial studies that demonstrate certain basic facts about the Wisconsin medical malpractice marketplace. These facts include:

- Wisconsin's malpractice insurance market compares favorably to other states in terms of affordability of insurance;
- States with caps on non-economic damages generally have more affordable malpractice insurance and loss ratios;
- States with low to medium caps are more likely to have favorable malpractice insurance markets.

Wisconsin's careful legislative balance--mandatory malpractice insurance and participation in the Fund, unlimited Fund protection for malpractice awards and settlements, and reasonable caps on non-economic damages--has contributed to Wisconsin's favorable malpractice insurance market. This is just one of the reasons we believe maintenance of a cap on non-economic damages in medical malpractice actions is critical.

In his concurring opinion in *Ferdon*, Supreme Court Justice Patrick Crooks emphasized that "statutory caps on noneconomic damages in medical malpractice cases, or statutory caps in general, can be constitutional." While finding the caps created by the Legislature in 1995 unconstitutional, Crooks concluded, "Wisconsin can have a constitutional cap on noneconomic damages in medical malpractice actions, but there must be a rational basis so that the legislative objectives provide legitimate justification, and the cap must not be set so low as to defeat the rights of Wisconsin citizens to jury trials and to legal remedies for wrongs inflicted for which these should be redress." We believe Assembly Bill 766 meets these standards.

The majority opinion in *Ferdon* recognized that, according to a study by the U.S. General Accounting Office, a shortage of physicians existed in rural locations in states without limitations on damage awards. Further, the majority recognized that malpractice pressures are among the factors that affect the availability of services.

There are a number of reports that outline Wisconsin's current and increasing shortage of physicians. Given Wisconsin's aging population and other changing demographics, the retention and recruitment of physicians are crucial in order to provide sufficient access to health care. In addition, there are studies that have found that the retention and

recruitment of physicians, especially in rural and urban areas, are more successful in states that have stable and affordable medical liability insurance rates.

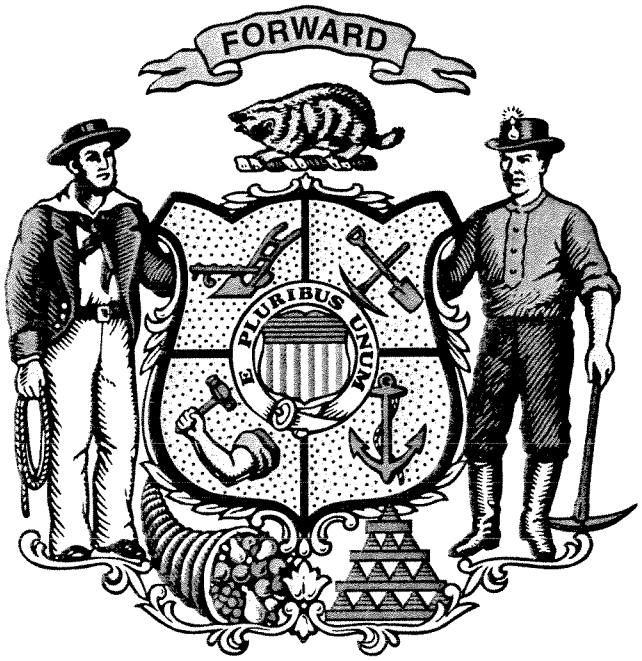
One of Mercy Health System's primary goals is to provide health care services in communities where the services are needed. In order to do that, we work diligently to recruit and retain high quality physicians. In light of a national shortage of physicians, recruitment and retention of physicians is always a difficult task.

Wisconsin has historically enjoyed a stable medical malpractice climate. Because we provide physician services both in Wisconsin and Illinois, Mercy has a good appreciation and perspective on the advantages of a stable medical malpractice climate. We have first hand experience with physicians who have left their practices in Illinois, some of them come to Wisconsin, because of the historically unfavorable Illinois medical malpractice climate. Our favorable malpractice climate has helped our recruitment and retention efforts.

CONCLUSION

As recognized by the Court in *Ferdon*, Wisconsin currently enjoys a stable and affordable medical liability environment. We believe that reasonable caps on non-economic damages in medical malpractice actions contribute to that environment. Based on actuarial analyses of the insurance exposure amount that would provide stable and affordable insurance rates and studies of the caps in other states, we believe a cap no greater than $550,000 will help maintain Wisconsin's current positive environment. On the other hand, based on the same and other studies, it is reasonable to conclude that a cap or limitation in an amount above $550,000 would have a negative impact on that environment. The studies and actuarial analyses indicate that a high cap or limitation would not provide the same predictability, stability, or affordability as a low or medium cap.

Coupled with assurances of recovery through mandatory malpractice insurance for health care providers and mandatory participation in the Fund, Assembly Bill 766 is a sound and rational approach to ensuring a stable malpractice environment and improving access to health care in Wisconsin by stabilizing or increasing the supply of physicians in Wisconsin and encouraging physicians and hospitals to provide health care services in rural and urban areas.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WISCONSIN HOSPITAL ASSOCIATION, INC.

October 18, 2005

TO: Assembly Committee on Insurance

FROM: Eric Borgerding, Senior Vice President

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

Chairperson Nischke and members, my name is Eric Borgerding and I am Senior Vice President for the Wisconsin Hospital Association (WHA). Thank you for this opportunity to speak today in support of AB 764, AB 765 and AB 766. This hearing, and the Speaker's task force that preceded it, are an extraordinarily rapid and high-priority response to a series of damaging Supreme Court decisions, and our 130 member hospitals appreciate your concern and commitment.

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

If you work in the health care system, that is, if you struggle with recruiting physicians to rural or urban areas, if you are a rural family practice doctor who also delivers babies, or more importantly, if you are a patient who may not have access to the care you need, you know that inaction, or an inadequate response to these recent decisions could be devastating.

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

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

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

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

Our opponents tell you to ignore the havoc out of control premiums are wreaking in other states -- but what has happened in Illinois, Oregon, Washington, Nevada, Ohio, and many other states without caps simply cannot be ignored or minimized:

- In Oregon, liability premiums for family practice physicians that deliver babies have increased 332% since caps on non-economic damages were struck down in 1999. By 2002, 34% of all physicians delivering babies in Oregon had quit performing deliveries.

- In Washington, where their short-lived caps were struck down in 1988, fewer doctors are delivering babies and more women are arriving in Washington hospitals never having received prenatal care.

- In Illinois, were in 2002 uncapped non-economic damages accounted for 91% of the average jury award, OB-GYNs have fled the state, many coming to Wisconsin. Southern Illinois is devoid of neurosurgeons and without head trauma coverage.

- In Ohio, where caps were struck down in 1991 and again in 1995, a 2004 survey of physicians conducted by the Ohio Department of Insurance indicated that nearly 40% of those who responded said they had retired, or planned on retiring in the next three years due to rising insurance costs. Only 9% of the respondents were over age 64.

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

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

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

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

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

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

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

Until very recently, Wisconsin had one of the most balanced, and frankly envied, medical liability systems in the country -- the sum of an equation that included two key factors – the Wisconsin Injured Patients and Families Compensation Fund and a cap on non-economic damages (some would include a third component – unlimited economic damages).

Indeed, on May 12, 2005, just six weeks before the Ferdon ruling, Wisconsin Commissioner of Insurance Jorge Gomez reported on the impact of 1995 Act 10 ($350,000 cap on non-economic damages plus inflation). In his report, the Commissioner described a then favorable medical liability climate, and the impact it has had on access to health care.

> *"To conclude ... Wisconsin's malpractice marketplace is stable. Insurance is available and affordable, and patients who are harmed by malpractice occurrences are fully compensated for unlimited economic losses. Tort reform of 1995, along with well regulated primary carriers and a well managed and fully funded Injured Patients & Families Compensation Fund has resulted in the stable medical malpractice environment,* ***and the availability of health care in Wisconsin."*** (emphasis added)

In the same report, again issued roughly two months before the Supreme Court overturned our cap on non-economic damages, Commissioner Gomez indicated that medical liability carriers were predicting premiums would remain roughly the same in Wisconsin over the coming year. However, he also made it very clear that, and again I quote:

> *"... rate stability could be dramatically impacted for both the Fund and primary carriers should the caps be removed and insurers face unlimited non-economic damages."*

Commissioner Gomez must have a crystal ball in his office, for today, three months since the Ferdon decision, his same concerns are being predicted by leading actuaries.

A fair system, one that balances the rights of injured parties with the basic need for an accessible health care system, is what we had in Wisconsin, and what we must strive to restore through this legislation. A system in which liability premiums do not drive out of business, out of the state, or into retirement, the very doctors we count on the most when we need them the most.

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

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

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

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

Finally, I would like to quote from testimony delivered on April 7, 2005 by my counterpart in Illinois, just one of many states facing a very real, very litigation-driven health care access emergency:

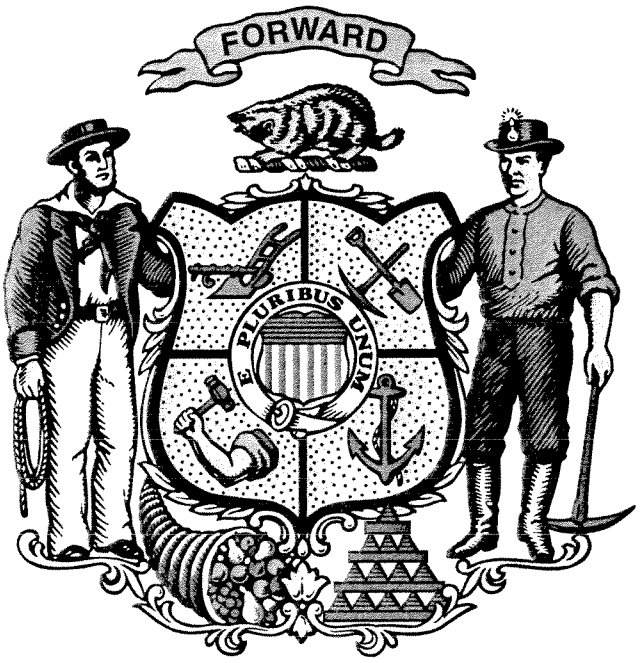
> *"The medical liability crisis in Illinois is causing an unprecedented health care access crisis throughout the state. While some areas of Illinois may be suffering more than others, the systemic problems driving these crises exist all over Illinois and show no signs of abating. In the areas hardest hit, we are finding an absence of obstetricians willing to treat "high risk" babies, emergency care physicians unwilling to provide trauma care, and neurosurgeons refusing to provide complex and high-risk procedures."*
>
> *The commercial insurance market has abandoned hospitals, leaving them to pay the astronomical costs of verdicts and settlements out of their own pockets – money that should be spent on caregivers and new technology and in dozens of other ways that would benefit patients and communities. This crisis is growing. If nothing is done, the health care access barriers may become insurmountable."*

This is not speculation or exaggeration, this is real life, and it is testimony I hope you will never here in Wisconsin.

On August 25, 2005, after passing the Democrat-controlled house and Democrat-controlled Senate, Illinois Governor Rod Blagojevich, also a Democrat, signed Illinois's new cap on non-economic damages into law.

We must learn from the mistakes of other states, not try to repeat them. We do not need to experience the dismantling of a health care system; we need to prevent it from happening.

WHA believes a balanced and equitable system can be preserved in Wisconsin but it will require the Legislature and Governor to act. We believe that system must have as its foundation a cap on non-economic damages and other important reforms, including recognition of collateral sources and IPFCF coverage for medical residents. We urge you to support AB 764, 765 and 766.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CURT GIELOW

State Representative

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

October 18, 2005

Madam Chair and Members,

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

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

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

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

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

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

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

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

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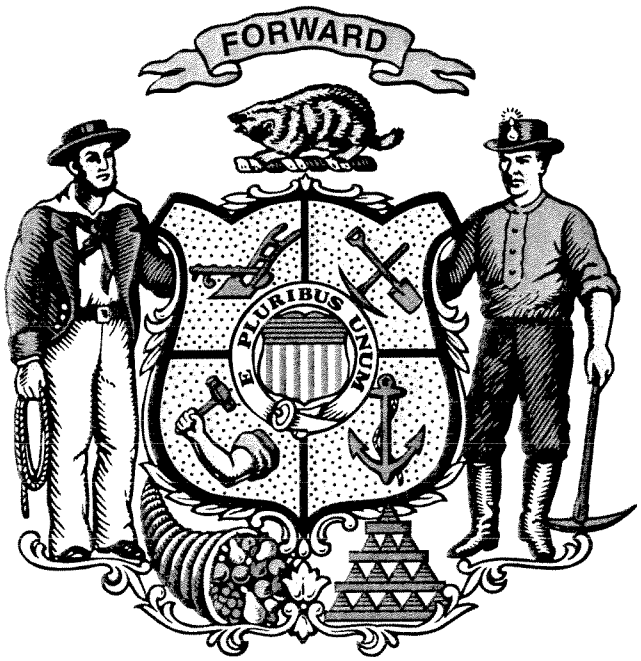
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STATEMENT

By

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GENERAL INTERNAL MEDICINE DEPARTMENT
MEDICAL DIRECTOR, GOVERNMENT RELATIONS
MARSHFIELD CLINIC

BEFORE THE
ASSEMBLY COMMITTEE ON INSURANCE

18 OCTOBER 2005

Chairperson Nischke and members of the Assembly Committee on Insurance, I am Doctor Robert Phillips, a practicing general internist and Medical Director of Government Relations for the Marshfield Clinic. I am here representing the 722 physicians and other healthcare providers in the Marshfield Clinic system. Thank you for the opportunity to testify in support of AB 766.

Marshfield Clinic's mission is to provide accessible high-quality healthcare, research, and education to all who access our system. Marshfield Clinic cares for all who seek our care regardless of their ability to pay. The repeal of caps on non-economic damages by the Wisconsin Supreme Court in the Ferdon vs. Wisconsin Patients Compensation Fund in June of this year has already begun to impact our system of care. Within days after this decision, Marshfield Clinic was notified by a plaintiff's attorney with an open claim against us that he was doubling damages in the case. Because of our self-funded primary medical malpractice insurance program for our physicians and staff, Marshfield Clinic is required by the Office of the Commissioner of Insurance to set aside reserves to cover possible claims. On September 28, 2005, Marshfield Clinic deposited an additional $900,000 into its trust fund to meet its funding requirement. This amount was determined to be necessary by the Clinic's independent actuary.

In 2004, Marshfield Clinic paid $1.8 million as assessments for its physicians and staff to the Injured Patients and Families Compensation Fund (IPFCF). The Fund provides coverage in excess of that provided by the Clinic's self-insurance plan. Although currently unknown, there is speculation that Fund assessments could as much as double over the next couple of years, which could require the Clinic to pay an additional $1.8 million to the IPFCF. The combination of the Clinic's self-insurance plan increased reserves and increased IPFCF assessments represents the amount that could be used to purchase a new $1.6 million linear accelerator for radiation oncology to treat cancer patients, a new $1 million CT scanner which would be used for diagnosing and following response to treatment of cancer patients and for diagnosis of other serious medical conditions, and a $600,000 digital mammogram machine which is used for breast cancer screening and diagnosis of early stages of breast cancer. Patient with cancer are often very ill with limited energy. Marshfield Clinic tries to bring cancer care closer to home for its patients because this facilitates more timely patient-centered healthcare.

In previous testimony, Marshfield Clinic pointed out the challenges of recruiting physicians, primary care and specialty positions, to our northern service areas. Stability of the medical malpractice insurance environment is important to physicians from out-of-state and our own resident physicians who are considering practicing within our system. Access to obstetrician/gynecologists, emergency room physicians, and specialty surgeons is very important to ensure that citizens in rural Wisconsin receive the same high-quality healthcare their urban counterparts do. As of September 30, 2005, the Clinic was recruiting 97 physicians in 43 different specialties. Marshfield Clinic finally recruited a pediatric general surgeon to its Marshfield Center after a 6-year search. On average time to recruit and fill positions in our rural centers is between 3-4 years. Recently, a vascular surgeon and nuclear medicine physician from out of state inquiring about positions in our system asked what impact the loss of caps on non-economic damages would have.

Marshfield cares for all who come to us regardless of their ability to pay, that includes the uninsured, Medicare, Medicaid, and BadgerCare patients on an unlimited basis. In two counties in north central Wisconsin in fiscal year 2004, Marshfield Clinic cared for 82% of the eligible

Medical Assistance patients and in another county 57% of eligible Medical Assistance patients. Because government sponsored healthcare programs cannot pay fully the cost of care, healthcare organizations like Marshfield Clinic will need to prioritize new service development vs. provision of healthcare services.

Because of our not-for-profit tax status, Marshfield Clinic invests net revenues in infrastructure development, new equipment, new clinical services, research, and/or student and resident education. Marshfield Clinic has invested millions of dollars since the early 1990s in an integrated computerized medical record linking all 41 of our centers, which includes physician's notes, consultations, lab, x-ray results, and electrocardiograms (EKG's). A clinical decision support service will link individual providers to the latest standards of medical treatment to ensure that patients receive the most current evidenced-based healthcare. A medication management program is providing a single medication portal with drug interaction and allergy warning software built in to ensure safe drug prescribing. A patient web portal currently allows patient access to immunization records, appointments, and lab results. These initiatives are examples of infrastructure development the Marshfield Clinic has invested in to enhance patient care. Diverting revenues to medical malpractice self-insurance reserves and IPFCF assessments will adversely affect development of new technologies.

Marshfield Clinic, a founding member of the Wisconsin Collaborative for Health Care Quality, is committed to ongoing public reporting of validated health outcomes, both quality and cost of care, so that government and private purchasers ultimately will pay differentially for quality healthcare and achieve value in services provided. Marshfield Clinic is concerned that the repeal of non-economic caps will impede healthcare organizations' willingness to report publicly quality of care institutionally and even individually. Our commitment to quality is predicated on the Institute of Medicine's six aims, healthcare that is safe, patient centered, timely, effective, efficient, and equitable.

Marshfield Clinic supports AB 766 because it will provide reasonable caps on non-economic damages in medical malpractice judgments based on age. The combination of reasonable caps on non-economic damages and the IPFCF's unlimited coverage for economic damages will ensure that limited healthcare resources can be invested in information technology for quality reporting, new clinical services and access to healthcare for all Wisconsin citizens.

Thank you again for the opportunity to testify.

I will be pleased to address any questions the committee might have.

Robert E. Phillips, M.D.