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# Medical Malpractice Caps

## The Impact of Non-Economic Damage Caps on Physician Premiums, Claims Payout Levels, and Availability of Coverage

### Executive Summary

Soaring premiums on medical malpractice insurance (“med mal”) are a national crisis, invading the practice of medicine, threatening the availability of care, and prompting widespread public outcry. Physicians and the insurance industry place the blame on out-of-control jury awards, and, in response, 19 states have implemented caps on non-economic damages—a key measure now included in various congressional proposals. However, the actual experience of the states with caps does not support these proposals. It shows that:

#### *Caps did reduce the burden on insurers...*

- In states with caps, the median payout between 1991 and 2002 was 15.7% lower than the median in states without caps, despite the fact that many states did not impose the caps until late in the 12-year period.
- Moreover, in states with caps, the payouts increased by only 37.8% from 1991 to 2002, while the rate of increase in states without caps was 71.3%, or nearly double.

#### *But most insurers continued to increase premiums at a rapid pace, regardless of caps...*

- In states with caps, the median annual premium went up by 48.2%, but, surprisingly, in states *without* caps, the median annual premium increased at a *slower* clip—by 35.9%.
- Among the states with caps, only 10.5% experienced flat or declining med mal premiums. In contrast, among the states *without* caps, the record was actually *better*: 18.7% experienced flat or declining premiums.

***These counter-intuitive findings can lead to only one conclusion: There are other, far more important factors driving the rise in med mal premiums than caps or med mal payouts. These include:***

- The medical inflation rate. In the 12-year period through 2002, medical costs rose 75%.
- The insurance business cycle. The property and casualty industry as a whole suffered an unusually long 12-year “soft” period in the insurance business cycle through 1999, resulting in loose underwriting practices—not enough money in premiums collected to cover anticipated claims. At the end of the cycle, in an attempt to catch up, insurers began to tighten underwriting standards and raise premium rates.

- The need to shore up reserves. Med mal insurers have been consistently under-reserving since 1997—to the tune of \$4.6 billion through December 31, 2001. The only way to shore up reserves is to increase premiums.
- A decline in investment income. With falling stock prices and declining interest rates, investment income for the entire property/casualty industry fell 23% in 2001 compared to 2000, and then *another* 2.5% in 2002. Moreover, investment income is particularly critical for lines of business like med mal where the duration of claims payouts typically spans several years.
- Financial safety. Based on the Weiss Safety Ratings, we find that 34.4% of the nation's med mal insurers are vulnerable to financial difficulties (those with a rating of D+ or lower), as compared to 23.9% of the property and casualty industry as a whole. In order to restore their financial health, many med mal insurers will remain under pressure to increase premiums despite new laws to cap payouts.
- Supply and demand. The number of med mal carriers increased until 1997, but has since fallen from 274 in that year to 247 in 2002. Moreover, in certain regions and medical specialties, there is evidence that some med mal insurers have pulled out or discontinued coverage.

Recommendations:

*Legislators* should put proposals involving non-economic damage caps on hold until convincing evidence can be produced to demonstrate a true benefit to doctors in the form of reduced med mal costs. *Regulators* must review and revise their parameters for approving rate increases. *Insurance companies* must never again allow marketing to divert or pervert prudent actuarial analysis and planning. The *medical profession* must assume more responsibility for policing itself, while states must be more pro-active in reviewing the licenses of individual practitioners. And *consumers* must not relinquish their right to sue for non-economic damages until the medical profession and/or state and federal governments provide more adequate supervision and regulation of doctors, hospitals, and other health care providers.

## Introduction

In the last few years, soaring premiums on medical malpractice insurance (“med mal”) have emerged as a national crisis, invading the practice of medicine, threatening the availability of care, and prompting widespread public outcry.

Many doctors, particularly in high-risk specialties, have received renewal notices announcing premium increases of 100% or even 200% over the previous year. Others have simply been dropped by their insurance carriers, forcing them to shop for new med mal coverage, practice without any coverage at all, or stop practicing medicine altogether—all painful alternatives.

The insurance industry places the blame on out-of-control jury awards. In response, legislators in many states, accepting this argument at face value, have implemented tort reform to restrict awards in their states. Their primary vehicle: *Non-economic damage caps*, which limit the awards to an injured patient for intangible injuries, such as pain and suffering. Since 1975, 19 states have implemented these caps<sup>1</sup> at various levels ranging from \$250,000 to \$1 million, as follows:

<u>State</u>	<u>Cap (\$)</u>	<u>Year Adopted</u>
Alaska	500,000	1997 <sup>2</sup>
California	250,000	1975
Colorado	250,000	1998
Hawaii	375,000	1976
Idaho	682,000	1990*
Indiana	1,000,000	1990
Kansas	250,000	1994
Louisiana	500,000	1975
Maryland	805,000	1986*
Massachusetts	500,000	1997
Michigan	624,000	1993*
Missouri	547,000	1988*
Montana	250,000	1997
New Mexico	600,000	1996
North Dakota	500,000	1996
Utah	250,000	1996
Virginia	1,000,000	1992
West Virginia	1,000,000	1986
Wisconsin	350,000	1995* <sup>3</sup>

\*Caps are adjusted annually for inflation.

<sup>1</sup> The implementation of caps on non-economic damages has no impact on jury awards for actual damages such as medical expenses and loss of income.

<sup>2</sup> Applies to incidents occurring before August 1997. After August 1997: the cap is the greater of \$400,000 or life expectancy times \$8,000 except in the case of severe disfigurement or physical impairment in which the cap is the greater of \$1 million or life expectancy times \$25,000.

<sup>3</sup> Applies to damages from all health care providers except in wrongful death cases. Damages in wrongful death are limited to \$500,000 for the death of a minor and \$350,000 for the death of an adult.

Now, in an attempt to cope with the emerging med mal crisis, the push to impose caps has reached the federal level, with a number of legislative proposals to institute reforms, usually including, as the most salient feature, a \$250,000 nationwide cap.

This white paper is not driven by a political ideology or industry-driven self-interest. It is, rather, an objective, data-driven analysis of:

- the real relationship between caps and med mal premiums (Part 1)
- other forces behind rising premium rates (Part 2)
- lessons to be learned from the crisis along with effective long-term solutions (Part 3).

## **Part 1. The Real Relationship between Caps and Med Mal Premiums**

On the surface, the theory behind caps on non-economic damage awards seems logical: caps would limit the payouts by insurers, and the lower payouts, in turn, would naturally enable the insurers to reduce med mal premiums. As we shall demonstrate below, however, in the real world of the med mal insurance business, only the first half of this theory is working.

### ***Caps do reduce the burden on insurers...***

Using data provided by the National Practitioner Data Bank, we compared the median payouts in the 19 states with caps to those in the 32 states without caps<sup>4</sup> for the period between 1991 and 2002, with the following results:

- **Payouts reduced.** In states without caps, the median payout for the entire 12-year period was \$116,297, ranging from \$75,000 on the low end to \$220,000 on the high end. In states with caps, the median was 15.7% lower, or \$98,079, ranging from \$50,000 to \$190,000. Since caps in many states were not imposed until late in the 12-year period, this represents a significant reduction.
- **Growth in payouts slowed substantially.** The median payout in the 32 states without caps increased by 71.3%, from \$87,553 in 1991 to \$150,000 in 2002. In contrast, payouts in the 19 states with caps increased at a far slower pace—by only 37.8%, from \$79,798 in 1991 to \$110,000 in 2002.

In short, it's clear that caps do accomplish their intended purpose of lowering the average amount insurance companies must pay out to satisfy med mal claims.

### ***But insurers continue to increase premiums at a rapid pace, regardless of caps.***

Using 1991 to 2002 data published by the Medical Liability Monitor, we examined the median med mal premiums paid by doctors in three high-risk specialties—internal medicine, general surgery, and obstetrics/gynecology. The results:

1. **States with caps had sharper increases in median annual premiums.** Since the insurers in the states with caps reaped the benefit of lower med mal payouts, one would expect that they'd reduce the premiums they charged doctors. At the very minimum, they should have been able to slow down the rate of premium increases. Surprisingly, the data show they did precisely the opposite:

- In the 19 states with caps, the median annual premium increased by 48.2%, from \$20,414 in 1991 to \$30,246 in 2002.

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<sup>4</sup> For the purposes of this analysis, the District of Columbia is being referred to as a "state" since it effectively operates as such with regard to insurance regulation.

- In the 32 states *without* caps, the median annual premium actually increased at a *slower* pace—by 35.9%, from \$22,118 in 1991 to \$30,056 in 2002.

Thus, on average, *doctors in states with caps actually suffered a significantly larger increase than doctors in states without caps.*

2. **A smaller proportion of states with caps were able to contain premium increases.** In some states, the median annual premiums remained flat or even declined at various times during the period. Was *this* related to the imposition of caps? In the overwhelming majority of states, the answer is clearly “no.” Indeed...

- Among the 19 with caps, only two states, or 10.5%, experienced flat or declining med mal premiums following the imposition of caps.
- Meanwhile, among the 32 without caps, the record was actually much better: Six states, or 18.7%, experienced flat or declining premiums.

3. **Premiums in states with caps are more likely to exceed national median.**

Focusing on the most recent data, we find that:

- In 47.4% of the states with caps (9 out of 19), 2002 median premiums were below the national median premium of \$30,093.
- Meanwhile, in 50% of the states without caps (16 out of 32), 2002 median premiums were *below* the national median.

In short, the results clearly invalidate the expectations of cap proponents. To review the surprising facts:

- Insurers in states with caps raised their premiums at a significantly faster pace than those in states without caps.
- Even with the imposition of caps, insurers in nearly nine out of ten states continued to raise rates, while insurers in states without caps were actually *more* likely to hold or cut their premium rates.
- In states with caps, insurers are more likely to charge med mal premiums exceeding the national median than those in states without caps.

These counter-intuitive findings can lead to only one conclusion: There are other, far more important factors driving the rise in med mal premiums than caps or med mal payouts, the subject of the next section.

## **Part 2. Other Factors Driving Up Med Mal Premiums**

We have identified six factors driving up premiums, each of which may be exerting a greater impact on premiums than the presence or absence of caps. These are (1) medical cost inflation, (2) the cyclical nature of the insurance market, (3) the need to shore up reserves for policies in force, (4) a decline in investment income, (5) overall financial safety considerations, and (6) the supply and demand of coverage. We examine each of these factors below.

### **1. Medical Cost Inflation**

The medical inflation rate in the 12-year period was 75%<sup>5</sup> (i.e., \$1 of medical expenses in 1991 cost \$1.75 in 2002). However, throughout the country, insurers had a general tendency to let their premium increases lag behind the pace of medical inflation. This was most likely due to the extended soft market experienced by the entire property and casualty insurance industry in the 1990s, explained below.

### **2. The Cyclical Nature of the Insurance Market**

The market for property/casualty insurance, including med mal, is historically and fundamentally cyclical, with periods of rising premium rates followed by periods of steady or declining premiums. In the declining portion of the cycle—"a soft market"—insurers relax their underwriting standards and underprice their products in order to retain or gain market share.

The most recent soft market lasted longer than usual—12 years, from 1987 to 1999—probably because of the raging bull market in stocks. Insurers made so much money in their investments they were able to aggressively underprice their policies, deliberately lose money in their underwriting, and still turn a profit overall. As a result, losses in their core operations, more than offset by surging gains from the stock market boom, were largely overlooked by the industry and regulators alike.

All that changed when the stock market boom turned to bust. Property and casualty insurers had to confront the ramifications of their loose underwriting practices: not enough money in premiums collected to cover anticipated claims. That's when they began to seriously tighten underwriting standards and raise premium rates.

### **3. The Need to Shore Up Reserves for Policies in Force**

When insurers write a new policy, they look at past claims experience, make some actuarial assumptions, and place a portion of that policy's premium into a reserve to cover expected future claims. A prudent insurer will make conservative assumptions and err on the side of having more in reserve than it ultimately needs to pay claims. At the end of each year, the insurer then evaluates its reserves for each block of business and determines if a change is warranted to either add or subtract reserves.

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<sup>5</sup> Medical inflation rate: 1991: 8.7%, 1992: 7.4%, 1993: 5.9%, 1994: 4.8%, 1995: 4.5%, 1996: 3.5%, 1997: 2.8%, 1998: 3.2%, 1999: 3.5%, 2000: 4.1%, 2001: 4.6%, 2002: 4.7%.

Data reported to the National Association of Insurance Commissioners (NAIC) show that med mal insurers have been consistently under-reserving since 1997—to the tune of \$4.6 billion through December 31, 2001. The under-reserving came to a head in 1999, at the tail end of the soft market. That's when loose underwriting practices caught up with the insurers, as claims rose to a higher level than expected. Thus, even before the bull market ended in the stock market, insurers were coming under increasing pressure to boost their reserves to make up for past shortfalls.

There's only one place these funds could come from—the company's capital; and there was only one way the company could maintain or build its capital—by making more profits. Thus, premium increases were inevitable.

#### **4. A decline in investment income**

Until 2000, most of the additional profits insurers needed could be covered by rising investment income and gains from the booming stock market. But during the three-year bear market from 2000 to 2002, as large stock market gains turned to even larger stock market losses, insurers were confronted with double trouble:

- After just one year of premium increases, they still had barely begun to restore their reserves.
- Now, aggravating their difficulties, they also needed to compensate for stock market losses. With falling stock prices and declining interest rates, investment income<sup>6</sup> for the entire property/casualty industry fell 23% in 2001 compared to 2000, and then *another* 2.5% in 2002; and we must assume that med mal insurers suffered a similar decline. Indeed, investment income is particularly critical for lines of business like med mal where the duration of claims payouts typically span several years.

Thus, it was the combination of two powerful forces—under-reserving throughout most of the 1990s *plus* the rapid fall in investment income in the 2000s—that largely drove the unusually rapid premium increases, not only in med mal, but in many other property and casualty lines as well.

#### **5. Financial Safety**

If insurers do not replace capital that has been used to shore up reserves, the financial strength of the company deteriorates, ultimately leading to the possibility of financial failure.

The Weiss Safety Ratings measure an insurer's overall financial strength based on evaluations of its capitalization, reserve adequacy, profitability, liquidity, and stability. Among the 2,851 property and casualty insurers reporting to the NAIC, 247 companies wrote at least some med mal policies in 2002, with 90 of these deriving at least 50% of their total premiums from the med mal sector.

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<sup>6</sup> Investment income is defined as capital gains plus interest income.

Within this group of 90, which we define as “med mal insurers,” there were a higher-than-average number of vulnerable companies, as compared to the property and casualty industry as a whole (Table 1).

Table 1. Safety of Insurers: Med Mal vs. All Property and Casualty Insurers

Weiss Safety Rating Category	2003 All P&C Insurers	2003 Med Mal Insurers
Secure	76.1%	65.5%
Vulnerable	23.9%	34.4%

“Secure” includes companies rated A (Excellent), B (Good), and C (Fair).

“Vulnerable” includes those rated D (Weak) and E (Very Weak)

What progress have med mal insurers made in restoring their financial health by raising premiums? So far, none: Despite higher premiums since 1999, there has been no improvement in the financial safety of the med mal insurers. Quite to the contrary, the proportion of insurers in the “vulnerable” category has increased since 1999 (Table 2).

Table 2. Safety of Med Mal Insurers: 2003 vs. 1999

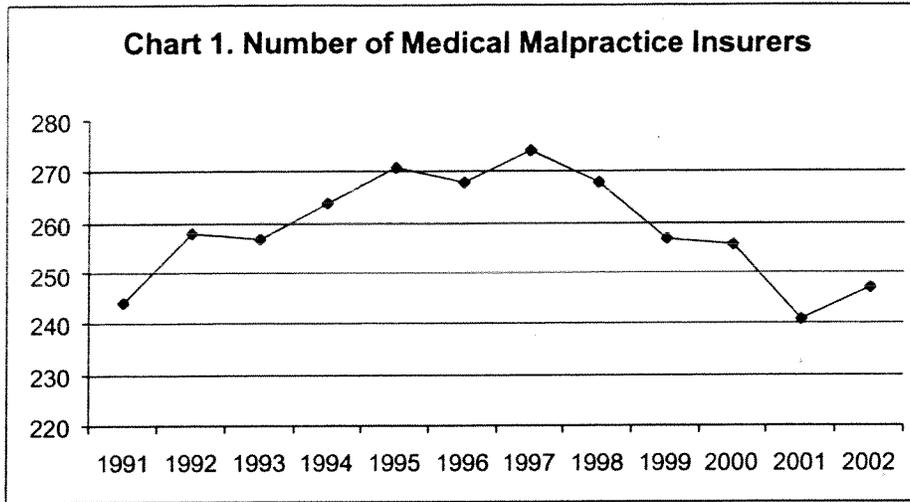
Weiss Safety Rating Category	2003 Med Mal Insurers	1999 Med Mal Insurers
Secure	65.5%	69.0%
Vulnerable	34.4%	31.0%

Thus, in order to restore their financial health, *many med mal insurers will remain under pressure to continue to increase premiums despite any new laws that are enacted to cap individual payouts.*

## 6. The Supply and Demand of Coverage

Press reports have highlighted the plight of physicians around the country who are closing up shop because their med mal insurer is pulling out of the local market.

To help determine if this is an industry-wide problem, for each year between 1991 and 2002, we counted the number of insurers that are writing new med mal policies and/or renewing existing policies (Chart 1).



The number of carriers providing med mal coverage nationwide increased from 244 in 1991 to a peak of 274 in 1997. Since 1997, however, the number of carriers declined steadily to a low of 241 in 2001, recovering slightly to 247 in 2002.

Compared to 1991, therefore, there has actually been a modest *increase* in the number of med mal carriers—from 244 to 247.

However, doctors are currently feeling the pressures of diminished supply reflected in the declining trend since 1997. Moreover, in certain regions and in certain medical specialties, there is abundant anecdotal evidence that certain med mal insurers have pulled out or discontinued coverage.

### **Part 3. Conclusions and Recommendations**

There is no doubt that the implementation of non-economic damage caps has resulted in lower claim payouts for insurers. For caps to be considered successful, however, the lower payouts would need to translate into lower med mal premiums for medical professionals. Unfortunately, that has not been the case due to the continuing presence of other, far more significant factors driving premium rates higher.

Indeed, the 1991 to 2002 data indicate that the presence of caps may be *inversely correlated* to med mal premium levels. We have no data to pinpoint the reasons for this perverse result and therefore can only speculate as to what they may be. Some possibilities include:

- Legislatures in states with a preponderance of unprofitable med mal insurers may have been among those that were most pressured by those insurers and their lobbyists to impose caps. Meanwhile, states that have not imposed caps so far may be those in which med mal insurers were relatively less desperate to begin with. Insurers in states with caps may have *already* been on the path toward faster rate increases even before the caps were legislated, and the changes in the legislation may have merely been a symptom of—not an impediment to—this trend.
- Once caps were imposed, regulators in those states may have been somewhat more liberal in allowing rate increases, making the false assumption that caps alone would sooner or later help to correct the imbalances in the marketplace.

Furthermore, med mal insurers have also had to deal with the added burden of high medical inflation, which directly impacts their claims experience. By the end of the soft market in 2000, these insurers found themselves in a position where claims costs had increased, but premium income had not even kept pace with inflation.

All of these forces led to an inevitable increase in the med mal premiums insurers charge to doctors and other medical professionals. But despite the increase in revenue, the med mal insurers as an industry have continued to weaken financially and remain weaker than the overall property/casualty insurance industry.

In summary, we believe the broad market forces prevailing in the property/casualty industry have driven—and continue to drive—med mal premiums up, evidently overwhelming any reduction in jury awards.

Thus, by focusing on caps as a solution..

- The insurance companies and their supporters are diverting the public's attention away from long years of mismanagement by an industry that continually allowed actuarial prudence to take a back seat to marketing strategy.
- The insurers, insurance regulators and insurance legislators are avoiding a much-needed post-mortem on what really went wrong in the property and casualty industry

in general and in the med mal sector in particular. Was it prudent to rely so heavily on investment income while underwriting income stayed chronically in the red? Did industry decision makers get caught up in the stock market euphoria like nearly everyone else?

- Worst of all, many companies and legislators are using the insurance crisis opportunistically to push tort reform. However, tort reform, to be productive, merits more pondered and balanced debate based on its own merits, independent of the insurance crisis.

We recommend the following steps:

**First, legislators must immediately put on hold all proposals involving non-economic damage caps until convincing evidence can be produced to demonstrate a true benefit to doctors in the form of reduced med mal costs.** Right now, consumers are being asked to sacrifice not only large damage claims, but also critical leverage to help regulate the medical profession—all with the stated goal that it will end the med mal crisis for doctors. However, the data indicate that, similar state legislation has merely produced the worst of both worlds: The sacrifice by consumers *plus* a continuing—and even worsening—crisis for doctors. Neither party derived any benefit whatsoever from the caps.

**Second, regulators must review and revise their parameters for approving rate increases.** The big lesson to be learned from the past decade is that it's dangerous to count on volatile investments—especially common stocks—to compensate for poor operations.

For many years, we have warned that rather than evaluating the property and casualty business based on total profits (including investment income), the focus should be on underwriting profits and losses, independent of investment income.<sup>7</sup> Had our warnings been heeded, premium rate increases may have risen gradually over time, rather than jumping suddenly during an already-painful bear market.

**Third, insurance companies must never again allow marketing to divert or pervert prudent actuarial analysis and planning.** Consumers and medical professionals can accept rate increases provided they are spread out evenly over time, and provided they are given good value for their premium dollars in terms of claims paying ability and stability. They cannot accept rate increases that are designed to cover up, or compensate for, serious mismanagement.

**Fourth, the medical profession must assume more responsibility for policing itself, while states must be more pro-active in reviewing the licenses of individual practitioners who have a significantly higher-than-average number of claims against them in their specialty, in proportion to their level of activity.** These individuals

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<sup>7</sup> "Property & Casualty Insurers Cashing in on Wall Street Windfalls to Offset Underwriting Losses," February 28, 1997. "Property and Casualty Insurers Suffer 40% Decline in Net Income in 1994," April 18, 1995.

greatly increase the risk associated with their specialties, pushing med mal premiums up for all doctors in that sector. States must also make major strides to share data on high-risk doctors. At the very minimum, they must cease licensing doctors who have lost their licenses in other states, often due to high-cost medical mistakes.

**Fifth, consumers must not relinquish their right to sue for non-economic damages until the medical profession and/or state and federal governments provide more adequate supervision and regulation of doctors, hospitals, and other health care providers.**

The imposition of caps will not make a significant dent in the problem, and may even have adverse impacts. It is no substitute for longer-term, fundamental solutions that address the actual factors behind the med mal crisis.

## Appendix 1

### States with Caps: Median Medical Malpractice Payouts/Premiums 1991 - 2002

State	Year Imposed	Amount of Cap (\$000)	1991 Median Payout (\$)	2002 Median Payout (\$)	% Change 1991 to 2002	1991 Median Premium (\$)	2002 Median Premium (\$)	% Change 1991 to 2002
Alaska	1997	500	166,246	165,000	-7	N/A	27,940	N/A
California	1975	250	42,160	67,500	60.1	20,354	30,430	49.5
Colorado	1998	250	33,249	100,000	200.8	22,678	33,651	48.4
Hawaii	1976	375	39,899	250,000	526.6	23,334	25,756	10.4
Idaho	1990	682	29,259	100,000	241.8	N/A	14,199	N/A
Indiana	1990	1,000	46,549	50,000	7.4	N/A	22,886	N/A
Kansas	1994	250	99,747	103,765	4.0	14,669	23,335	59.1
Louisiana	1975	500	86,448	100,000	15.7	20,291	37,280	83.7
Maryland	1986	605	99,747	180,000	80.5	24,193	34,771	43.7
Massachusetts	1997	500	132,996	250,000	88.0	N/A	30,246	N/A
Michigan	1993	624	79,798	77,000	-3.5	65,946	68,225	3.5
Missouri	1988	547	106,397	162,500	52.7	25,999	38,759	49.1
Montana	1997	250	39,899	100,000	150.6	18,697	27,011	44.5
New Mexico	1996	600	132,996	110,000	-17.3	N/A	67,161	N/A
North Dakota	1996	500	76,473	75,000	-1.9	N/A	16,238	N/A
Utah	1996	250	26,599	115,000	332.3	20,474	37,290	82.1
Virginia	1992	1,000	66,498	200,000	200.8	16,497	21,343	29.4
West Virginia	1986	1,000	132,996	140,465	5.6	N/A	56,989	N/A
Wisconsin	1995	350	119,697	256,357	114.2	18,111	17,213	-5.0
Total			79,798	110,000	37.8	20,414	30,246	48.2

Source: Compiled and analyzed by Weiss Ratings, Inc. from data supplied by Medical Liability Monitor and the National Practitioners Data Bank

## Appendix 2

### States without Caps: Median Medical Malpractice Payouts/Premiums 1991 - 2002

State	1991 Median Payout (\$)	2002 Median Payout (\$)	% Change 1991 to 2002	1991 Median Premium (\$)	2002 Median Premium (\$)	% Change 1991 to 2002
Alabama	99,747	200,000	100.5	25,629	23,490	-8.3
Arizona	88,941	169,240	90.3	37,601	38,571	2.6
Arkansas	96,416	125,000	29.6	10,422	16,384	57.2
Connecticut	88,659	250,000	182.0	29,198	40,146	37.5
Delaware	97,804	150,000	53.4	N/A	24,731	N/A
District of Columbia	228,754	162,500	-29.0	28,085	40,871	45.5
Florida	126,347	162,500	28.6	43,600	95,474	119.0
Georgia	99,747	175,000	75.4	27,998	30,093	7.5
Illinois	152,946	320,000	109.2	39,260	49,948	27.2
Iowa	54,861	102,500	86.8	21,140	18,607	-12.0
Kentucky	64,181	49,000	-23.7	23,666	44,834	89.4
Maine	99,747	250,000	150.6	22,118	18,583	-16.0
Minnesota	59,848	125,000	108.9	8,117	10,142	25.0
Mississippi	59,848	131,500	119.7	19,726	30,871	56.5
Nebraska	46,549	131,250	182.0	N/A	14,710	N/A
Nevada	43,224	175,000	304.9	24,988	59,776	139.2
New Hampshire	66,498	250,000	276.0	N/A	27,157	N/A
New Jersey	99,747	210,000	110.5	20,162	38,307	90.0
New York	99,747	200,000	100.5	48,026	50,970	6.1
North Carolina	95,757	195,000	103.6	11,294	31,687	180.6
Ohio	32,806	137,500	319.1	31,450	52,764	67.8
Oklahoma	66,498	97,000	45.9	9,137	12,766	39.7
Oregon	86,448	95,000	9.9	17,268	26,711	54.7
Pennsylvania	132,996	200,000	50.4	11,433	71,260	523.3
Rhode Island	83,123	125,000	50.4	N/A	27,922	N/A
South Carolina	79,100	100,000	26.4	12,984	21,337	64.3
South Dakota	33,249	150,000	351.1	9,618	13,853	44.0
Tennessee	78,135	110,000	40.8	15,601	30,018	92.4
Texas	93,559	150,000	60.3	27,945	55,951	100.2
Vermont	56,523	40,865	-27.7	N/A	15,690	N/A
Washington	53,199	150,000	182.0	18,158	23,100	27.2
Wyoming	106,397	125,000	17.5	22,758	39,829	75.0
Total	87,553	150,000	71.3	22,118	30,056	35.9

Source: Compiled and analyzed by Weiss Ratings, Inc. from data supplied by Medical Liability Monitor and the National Practitioners Data Bank

## Appendix 3

### Weakest Medical Malpractice Insurers

<b>Company</b>	<b>2002 Total Med Mal Premium (\$000)</b>	<b>2002 Total Premium (\$000)</b>	<b>Weiss Safety Rating</b>
Academic Health Professionals Insurance	16,484	16,484	E
American Association of Orthodontist RRG	4,505	4,506	D
American Excess Insurance Exchange RRG	33,682	39,747	E
American Physicians Assurance	170,440	230,224	D
American Physicians Insurance Exchange	34,887	34,887	D
Campmed Casualty & Indemnity of MD	3,750	7,237	E+
Commonwealth Medical Liability Insurance	29,648	29,893	D+
Delaware Professional Insurance	732	732	E+
Eastern Dentists Insurance RRG	6,961	7,314	D
Franklin Casualty Insurance RRG	19,377	19,377	D-
Hanys Insurance	74,529	76,260	D+
Hospital Casualty	22,637	26,112	E
Hospital Underwriting Group	22,620	22,776	E
Lion Insurance	51	86	D+
MCIC Vermont RRG	155,021	162,325	D
MedAmerica Mutual RRG	7,838	7,838	D+
National Guardian RRG	7,422	7,422	E
New England Medical Center of VT	1,166	1,166	D-
Northwest Physicians Mutual Insurance	33,094	33,200	D+
OHIC Insurance	136,926	151,597	D
PACO Assurance	3,171	3,172	D+
Physicians Liability Insurance	40,626	75,071	E+
Physicians Reciprocal Insurers	185,333	186,924	E+
Physicians Reimbursement Fund	2,193	2,193	E+
Preferred Physicians Medical RRG	24,906	24,905	D+
Princeton Insurance	240,266	374,811	D
SCPIE Indemnity	100,198	101,675	D+
Texas Hospital Insurance Exchange	7,304	14,009	D-
Tri Century Insurance	24,238	24,238	D+
VHA Risk Retention Group	29,071	30,616	D-
Virginia Health Systems Alliance	12,058	12,242	E

A = Excellent; B = Good; C = Fair; D = Weak; E = Very Weak

Source: Weiss Ratings, Inc.

## Appendix 4

### Other Studies and Position Statements published by Participants in this Debate

“Florida’s Medical Malpractice Insurance Crisis: An Examination of Strategic Public Policy Issues.” The Florida Center for Public Policy and Leadership at the University of North Florida. March 2003. This study is currently being updated, but will be available at [http://www.unf.edu/thefloridacenter/press\\_room/index.shtml](http://www.unf.edu/thefloridacenter/press_room/index.shtml) when complete.

“Hype Outpaces Rates in Malpractice Debate; Degree of Crisis Varies Among Specialties and From State to State.” *USA Today*. March 4, 2003.  
[http://www.usatoday.com/news/nation/2003-03-04-malpractice-cover\\_x.htm](http://www.usatoday.com/news/nation/2003-03-04-malpractice-cover_x.htm)

“Medical Malpractice Analysis.” Milliman USA on behalf of Florida Hospital Association. November 7, 2002.  
[http://health-fl-health-care-pdf.netcoms.us.com/resources\\_MillimanUSAstudy.pdf](http://health-fl-health-care-pdf.netcoms.us.com/resources_MillimanUSAstudy.pdf)

“Medical Malpractice Insurance: Stable Losses/Unstable Rates.” Americans for Insurance Reform. October 10, 2002.  
<http://www.insurance-reform.org/StableLosses.pdf>

“Medical Malpractice: Questions and Answers.” American Trial Lawyers Association.  
[http://www.atla.org/ConsumerMediaResources/Tier3/press\\_room/FACTS/medmal/icqanda.aspx](http://www.atla.org/ConsumerMediaResources/Tier3/press_room/FACTS/medmal/icqanda.aspx)

“Premium Deceit: The Failure of ‘Tort Reform’ to Cut Insurance Prices.” Center for Justice & Democracy. July 29, 1999; reissued February 12, 2002.  
<http://www.insurance-reform.org/PremiumDeceit.pdf>

“President’s Medical Malpractice Plan Based on Biased, Inaccurate Information; CFA Identifies Insurer Practices as Cause of Soaring Rates.” Consumer Federation of America. July 31, 2002.  
<http://www.consumerfed.org/073102medmalrelease.html>.

“Update on the Medical Litigation Crisis: Note the Result of the ‘Insurance Cycle’.” U.S. Department of Health and Human Services, Office of Disability, Aging and Long-Term Care Policy. September 25, 2002.  
<http://www.aspe.hhs.gov/daltcp/reports/mlupd2.htm>

Statement by the Physician Insurers Association of America. January 29, 2003.  
[http://www.thepiaa.org/publications/pdf\\_files/January\\_29\\_Piaa\\_Statement.pdf](http://www.thepiaa.org/publications/pdf_files/January_29_Piaa_Statement.pdf)

**FILING MEMORANDUM**

**Physicians Insurance Company of Wisconsin, Inc.**

Physicians and Surgeons Professional Liability  
Wisconsin

Rate Filing  
Effective 1/1/2004

Effective 1/1/2004, rate changes will be implemented that increase the overall rate level by approximately +9.4%. This increase is needed to maintain an acceptable loss ratio, and is consistent with the range of pure premium indications recommended by our actuarial consultant.

The overall rate level change is distributed as follows:

Claims-Made Rates	+6.0%
Occurrence Rates	+15.3%
Corporate Coverage Charge	+1.0%
Total	+9.4%

Manual Rate Changes

			Claims- Made	Occ.
All physicians, surgeons, and ancillary providers except as noted below			+6.4%	+15.8%
Exceptions:	Relativity			
	Curr. Rev.			
• 80254 Allergy	.60 .65		+15.3%	+25.4%
• 80256 Dermatology- No Surgery	.60 .65		+15.3%	+25.4%
• 80249 Psychiatry	.60 .65		+15.3%	+25.4%
• 80266 Pathology- No Surgery	.75 .95		+34.8%	+46.7%
• 80235 Physiatry	.75 .95		+34.8%	+46.7%
• 80431 Psychiatry w/ECT	.75 .95		+34.8%	+46.7%
• 80420 Fam./Gen. Practice- No Surgery	.85 .95		+19.0%	+29.4%
• 80267 Pediatrics- No Surgery	.85 .95		+19.0%	+29.4%
• 80261 Neurology- No Surgery	1.00 1.15		+22.4%	+33.1%
• 80274 Gastroenterology- Minor Surgery	1.15 1.25		+15.7%	+25.8%
• 80102 Emergency Medicine	2.36 2.55		+15.0%	+25.1%
• 80151 Anesthesiology	1.50 1.34		-4.9%	+3.4%
• 80166 Abdominal Surgery	3.50 3.00		-8.8%	-0.8%

• 80143	General Surgery	3.50	3.60	+9.5%	+19.1%
• 80167	Gynecology Surgery	3.50	3.00	-8.8%	-0.8%
• 80169	Hand Surgery	3.50	3.00	-8.8%	-0.8%
• 80170	Head and Neck Surgery	3.50	3.00	-8.8%	-0.8%
• 80155	ENT Surgery- Incl. Plastic	3.50	3.00	-8.8%	-0.8%
• 81157	Neonatology Surgery	3.50	3.00	-8.8%	-0.8%
• 80156	Plastic Surgery (N.O.C.)	3.50	3.00	-8.8%	-0.8%
• 81154	Orthopedic Surgery- Excl. Spine	3.68	3.00	-13.2%	-5.6%
• 80154	Orthopedic Surgery- Incl. Spine	4.60	3.90	-9.8%	-1.8%
	Combined Total			+6.0%	+15.3%

Our occurrence coverage loss experience has been relatively adverse when compared to our claims-made loss experience. The larger rate increase for occurrence coverage is in recognition of this experience, and the need for a larger rate increase to achieve a more adequate rate level for occurrence coverage.

Rate relativities were revised for selected specialties, as noted above, based on consideration of loss experience as well as market conditions.

#### Corporate Coverage Charge Increase

The corporate coverage charge will increase to 7.5% (currently 6%). For Member Benefit Program policyholders, the corporate coverage charge will increase to 4.5% (currently 3.6%), maintaining the 40% corporate coverage charge discount for eligible Member Benefit Program policyholders. The overall premium impact is estimated to be +1.0%.

#### Rate Manual Pages

Attached are the revised manual rate pages for physicians, surgeons and ancillary providers. The revised class plan pages depicting the assignment of medical specialty to rate class are also attached. Also attached are the revised Wisconsin Programs pages.

**The Medical Protective Company**  
**Wisconsin**  
**Physicians & Surgeons**  
  
**Actuarial Memorandum**

The attached exhibit supports a rate revision to the Physicians and Surgeons Occurrence and Standard Claims Made programs for the Medical Protective Company (MPCo) in the state of Wisconsin effective January 1, 2004. The proposed revisions will result in an overall premium increase of 50.7% for both new and renewal business. The increase will be accomplished through Classification Relativity and increased limit revisions (combined +14.7% rate impact), adjustment to the claims made factor (+1.1% rate impact) and base rate revision (+30.0% rate impact).  $[0.507 = 1.147 \times 1.011 \times 1.300 - 1.0]$ .

**FREQUENCY LEVEL CHANGES**

Beginning in 2001, we have experienced substantial increases in reported counts (frequency) in Wisconsin Physicians & Surgeons Professional Liability. In addition to the spike in counts, we have seen similar increases in incurred losses, with little or no change in exposure. All emerging experience indicates that Wisconsin has entered a new frequency distribution significantly higher than historical levels. Since this frequency increase impacts only the last two years, rate indications relying on historical paid data would not reflect this increased risk. Though our recent data indicates that the ultimate frequency may be 50-100% higher than historical levels, we have selected a 30% increase to our ultimate frequency levels to mitigate the effect on our policyholders.

**EXHIBIT I: CLASSIFICATION/INCREASED LIMIT CHANGES**

The Medical Protective Company has conducted a review of its currently filed classification relativities and increased limit factors. The review involved a number of considerations including: an analysis of indicated relativities from national statistical organizations, an analysis of MPCo's countrywide experience by classification, an evaluation of stability issues and underwriting judgment. The culmination of these considerations resulted in the rate changes outlined in the Exhibit I. The rate impact of these combined changes is +14.7%.

**REVISIONS TO CLAIMS-MADE FACTOR**

The mature claims-made factor will be revised for the Claims-made Program. The revised factor will be modified from .860 to .900, resulting in an overall impact of +1.1%.

**REVISED MANUAL RATE PAGES**

Revised manual rate and rule pages for the Occurrence and Standard Claims Made programs are included for your review.

# OHIC

Insurance Company

an OHIC Group company

September 8, 2003

Office of the Commissioner of Insurance  
Property and Casualty Rate Filings  
125 South Webster Street  
P.O. Box 7873  
Madison, WI 53707-7873

2003 SEP 10 10:10 AM

RECEIVED  
PROPERTY AND CASUALTY RATE FILINGS  
SEP 10 2003

RE: OHIC Insurance Company  
NAIC #: 35602  
Physicians and Surgeons Professional Liability Rate Filing  
Filing Number: PPL-03-01-WI  
Effective Date: November 1, 2003

Dear Sir or Madam:

We submit for your approval revisions to our Wisconsin Physician and Surgeons rates for our Healthcare Professional Liability program.

We are filing for a base rate change of +23.0%. In addition we have made an adjustment to our charge for separate limits on corporate entities resulting in an overall rate level change of +24.5%. Please see the attached Actuarial Memorandum and exhibits for a detailed explanation of the rate change. This filing is to be effective November 1, 2003.

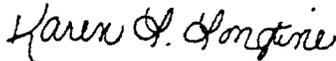
The following items are included in this filing

- Completed Rate/Rule transmittal form (2 copies)
- Revised Rate Pages 1-10
- Supporting Actuarial Memorandum and Exhibits 1-16
- Revised Rule Pages 9-11 11/03 edition and obsolete pages 9-11 01/00 edition. The only changes to these pages are highlighted on the 11/03 edition of the rule pages.

Please return a copy of the approved transmittal form to my attention in the enclosed self-addressed stamped envelope. If you have any questions prior to October 3, 2003, you may reach me by phone at 1-800-666-6442, extension 2570 or by e-mail at [longtinekl@ohic.com](mailto:longtinekl@ohic.com). After October 3, I will be on maternity leave, so please direct your questions to Kay Irwin at [irwinkp@ohic.com](mailto:irwinkp@ohic.com) or extension 2190.

Thank you very much for your time and consideration. We look forward to your approval.

Sincerely,



Karen L. Longtine  
Business Systems Analyst  
e-mail: [longtinekl@ohic.com](mailto:longtinekl@ohic.com)

## Top Medical Malpractice Insurers in Wisconsin 1995-2001<sup>①</sup> Market Share and Loss Ratios<sup>②</sup>

Insurer	1995		1996		1997		1998		1999		2000		2001	
	Market Share	Loss Ratio												
Physicians Ins. Co. (PIC-WIS)	34.0%	47	35.0%	4	34.2%	12-	33.6%	31	32.7%	47	33.4%	39	35.1%	32
Medical Protective	15.0%	26	18.9%	23	18.3%	75-	18.7%	21-	20.5%	14	20.2%	36	18.2%	58
WI Health Care Lia. (WHCLIP) <sup>③</sup>	6.2%	47	4.0%	17	4.1%	139-	3.4%	209-	3.1%	399-	2.8%	613-	2.3%	656-
St. Paul Fire & Casualty	9.7%	9	7.8%	3	6.6%	1-	7.1%	22	5.2%	12-	5.8%	31	4.4%	87
Ohio Hospital Insurance Co.	7.7%	81	8.1%	28	10.4%	71	9.5%	98	8.9%	70	9.8%	79	10.1%	117
American Continental	4.9%	17	5.6%	47	4.2%	41-	5.5%	52	4.5%	104	4.1%	102	1.6%	89
Preferred Professional Ins.													4.5%	56-
Loss Ratio for all WI Insurers		45		14		11-		13		29		16		32

① Writing this line of insurance. Malpractice insurers having approximately 4% or more of the market in Wisconsin and WHCLIP.

② A loss ratio is that percentage of the premium dollar an insurance company estimates it will have to pay in claims for that policy year, both for known claims and all future claims. A negative loss ratio, shown as a percentage of the premium dollar, indicates an insurance company will have moneys left over in a policy year, even after paying its estimated claims. This usually happens when a company receives moneys back from prior year claims or revises its estimates of claims yet to be paid.

③ WHCLIP's large negative loss ratios are due to distribution of excess surplus to policyholders.

Source: Office of the Commissioner of Insurance, Wisconsin Insurance Reports 1995-2001.

**WISCONSIN INJURED PATIENTS AND FAMILIES COMPENSATION FUND**

Balance Sheet as of June 30, 2004

	Fund Assets as of June 30, 2004	Fund Liabilities as of June 30, 2004
Investment Fund	\$24,099,928	Unpaid Losses & LAE (Undiscounted) \$880,444,510
Bonds (market value)	581,691,452	Offset for Investment Income (213,948,016)
Equities	91,374,516	Net Unpaid Losses & LAE 666,496,494
Cash	388,781	Funds Held on Behalf of Primary Companies 400,000
Assessments Receivable	127,707	Medical Expense Reserves 1,588,872
Short-term Interest Receivable	22,051	Assessments Received in Advance 2,706,535
Furniture & Equipment (net of depreciation)	3,021	Provider Refunds Payable 210,493
Other Receivables	35,025,521	Medical Mediation Panels 73,232
Accrued Income (Bond Investment Income, Other)	<u>8,549,901</u>	General Expense Payable 55,519
Total Assets	\$741,282,878	Vouchers Payable 45,104,664
		Compensated Absences 30,746
		<u>Total Liabilities \$716,666,555</u>

Fund Surplus as of June 30, 2004: \$24,616,323

STATE OF WISCONSIN

IN THE ASSEMBLY

---

In re the matter of:

TORT REFORM

Assembly Bill 36

---

Floor Debate

Januray 31, 1995

State Capitol

Madison, Wisconsin

**MAGNE-SCRIPT®**

4401 Travis Terrace

Madison, Wisconsin 53711

Voice or Fax (608) 233-3312

WATL App. H-1

1 MR. SPEAKER: Thank you. The question is  
2 tabling. The gentleman from the 4th.

3 4TH: Thank you, Mr. Speaker. The good lady  
4 from the 45th spoke on a wide range of subjects far afield from  
5 the amendment. I would like to point out a few things. First  
6 off, in terms of the Patients Compensation Fund, which is one of  
7 the principal reasons that we're taking a look at this legislation  
8 today, her -- the suggested amount that she would have doesn't  
9 address the problem. As many of you may know, we have a  
10 \$69 million actuarial deficit in the Patients' Compensation Fund  
11 and simply capping at \$1 million will not solve that, will not  
12 bring down. I also need to -- to correct something she said.  
13 That special committee did not recommend \$1 million cap; it  
14 said a cap not to exceed \$1 million. There's an important  
15 difference.

16 We have an actuarial deficit with the Patients'  
17 Compensation Fund. We have only a few options for addressing  
18 that. We could raise premiums. That's been rejected several  
19 times by this body. We could offer GPR dollars, not something  
20 I think that any of us cares to do, especially at this point in  
21 history. Or we could stop paying claims, something I think that  
22 all of us would reject. Putting a cap on liability, a cap at  
23 \$350,000, I think begins to address the problem of an actuarial  
24 deficit in a responsible manner.

25 I think another couple of problems: Don't forget the UW



Tommy G. Thompson  
Governor

Josephine W. Musser  
Commissioner

121 East Wilson Street  
P.O. Box 7873  
Madison, Wisconsin 53707-7873  
(608) 266-3585

**Testimony relating to medical malpractice reform  
before the Assembly Committee on Insurance, Securities, and Corporate Policy  
by the Office of the Commissioner of Insurance  
Thursday, January 19, 1995**

Good morning. Chairperson Albers and members of the committee, I appreciate the opportunity to present information on LRB 1913/3. I am Peter Farrow, Executive Assistant to the Commissioner of Insurance. Commissioner Musser regrets that prior commitments precluded her attendance. With me is Dan Bubolz, Chief of the Patients Compensation Fund (PCF).

I am providing informational testimony expanding upon the positions taken by the Patients Compensation Fund's Board of Governors (Board) relating to issues contained in LRB 1913/3.

### **PCF Background**

The PCF was created in 1975 to provide additional medical malpractice insurance for Wisconsin health care providers. The PCF is governed by a 13-member Board and is administered by the Office of the Commissioner of Insurance.

For a number of years, the Board has been studying ways to improve the PCF's operations and retire its financial deficit. On February 24, 1993, the Board formed a Special Committee to respond to the findings of a study on the operations and purpose of the PCF. The study was conducted by a Joint Task Force formed by the State Medical Society of Wisconsin and the Wisconsin Hospital Association. Thereafter, on September 22, 1993, the Board expanded the charge of the Special Committee to include responding to concerns raised by the Wisconsin Legislative Audit Bureau in its report on the financial condition of PCF as of June 30, 1992.

The Special Committee met several times from October 1993 through June 1994 culminating in the issuance of its report on June 13, 1994. This report contained four recommendations. In June 1994, the Board postponed taking formal action on these

recommendations, pending further discussion, and sent an informational copy to the Joint Legislative Audit Committee.

At its December 21, 1994, meeting the Board discussed the Special Committee's report. The four recommendations were as follows:

1. Implement a 25-year amortization schedule to retire the deficit;
2. Introduce a cap on noneconomic damages of \$250,000;
3. Pursue statutory changes to allow for periodic payments of future medical expenses; and,
4. Pursue statutory changes to impose a minimum fee level.

The Board adopted the committee's recommendations relating to 1, 3, and 4. It singled out for separate discussion, however, the recommendation related to the \$250,000 cap. During its discussion, the Board debated the level at which noneconomic damages should be capped, and whether the cap should be applied to claims that were incurred, or filed, after the effective date of enactment of a cap. The Board ultimately adopted a position to recommend that a noneconomic damage cap, not to exceed \$1,000,000, be applied to claims occurring on or after the cap's enactment date.

#### **Fiscal Impact of a Noneconomic Damage Cap**

To illustrate the impact of a cap on PCF fees, the actuaries have assumed that the cap would have been effective June 30, 1994. The PCF fees adopted for the July 1, 1994-1995, fiscal year were based on the "break-even" fee levels.

Had a cap of \$250,000 been enacted as of June 30, 1994, the estimated percentage reduction in the break-even fee level for fiscal year 1994-1995 would have been 19.0%. By comparison, if a cap of \$500,000 or \$1,000,000 had been enacted, the estimated percentage reductions in the break-even fee level would have been 13.7% and 7.6%, respectively.

Enactment of a cap to be applied prospectively, as proposed by the Board and LRB 1913/3, would result in no impact on the PCF's current deficit position. This is because the deficit is based upon a projection of claims incurred to date. Since the noneconomic damage cap will not apply to claims incurred prior to enactment of the cap there is no fiscal affect on the deficit.

The actuaries did project the fiscal impact on the PCF deficit if the cap were to be applied instead on any claim that was filed on or after the effective date of enactment. Those results are reflected in the memo attached to this testimony.

### **Future Medical Expense Payments**

The Board recommends enactment of a law that would reinstate periodic payments for future medical expenses. Currently the PCF is obligated to pay for future projected medical expenses payments in one lump sum at the time the claim is settled unless the plaintiffs agree to the use of a structured settlement. It is difficult to predict with any certainty the fiscal affect of reinstating periodic payments for future medical expenses. However, in one case that was ultimately settled for slightly more than \$18,000,000, the PCF had to issue a check for the entire settlement amount, even though approximately \$15,000,000, was projected to be related to future medical expenses to be insured over the life of the patient. In the event that future medical expenses are estimated too high or the patient dies prematurely, the PCF has prepaid an expense that will never be incurred and the excess of which will not be returned to the PCF.

To resolve this, the Board adopted the committee's recommendation that statutory changes should be drafted to include the following provision:

1. Pay future medical expenses on an as-incurred basis rather than as a lump sum payment;
2. Allow for payments to continue until the patient dies, rather than only until the account is exhausted; and,
3. Allow the claimant's attorney to receive either periodic payments or a lump sum payment of contingency fees based on the discounted future medical expenses.

Both the patient and the PCF should benefit by these changes. The patient would benefit by receiving medical payments for as long as needed, and not be subject to the risk of exhausting an amount projected for future medical expenses. The fund would benefit by not having to pay out future medical expenses in a lump sum thus preserving its asset base and improving its cash flow.

### **The Application of a Maximum Annual Payment Per Year of \$500,000**

LRB 1913/3 proposes to reinstate a provision that limits the maximum amount the PCF is required to pay during a year to \$500,000 notwithstanding payments for future medical expenses. The Board has not taken any specific formal action on the issue of

limiting the maximum amount the PCF would have to pay during one fiscal year. Nevertheless, its recommendations relative to capping noneconomic damages and instituting periodic payments for future medical expenses should produce significant improvement in the PCF's cash flow in the two areas of greatest concern.

### **Wrongful Death In Medical Malpractice**

While the Board has not yet taken a formal position on this issue, discussions concerning emerging court decisions that held the medical profession to a higher standard for compensating a wrongful death claim have been of great concern to the Board. The proposed language would rectify the discrepancy between how the medical profession and others are held accountable for wrongful death claims.

### **Statutory Requirement for Minimum Fee Level**

This provision is not currently in LRB 1913/3, however, the Board recommends that the statutes be amended to establish a minimum fee level. While the statutes define a maximum level on PCF fees, they are silent as to a minimum. The Special Committee noted that in five of the nine fiscal years since July 1, 1985-1986, the final fee levels approved by the legislature were below the break-even fee levels estimated by the PCF's actuaries. It was the consensus of the Special Committee that this impedes the Board's ability to reduce the deficit. In recommending that a minimum level be set on PCF fees, the Board proposes a statutory change that would help ensure that the deficit would not increase in the future. The minimum fee level would be set equal to the actuarially determined break-even fee level as approved by the Board.

Thank you, again, for the opportunity to offer information on LRB 1913/3. OCI will continue to analyze the technical aspects of the draft and will forward comments to you as soon as prepared.

AsstSec01

**WISCONSIN INJURED PATIENTS AND FAMILIES COMPENSATION FUND**

**COMPARISON OF PUBLISHED SURPLUS / (DEFICIT)  
TO HINDSIGHT DEFICIT**

Financial Statement Date	Published Surplus/(Deficit)	Hindsight Surplus/(Deficit)
June 30, 2004	\$24,616,324	24,616,324 *
June 30, 2003	\$7,932,348	82,655,325
June 30, 2002	\$4,888,065	127,606,855
June 30, 2001	\$28,724,959	165,777,386
June 30, 2000	\$27,210,974	189,612,489
June 30, 1999	\$8,579,767	194,099,916
June 30, 1998	(\$19,383,934)	195,982,368
June 30, 1997	(\$44,094,214)	178,044,919
June 30, 1996	(\$41,795,496)	161,537,129
June 30, 1995	(\$57,722,772)	135,133,860
June 30, 1994	(\$67,903,761)	120,337,198
June 30, 1993	(\$71,613,641)	126,753,323
June 30, 1992	(\$78,982,681)	110,252,749
June 30, 1991	(\$71,679,588)	94,005,683
June 30, 1990	(\$73,597,992)	57,623,296
June 30, 1989	(\$108,256,349)	14,292,005
June 30, 1988	(\$122,722,600)	(25,156,233)
June 30, 1987	(\$112,101,947)	(32,740,686)
June 30, 1986	(\$100,555,257)	(69,795,008)
June 30, 1985	(\$79,624,322)	(58,580,371)
June 30, 1984	(\$49,623,089)	(81,211,029)
June 30, 1983	(\$19,826,057)	(72,514,141)
June 30, 1982	(\$8,954,431)	(62,817,470)
June 30, 1981	\$492,000	(45,144,847)
June 30, 1980	(\$1,919,872)	(34,664,878)
June 30, 1979	(\$728,759)	(15,648,947)
June 30, 1978	NA	NA
June 30, 1977	NA	NA
June 30, 1976	NA	NA

\* Estimated

Original URL: <http://www.jsonline.com/alive/news/nov04/274531.asp>

## Pressing Need

### With a dearth of doctors on Milwaukee's north side, patients and physicians feel the crunch

By CZERNE M. REID  
 Special to the Journal Sentinel

Posted: Nov. 14, 2004

A shortage of primary care doctors in Milwaukee's poorer communities is leaving more and more people without access to quality, affordable health care where they live. That forces them to travel far distances to get medical attention, use the few remaining hospital emergency rooms for primary care, or simply put off seeing a doctor.

"We have a shortage that's far more acute than 10 years ago," said Paul Nannis, former Milwaukee Health Commissioner, now vice president of government and community relations at Aurora Health Care.

The problem has begun to feed on itself: Doctors surrender the struggle to keep practices in poor areas afloat, saying they are under-compensated and overworked. The more they flee to the suburbs or other states, the more the burden falls to the small number of doctors who remain. The more that burden grows, the more the remaining doctors consider leaving.

Even federal incentives - such as the National Health Service Corps loan forgiveness program that repays student loans and offers tax relief for doctors, or the visa waiver program that extends the stay of non-U.S. doctors who study in America - often can't persuade physicians to stay in underserved areas after they fulfill their program obligations.

Wesley Brown, who lives on Glendale Ave. on the north side of Milwaukee, had hoped to find care nearby.

"In my area I don't see any doctor's offices," he said. "I was trying to find a family doctor - someone close - but I couldn't."

Brown takes a van paid for by federal Title 19 funds to see Abalo Nunyakpe, who practices at Omni Family Medical Clinic, near the city's northern border. Nunyakpe, one of those overworked remaining doctors, said he hasn't had a day off in the three years since he opened the clinic. He said he typically treats patients and catches up on paperwork from 8 a.m. to 10 p.m.

Nunyakpe, one of a handful of doctors who continue to practice solo, does not fault others for leaving. "I can understand the reason," he said. The doctor's suburban colleagues earn more than he does and have lighter schedules because they have fewer, better-insured patients.

"The day of the solo practice is essentially over," Nannis said.

And it's not just solo practices that are threatened.

Perry Margoles, a lawyer who used to represent doctors, runs an immediate care center on the north side. The clinic is the only full-time urgent care facility in the area, he said. But because

#### North Side Health Care



Photo/Jack Orton

“ People have more need in this area than other areas. I will see and help more people and feel like I'm accomplishing more. ”

- Abalo Nunyakpe,  
 Milwaukee doctor



Photo/Jack Orton

Abalo Nunyakpe, the lone physician at Omni Family Medical Clinic, 8320 W. Beatrice Court, examines Mary Maxie of Milwaukee.

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of what he considers inadequate reimbursement from a state-contracted HMO, Margoles - who said he has not paid himself a salary in 18 years - now faces the possibility of losing both the clinic and his home. He first mortgaged his home in 1985 to start the clinic and again in late September to help support the clinic, he said.

With fewer doctors within reach, many low-income Milwaukeeans resort to emergency rooms for their medical care. More than 80,000 emergency room visits at city hospitals last year were from uninsured patients, said John Bartkowski, chief executive officer of the Sixteenth Street Clinic. Of these visits, 60% were for primary care.

A small number of hospitals - including Aurora Sinai in downtown Milwaukee - bear the greatest burden of caring for that uninsured and underinsured clientele.

## Coverage central to issue

All discussions of health care availability turn into discussions of insurance coverage - or the lack thereof - because many see that as the root of the problem.

More and more people are without proper insurance coverage as they lose their jobs and the accompanying employer-sponsored health insurance. But even people who have some insurance may have to pay large sums out of pocket before their insurance kicks in. From 2001 to 2003, 10% - on average - of Wisconsin's population was uninsured, according to the U.S. Census Bureau.

More than 600,000 people in the state were enrolled in Medicaid in 2000, according to The Kaiser Commission on Medicaid and the Uninsured, a branch of the Kaiser Family Foundation. In Milwaukee County, as of September, more than 150,000 people were enrolled in the low-income family Medicaid and BadgerCare programs. More than 80% of these people are represented by two of three HMOs that serve the county. Primary care physicians say Medicaid pays them only 25% to 35% of what they bill for treating a patient. Medicare pays up to half the charges.

"We don't concern ourselves with the actual cost of a doctor's (services)," said Mark Moody, state Medicaid director. "(Medicaid) says 'here's what we pay.' Unfortunately we pay low."

The government does try to help the situation, however, by giving extra reimbursement to providers who practice - or whose patients live - in poor or rural communities that the federal government labels as shortage areas, said Russ Peterson, a section chief in the state Medicaid program. In addition, the state gives bonus payments for certain pediatric office visits and emergency department visits.

But it may not be enough.

"The government is well aware that they're paying less than it costs to provide care," said Denis Laurencin, lead physician at Midtown Health Center, a primary care clinic on Capitol Drive.

## Making lemonade . . .

Low reimbursement rates have forced doctors to come up with solutions.

Some limit the number of poorly insured patients they treat.

Others have become known as "Medicaid mills," performing unnecessary procedures and tests so they can pull in extra reimbursement.

Some doctors make up in patient volume what they lack in payments. For example, it's not unusual for Nunyakpe to see 30 or

Nunyakpe says he hasn't had a day off in three years since he opened the north side clinic.



Photo/Jack Orton

Abalo Nunyakpe talks with patient Marilyn Brown of Milwaukee at his Omni Family Medical Clinic. Nunyakpe sees about 30 patients a day, most of whom are covered by government-sponsored health programs.

## Quotable

“ We need new ideas to creatively and effectively address the health care problem. ”

- Perry Margoles,  
a doctor



Photo/Jack Orton

Unable to find a family doctor near his house, Wesley Brown travels 25 minutes to see Nunyakpe

more patients in one day. Most are covered by government-sponsored health programs: a quarter have Medicaid, more than half are on the Milwaukee County General Assistance Medical Program, or GAMP, that benefits people with no other form of medical coverage. But some think the county may cut that assistance program and so remove close to \$40 million from the health care system. Only 15% of Nunyakpe's patients have private insurance.

"People have more need in this area than other areas," Nunyakpe said. "I will see and help more people and feel like I'm accomplishing more."

Nunyakpe hopes to continue to build his clientele and eventually share a clinic with other physicians.

## Sharing the load

This is what Laurencin did. He and three other primary care doctors, worn out from going it alone, are now splitting operating costs by working together at Midtown Health Center. The clinic is associated with Aurora Health Care.

Obstetrician and gynecologist Wayman Parker came aboard at the start of this year, folding a quarter century of solo practice on the north side to join Laurencin and colleagues. The clinic sits less than a mile from Parker's old office so his patients were able to follow him.

"About a year ago I just got really tired," Parker said. "And I decided that I had to go an easier way."

The clinic embodies a dream of the late William Walker, a Milwaukee physician who devoted decades of service to Milwaukee's poor. Walker wanted to put together a team of doctors in a state-of-the-art facility to serve north side residents. The group supplements its income by leasing out laboratory space for services such as blood testing and radiology, Laurencin said. The extra dollars help to pay salaries for physicians, other health care personnel, administration and billing staff, and rent.

Laurencin said that when he was in solo practice, overhead costs ate up 70% of his revenue. Midtown will only remain successful if most of its patients stay employed, Laurencin said. About 40% of its patients are covered by private insurance companies or private HMOs, which pay 65% to 100% of the cost of care. Another 40% are covered by Medicare and 20% of the patients are covered by Medicaid.

The clinic is a way for Parker, 60, to keep serving the community. He came to the city's north side in the late 1970s to work with obstetrician and gynecologist Bill Finlayson. Parker wanted to practice in an area that had a number of black people and many poor people. "That's what I'm from," he said.

Over the years, Parker mentored many young doctors as part of his dream to develop a cadre of black physicians responsive to the community's needs, he said.

"Folks, you're going to work harder and make less money," Parker said he told his proteges.

He often had to take pay cuts so he could pay the young doctors, he said. Eventually he could no longer afford to take on new doctors.

## Stuck between cost and payment

Eighteen years ago, physician Margoles and colleagues came up with a plan for a viable health care model after watching primary care doctors bail out of the city's poor neighborhoods. He believes his clinic - Milwaukee Immediate Care Center - is in a position to serve the city's inner core and other communities.

"We need new ideas to creatively and effectively address the health care problem," Margoles said. "I think we're one of the answers to the health care crisis in the inner city."

Margoles' business model addressed three central issues: having a favorable location, creating a low-stress environment for doctors and patients, and adding an appreciable number of well-insured patients.

The clinic is on Capitol Drive, a busy commercial thoroughfare that straddles several Milwaukee neighborhoods. Margoles said that contributes to the fact that more than 20% of the clinic's patients come from throughout the metro area, including communities such as Whitefish Bay and Waukesha.

About 30% of the clinic's patients pay out-of-pocket or have private insurance, 10% have Medicare, and 60% are enrolled in BadgerCare. Margoles said that when patients come to the clinic, the first question is never "What's your insurance?"

But the clinic cannot survive on the current level of payment it receives, Margoles said. The urgent care clinic has higher overhead costs than a primary care practice because it offers additional resources such as pharmacy, dental, vision and behavioral health services. But one state-contracted BadgerCare HMO that covers many of the clinic's patients pays the lower, primary care rate, he said.

Margoles said he has asked the state to intervene. But the state can't get in the middle of disputes between HMOs and providers over payment amounts, said Angie Dombrowicki, director of the state's Bureau of Managed Health Care Programs. "This is a business relationship between HMOs and providers. (They) have to negotiate their own contracts. Dombrowicki said. "If we're in the middle of that we would be undermining the HMOs' ability to manage care."

One of Margoles' solutions could be to refuse patients who carry that particular coverage, but that would drastically cut his clientele, and defeat the whole purpose of the clinic.

"It's a decent, honest operation," Margoles said. The clinic offers an effective alternative to unnecessary emergency room visits and saves ERs millions of dollars each year, he added. But he is frustrated that he might lose his fight to keep the clinic open, he said, unless the state steps in or the HMO increases its payments.

## **Building stronger relations**

Putting aside rivalries, Milwaukee's private hospital systems and federally qualified community health centers have teamed up to help reduce inappropriate use of hospital emergency rooms while ensuring the health centers' survival. The partnership works in part because Medicaid and Medicare repay federally qualified health centers the full cost of treating patients enrolled in those programs. Hospitals have lower reimbursement rates.

"Community health centers are stronger than they have ever been," said Nannis, the Aurora vice president. "They are well-staffed."

But health centers go unpaid for treating a large number of patients who have no insurance coverage. They are becoming increasingly unable to keep up with the growing numbers of uninsured and underinsured.

"The clinics are full," Nannis said. "We need to increase (their) capacity."

The hospital and health center partners want to expand existing health centers and open satellite locations where necessary. They have asked the U.S. Health and Human Services Department for \$8 million over three years to help health centers accommodate at least 35,000 new patients, Nannis said.

"The more patients they see in the health centers, the fewer patients we see in the ER," he added. Nannis estimates that it costs \$600 to do the battery of standard tests required when a patient visits an emergency room. By contrast, it costs only about \$150 to receive comprehensive care at a health center.

"We are the best-kept secret when you look at this entire dilemma," said C.C. Henderson, president and chief executive officer of Milwaukee Health Services, a federally qualified community health center that has two locations on the north side.

But health centers provide only a partial solution to a big problem.

"Nothing will take the place of having insurance," Nannis said. "But we don't seem to have the political will in this country to insure the 44 million (uninsured) in the country."

Just 3% more than the \$125 billion the nation now spends on personal health care would do the trick, according to the Kaiser

Commission on Medicaid and the Uninsured.

But until everyone has proper insurance, the goal is to have a system that gives quality care to the poor, while making sure health care providers can survive.

"If you're not an effective business," said Wayne Moyer, executive director of Westside Healthcare Association - a community health center, "I don't care how moral your mission and how much good you're doing for the community - you won't be here 50 years from now."

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