Task Force Meeting Attendance Sheet

Medical Malpractice Task Force

Date: 8/30/05 **Meeting Type:** Public Hearing - Invited Speakers

Location: 412 East State Capitol

Committee Member	Present	Absent	Excused
Representative Curtis Gielow, Chair	☑	☐	☐
Representative Mike Huebsch	☑	☐	☐
Representative Ann Nischke	☑	☐	☐
Representative Jason Fields	☑	☐	☐
Representative Bob Ziegelbauer	☑	☐	☐
Mr. David Strifling	☑	☐	☐
Ms. Mary Wolverton	☑	☐	☐
Dr. Clyde "Bud" Chumbley	☑	☐	☐
Mr. David Olson	☑	☐	☐
Mr. Ralph Topinka	☑	☐	☐

Totals: 10 ϕ ϕ

John Reinemann

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Task Force Clerk

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LEGISLATIVE COUNCIL STAFF: Richard Sweet, Senior Staff Attorney

August 22, 2005

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Testimony of Christine Bremer Muggli

on behalf of the

Wisconsin Academy of Trial Lawyers

before the

Assembly Medical Malpractice Task Force

Representative Curt Gielow, Chair

August 30, 2005

Good morning, Representative Gielow and members of the Task Force. My name is Christine Bremer Muggli. I am private practitioner in Wausau Wisconsin and I serve as the Secretary of the Wisconsin Academy of Trial Lawyers (WATL). On behalf of WATL, I thank you for the opportunity to appear today to testify today.

Our Wisconsin Constitution grants citizens several rights – the right to trial by jury, the right to remedy, the right to due process and the right to be treated equally under the law. We believe these are very important rights. Everyday we represent people in the state of Wisconsin who need these rights protected. Courts are places where people can go to have these rights vindicated. Not the Legislative or Executive branches. Courts then serve uniquely different functions than the Legislature or Executive branches. As Senator Lindsay Graham recently remarked while discussing judicial independence, courts are places people can go that politics often won't give them access to, where the unpopular can be heard, the poor can take on the rich and the weak can take on the strong.

We have a perfect example with the establishment of this task force. Where are the people who have been injured as a result of malpractice? They do not have a place at this table. While the legislative process shuts them out, the courts are required to listen to them. They are on equal footing with the special interests. Here in the Legislature injured patients are ignored, while the legislative process once again seeks to take away their rights.

Because courts cannot ignore the plight of injured patients, the issues involving medical malpractice are given a full and fair hearing.

Today with me is Tim Kaul from Grafton, Wisconsin. Mr. Kaul is a 5th generation farmer, avid fisherman and sportsman and a taxidermist. He is also the father of a profoundly disabled child as result of medical negligence as determined by a jury in Ozaukee County. Tim's son, Sean Kaul developed hypoglycemia and hypovolemia that developed shortly after his birth and timely and proper treatment was not provided. As a result of this alleged negligence, Sean is catastrophically brain damaged.

Sean is visually impaired, suffers from cerebral palsy, epilepsy, and is developmental delayed. He is 8 ½ years old, but mentally nearer the age of a one-year-old. He is learning to walk and is still being fed through a tube.

For this life-long disability, the jury determined, after listening to all the evidence, he should receive the amount of $930,000. The previous cap reduced the amount the jury determined by 55 percent — a significant reduction. What do we gain in as a society by penalizing the most severely injured citizens, many children like Sean.

What about the case of Kristopher Brown? He was 16-years-old and broke his leg in a moto-cross accident. The break occurred at the tip of the tibia. Early on, his mother noticed no pulse in the leg. However, the leg was put in a cast. Kristopher immediately began experiencing a lot of pain. Despite complaining, the doctor did not respond to their concerns. A few days later the cast was removed and the leg was 4 times the size of a normal leg. There was a blood clot behind the knee cutting off circulation. After many surgeries Kristopher's foot was amputated.

An Eau Claire County jury unanimously found that health care providers were careless in their 1998 treatment of 16-year-old. The jury said Kristopher should receive $1.25 million for past and future pain and suffering, and his parents should receive $100,000 for their noneconomic damages. With the cap, Kristopher and his family received less than a third of what the jury said he deserved.

Finally let's take the case that brought us here today. Matthew Ferdon is a child who was born in Brown County. The doctor who delivered him injured him at birth. He now lives with a deformed and partially paralyzed right arm. His parents brought a case on his behalf against the doctor. A jury composed on average citizens sat through days of testimony. Each side presented its witnesses. The jury then weighed the evidence and it determined that the Ferdons' had met their burden of proof and found the doctor negligent in causing Matthew's injury. The jury then determined the proper measure of damages for Matthew included $700,000 for his pain, suffering and disability. That amounted to about $10,000 a year. After the verdict was entered, the trial court entertained motions after verdict and because of the cap, the amount was reduced over 40 percent.

These are the Wisconsin citizens trial lawyers all across Wisconsin are representing on a daily basis — real people injured through no fault of their own — who simply want to understand what happened to them and have whoever caused the wrong held responsible. They are not asking for special treatment, but they expect whoever caused the injury should be held financially and legally responsible.

The Ferdons' challenged the cap's reduction because the law did not treat them equally. The Supreme Court took this challenge very seriously. In a scholarly, exhaustive and well-reasoned opinion, the Court reviewed the legislative purpose of the 1995 cap as well as evidence to support and refute it. The Court reviewed over 50 reports and articles. We believe that it is critically important for this task force to have all the information relied on by the Court, so we are providing members of the committees with as many of cited documents as we could obtain. In addition, we have included the brief our organization filed in the case and a few new articles and reports that have come out since the opinion was released.

We hope that once the task force reviews the evidence you will come to the same conclusion as the Supreme Court – caps on noneconomic damages treat the most severely injured patients and their families unfairly and are an arbitrary and irrational way to address problems facing the health care system.

I would like to highlight the evidence against the caps.

Medical malpractice insurance premiums are an exceedingly small portion of overall health care costs. In Wisconsin, they are now less than 40 cents out of every $100 dollars spent on health care and it is a declining proportion. *Expansion Magazine* has rated Wisconsin's malpractice costs as the lowest in the nation. Meanwhile, Wisconsin health insurance premiums are rated second highest in the nation. There is no correlation between malpractice costs and health care costs.

The Court found that "even if the $350,000 cap on noneconomic damages would reduce medical malpractice insurance premiums, this reduction would have no effect on consumer's health care costs." That certainly proved true under the $350,000 cap. Did anyone experience lower health care costs since 1995? The Court concluded, "Accordingly, there is no objectively reasonable basis to conclude that the $350,000 cap justifies placing such a harsh burden on the most severely injured medical malpractice victims, many of whom are children."

Just nine (9) jury verdicts were impacted by the cap from 1995-2005. Below is a summary of the case and how the cap impacted the injured patients and their families.

Jury Verdict Date, County, Case #	**Injured Patient and Age**	**Nature of injury**	**Noneconomic damages jury awarded, including pain and suffering**	**Final award**	**Percentage Reduced**
April 2005 Milwaukee 2003CV3456	Joseph Richard mid-50's	He underwent an unnecessary removal of his rectum, with a leak of the anastomosis, ten further surgeries, and permanent bowel problems.	$540,000	$432,352	20%
May 2004 Marinette 2002CV60	David Zak mid-30s	Failure to diagnose suspicious infection causing body to shut down resulting in loss of bodily function	$1 million	$422,632	57%

Jury Verdict Date, County, Case #	Injured Patient and Age	Nature of injury	Noneconomic damages jury awarded, including pain and suffering	Final award	Percentage Reduced
April 2004 Kenosha 2001CV1261	Estate of Helen Bartholomew Early 60s	Failure to diagnose heart attack causing massive heart and brain damage requiring her to live in nursing home and resulting in her death 3 years later	$1.2 million	$350,000	70%
Dec. 2003 Ozaukee 1999CV360	Sean Kaul infant	Negligent failure to provide timely and proper treatment for hypoglyceminia and hypovolemia that developed shortly after birth rendered child permanently disabled	$930,000	$422,632	55%
Dec. 2002 Brown 2001CV1897	Matthew Ferdon infant	Negligent delivery resulting in right arm being deformed and partially paralyzed	$700,000	$410,322	40%
June 2002 Dane 2000CV1715	Scott Dickinson mid-30s	Negligent treatment during a psychotic episode and rendered a quadriplegic.	$6.5 million	$410,322	93%
June 2001 Eau Claire 2000CV120	Kristopher Brown 16 years old	Negligent treatment of a broken leg resulting in part of the leg being amputated	$1.35 million	$404,657	67%
March 2000 Eau Claire 1998CV508	Bonnie Richards Early 40s	Common bile duct clipped during laproscopic cholecystectomy resulting in residual hernias requiring additional surgeries and almost dying twice.	$660,000	$381,428	41%
October 1999 Portage 1998CV169	Candice Sheppard mid-20s	Negligent surgery to remove a cyst in the vaginal area resulted in permanent pain and injury	$700,000	$350,000	50%

These nine cases show a reduction of approximately $10.2 million from what the juries determined the damages to be after hearing all the evidence compared to the damages available under the cap enacted in 1995. That's about $1 million per year. That comes to 18 cents per person in Wisconsin per year. Furthermore, because an injured patient shares the cap with family members, the cap has a disparate effect on patients with families. It is these injured patients and their families who are bearing the total

burden if medical malpractice occurs and a jury awards more than the cap. Why is it fair to burden the most seriously injured while providing monetary relief to health care providers and their insurers?

The data from the National Practitioner Data Bank, to which all payments to people injured by medical negligence must be reported, show that Wisconsin was the third lowest state for the number of payments per 1,000 doctors in 2003, the same ranking we held in both 1994 and 1995, before the cap on damages took effect.

With a cap, the Fund's enormous assets are denied to patients for whom juries have awarded compensation above the cap. In the last 10 years, the Fund's assets have almost tripled, increasing an average of $47 million a year to almost $750 million. During the same period, the Fund was only drawn upon an average of 19 times per year and payments made to families averaged only $28.5 million per year. *That amounts to $18.5 million less than the average annual increase in Fund assets.* Meanwhile, the Fund's assets, while barely tapped by injured patients, have been utilized to reduce Fund malpractice fees for doctors. Fund fees have been cut six of the last seven years, most recently by 30 percent. *The Fund fees for 2005-2006 are more than 50% lower than fees from 1986-87.*

Injured Patients & Families Compensation Fund

Year	Number of Cases Paid	Losses Paid to Injured Patient & Families
1994-95	25	$24,098,896
1995-96	28	$51,456,670
1996-97	16	$34,679,277
1997-98	24	$18,718,458
1998-99	28	$19,929,978
1999-2000	12	$19,657,326
2000-01	22	$39,636,276
2001-02	14	$35,304,773
2002-03	11	$22,074,552
2003-04	13	$19,496,969
Total	**193**	**$285,053,175.00**
Average	**19.3**	**$28,505,318**

WATL believes that grossly inaccurate actuarial projections have fueled the need for a cap. In 1995, sponsors of the cap legislation used the inaccurate projections by actuaries as a reason to impose the noneconomic damages cap. Legislators were told there was a *$67.9 million projected actuarial deficit* as of June 30, 1994. Instead, the actuaries now estimate there was a *$120 million actuarial surplus*. ***It shows that when the Legislature acted in 1995, it was given estimates that were off by almost $188***

million!! As the Supreme Court it didn't seem to make any difference if there was or wasn't cap because the Fund has flourished both with and without a cap.

In Wisconsin, few medical malpractice claims are filed. In a state with 5.5 million people, with millions of doctor-patient contacts yearly, only 240 medical negligence claims were filed in 2004 with the Medical Mediation Panels. That is one claim for every 22,916 Wisconsin citizens. The number has been steadily decreasing since the mid-80s. This pattern suggests that even when there was no cap on damages from 1991-1995, there was no corresponding explosion of claims. In fact, there was a decline in filings. So, the imposition of a cap is simply an additional, but wholly arbitrary, barrier to justice for most families.

Year	Medical Mediation Claims Filed	Amount of Cap*
1986	***	$1,000,000
1987	398	$1,030,000
1988	353	$1,070,170
1989	339	$1,123,678
1990	348	$1,179,862
Total	**1438**	
Average	**359.5**	
1991	338	No Cap
1992	313	No Cap
1993	276	No Cap
1994	292	No Cap
Total	**1219**	
Average	**304.75**	
1995	324	$350,000
1996	244	$359,800
1997	240	$369,874
1998	305	$375,052
1999	309	$381,428
2000	280	$392,871
2001	249	$404,657
2002	264	$410,322
2003	247	$422,632
2004	240	$432,352
Total	**2702**	
Average	**270.2**	

** The $1 million cap went into effect on June 15, 1986 and the cap was indexed on that day each year. The $350,000 cap went into effect on May 25, 1995 an was indexed each year on May 15.*
**** No numbers for that year.*

One of the most persistent assertions about caps is that they would hold down malpractice premiums for doctors. The Court analyzed several studies and found that "according to a General Accounting Office report, differences in both premiums and claims payments are affected by multiple factors in addition to damage caps, including state premium rate regulation, level of competition among insurers, and interest rates and income returns that affect insurers' investment returns. Thus, the General Accounting Office concluded that it could not determine the extent to which differences among states in premium rates and claims payments were attributed to damage caps or to additional factors. For example, Minnesota, which has no caps on damages, has relatively low growth in premium rates and claims payments. "

In fact if you listened to the insurance companies own executives, they would not promise any savings from caps. This was recently highlighted in Illinois. In a recent news article it was reported, "As for caps on awards resulting in reduced rates for malpractice insurance premiums that doctors must pay, supporters of caps say they can't promise the new caps will significantly lower insurance rates.

Ed Murnane, the leading tort reform advocate in Illinois, said at a tort reform summit in mid-May, 'No, we've never promised that caps will lower insurance premiums.'"

Insurance execs speak up

"We wouldn't tell you or anyone that the reason to pass tort reform would be to reduce insurance rates." Sherman Joyce, President of the American Tort Reform Association, (Source: "Study Finds No Link Between Tort Reforms and Insurance Rates." *Liability Week*, July 19, 1999.)

"Insurers never promised that tort reform would achieve specific premium savings . . ." (Source: March 13, 2002 press release by the American Insurance Association (AIA).)

"[A]ny limitations placed on the judicial system will have no immediate effect on the cost of liability insurance for health care providers." (Source: "Final Report of the Insurance Availability and Medical Malpractice Industry Committee," a bi-partisan committee of the West Virginia Legislature, issued January 7, 2003.)

An internal document citing a study written by Florida insurers regarding that state's omnibus tort "reform" law of 1986 said that ***"The conclusion of the study is that the noneconomic cap . . . [and other tort 'reforms'] will produce little or no savings to the tort system as it pertains to medical malpractice."*** (Source: "Medical Professional Liability, State of Florida," St. Paul Fire and Marine Insurance Company, St. Paul Mercury Insurance Company.)

This theme was further bolstered by a recent rate filing by GE Medical Protective, which sought a 19% rate increase just one year after Texas voters narrowly approved a $250,000 cap on non-economic damages in medical malpractice cases. After claiming that caps would reduce malpractice premiums, the insurer admitted in its rate-filing request that "capping non-economic damages will show loss savings of 1%."

Further, we must agree with the Supreme Court that, "Victims of medical malpractice with valid and substantial claims do not seem to be the source of increased premiums for medical malpractice insurance, yet the $350,000 cap on noneconomic damages requires that they bear the burden by being deprived of full tort compensation."

Various new studies have been released to bolster this statement. In Texas, researchers looking at Texas found that soaring malpractice premiums were not correlated with malpractice lawsuits and settlements. A team of legal scholars from the University of Texas, Illinois, and Columbia examined all closed claim cases from 1988 to

2002. The law professors found that claims rates, payments and jury verdicts were roughly constant after adjusting for inflation and concluded that the premium increases starting in 1999 "were not driven primarily by increases in claims, jury verdicts, or payouts. In the future, malpractice reform advocates should consider whether insurance market dynamics are responsible for premium hikes."

A second comprehensive study of medical malpractice claims, this time in Florida, also shows no sharp increase in lawsuits relative to population growth and a modest increase in the size of settlements. "When we compared the number of malpractice cases to the population in Florida," said Neil Vidmar, one of the study's authors and professor at Duke's School of Law, "there has been no (large) increase in medical malpractice lawsuits in Florida." Vidmar said rising health-care costs and more serious injuries resulting in larger claims or litigated payments caused the increase in the claim total. Finally, the report concludes the "vast majority of million-dollar awards were settled around the negotiation table rather than in the jury room." Of the 831 million-dollar awards reported since 1990, 63 were awarded by juries. The rest occurred as settlements.

The National Bureau of Economic Research study reviewed the relationship between the growth of malpractice costs and the delivery of health care in three areas: (1) the effect of malpractice payments on medical malpractice premiums, (2) the effect of increases in malpractice liability to physicians closing their practices or moving and (3) defensive medicine. The study found a weak relationship between medical malpractice payments and malpractice premium increases.

A July 7, 2005, study released by Center for Justice and Democracy finds that net claims for medical malpractice paid by 15 leading insurance companies have remained flat over last five years.

Meanwhile, net premiums have surged ***120 percent.*** During the 2000-04 period, the increase in premiums collected by leading 15 medical malpractice insurance companies was ***21 times*** the increase in claims they paid. The study shows an "overall surge in malpractice premiums with no corresponding surge in claim payments during the last five years."

Other key highlights of the study:

- "Over the last five years, the amount the major medical malpractice insurers have collected in premiums more than doubled, while their claims remained essentially flat."
- "...In 2004, the leading medical malpractice insurers took in approximately three times as much in premiums as they paid out in claims."
- "{T}he surplus the leading insurers now hold is almost double the amount the National Association of Insurance Commissioners deems adequate for those insurers."

Wisconsin Unique System: The Injured Patients and Families Compensation Fund

A short history of the Injured Patients and Families Compensation Fund may be in order since it has figured so prominently in the discussion of Wisconsin's malpractice system. Wisconsin's medical malpractice insurance structure was set up in 1975 to deal with a serious problem in availability of medical malpractice insurance. The Legislature guaranteed the availability of insurance by creating the Wisconsin Health Care Liability Insurance Plan (WHCLIP) as a risk-sharing plan to provide primary insurance coverage and by creating the Patients Compensation Fund (the Fund) to pay claims in excess of primary coverage. (The Legislature changed the Fund's name in 2003 to the Injured Patients and Families Compensation Fund. 2003 WI Act 111.) The same Board of Governors governs both.

The 1975 Statutory Scheme

The statutory scheme is unique: insurance is mandatory for physicians (except government-employed) and hospitals; primary coverage is from WHCLIP or a private company; the Fund fees are also mandatory and provide unlimited coverage over the primary level.

WHCLIP is run like an insurance company; the Fund is not. Fund fees were originally calculated as a percentage, not to exceed 10%, of the WHCLIP rates. Fees were to be reduced if "additional fees would not be necessary to maintain the Fund at $10 million."

The 1975 legislation contained a potential limitation on payouts. Wis. Stat. § 655.27(6) initially provided,

> If, at any time after July 1, 1978 the commissioner finds that the amount of money in the Fund has fallen below $2,500,000 level in any one year or below a $6,000,000 level for any 2 consecutive years, an automatic limitation on awards of $500,000 for any one injury or death on account of malpractice shall take effect. ... This subsection does not apply to any payments for medical expenses.

In March 1980, the law was changed to require an annual report for the Fund, prepared according to generally accepted actuarial principles, that would give the present value of all claims reserves and all

Timeline of the Fund

1975 — Legislature establishes Patients Compensation Fund (Fund) and the Wisconsin Health Care Liability Insurance Plan (WHCLIP). The legislation required that all physicians carry malpractice insurance either from a private insurer or WHCLIP for up to $200,000 and then mandates participation in the Fund, which provides unlimited coverage and pays claims in excess of primary coverage. The same 13-member Board of Governors governs both. WHCLIP is run like an insurance company; the Fund is not. Fund fees were originally calculated as a percentage, not to exceed 10%, of the WHCLIP rates and the Fund was not to have more than $10 million in assets.

1980 — The fiscal nature of the Fund was changed to give the present value of all claims reserves and all incurred but not reported (IBNR) claims. IBNR claims are claims that are not presently known but are presumed to exist. This changed the Fund from a form of "pay as you go" system to a system with a potential surplus or deficit.

1986 — The Legislature adopts an indexed $1 million cap on pain and suffering. The Fund also collapsed the number of Fund classes from 9 to 4 for purposes of calculating fees.

1987 — Doctors' primary coverage increased to $300,000.

1988 — Doctors' primary coverage increased to $400,000

1991 — $1 million indexed cap sunsets.

1995 — $350,000 indexed cap adopted.

1997 — Doctors' primary coverage increased to $1,000,000.

2003 — Fund name changed to Injured Patients and Families Compensation Fund.

incurred but not reported (IBNR) claims. IBNR claims are those claims that are not presently known but are presumed to exist; they have played an important role in the Fund's financial situation ever since 1980.

The net effect of this statutory change was to change the Fund from a form of "pay as you go" system to a system with a potential surplus or deficit based on the annual actuarial reports. The potential surplus or deficit relied heavily on the projected value of claims reserves and IBNR claims.

The Fund was established to pay claims in excess of primary coverage. Health care providers are required to purchase primary coverage — $200,000 in 1975, $300,000 in 1987, $400,000 in 1988, and $1,000,000 in 1997. Fees assessed against all health care providers in the state pay for the Fund. The Fund fees are created by administrative rule, providing the Legislature with oversight authority. The Fund is divided into no more than four

The 1986 Legislative Changes

In the early and mid-80s, was a sudden and dramatic requests for premium and fee increases. This led to a second "crisis" in medical malpractice insurance. Because WHCLIP and the Fund mechanisms worked as intended, Wisconsin did not have problems with *availability* of insurance as it had in 1975. Instead, Wisconsin suffered an "*affordability* crisis," that is; the dramatic price increases made insurance premiums and Fund fees less affordable.

The highest Fund fee increase suggested by the actuaries was a 160% fee increase for 1985-86; more than half of the increase was meant to offset a portion of the actuarial deficit. The Legislature would not go along with that huge increase but did approve a 90% fee increase.

The increased cost of medical malpractice insurance led health care providers to lobby the Legislature for strong tort "reform" measures, including caps on damages, limits on the attorneys fees of injured consumers, and limits on payments for future medical expenses. After much debate, the Legislature made numerous changes to the law in 1986 including a cap of $1 million on all noneconomic damages. The legislation, however, made few changes to directly address the elimination of the Fund's actuarial

deficit. Nevertheless, Fund fees were only moderately increased from 1986 through 1994. There was virtually no impact on fees after the noneconomic damage cap sunset on December 31, 1990 (resulting in no cap being in effect).

In addition, during the 1980s, the Fund collapsed the number of classes from nine to four, thereby moderating costs between general practitioners (Class 1) and neurologists and OB-GYNS (Class 4).

The establishment of the Fund represented an egalitarian reform that involved *sharing of risk* among all providers to hold down malpractice rates. Consequently, the Fund's premium structure divided the medical profession into just four categories, resulting in substantially lower rates for higher-risk specialties and somewhat higher rates for lower-risk categories. This sharing of risk helps Wisconsin to retain doctors in high-risk specialties upon whom general practitioners can rely for referring patients in need of more specialized care.

In sharp contrast, the cap on pain and suffering imposed a *shift of risk* from providers as a whole to patients and the public. Patients could no longer count on the legal system to give them full compensation for the pain and suffering caused by medical negligence. Juries were deprived of the power to fully compensate injured patients.

Moreover, it is precisely the Fund's unique and progressive features—not the cap—that have actually accounted for the decreases in malpractice premiums:

a) **Non-profit:** The Fund is not-for-profit. In contrast to private insurance corporations characterized by huge executive salaries, massive bureaucracies, and wild swings in premium rates contingent on stock and bond

How Wisconsin doctors are insured against malpractice

Nature of malpractice claim	Source of insurance	Premiums
For claims up to $1 million	Private insurers	Set by insurance firms, highly dependent on stock and bond investments
For claims up to $1 million when private insurance is not available	WHCLIP (serves only 2.3% of doctors)	Rates are set by the Board, and are set higher than other private malpractice insurance
For claims above $1 million	Injured Patients and Families Compensation Fund	Set by Fund Board. Fees have been cut to sub-1986 levels.

market investments, the Fund does not subject Wisconsin medical providers to these burdens.

b) **Universal:** The Fund is universal, covering virtually all health care providers in the state. Thus, the Fund draws upon a large pool of doctors to share the risk and hold down costs.

c) **Sharing the risk:** The Fund spreads the cost of insuring against risk across interrelated medical professions, so that high-risk specialties do not bear an inordinately heavy burden.

Because the Fund has been so successful at accumulating assets — almost $750 million assets. As the Supreme Court noted in *Ferdon v. WCFP*, 2005 WI 125, ¶158 "The Fund has flourished both with and without a cap. If the amount of the cap did not impact the Fund's fiscal stability and cash flow in any appreciable manner when no caps existed or when a $1,000,000 cap existed, then the rational basis standard requires more to justify the $350,000 cap as rationally related to the Fund's fiscal condition."

Conclusion

If this task force is serious about tackling the problems with medical malpractice then more than caps must be on the table — it must include insurance regulation, strengthening physician discipline and patient safety concerns.

The ominous implications for the Constitutional rights of Wisconsin citizens—particularly injured patients—were minimized during the legislative debate in 1995 that imposed the cap on pain and suffering in medical malpractice cases. Instead, advocates of the cap argued that this loss of legal access for a relative few would be far outweighed through a tradeoff for broader public benefits — lower health care costs, more doctors in underserved areas and a solvent and stabilized Fund for injured patients and their families.

In practice over the past decade, the tradeoff of legal rights for public benefits proved to be disastrous. While our legal rights certainly were diminished, the promised benefits have never appeared. Wisconsin does not have lower health care costs, doctors are still not going to underserved areas and the Fund was never in jeopardy, it had been in surplus since 1990, the year the $1 million cap expired.

The Legislature appears to be following down the trail again to impose a cap the attempts to ask the most severely injured patients and their families of severely injured patients to bear the burden of "fixing" the legal malpractice system alone. That is neither fair nor just.

Caps are a barrier to the courthouse for injured patients and their families and strike at the very heart of the civil justice system. It deprives juries of their constitutional mandate to do *justice* in individual cases. You are once again tilting the scales of justice in Wisconsin against severely tilted against injured patients and their families in favor of health care providers and their insurance companies.

We believe that is not only immoral, but unconstitutional.

Studies cited in majority opinion in *Ferdon v. WPCF*, 2005 WI 125

U.S. Government Documents:

1. **U.S. General Accounting Office, Medical Malpractice: A Framework for Action, GAO/HRD-87-73, at 3, 12-19 (May 1987).** The General Accounting Office concluded that one of the surest ways to "deal with the problem of increasing insurance costs" is to eliminate the conditions that result in acts amounting to medical malpractice. Efforts to accomplish this may include (1) disciplining or removing from practice those physicians not providing an acceptable quality of care; (2) protecting patients from physicians who lose their licenses in one state but have them in another; and (3) developing and expanding risk management programs to educate providers concerning better ways of delivering an acceptable quality of health care, minimizing the possibility of future malpractice suits.

2. **U.S. General Accounting Office, Medical Malpractice: Characteristics of Claims Closed in 1984, GAO/HRD-87-55 (Apr. 1987)** (4% of all claims, with all damages included, were over $250,000. 2.1% of noneconomic damages were over $200,000.).

3. **U.S. General Accounting Office, Medical Malpractice: Effects of Varying Laws in the District of Columbia, Maryland and Virginia (1999).**

4. **U.S. General Accounting Office, Medical Malpractice Insurance: Multiple Factors Have Contributed to Increased Premium Rates, GAO-03-702 (June 2003)** (indicating that while medical malpractice suits are one of the leading costs for insurance carriers, the effect on premium rates cannot be determined; a number of factors go into health care providers' premium rates).

5. **U.S. General Accounting Office 03-836, Medical Malpractice: Implications of Rising Premiums on Access to Health Care 30 (Aug. 28, 2003),** available at http://www.gao.gov

6. **U.S. Dep't of Health & Human Servs., Confronting the New Health Care Crisis: Improving Health Care Quality and Lowering Costs by Fixing Our Medical Liability System (July 25, 2002),** available at http://aspe.hhs.gov/daltcp/reports/litrefm.htm.

7. **U.S. Dep't of Health & Human Servs., Addressing the New Health Care Crisis: Reforming the Medical Litigation System to Improve the Quality of Health Care, at 15 (Mar. 3, 2003)** ("Most victims of medical error do not file a claim . . . only 1.53% of those who were injured by medical negligence even filed a claim.").

8. **Joint Economic Committee, Liability for Medical Malpractice: Issues and Evidence 23 (May 2003),** available at http://www.house.gov/jec/tort/05-06-03.pdf. The U.S. Congress Joint Economic Committee has recently, in conjunction with efforts to pass federal medical malpractice tort reform, issued

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9. **Joint Economic Committee, The Perverse Nature of the Medical Liability System (March 2005)** (noting that only 3% of injured patients actually file suit against their health care provider).

10. **Congressional Budget Office, Limiting Tort Liability for Medical Malpractice (Jan. 8, 2004).**

11. **Office of Technology Assessment, U.S. Congress, Defensive Medicine and Medical Malpractice 3 (1994),** available at http://www.wws.princeton.edu/~ota. ("Defensive medicine has been defined as occurring "when doctors order tests, procedures, or visits, or avoid high-risk patients or procedures, primarily . . . to reduce their exposure to malpractice liability.")

12. **Fred J. Hellinger & William E. Encinosa, U.S. Dept. of Health & Human Services, The Impact of State Law Limiting Malpractice Awards on the Geographic Distribution of Physicians (July 3, 2003).** (Yet another study indicates that between 1970 and 2000 in states with caps on noneconomic damages, the percent increase in the number of physicians per capita was 95.7%. For states with no cap, or a cap that was overturned, the increase in physicians was only 79.1%. No state listed in this study, with or without a cap, showed a decrease in the number of physicians. In fact, Wisconsin saw, according to this study, an increase in physicians of 104.5%. However, the study fails to take into account that for the 30-year period examined, Wisconsin did not have a cap for approximately half that time. Wisconsin's increase in physicians is consistent with 11 other states with no caps on noneconomic damages, and Wisconsin had a smaller increase than seven states without noneconomic damage caps (Alabama, Maine, New Jersey, North Carolina, Rhode Island, South Carolina and Tennessee)).

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2. **U.S. General Accounting Office, Medical Malpractice: Characteristics of Claims Closed in 1984, GAO/HRD-87-55 (Apr. 1987)** (4% of all claims, with all damages included, were over $250,000. 2.1% of noneconomic damages were over $200,000.).

3. **U.S. General Accounting Office, Medical Malpractice: Effects of Varying Laws in the District of Columbia, Maryland and Virginia (1999).**

4. **U.S. General Accounting Office, Medical Malpractice Insurance: Multiple Factors Have Contributed to Increased Premium Rates, GAO-03-702 (June 2003)** (indicating that while medical malpractice suits are one of the leading costs for insurance carriers, the effect on premium rates cannot be determined; a number of factors go into health care providers' premium rates).

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6. **U.S. Dep't of Health & Human Servs., Confronting the New Health Care Crisis: Improving Health Care Quality and Lowering Costs by Fixing Our Medical Liability System (July 25, 2002),** available at http://aspe.hhs.gov/daltcp/reports/litrefm.htm.

7. **U.S. Dep't of Health & Human Servs., Addressing the New Health Care Crisis: Reforming the Medical Litigation System to Improve the Quality of Health Care, at 15 (Mar. 3, 2003)** ("Most victims of medical error do not file a claim . . . only 1.53% of those who were injured by medical negligence even filed a claim.").

8. **Joint Economic Committee, Liability for Medical Malpractice: Issues and Evidence 23 (May 2003),** available at http://www.house.gov/jec/tort/05-06-03.pdf. The U.S. Congress Joint Economic Committee has recently, in conjunction with efforts to pass federal medical malpractice tort reform, issued

difficult to draw any conclusions from premium numbers based solely on the enactment of Wisconsin Act 10.").

14. **Theresa Wedekind, Patients Compensation Claims Experience, WiscRisk (Wis. Patients Comp. Fund), Spring 2004,** at 2.

15. In Wisconsin, the Wisconsin Health Care Liability Insurance Plan acts "as the insurer of last resort for doctors, hospitals, and other health professionals who are unable to find coverage in the private market." **See Office of the Commissioner of Insurance, Special Report, Wisconsin Health Care Liability Insurance Plan (WHCLIP): Preliminary Report on Medical Malpractice in Wisconsin, Report Number IP13-92, at 1 (1992).**

16. **Legislative Fiscal Bureau, Injured Patients and Families Compensation Fund** (Insurance and Health and Family Services), Paper #450 to Joint Committee on Finance 2 (May 17, 2005) (hereinafter Legislative Fiscal Bureau Paper #450).

17. **Legislative Fiscal Bureau, Patients Compensation Fund (Insurance and Health and Family Services)**, Paper #458 to Joint Committee on Finance 13 (Apr. 23, 2003) (hereinafter Legislative Fiscal Bureau Paper #458).

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20. Memorandum from Robert L. Sanders, Milliman & Robertson, Inc., to Danford C. Bubolz, Chief, Patients Compensation Fund 3 (Jan. 18, 1995) (available in Bill File at the Wisconsin Legislative Council, Madison, Wisconsin); Wis. Patients Comp. Fund, Report To The Joint Legislative Audit Committee (prepared by the Special Committee of the Board of Directors) Executive Summary 3, 14 (June 13, 1994).

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24. **Elizabeth Stewart Poisson, Comment, Addressing the Impropriety of Statutory Caps On Pain and Suffering Awards in the Medical Liability System, 82 N.C. L. Rev. 759, 767-70 (2004)** (discussing a variety of other factors that may well be more of an impact on medical malpractice premium rates).

25. **Melissa C. Gregory, Note: Capping Noneconomic Damages in Medical Malpractice Suits is Not the Panacea of the "Medical Liability Crisis", 31 Wm. Mitchell L. Rev. 1031, 1044-45 (2005).**

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27. **David B. Simpson, Compulsory Arbitration: An Instrument of Medical Malpractice Reform and a Step Towards Reduced Health Care Costs?, 17 Seton Hall Legis. J. 457, 459-60 (1993)** (finding that in 1991 not even one percent of the total costs associated with health care could be attributed to medical malpractice premiums)

28. **David Morrison, In Search of Savings: Caps on Jury Verdicts Are Not a Solution to Health Care Crisis, 7 Loy. Consumer L. Rep. 141, 149 (1995)** (showing that Indiana's cap on damages has not resulted in a savings for health care consumers).

29. **Jacqueline Ross, Note, Will States Protect Us, Equally, From Damage Caps in Medical Malpractice Litigation?, 30 Ind. L. Rev. 575, 588 (1997)** (medical malpractice insurance rates are a tiny percentage of overall health care costs).

difficult to draw any conclusions from premium numbers based solely on the enactment of Wisconsin Act 10.").

14. **Theresa Wedekind, Patients Compensation Claims Experience, WiscRisk (Wis. Patients Comp. Fund), Spring 2004,** at 2.

15. In Wisconsin, the Wisconsin Health Care Liability Insurance Plan acts "as the insurer of last resort for doctors, hospitals, and other health professionals who are unable to find coverage in the private market." **See Office of the Commissioner of Insurance, Special Report, Wisconsin Health Care Liability Insurance Plan (WHCLIP): Preliminary Report on Medical Malpractice in Wisconsin, Report Number IP13-92, at 1 (1992).**

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30. **W. John Thomas, The Medical Malpractice "Crisis": A Critical Examination of a Public Debate, 65 Temp. L. Rev. 459, 506 n.329 (1992)** (malpractice insurance premiums are less than one percent of health care costs).

31. **Thomas Horenkamp, Comment, The New Florida Medical Malpractice Legislation and Its Likely Constitutional Challenges, 58 U. Miami L. Rev. 1285, 1326 (2004)** (medical malpractice insurance premiums amounted to one percent of total health care expenditures in 1988, 0.56% in 2000, and approximately one percent in 2004).

32. **Paul C. Weiler, Reforming Medical Malpractice in a Radically Moderate—and Ethical—Fashion, 54 DePaul L. Rev. 205, 208 (2005)** (malpractice insurance and litigation costs are approximately one percent of total health care costs).

33. **Michelle M. Mello & Troyen A. Brennan, Deterrence of Medical Errors: Theory and Evidence for Malpractice Reform, 80 Tex. L. Rev. 1595, 1607 (2002)** (discussing potential deterrent effects of medical malpractice liability and indicating that "[i]t is likely that defensive medicine, to the extent that it ever took place, has diminished over time in response to the growing presence of managed care.").

34. **Dennis J. Rasor, Mandatory Medical Malpractice Screening Panels: A Need to Reevaluate, 9 Ohio St. J. on Disp. Resol. 115, 119 (1993)** (concluding that "[t]he cost of medical malpractice insurance can not be greatly responsible for the increase in the cost of medical care.").

35. **Lauren Elizabeth Rallo, Comment, The Medical Malpractice Crisis—Who Will Deliver the Babies of Today, the Leaders of Tomorrow?, 20 J. Contemp. Health L. & Pol'y 509, 510-511 (2004)** (discussing the protests by surgeons and obstetricians in several "problem" states, of which Wisconsin is not one).

36. **Geoff Boehm, Debunking Medical Malpractice Myths: Unraveling the False Premises Behind "Tort Reform", 5 Yale J. Health Pol'y & Ethics 357, 362 (2005)** (suggesting the cost of medical malpractice insurance is about two percent of total health care costs).

37. **Daniel Kessler & Mark McClellan, Do Doctors Practice Defensive Medicine?, 111 Quarterly J. of Econ. 353 (1996).**

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38. **Amitabh Chandra et al., The Growth of Physician Medical Malpractice Payments: Evidence from the National Practitioner Data Bank, W5-243, W5-247 (May 31, 2005),** available at http://www.healthaffairs.org. (Article concluded that medical malpractice payments have leveled off since 2000 and that any rise

in malpractice payments is proportionate with overall changes in health care spending Furthermore, the few large awards are not growing at the same pace as awards that would not be affected by a cap on damages.)

39. **David Studdert et al., Are Damages Caps Regressive? A Study of Malpractice Jury Verdicts in California, 23 Health Affairs 54, 65 (2004)** ("Decisions to implement [damage caps] should be made with an awareness that they are likely to exacerbate existing problems of fairness in compensation.").

40. **William E. Encinosa & Fred J. Hellinger, Have State Caps On Malpractice Awards Increased The Supply of Physicians? (May 31, 2005),** available at http://www.healthaffairs.org. The article, published by the online journal Health Affairs.

41. **Alan Sager & Deborah Socolar, Health Care Costs Absorb One-Quarter of Economic Growth, 2000-2005, (Feb. 9, 2005),** available at http://dcc2.bumc.bu.edu/hs/ushealthreform.htm.

42. **Kenneth E. Thorpe, The Medical Malpractice 'Crisis': Recent Trends and the Impact of State Tort Reforms, Health Affairs W4-20, W4-25, W4-24 (Jan. 21, 2004),** at http://content.healthaffairs.org/cgi/reprint/hlthaff.w4.20v1 ("[D]eterring substandard medical care is a major rationale for using a tort-liability system for medical malpractice." Also, "[r]ising claims costs may reflect a rise in underlying negligence.").

43. **Jonathon Klick & Thomas Stratmann, Does Medical Malpractice Reform Help States Retain Physicians and Does It Matter? 9 (Oct. 2, 2003)** (unpublished manuscript, available at http://papers.ssrn.com/sol3/papers.cfm?abstract_id=453481).

44. **American Medical Association, Medical Liability Reform – NOW! 8 (Dec. 3, 2004),** available at http://www.amaassn.org/go/mlrnow.

45. **Health Insurance Association of America, Issue Brief: Why Do Health Insurance Premiums Rise (Sept. 2002)** (indicating that rising consumer health insurance premiums are due to increases in the overall cost of health care and that "claims and consumer service" account for only 0.12 cents of every dollar spend on health care).

Other States

46. A report focusing exclusively on Pennsylvania mentions the exit of a medical malpractice insurer from the medical malpractice insurance market. **Randall R. Bovbjerg & Anna Bartow, Understanding Pennsylvania's Medical Malpractice Crisis (2003),** available at http://medliabilitypa.org/research/. The report does not mention the national market share of the insurance company that

30. **W. John Thomas, The Medical Malpractice "Crisis": A Critical Examination of a Public Debate, 65 Temp. L. Rev. 459, 506 n.329 (1992)** (malpractice insurance premiums are less than one percent of health care costs).

31. **Thomas Horenkamp, Comment, The New Florida Medical Malpractice Legislation and Its Likely Constitutional Challenges, 58 U. Miami L. Rev. 1285, 1326 (2004)** (medical malpractice insurance premiums amounted to one percent of total health care expenditures in 1988, 0.56% in 2000, and approximately one percent in 2004).

32. **Paul C. Weiler, Reforming Medical Malpractice in a Radically Moderate—and Ethical—Fashion, 54 DePaul L. Rev. 205, 208 (2005)** (malpractice insurance and litigation costs are approximately one percent of total health care costs).

33. **Michelle M. Mello & Troyen A. Brennan, Deterrence of Medical Errors: Theory and Evidence for Malpractice Reform, 80 Tex. L. Rev. 1595, 1607 (2002)** (discussing potential deterrent effects of medical malpractice liability and indicating that "[i]t is likely that defensive medicine, to the extent that it ever took place, has diminished over time in response to the growing presence of managed care.").

34. **Dennis J. Rasor, Mandatory Medical Malpractice Screening Panels: A Need to Reevaluate, 9 Ohio St. J. on Disp. Resol. 115, 119 (1993)** (concluding that "[t]he cost of medical malpractice insurance can not be greatly responsible for the increase in the cost of medical care.").

35. **Lauren Elizabeth Rallo, Comment, The Medical Malpractice Crisis—Who Will Deliver the Babies of Today, the Leaders of Tomorrow?, 20 J. Contemp. Health L. & Pol'y 509, 510-511 (2004)** (discussing the protests by surgeons and obstetricians in several "problem" states, of which Wisconsin is not one).

36. **Geoff Boehm, Debunking Medical Malpractice Myths: Unraveling the False Premises Behind "Tort Reform", 5 Yale J. Health Pol'y & Ethics 357, 362 (2005)** (suggesting the cost of medical malpractice insurance is about two percent of total health care costs).

37. **Daniel Kessler & Mark McClellan, Do Doctors Practice Defensive Medicine?, 111 Quarterly J. of Econ. 353 (1996).**

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38. **Amitabh Chandra et al., The Growth of Physician Medical Malpractice Payments: Evidence from the National Practitioner Data Bank, W5-243, W5-247 (May 31, 2005),** available at http://www.healthaffairs.org. (Article concluded that medical malpractice payments have leveled off since 2000 and that any rise

is withdrawing from the market, but that insurance group accounted for only 3.3% of the Pennsylvania market. The report draws no specific conclusions outside of Pennsylvania, noting that "Pennsylvania has been especially hard hit." The report concludes, "No clear evidence yet exists as to the effects of the malpractice crisis on Pennsylvania's health care system."

47. The recent study by Duke University Law Professor Neil Vidmar, commissioned by the Illinois State Bar Association, reported that despite claims by the American Medical Association that doctors were leaving the state as a result of medical malpractice actions and a rise in premiums, the facts did not support the AMA's assertion. **Neil Vidmar, Medical Malpractice and the Tort System in Illinois: A Report to the Illinois State Bar Association, 73-82 (May 2005) (provided to the Illinois General Assembly on May 10, 2005).**

Additional studies and information included:

"Justice Capped: Tilting the Scales of Justice Against Injured Patients and Their Families," May 2005 by Wisconsin Citizen Action and Wisconsin Academy of Trial Lawyers.

Amicus Curiae Brief filed in the *Ferdon* case by the Wisconsin Academy of Trial Lawyers.

"Falling Claims and Rising Premiums in the Medical Malpractice Insurance Industry," by Jay Angoff, Center for Justice and Democracy, July 2005.

"Measured Costs," by J. Robert Hunter, Americans for Insurance Reform, July 2005.

"Health Care Expenses are a Key," Expansion Management Magazine, February 2005.

U.S. General Accountability Office, Milwaukee Health Care Spending, GAO-04-1000R, August 2004.

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Wisconsin Medical Society

Your Doctor. Your Health.

TO: Members, Speaker's Medical Malpractice Task Force

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

DATE: August 30, 2005

RE: Restoring stability to the medical liability climate

On behalf of more than 10,000 members statewide, the Wisconsin Medical Society thanks you for this opportunity to testify on a matter of critical importance for the state's health care system: restoring a reasonable cap for noneconomic damages.

It is important to note that five out of seven Wisconsin Supreme Court justices believe there can be a constitutional cap on noneconomic damages. While the Court's decision has been jarring, the wide bipartisan call in the Capitol and by the general public to restore the caps provides comfort. This cry for action shows that health care affordability and availability are nonpartisan issues.

Two members of the Supreme Court have specific concerns with how the Legislature decided on the cap figure in the 1995 legislation. The creation of this Task Force has already started to correct that flaw – the Task Force has the opportunity to build a legislative history that most bills do not enjoy. This can only reassure the Court that a coequal branch of government, the State Legislature, has acted far from arbitrarily in setting the new cap. Crafting a solution through fact-finding and data analysis can also reassure the Governor that the Legislature has properly taken the Court's opinions into account.

As this Task Force deliberates toward a recommendation to restore stability to the state's medical liability system, we ask you to keep the following tenets in mind:

I. The Cap Needs to be Reasonable and Effective

Throughout the United States, maintaining or restoring balance and stability to the medical liability system is a primary focus of the medical community. While other states have struggled for years trying to find the right mix of reforms, Wisconsin succeeded in creating a stable medical liability environment. From 1995 until July 13 of this year, two branches of our state government hit upon a system allowing Wisconsin to become one of just six states without a medical liability crisis or near-crisis.

If we assume the Court's concerns must be considered when setting the new cap, that new law must be reasonable – that is, it must not be set arbitrarily and must amply show legislative reasoning for the specific cap figure or solution. It must balance the needs of the injured patient with those of all Wisconsin citizens who desire affordable and available health care – especially high-risk specialty or emergency medicine care.

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The cap must also be effective. This seems obvious on its face, but in implementation it is possible to set a cap too high to achieve the stability of medical liability premiums and access to medical care, particularly specialty care in rural communities. We believe there is a "tipping point" above which a cap does little to prevent physicians from fleeing the area to practice in states with a more favorable medical liability climate, or prevent questionable lawsuits that tend to discourage the efficient, yet effective practice of medicine. Defensive medicine is far from a myth; one study, cited by the U.S. Department of Health and Human Services, suggests that defensive medicine cost the nation as much as $126 billion in health costs in 2003.

Arriving at the eventual dollar amount of the cap or establishing the "tipping point" for effective medical liability reform is not necessarily simple, but we believe it can and must be accomplished.

II. The Cap Needs to be Passed and Enacted as Soon as Possible

While less than seven weeks have passed since the Supreme Court removed the noneconomic damage cap, Wisconsin is already beginning to witness the effects. Physician recruiters are hearing doubts from those physicians who had previously considered Wisconsin a safe haven. Medical students are well aware of the sudden climate change and are asking questions about other state's situations.

Meanwhile, those other states' environments are becoming more, not less, attractive when compared with Wisconsin's medical liability climate. A week ago Illinois' governor signed a cap into law. Alaska, Georgia, Mississippi, Missouri, Nebraska, Nevada, Oklahoma, South Carolina, Texas and West Virginia have all successfully worked to create or strengthen their medical liability environment in just the last two years. The medical liability litigation problem is real across the country, and other states are taking steps to solve it. Meanwhile, Wisconsin is dramatically shifting in the other direction. Our state must quickly reinstate a reasonable noneconomic damage cap or face the real possibility of a physician exodus to these other suddenly more-attractive states.

III. Other Medical Liability-Related Tort Reforms

In addition to removing the cap on noneconomic damages in medical liability cases, the Supreme Court issued other decisions that will likely have an adverse affect on the state's formerly positive medical liability environment. The Court determined that first-year unlicensed medical residents are not "health care providers" under the noneconomic damages statutes (the *Phelps* case); the Legislature could remedy this when creating the new cap, by clearly providing that unlicensed residents are covered by the Injured Patients and Families Compensation Fund and are subject to any statutory cap on damages in medical liability cases.

The Court also nullified another 1995 statute allowing juries to hear evidence of payments injured patients have received due to insurance settlements, etc., before deciding an award amount at trial (the *Lagerstrom* case). The Court's decision in the *Lagerstrom* case prohibits juries from reducing the amount of an award based on evidence of collateral source payments. This "collateral source" decision could also warrant legislative attention to afford juries the opportunity to properly contain the size of awards in medical liability cases based on collateral source evidence, thereby helping to reduce health care costs.

While other tort areas merit fixes, reinstating a reasonable and effective noneconomic damage cap is clearly the top priority, as it has the largest impact on physician access and health care costs. Any bill reinstating the cap should be drafted and passed with the goal of gaining the Governor's approval and withstanding constitutional scrutiny. Adding too much to any one bill decreases the chances of the bill's ultimate success.

Thank you again for this opportunity to provide testimony. If you need more information on this or any other issue, please contact me at markg@wismed.org or by phone at 608.442.3768.