Task Force Meeting Attendance Sheet

Medical Malpractice Task Force

Date: 9/8/05 **Meeting Type:** Public Hearing

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: 9 ∅ 1

Julie Sawyer

Julie Sawyer
Task Force Clerk

Not Scanned

2005-06
TF-MM
(Medical
Malpractic
Task Force)

Speaker Gard's Medical Malpractice Reform Task Force
September 8, 2005
Meeting Minutes

Members: Present: Rep. Curt Gielow, Rep. Mike Huebsch, Rep. Anne Nischke, Rep. Jason Fields, Rep. Bob Ziegelbauer, Mr. David Strifling, Dr. Clyde "Bud" Chumbley, Mr. Ralph Topinka, and Mr. David Olson. Absent (excused): Ms. Mary Wolverton.

At approximately 10:05 a.m., the Chair of the Task Force, Rep. Curt Gielow, called the meeting to order.

The meeting began with Opening Remarks by Chairman Gielow and the clerk called roll. The next hearing date of the Task Force was set for Thursday, September 29th at 10:00 a.m., location to be announced. The next hearing will be a discussion/working group of the Task Force. The members will discuss ideas, recommendations and proposals for legislation.

The first presentation to the Task Force was by Commissioner Jorge Gomez, Office of the Commissioner of Insurance. Commissioner Gomez provided written testimony to the Task Force and reviewed the history of the Fund, the Board of Governors and discussed participation in the Fund. Commissioner Gomez answered questions from Task Force members following his presentation.

The second presentation was a joint presentation by Attorney Mark Adams, Legal Counsel, Physicians Insurance Company of Wisconsin (PIC WI) and Mr. Andrew Ravenscroft, VP of Operations, PIC WI. Attorney Adams and Mr. Ravenscroft provided written testimony and other information to the Task Force including the Oregon study prepared by Stephen Grover, Ph.D., entitled "Medical Malpractice Damage Caps: Impacts of Limiting Noneconomic Damages." The speakers answered questions from the Task Force following their presentation. A request for follow-up information was made by Mr. Strifling and Chairman Gielow. Mr. Ravenscroft and Attorney Adams agreed to gather that information and provide it to the Task Force.

The third presentation came from Attorney Barbara Kuhl, General Counsel, Marshfield Clinic. Dr. Robert Phillips, Marshfield Clinic, provided a brief introduction of Attorney Kuhl to the Task Force. Attorney Kuhl provided written testimony to the Task Force addressing Marshfield Clinic's concerns as a self-funded organization regarding the removal of the non-economic damage cap. Attorney Kuhl answered questions from the Task Force following her presentation.

Following the presentations, Chairman Gielow requested that Task Force members provide recommendations to Legislative Council or to his office by September 19, 2005.

The next hearing of the Task Force will be: Thursday, September 29, 2005 at 10:00 a.m.

The hearing was adjourned at approximately 11:30 a.m.

Sawyer, Julie

From: Bob Ziegelbauer [bziegel@lakefield.net]
Sent: Wednesday, August 31, 2005 7:45 PM
To: Rep.Gielow
Subject: questions that the Med Mal Study Committee should look at

Curt:

As you are beginning to plot the direction you want to take the committee on in it's assignment, I wanted to forward a couple of thoughts as to issues or areas on which I would like to hear more discussion.

Essentially we have an issue which has two sides (the docs and the trial lawyers) making some pretty strong factual assertions that are, to say the least, contradictory. I would very much like to see us get beyond anecodotal evidence from both sides, and try and determine what the facts really are, what they mean, especially where there is good data available if only we'll take the time to collect and organize it.

I recognize that we are on a relatively short time line. However I share your obvious belief that this is a very important policy area where we can potentially have a positive impact with our work. I approach this assignment with an open mind and look forward to the challenge.

Here, then are a couple of first questions and suggestions:

1. The trial lawyers say that malpractice insurance premiums are historically low, have always been low in Wisconsin, and are only a minute fraction of the cost of health care (less than 1%). In essence they say that the cap was irrelevant to the cost of health care.

What about that? Can we see some data which shows not only the history (20 years would be nice) malpractice insurance rates, but also what is happening in a variety of other States with different legal environments?

2. As I mentioned Tuesday, we do need to hear more about how insurance companies write malpractice coverage and work that into the multi-State comparison.

The references so far to the high pay of executives, the impact of the stock market, or anecdotal stories about one doctor's malpractice insurance rate increase without context explaining the competitive and underwriting practices of the liability insurance industry don't help us much, don't you agree?

We need to hear in open session about competition for customers in that industry, how claims reserves are calculated and accounted for, the various methods used for pooling risks, and all of the factors that go into calculating a "rate". Also if would be interesting to hear if any desirable but currently unavailable alternatives are possible in the marketplace for primary coverage that would need statutory changes or other help from the State.

A similar full blown discussion of the finances and practices of the Patient's Compensation Fund is also very important, especially in the context of a response to the issues raised in the most recent Legislative Audit Bureau report which suggested that the rates being charged were still too high because of claims projections which were too conservative.

3. The Docs say that the malpractice insurance "climate" is a huge issue impacting upon recruitment, locational decisions, and the cost of health care in general.

We need to get beyond anecdotal evidence on that as well.

How do they see malpractice coverage costs as a percentage of total cost. What is the cost of malpractice coverage relative to doctor incomes in Wisconsin and other States? There should be data on this that can be assembled in a meaningful way that will put the potential of a "malpractice insurance crisis" in context.

4. The Docs point to the cost to consumers of defensive medicine (as substantiated in a Federal study) in an unfriendly malpractice inurance cost environment. Fair enough. Can we see data that attempts to quantify how that cost is different in "good" States and "bad" States? Or is it possible that the cost of defensive medicine is ingrained in the mentality of the health care providers and doesn't differ much from State to State based on the malpractice insurance environment? We should be able to learn more about this phenomenon.

5. Beyond all of this, assuming that this isn't just a political excercise to get something for the Governor to veto to give a hammer to his opponent in the next election, when we get to discussions of specific recommendations (I assume many anticipate a bill with another slightly different cap similar to what was in place before the Supreme Court ruling.) I would hope that we would have a "heavyweight" legal presentation about what the options available to the Legislature are, including the probability distribution of the constitutionality of each.

These are just a few private thoughts to get started, offerred to try to be helpful. I very much appreciate your taking the time to consider them.

As always, please don't hesitate to call on me anytime I can be of assistance on this or any other issue of importance to you.

Bob Ziegelbauer

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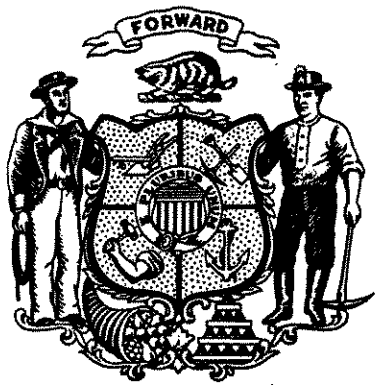

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Sawyer, Julie

From: Mary Wolverton [mwolverton@pjmlaw.com]
Sent: Friday, September 02, 2005 12:55 PM
To: Rep.Gielow
Subject: Re: Next Hearing of the Medical Malpractice Task Force 9/8/05at 10:00 a.m.

It is not looking good for me to participate by phone given the timing and location of my Seattle deposition. I trust the testimony will again be provided in written form and I will read that documentation with interest.

Mary

MARSHFIELD CLINIC.
Where the future of medicine lives

DATE: September 7, 2005

TO: Speaker's Medical Malpractice Task Force

FROM: Barbara A. Kuhl

SUBJECT: Medical Liability Climate

Chairman Gielow and members, my name is Barbara Kuhl and I am General Counsel at Marshfield Clinic. It is a privilege to testify before this task force, and I would like to thank you on behalf of Marshfield Clinic for this opportunity.

Marshfield Clinic has several concerns as a result of the elimination of the non-economic damage cap, including the ability to continue to recruit and retain quality physicians to Wisconsin, access to care for all of us who live in Wisconsin, the impact on self-insured organizations and the cost of health care. I will address each of these concerns separately.

Recruitment and Retention of Physicians

Physician recruitment is already difficult and competitive in light of a national shortage of physicians. When I queried the manager of our physician recruitment department in anticipation of testifying here today, she told me: "We have always touted the fact that Wisconsin has a stable malpractice climate, which certainly appeals to physicians in those states in crisis, so I would hate to lose that edge."

The malpractice climate comes up regularly in discussions with candidates who interview for positions at Marshfield Clinic. It also comes up as physicians who are in our residency program decide whether to stay in this state to practice or go elsewhere. Marshfield Clinic co-sponsors graduate residency programs in internal medicine, pediatrics, general surgery, internal medicine/pediatrics (med-peds), dermatology and palliative care. Currently, these residency programs collectively have 56 residents. Medical education is an important part of Marshfield Clinic's mission, but we also hope that these resident physicians will decide to practice in this State as they reach the end of their residencies.

Recruiting physicians to rural areas is particularly challenging. We took note of the Wisconsin Hospital Association's report of a decline in practicing physicians in states which eliminated non-economic damage caps, and we are concerned that the rural areas in these states were the hardest hit. All 28 of the counties in Marshfield Clinic's primary care service area are in total or in part designated as Medically Underserved Areas or Health Professional Shortage Areas or both.

Marshfield Clinic currently has 99 active physician recruiting searches across our system of care. The estimated average time to fill a search depends not only on the location, but on the type of specialty. We have experienced on average 12 months to fill a search from activation to start date for some of our larger sites. Some positions have been open for much more than one year, especially the sub-specialty positions. For our smaller more rural sites we have had much more difficulty; filling positions for these locations takes on average three to four years. If recruiting and retaining physicians becomes more difficult in this State as a result of the elimination of the cap, then the next issue becomes access to health care for all of us who are Wisconsin residents.

Access to Care

Marshfield Clinic's mission statement is "To serve patients through ***accessible***, high quality health care, research and education." The Clinic's 722 physicians represent 83 medical specialties and sub-specialties. Continued access to care is possible only in an environment which allows us to recruit and retain quality physicians.

Marshfield Clinic provides access to care for many patients who already have limited options for health care. We accept patients regardless of the ability to pay. We have a formal charity care program. We accept Medicare, Medicaid and BadgerCare patients on an unlimited basis. Although we have locations in many rural areas, even in the more populated areas we serve, the Clinic does substantially more than its part to ensure that patients are seen who would otherwise have no access or limited access to health care. For example, for the Clinic's fiscal year ended September 30, 2003 –

- In Eau Claire County, Marshfield Clinic physicians represented 19% of the total physicians. However, Marshfield Clinic served approximately 82% of the County's Medicaid population.

- In Marathon County, Marshfield Clinic physicians represented 30% of the total physicians. However, Marshfield Clinic served approximately 57.2% of the County's Medicaid population.

In addition, Marshfield Clinic provides coverage under our Self-Insurance Plan for medical malpractice to those of our physicians and staff who work in neighboring free clinics, again doing our part to provide access to care for Wisconsin residents. We would like to continue to offer our Plan's coverage for this purpose but would be forced to re-think that position if we start to see increased numbers of malpractice claims or increased non-economic damage awards in Wisconsin. We are not sure that our physicians and staff would continue to work in these free clinics if they were without the protection of the Plan's coverage.

Impact on Self-Insured Organizations

Marshfield Clinic has been self-insured for medical malpractice since 1978. The Clinic's self-insurance plan (the "Plan") was created in lieu of purchasing commercial malpractice insurance and provides primary occurrence based coverage for the Clinic and its employed physicians, CRNAs and other patient care staff. Today we insure 722 physicians, 56 residents, 39 CRNAs and over 5,800 additional staff.

The Clinic's Plan is required to maintain a trust fund at an actuarially determined funding level. The Pinnacle News Flash dated August 2005 reported that in addition to increases of between 12% to 15% in commercial insurance premiums, "insurance industry reserves may experience

additional adverse development of $35 - $40 million because of the court's ruling." If the Pinnacle report is accurate, the Clinic will be required to deposit a substantial additional sum in its trust fund this year, regardless of past claim experience which has been very favorable to the Clinic over the 27-year life of the Plan. I have spoken with our Plan's actuary at Towers Perrin, Brian Young. While the actuarial industry struggles to come up with new funding levels in the State of Wisconsin, Mr. Young has told me that creation of caps in other states resulted in funding decreases in insurance reserves. The opposite is true in states which eliminated caps. In states such as Oregon which lost their caps, the frequency of cases also increased. Thus, while commercially insured organizations may see increased premium rates for future years, the financial impact for self-insured health care organizations is more immediate. Self-insured organizations will not only experience annual ongoing premium increases but will also need to increase reserves for the anticipated impact of the elimination of the cap on claims which are currently open and claims which are not yet reported. To illustrate the immediate impact of the elimination of the cap, within days of the *Ferdon* decision, we received a call from an attorney representing a plaintiff who had an open claim against Marshfield Clinic. The attorney informed us that he was doubling the amount of the plaintiff's demand as a result of the *Ferdon* decision.

Increased Cost of Health Care

Without a non-economic damage cap, we believe an increase in the cost of health care in this State is a certainty. Marshfield Clinic is a not-for-profit corporation. Net earnings are re-invested in infrastructure and in new equipment and services. Any required increased funding of our self-insurance trust fund will necessarily displace other needed funding for equipment, services and the like.

I read with interest the testimony on behalf of the Wisconsin Academy of Trial Lawyers. Although eloquent, the testimony fails to disclose an inherent bias. Attorneys who represent plaintiffs in medical malpractice cases generally are paid on a contingency basis and receive up to one-third of any damage award.

Marshfield Clinic believes that it makes more sense to spend health care dollars on initiatives which will improve quality of care and access to care for all Wisconsin residents rather than on unlimited non-economic damage awards, substantial portions of which will go to satisfy contingency fees of attorneys. The Executive Summary of the Institute of Medicine Report, Crossing the Quality Chasm, provides: "The development and application of more sophisticated information systems is essential to enhance quality and improve efficiency." Since the early 1990's, Marshfield Clinic has invested tens of millions of dollars on integrated computer technology for high quality, efficient patient care. We also recently initiated a patient web portal for on-line health management for patients. We have heard a report that, nationwide, half of all adverse drug reactions may be prevented by computer prescribing. Marshfield Clinic recently implemented an electronic prescribing program. These are the types of initiatives which will improve the quality of care for all Wisconsin residents. This is where we should be spending our health care dollars.

Marshfield Clinic is a founding member of the Wisconsin Collaborative for Healthcare Quality. The Collaborative is a voluntary consortium of organizations focused on improving health care in the State of Wisconsin. The members of the Collaborative agree on quality indicators which are then publicly reported. If the medical malpractice climate in Wisconsin deteriorates as a result of the elimination of the non-economic damage cap, this could serve to chill voluntary reporting. It could also cause physicians in this State to practice defensive medicine to avoid medical malpractice claims. Progress toward the Institute of Medicine's goal of evidence-based medicine

could be deterred and defensive medicine instead of evidence-based medicine could increase the cost of care dramatically.

Conclusion

In conclusion, reinstating a non-economic damage cap as soon as possible is necessary to ensure that Wisconsin has an adequate number of physicians for its future to provide access to care for all its residents. Reinstatement of a cap will allow more health care dollars to be spent on quality initiatives that will serve all of us. A stable malpractice climate will provide an environment where physicians and health care providers are more comfortable publicly reporting quality indicators rather than practicing expensive defensive medicine.

Thank you again for the opportunity to provide testimony here today. If you need any additional information, I may be reached at (715)-389-4885 or by e-mail at kuhl.barbara@marshfieldclinic.org

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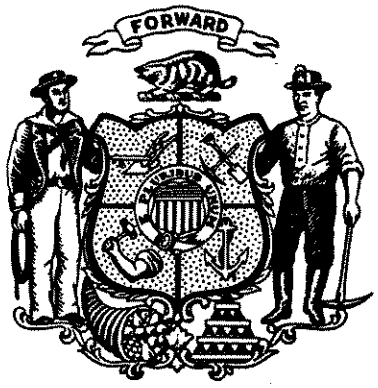

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Injured Patients and Families Compensation Fund Information
Presented by the Office of the Commissioner of Insurance
To the Medical Malpractice Task Force
September 8, 2005

History

Chapter 655, which created the Fund, was enacted in 1975 in response to a medical malpractice crisis. Health care providers were having serious problems obtaining affordable medical malpractice insurance. The enactment of Chapter 655 was intended to limit the increasing cost of medical malpractice claims, both to those who provide health care and to their employees, in order to reduce the potential of those claims diminishing the availability of health care in Wisconsin, as well as to ensure that monies are available to compensate any person who is injured by medical negligence.

To address this crisis, the legislature required all health care providers to carry minimum amounts of medical malpractice insurance. The legislature created the fund to cover claims in excess of that minimum level of coverage. The Fund is financed through assessments against the health care provider. The 1975 act required that a portion of future medical expense damages in excess of $25,000 be placed in a special account to be paid to the claimant as those expenses were incurred.

In 1985, chapter 655 was amended to impose a $1,000,000 cap on non-economic damages which expired on January 1, 1991.

In 1995, the legislature voted to reestablish a cap on non-economic damages and the future medical expense account. The legislature passed 1995 Wis. Act 10, effective May 25, 1995, which amended chapters 655 and 803 to cap non-economic damages at $350,000 per occurrence (adjustable for inflation annually).

Economic damages, including damages for future medical expenses, have never been capped. However, in 1995, the amendment to Wis. Stat 655.015 reinstated the account for future medical expenses and raised the threshold limit for a future medical expense account from $25,000 to $100,000. The legislature also enacted provisions requiring creation of a separate account for each claimant and payment of interest on account funds.

Governance

The Fund is governed by a 13 member Board of Governors that consists of:

- 3 insurance industry representatives
- 1 member named by the Wisconsin Academy of Trial Lawyers
- 1 member named by the state Bar Association
- 2 members named by the State Medical Society
- 1 member named by the Wisconsin Hospital Association
- 4 public members appointed by the Governor

The Commissioner of Insurance serves as the board chair.

The Board has a fiduciary responsibility to protect the corpus of the Fund and to ensure that monies are available to compensate those injured by medical malpractice.

The board is assisted by committees (Figure 1). The committees consist of members of the board as well as representatives of industry, physicians, lawyers and the public.

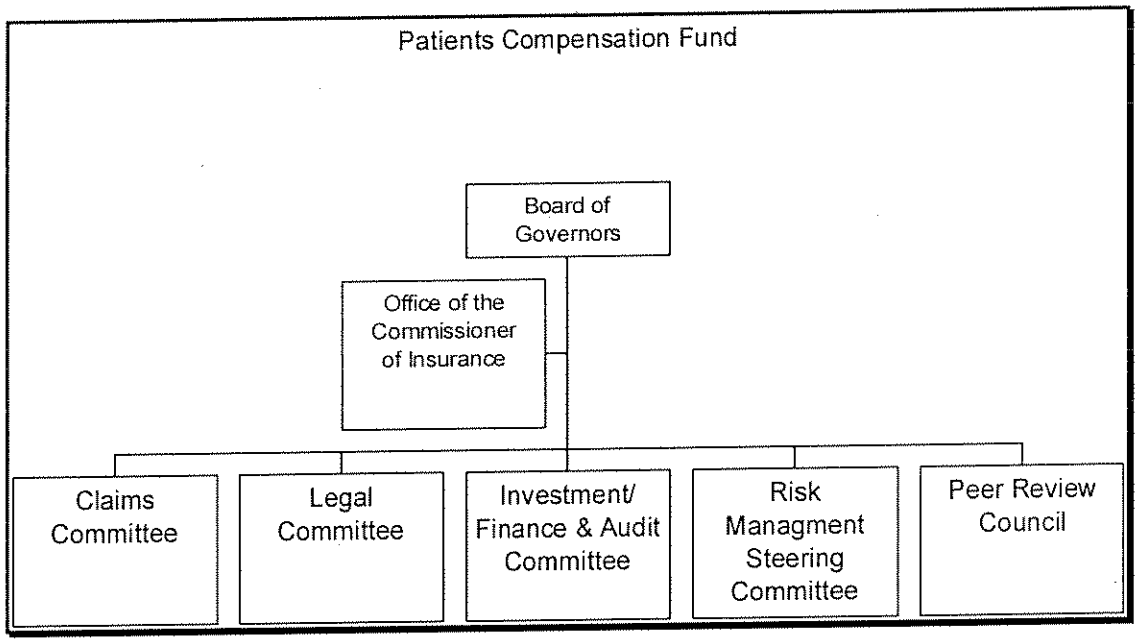

Figure 1. IPFCF Board of Directors Organization

Administrative services are provided by the Office of the Commissioner of Insurance. These services include claim payments, billing of assessments, maintenance of primary insurance certificates and to ensure compliance by health care providers with the provisions of the statute. The performance of these services is done with the assistance of outside vendors; primarily a claims contractor to perform the day to day handling of claims.

Participation

As of December 31, 2004, there were a total of 13,714 Fund participants comprised of 11,603 physicians, 127 hospitals, 490 nurse anesthetists, and the remainder consisting of health care entities.

Participation in the Fund is mandatory, however, the regulations do allow for exemption from Fund participation if the health care provider meets specific criteria. As of December 31, 2004, 10,157 providers licensed in WI were exempt from participation in

the Fund. The majority of those were exempt either due to practicing less than 240 hours a year or they were not practicing in the state.

Claims

From July 1, 1975 through December 31, 2004, 5,080 claims had been filed in which the Fund was named. In order to recover from the Fund in Wisconsin, the Fund must be a named defendant in a medical malpractice claim. The total number of claims paid during this period was 618, totaling $570,279,507. There were 3,888 claims were closed with no indemnity (loss) payment.

The Fund hires outside counsel on all cases in which it is a named defendant. The Fund will generally monitor a claim, not actively defend, unless or until it becomes apparent that potential damages may pierce the Fund. As deemed appropriate and with the guidance of the Board's Claims Committee, the Fund's claims contractor will seek to settle cases in which it is believed that the potential outcome would result in financial impact to the Fund.

Claims closed over the last three fiscal years:

Settled with Fund money	28
Tried – Defense verdict	71
Tried – Plaintiff verdict	12
Dismissed (Fund)	795
Settled within primary Limit	112

Seventy percent of losses paid with Fund money are paid as a result of a settlement, not a jury verdict. These are generally the cases with "bad" facts and were settled to try to mitigate the financial impact to the Fund – protecting the corpus of the Fund to ensure monies available to pay all injured patients. Settlement issues will change, and in some cases become more difficult without the cap on non-economic damages.

During this same time period; of the 12 cases lost at trial, 3 jury awards were reduced due to the non-economic damages cap and one was reduced to the wrongful death cap (which thus far has been upheld by the Supreme Court)

Rate History

In review of rate history it is important to note that the threshold or point at which the Fund starts paying claims, has increased over time. The threshold history is:

July 1, 1975 – July 1, 1987	$200,000
July 1, 1987 – July 1, 1988	300,000
July 1, 1988 – July 1, 1997	400,000
July 1, 1997 – present	1,000,000

Medical Malpractice Task Force
Office of the Commissioner of Insurance
September 8, 2005

Fees

Fees, or assessments, are established annually by the Board of Governors. Outside actuaries provide assistance to the Board Actuarial committee which makes a recommendation to the Board. The full Board establishes the fees for the next fiscal year. OCI then prepares an administrative rule for approval by the Legislature.

The Board of Governors has determined that due to the nature of the Fund; it is a risk sharing pool (not individually underwritten), and participation is mandatory, it is reasonable to maintain a surplus level near zero.

The rate changes implemented over the past ten years are:

2005	30% Decrease
2004	20% Decrease
2003	5% Increase
2002	5% Decrease
2001	20% Decrease
2000	25% Decrease
1999	7% Decrease
1998	3% Increase
1997	18% Decrease
1996	10% Increase
1995	7% Decrease
1994	7% Increase
1993	10% Increase

(Attached – actual fee schedules by class)

Rates are effected by both the experience (claims paid) which as been favorable, and the investment income (interest, dividends and capital gains). The Fund's outside actuary estimated an approximately 20% savings annually in the amount of fees needed to pay claims occurring in a given year, for each of the years since 1995.

PCF RATES

Fiscal years	00-01	01-02	02-03	03-04	04-05	05-06 6 May
CLASS						
1	1898	1538	1461	1534	1227	859
2	3606	2769	2630	2761	2209	1546
3	7877	6385	6063	6366	5092	3565
4	11388	9231	8766	9204	7362	5154
CRNA	475	378	359	377	302	211
Part-time	475	385	365	384	307	215
Res Moonlighter	1139	923	911	920	736	515
Panel Fee	38	38	19	19	46	34
Interest Rate	0.05143	0.06215	0.02683	0.0155	0.01025	0.01789
NonEcon Effective		5/15/2001	5/15/2002	5/15/2003	5/15/2004	5/15/2005
Damage Cap		$404,657	$410,322	$422,632	$432,352	455,755

PATIENTS COMPENSATION FUND

YEARS	90-92	92-93	93-94	94-95	95-96	96-97	97-98	97-98	98-99	98-99	99-00	99-00	00-01	01-02	02-03	03-04
CLASS								600K3M	600K3M	1M/3M	800K3M	1M/3M				
1	2571	2674	2941	3150	2923	3215	2647	3073	3159	2721	2716	2531	1898	1538	1461	1534
2	5142	5348	5882	6300	5846	6430	5294	6146	6002	5170	5160	4809	3606	2769	2630	2761
3	12854	13370	14705	15750	12569	13825	11382	13215	13110	11292	11271	10504	7877	6385	6063	6366
4	15425	16044	17646	18900	17538	19290	15882	18439	18954	16326	16295	15186	11388	9231	8766	9204
CRNA	688	716	788	844	749	824	678	787	787	678	677	631	475	378	359	377
PART TIME/RETIRED	643	669	735	788	731	804	662	769	789	680	678	632	475	385	365	384
RES MOONLIGHTER	1543	1604	1765	1890	1754	1929	1588	1844	1896	1633	1630	1519	1139	923	911	920
PANEL FEES	40	60	50	50	38	38	32	32	16	16	16	16	38	38	19	19
INTEREST	0.08261	0.06318	0.04135	0.03756	0.05117	0.05425	0.05201	0.05201	0.053363	0.053363	0.04965	0.04965	0.05143	0.06215	0.02683	0.0155

-04-05
int rate
1.025%

Exhibit 56

WISCONSIN INJURED PATIENTS AND FAMILIES COMPENSATION FUND

Savings Due to Non-Economic Cap on Losses – Rate Indication

Fund Year	Percent Savings
1995-96	16.90%
1996-97	18.22%
1997-98	19.46%
1998-99	19.78%
1999-00	19.96%
2000-01	20.05%
2001-02	20.20%
2002-03	20.24%
2003-04	20.65%

END

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WISCONSIN HOSPITAL ASSOCIATION, INC.

September 8, 2005

To: Speaker's Task Force on Medical Liability Reform

From: Eric Borgerding, Senior Vice President
Laura Leitch, Vice President and General Counsel

Re: Immediate Impacts of *Ferdon* Decision.

On several occasions, members of this task force, other legislators and members of the media have asked us *when* will the Wisconsin Supreme Court's July 14, 2005, *Ferdon* decision (overturning Wisconsin's caps on noneconomic damage awards) have an impact on the medical liability environment in Wisconsin. The answer is immediately.

We have heard from a number of defense attorneys that it is becoming increasingly difficult to reach a reasonable settlement figure in medical liability cases. We have heard from insurers that their reserves for outstanding cases have been increased (any case that was not settled or adjudicated prior to the Ferdon ruling is not subject to the caps). And we have heard from hospitals that trying to recruit physicians to their communities has become more difficult specifically due to the *Ferdon* decision and the likely unstable medical liability environment that will follow – a situation we believe will become even more difficult as states like Illinois take significant steps to restore balance to, rather than dismantle, their medical liability systems.

In fact, the *Ferdon* decision is having an immediate and tangible impact. On August 31, 2005, a day after the last task force hearing, the Court of Appeals issued a decision in the *Kaul v. St. Mary's Hospital – Ozaukee* case. In 2002, the jury awarded the plaintiffs in *Kaul* $5 million in economic damages and $930,000 in noneconomic damages. The circuit court had reduced the noneconomic damages consistent with the legislative cap. Eight days ago the appeals court reversed the circuit court decision and, based on *Ferdon*, determined that the plaintiff should receive the $5 million in economic damages plus all of the noneconomic damages, including the amount beyond the level of the legislative cap. With *Ferdon* already having an impact on past cases, there is reason to be concerned about the future.

Beyond the impact of the *Ferdon* decision, the Supreme Court's recent *Lagerstrom* decision also impacted the *Kaul* case. Prior to *Lagerstrom*, if a plaintiff's medical bills or other costs were paid by another party (such as a health insurer), the jury could hear about those payments and take them into account when determining the amount of the award intended to reimburse the plaintiff for the costs associated with those payments ("collateral source"). In *Kaul*, the appeals court found that the plaintiff must be awarded all medical costs, including those that have been paid by another party, even if the plaintiff will not reimburse that party for those costs. This provides for an award greater than the jury intended. The Wisconsin legislature and health care providers, through the Injured Patients and Families Compensation Fund, have strongly supported ensuring that patients are compensated for all economic damages. We do not believe, however, that the legislature intended to provide double recovery.

cc: Assembly Committee on Judiciary
Senate Committee on Judiciary, Corrections and Privacy

5510 Research Park Drive P.O. Box 259038 Madison, WI 53725-9038 P (608.274.1820) F (608.274.8554) wha.org

Keeping Wisconsin Families Safe
www.watl.org

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MEMO

To: Assembly Medical Malpractice Task Force

From: Daniel A. Rottier, President-Elect

Date: September 8, 2005

Re: The Case For Reform In The Medical Negligence Insurance Industry

When the Legislature created an insurance program for health care providers initially in 1975, it required them to carry underlying limits of $ 100,000 per claim. Above that there was unlimited coverage provided by the Wisconsin Patients Compensation Fund. (Since renamed the Injured Patients and Families Compensation Fund).

This legislation accomplished several things: 1) It eliminated any personal liability on the part of health care providers; all were fully insured for all claims; 2) It took most of the profit out of the medical negligence insurance industry in that only the first $ 100,000 of coverage was in the private insurance market....the balance was a government managed and invested, non-profit, fund.

Since 1975, what has happened? Over time, and in graduated steps, the Legislature increased the underlying limit to $ 1,000,000 per claim---ten times the original amount required. The Fund remains the excess insurer beyond that amount.

What has this change done to the system?

- The "for-profit" insurance industry now is the recipient of the majority of the premiums paid by health care providers; the Fund has become a much smaller player in the overall insuring program.
- The health care providers are subject to the rate setting of the private market with its constant pressure for profits.
- The Fund, with its reduced exposure, has grown from a no capital start-up in 1975 to a bloated $ 750,000,000. In recent years the investment income earned by the Fund has exceeded total payouts to the "injured patients and families" it is intended to compensate.
- Meanwhile, the underlying carriers have the health care providers at their mercy.
- Some of the largest groups of practitioners, in an effort to avoid the price gouging of the private market have self-insured for the first $ 1,000,000; unfortunately, this is not practical for all of our health care providers.

Let's take one example, Physicians Insurance Company of Wisconsin, Inc. (PIC) It's financial statements are available from the Office of the Commissioner of Insurance. Owned primarily by doctors and large clinics, this company is reported to insure about 42% of the medical malpractice market in Wisconsin. Among its original investors was the State Medical Society. Even now, PIC has referral and royalty agreements with the State Medical Society and its subsidiary, paying commissions in excess of $ 2,000,000 in 2004 and royalties of $ 975,000 to them in 2004. Dividends of over $ 1 million were paid out to policyholders in 2004.

These sweetheart deals, created by PIC and the Wisconsin Medical Society, essentially allow premiums to be inflated and profit funneled back to some, but not all of the health care providers in this state. Does this make sense?

With 2004 "surplus as regards policyholders" of $ 89 million, PIC has become a takeover target because of its level of profitability. As reported in the Milwaukee Jounal Sentinal this week, a publicly traded Michigan based company, American Physicians Capital, Inc. has just announced purchase of 9.9% of the stock of PIC for $ 3,800 per share for a total of $ 7.4 million. This minority interest, presumably discounted because of lack of control, equates to a value of nearly $ 75 million for PIC, demonstrating the accuracy of the "surplus" of $ 89 million shown on its books.

This purchase by American Physicians occurred after the Supreme Court decision finding caps on awards unconstitutional. The market has spoken. The per share price was no different than the amount offered before the Supreme Court decision. There is profit to be made in companies like PIC, with or without caps.

Consider this modest proposal. Bring the Fund coverage down to the first dollar of coverage. Eliminate profit; eliminate commissions which are now part of the cost to our health care providers. Eliminate the commission and royalty kickbacks to the Medical Society and its subsidiary. No more dividends to a few at the expense of the many.

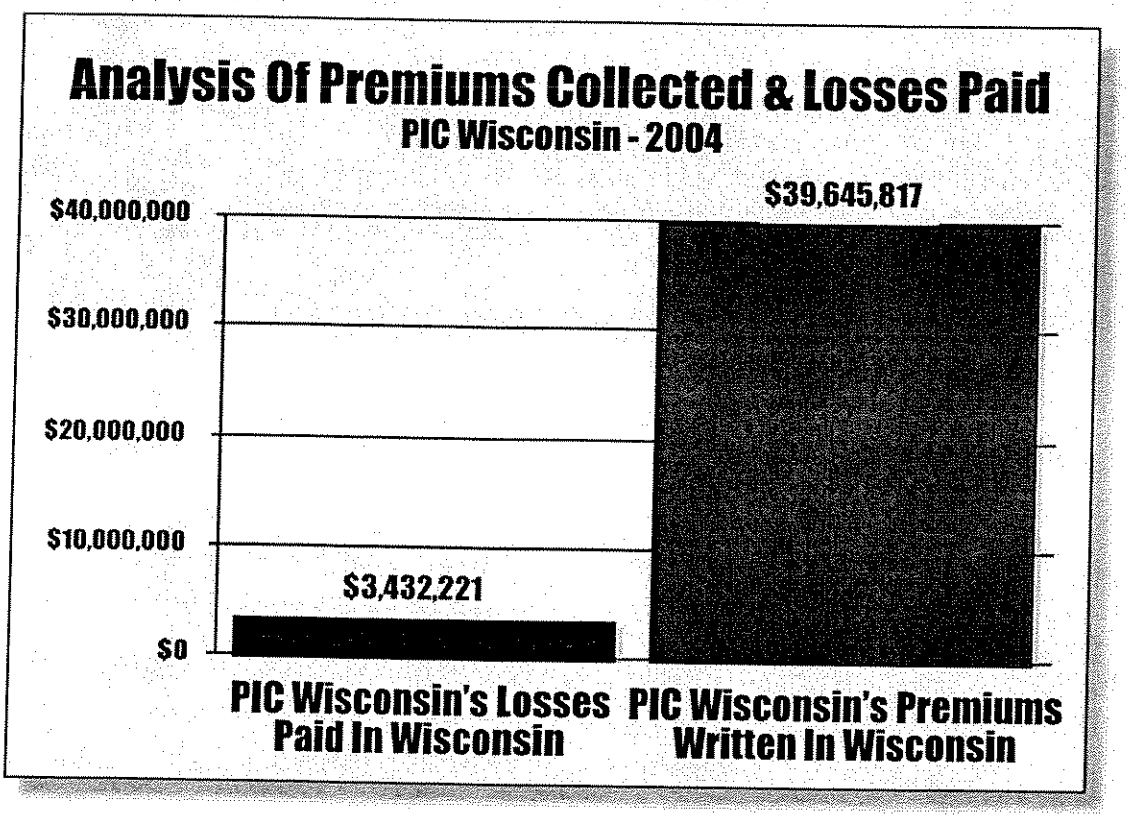
What would happen? PIC could carry on its business in Illinois, Iowa, Minnesota, Nebraska, Nevada and South Dakota, all as shown on its 2004 financials. Just say good bye to Wisconsin. Let PIC and American Physicians and companies like them be the losers; let the health care providers of Wisconsin be the winners.

Dollar One Coverage! That should be the demand of every doctor and hospital in this state. (except those who own stock in PIC and companies like them).

Take the profit out of the system to hold down premiums. Isn't that the right thing to do? Isn't that more appropriate than denying those most seriously injured by medical negligence reasonable compensation? Should these most seriously injured patients be required to bear the weight of commissions, royalties, sales costs, dividends and profits? Not in a fair society.

Medical Malpractice

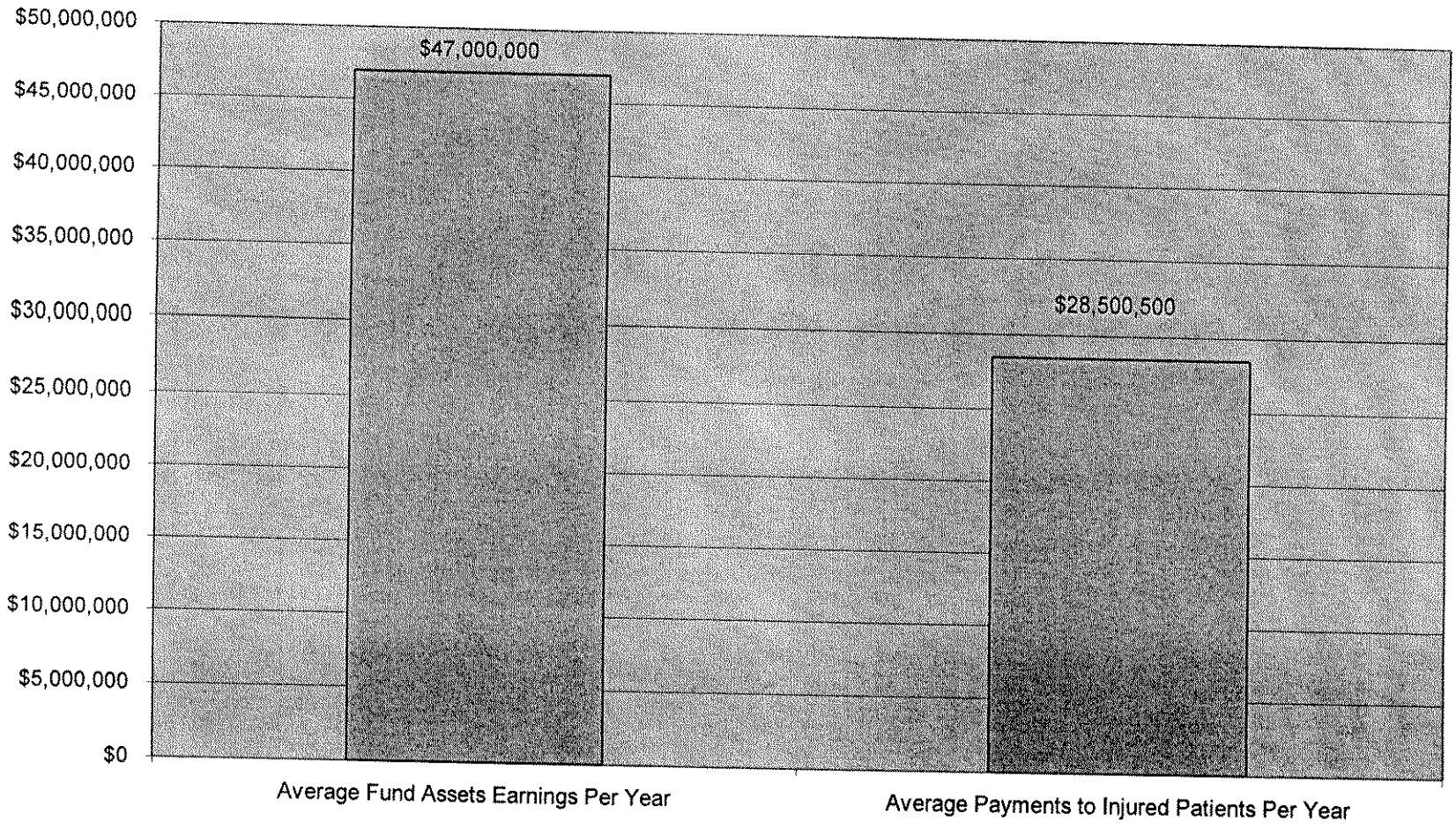
Is Wisconsin's Top Insurer Overcharging?



- **Wisconsin's Largest Medical Malpractice Writer Took In Ten Times What It Paid Out**
- **This Gain Is In Addition To The $3,892,135 Gain Made By Investing Its Doctors' Money**
- **Insurance Reform - NOT Tort Reform - Is Needed To Reduce Medical Malpractice Premiums**

Source: taken directly from the company's annual statement for the year ending December 31, 2004. All data is from " Schedule T: Exhibit of Premiums Written Page. Dollar figure for investment gain represents total investment multiplied by percentage of premiums written of total for the state. Statement available at : http:naic.org/cis . PIC Wisconsin is the largest insurer in the state with approximately 39.3% of the state's market (AM Best).

10 Year Averages:
Fund Assets Earned Per Year versus Payments made to Injured Patients Per Year 1994-2004

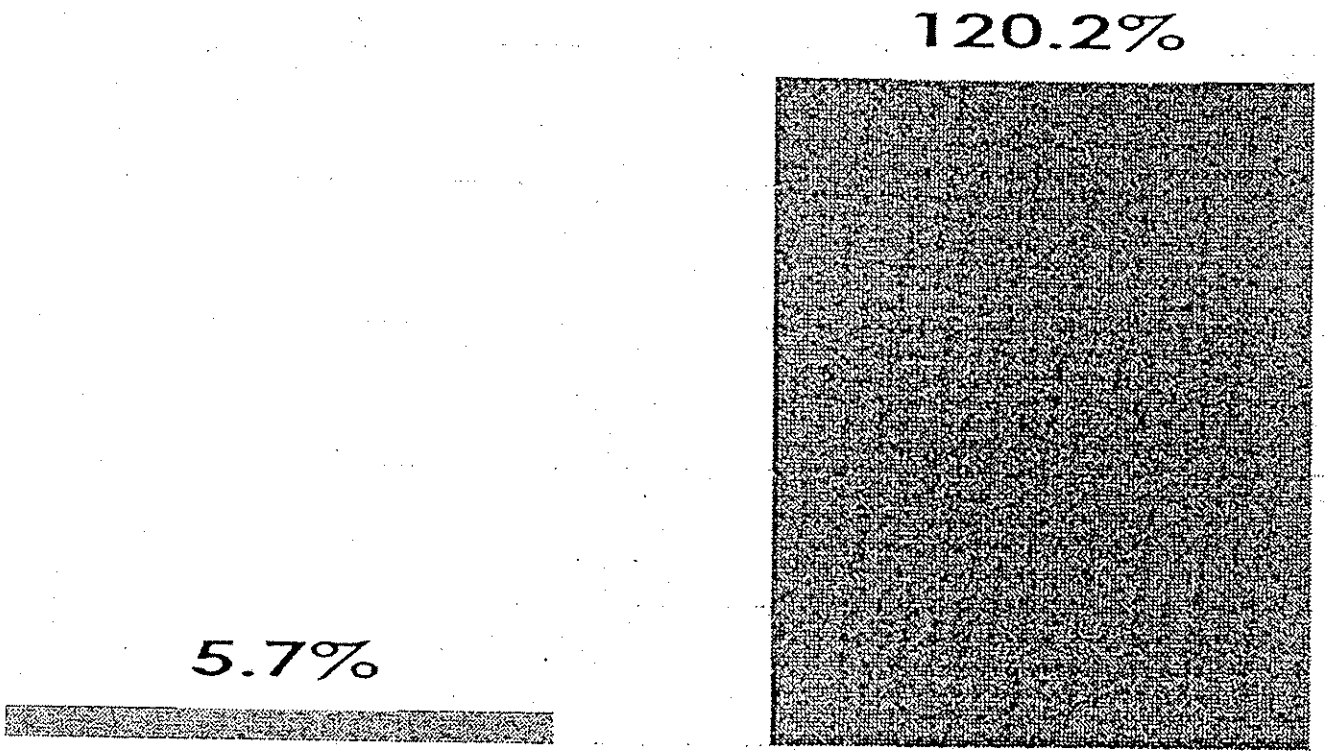


Source: Injured Patients and Families Compensation Fund

Malpractice payouts flat yet premiums soar

Net Premiums Written vs. Net Losses Paid,

2000-2004



Center for Justice and Democracy

Speaker Gard's Medical Malpractice Reform Task Force
August 30, 2005
Meeting Minutes

Members: Present: Rep. Curt Gielow, Rep. Mike Huebsch, Rep. Anne Nischke, Rep. Jason Fields, Rep. Bob Ziegelbauer, Mr. David Strifling, Ms. Mary Wolverton, Dr. Clyde "Bud" Chumbley, Mr. Ralph Topinka. Appearing via telephone conference call: Mr. David Olson.

At approximately 10:10 a.m., the Chair of the Task Force, Rep. Curt Gielow, called the meeting to order.

The meeting began with Opening Remarks by Chairman Gielow. Chairman Gielow's opening remarks welcomed the members of the Task Force, provided a brief synopsis of each member's background, outlined the purpose, goals and proposed future meetings of the Task Force.

The first presentation to the Task Force was by Richard Sweet of Legislative Council. Attorney Sweet reviewed a Legislative Council information memorandum that he prepared on the decision by the Wisconsin Supreme Court in the case *Ferdon v. Wisconsin Patients Compensation Fund.* Attorney Sweet answered questions from Task Members following his presentation.

The second presentation to the Task Force was by Christine Bremer Muggli representing the Wisconsin Academy of Trial Lawyers. Accompanying Attorney Muggli was Mr. Timothy Kaul of Grafton, Wisconsin.

Attorney Bremer Muggli provided written copies of her testimony to the Task Force, and the Wisconsin Academy of Trial Lawyers provided a packet for each task force member of the studies cited by the majority opinion in the *Ferdon* case. Following her presentation, Attorney Bremer Muggli answered questions posed by members of the Task Force.

The third presentation to the Task Force was a joint presentation by Mr. Eric Borgerding representing the Wisconsin Hospital Association, Inc. and Mr. Mark Grapentine, JD, representing the Wisconsin Medical Society. Mr. Borgerding and Mr. Grapentine spoke to the Task Force, provided their testimony in writing and answered questions posed by members of the Task Force.

Following the presentations, the Task Force agreed to hold the next meeting on Thursday, September 8, 2005. The location and names of speakers for the hearing will be forwarded to task force members prior to that date.

The hearing was adjourned at approximately 11:45 a.m.