Task Force Meeting Attendance Sheet

Medical Malpractice Task Force

Date: 9/29/05 **Meeting Type:** Working Session

Location: 328 NW 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 0 0

John Reinemann

John Reinemann
Task Force Clerk

S:\Medical Malpractice task force\Attendance Sheet.doc

Cont. pt. 2

Packet distributed to
TF members via Email
To be discussed at hearing
9/20/05. Part of Public
Record.

WISCONSIN LEGISLATIVE COUNCIL

Terry C. Anderson, Director
Laura D. Rose, Deputy Director

TO: REPRESENTATIVE CURT GIELOW AND MEMBERS OF THE ASSEMBLY MEDICAL MALPRACTICE TASK FORCE

FROM: Richard Sweet and Ronald Sklansky, Senior Staff Attorneys

RE: Possible Recommendations

DATE: September 27, 2005

This memorandum is a brief summary of possible recommendations submitted to staff by members of the Assembly Medical Malpractice Task Force. Additional details and rationale for some of the recommendations are included in attachments to this memorandum.

Noneconomic Damage Cap

The following four recommendations were submitted to address the elimination of the statutory limit on noneconomic damages in medical malpractice cases by the Wisconsin Supreme Court in *Ferdon v. Wisconsin Patients Compensation Fund*, 2005 WI 125 (2005). In discussing any of these four proposed recommendations or any other recommendations regarding noneconomic damage caps, the Task Force may wish to consider the following in order to bolster the constitutionality of the recommendations:

- Make any new noneconomic damage cap prospective only. In other words, the cap would apply only to incidents of malpractice that occur after the bill's effective date.
- Index any dollar amounts for inflation.
- Include a statement of legislative findings that addresses issues such as adequate compensation of victims, and stability of medical malpractice premiums and the Injured Patients and Families Compensation Fund (referred to in this memorandum as "the Fund").

One East Main Street, Suite 401 • P.O. Box 2536 • Madison, WI 53701-2536
(608) 266-1304 • Fax: (608) 266-3830 • Email: leg.council@legis.state.wi.us
http://www.legis.state.wi.us/lc

The following four recommendations were submitted with respect to the noneconomic damage cap:

Option 1

- Establish the cap on noneconomic damages at $500,000, with an increase of $5,000 per year of life expectancy of the injured patient.

- Establish a separate cap for each family member who is entitled to noneconomic damages under current law at 25% of the cap for the injured patient.

Option 2 (see attachment from David Strifling)

- Establish the cap on noneconomic damages at $500,000 or $8,000 times each year of life expectancy of the injured patient, whichever is greater.

- Create a higher cap (e.g., $750,000) for noneconomic damages for the most severely injured patients. Consider not making the higher cap applicable in high-risk medical fields, such as emergency care or obstetrics/gynecology.

- Do not adjust the caps for additional family members who are entitled to noneconomic damages under current law (i.e., one cap would apply to the injured patient and all family members in the case).

Option 3

- Maintain the current cap ($445,755) as the maximum liability on individual health care providers but require the Fund to pay noneconomic damage awards in excess of that amount, subject to the limits established in the next item.

- Limit noneconomic damages for the injured patient to $2 million. The $2 million cap would be reduced by 1% for each year that the patient's age exceeds 20 years at the time the malpractice occurred.

- Limit noneconomic damages for family members who are entitled to noneconomic damages under current law to 10% of the noneconomic damages awarded to the patient or $20,000, whichever is greater, for each family member who suffers noneconomic damages.

- Ensure that insurance premiums and Fund assessments do not increase due solely to inflationary increases in caps.

Option 4 (see attachment from Ralph Topinka)

- Cap noneconomic damages at $550,000 through one of the following mechanisms: (1) provide immunity from liability for health care providers for amounts above this level; (2) provide immunity from liability for health care providers for amounts above this level if the providers participate in Medical Assistance.

- Establish a state fund that is separate from the Injured Patients and Families Compensation Fund to cover noneconomic damages up to the $550,000 cap. The new fund would be financed through assessments on providers and general revenues and be backed by the full faith and credit of the state.

Medical Residents (see attachment from David Strifling)

This item addresses the issue raised by the Wisconsin Supreme Court's decision in *Phelps v. Physicians Insurance Company of Wisconsin, Inc.*, 2005 WI 85 (2005). In that case, the court held that the statutory cap on noneconomic damages did not apply to a person during his or her medical residency who was not yet a physician and, in the circumstances of the particular case, was not an employee of a hospital. However, the Supreme Court sent the case back to a lower court for a determination of whether or not the medical resident can be considered to be a "borrowed employee" of a hospital.

The recommendations in this area are as follows:

- List medical residents as persons who are covered by the cap on noneconomic damages.

- Consider covering medical residents who are not direct employees of a hospital under the Fund and providing for assessments on those residents for Fund coverage.

Collateral Sources

The recommendation in this area relates to the Wisconsin Supreme Court's decision in *Lagerstrom v. Myrtle Werth Hospital-Mayo Health System*, 2005 WI 124 (2005). In that case, the court noted that current statutes provide that a jury may receive information about other sources of payments for the injured patient's injuries, in addition to payments from the defendant, but the statutes are silent on how the jury is to use that information. The court held that the jury may not use the information about collateral sources to reduce the award to the injured patient, but may use the information to determine the value of medical services rendered.

Option 1 (see attachment from David Strifling)

- Require the jury to reduce the injured patient's award by any collateral source payments received. Offset this reduction by the amount of any obligations that the injured patient has to reimburse the collateral sources (e.g., Medicare).

Option 2 (see attachment from Ralph Topinka)

- Allow or require the jury to reduce the injured patient's award by any collateral source payments received. Require a collateral source to seek redress for payments only from the defendant rather than the plaintiff.

Health Courts (see attachments from Reps. Jason Fields and Ann Nischke)

- Create health courts that deal exclusively with medical malpractice cases.

Audits of the Fund (see attachments from Reps. Bob Ziegelbauer and Jason Fields)

- Require a periodic ***actuarial*** audit of the Fund. Current statutes require that the Legislative Audit Bureau perform a ***financial*** audit of the Fund at least once every three years.

Coverage by the Fund

Currently, the Fund provides coverage for awards above $1 million per occurrence and $3 million per calendar year.

- Allow the Fund to provide first dollar coverage for medical malpractice cases through a subsidiary (see attachment from Rep. Bob Ziegelbauer).

- Reduce the coverage levels of the Fund to $500,000 per occurrence and $1.5 million per calendar year (see attachment from Insurance Commissioner Jorge Gomez).

- Allow the Fund to function as a private insurer (see attachment from Rep. Jason Fields).

Medical Malpractice Prevention (see attachment from Rep. Bob Ziegelbauer)

- Review recommendations made by the Joint Legislative Council's Special Committee on Discipline of Health Care Professionals in 1999 Senate Bills 317 and 318. (A copy of a report describing those bills is attached to this memorandum.)

Worker's Compensation Type of Program (see attachment from Rep. Ann Nischke)

- Consider a long-term reform of creating a medical malpractice system that is similar to the Worker's Compensation system.

Attorney Contingency Fees (see attachment from David Olson)

Currently, attorney's contingency fees in medical malpractice cases are limited to 33-1/3% of the first $1 million received (25% if liability is stipulated within 180 days after filing and not later than 60 days before the trial date), and 20% of amounts in excess of $1 million. A court may approve higher amounts for exceptional circumstances, including an appeal.

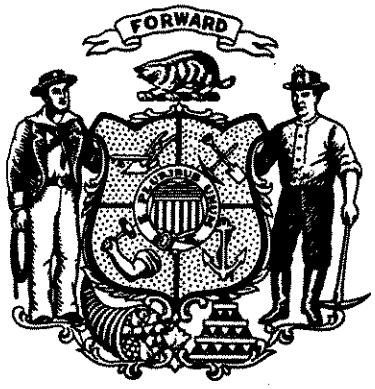
- Limit contingency fees to 40% of the first $50,000 received, 33.3% of the next $50,000, 25% of the next $500,000, and 15% of amounts recovered above $600,000.

Feel free to contact us if we can be of further assistance.

RNS:RS:jal

Attachments

END



END

Rep.Gielow

From: Peer, Adam

Sent: Friday, September 23, 2005 10:15 AM

To: Rep.Gielow

Subject: Rep Nischke's Med Mal Recommendations

Rep. Gielow: Rep Nischke asked that I forward these recommendations on Medical Malpractice Reform from her constituents. Please let me know if you have any questions. Adam

ADAM PEER, Legislative Assistant
www.RepNischke.com

Contact • Constituent Services • Legislation
Insurance Committee • Insurance Advisory Council

ANN
Nischke
www.RepNischke.com

TO: REPRESENTATIVE ANN NISCHKE

From: Adam Peer, Legislative Assistant

Date: September 9, 2005

RE: Recommendations to the Speaker's Taskforce on Medical Malpractice Reform

You have requested a summary of recommendations voiced at the Insurance Advisory Council relating to the Medical Malpractice Reform Taskforce. Here are the following broad suggestions the council talked about that they hoped would be considered in a potential statutory cap on non-economic damages:

1. It *is desirable* the cap consider plaintiff life expectancy.
2. It *is not desirable* that the cap based on economic damage.
3. If persons, e.g. family members, other than the immediate plaintiff are considered for non-economic compensation, very strict standards defining who may be compensated be established.
4. The Legislature considers a long-term reform that creates a complete compensation system that includes non-economic compensation similar to the state Worker's Compensation Systems.
5. The creation of "health courts" (see attached article.).

Please let me know if you have any questions or if you would like more information or additional information about any of these items.

ASP

State Capitol, Room 8 North, PO Box 8953, Madison, WI 53705-8953
Capitol: 608-266-8580, Fax 608-282-3697

The Washington Times

June 09, 2005
Washington D.C. M/
SUNNY 84° F

Health courts could solve malpractice

By Andrew Damstedt
UNITED PRESS INTERNATIONAL

Washington, DC, Jun. 8 (UPI) -- Health courts, along with non-economic judgment caps and tighter regulation of the insurance industry, might constitute an effective approach to solve the problem of how best to reform medical-malpractice litigation, a panel of experts said.

The Progressive Policy Institute, a centrist Democratic think tank, hosted the panel on Capitol Hill this week to discuss how health courts could benefit doctors, lawyers and most of all patients who have been injured in malpractice cases.

Will Marshall, the institute's president, said the current litigation system is "broken and in need of radical reform." He said one current problem is the issue is being debated along political lines, with Republicans arguing that non-economic caps are necessary and Democrats attempting to protect the

UPI PERSPECTIVES

- Analysis: Africa tops EU agenda
- Outside View: Stability key to C. Asia
- Mideast Watch: Iran and the world order
- Politics & Policies: Egypt's contradiction
- Israel, Palestinians to coordinate
- Report: Gaza's economy needs Israel
- Analysis: Roh heads for talks with Bush
- Review of the Arab press
- Terror case raises fears of sleeper cells
- UPI Hears...
- UPI Intelligence Watch
- BRAC states are both Red and Blue
- Analysis: Iranians hard to pin down
- Skype expands VoIP services
- Health courts could solve malpractice
- Is portable TV TiVo's winning ticket?
- Commentary: Penny-wise, pound-foolish
- Analysis: Was Advani right?
- OAS rebuffs U.S. democracy proposal
- Schumer pushes Bush to have China summit

Employment
Health
Services Directory
Market Place
Tourist Guide
Holiday Gift Guide
International Reports
Archive
Subscription Services
Advertise
About TWT
Contact Us
TWT Gift Shop
National Weekly
Insight Magazine
The World & I
Middle East Times
Tiempos del Mundo
Segye Ilbo
Segye Times USA
Chongyohak Shinmun
Sekai Nippo
GolfStyles
World Peace Herald
Times Color Graphics
Arbor Ballroom

lawyers.

Marshall said the issue is more complicated than merely choosing sides, however. More often than not, the patient loses under the current system and some of the reform proposals offer "false choices between phony solutions."

The PPI's solution, he told reporters, is to establish a system of health courts that would function similar to patent and bankruptcy courts by eliminating juries and maintaining judges with specialized experience.

David Kendall, a senior fellow at the institute, said health courts would allow patients who think they have been wrongfully injured to file claims with a local review board. Each board, which would be set up by a hospital and operated under the jurisdiction of a health-court judge, would then investigate the claim, free of charge to the patient, and would issue one of three rulings:

-- If there is clear evidence of medical malpractice, the patient is compensated immediately.

-- If no malpractice is found, or if the injury is too minor to justify compensation, the case is rejected.

-- If the circumstances of the injury are not clear, the case is sent to the health-court judge for review or trial.

Both sides could be represented by lawyers and the health courts would employ specially qualified judges, who Kendall said did not need to be doctors but would be trained to understand the healthcare system. The courts also would hire neutral experts to review claims. Judges would decide the cases, not juries -- a potential sticking point, because lawyers probably would object to the courts depriving patients of the right to a jury trial.

"Juries are not the problem," Kendall said. "We are asking them to do an impossible job." He explained that in criminal trials juries are given clear definitions of the alleged crimes, but in medical trials juries are basically told to figure things out for themselves.

Carlton Carl, director of media relations at the Association of Trial Lawyers of America, told United Press International the whole idea of health courts could be unconstitutional. If 12 ordinary men and women can decide Enron is guilty of corruption with

Electronics / Computers
Education
Health
Entertainment
Today's Newspaper Ads

no expertise on corruption, then they can listen to evidence and make intelligent decisions about whether a doctor has committed malpractice, he said.

"This is another effort to stand in the way of patients injured by medical practice to get justice," Carl said.

"These proposals are being sold to the public as good for patients, but in fact they would be devastating for many, especially the most severely injured," Joanne Doroshow, executive director of the Center for Justice & Democracy in New York City, told UPI. "This is yet another attempt by the healthcare industry to limit its liability exposure by proposing to take compensation judgments away from juries, and replacing the jury system with a statutory structure over which their political action committee money can have more control."

Dr. Donald Palmasino, the immediate past president of the American Medical Association, said his organization supports California's Medical Injury Compensation Reform Act of 1975 as a pattern to reform medical-liability laws. It is a proven performer and has seen success in other states, he said. This would include placing a cap on non-economic damages, but not creating a specialized health court.

"We can stop the problem of escalating costs," Palmasino told UPI.

Philip Howard, a New York corporate lawyer and founder of Common Good, a bipartisan coalition dedicated to restoring the foundation of reliable law, said health courts would be able to establish guidelines for the medical profession.

Howard said the current system tends to polarize viewpoints, while a health-court system would allow people to come together and work things out.

"The most important factor is that the judges will make deliberate choices as a matter of law," Howard told reporters at the panel discussion.

At the news conference, Kendall said health-court judges would make awards based on a schedule of benefits, meaning instead of juries awarding similar cases different amounts, there would be similar awards for similar circumstances.

"Scheduled benefits would bring consistency and hold the system accountable for avoidable errors,"

United Press International

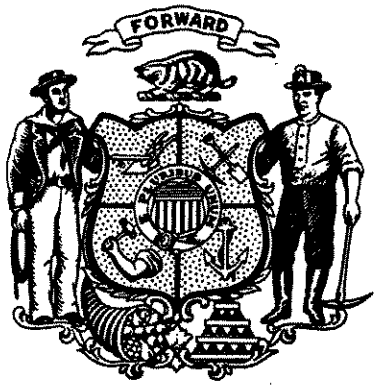
the senior citizens' advocacy group, said his organization supports the "experiment" of health courts and a no-fault system of medical malpractice. There is a worry, however, that a loss of unpredictability in damage awards could result in a deterioration of quality of care, he said.

"A hospital administrator could set someone aside and say 'their damages would only be $100,000' because the hospital can afford that," Jackson told reporters.

--

Andrew Damstedt is an intern for UPI Science News.
E-mail: sciencemail@upi.com

END



END

WISCONSIN STATE LEGISLATURE

11TH ASSEMBLY DISTRICT

JASON M. FIELDS

STATE REPRESENTATIVE

DATE: September 19, 2005

TO: Representative Curt Gielow, Chair, Medical Malpractice Task Force

FROM: Representative Jason M. Fields

RE: Ideas for Medical Malpractice Task Force

As we continue to deliberate medical malpractice caps in the state of Wisconsin and prepare to submit our final recommendations, I ask that you please consider the following proposals:

Health Courts

I propose that the Task Force look at the feasibility of creating a health court system similar to that of the worker's compensation system. Health courts will be less expensive than the current system. Today, more than 50 percent of court awards go to court costs and lawyer fees. That is nearly twice the overhead of a typical workers' compensation case. Initially, premiums will remain the same. However, over time, medical malpractice premiums should fall as compensation for injured patients becomes more predictable and the new system helps clarify standards of practice to reduce injuries. This will result in malpractice insurers no longer having to pay any of the sizable awards that make headlines in the current system. They will pay limited compensation awards more frequently.

Compensation Fund

The Task Force should explore auditing the Injured Patients and Families Compensation Fund (Fund) on a periodic basis as to determine actuarially the reality of using the fund to pay claims dollar for dollar. In addition, the Task Force should consider authorizing the Fund to function as a private insurer.

Thank you in advance for your consideration.

State Capitol, P.O. Box 8952, Madison, WI 53708 ◆ (608) 266-3756 ◆ Toll-free: 1-888-534-0011
Fax: (608) 282-3611 ◆ E-mail: rep.fields@legis.state.wi.us

316-North

BOB ZIEGELBAUER

STATE REPRESENTATIVE • TWENTY FIFTH ASSEMBLY DISTRICT

DATE: September 19, 2005

TO: Representative Curt Gielow, Chair
Medical Malpractice Task Force

FROM: Representative Bob Ziegelbauer

RE: Member ideas, recommendations

At our last meeting you asked for suggestions from the members of proposals to be considered for inclusion in our final package of recommendations. I would like to offer these:

I. **Insurance Market Reforms**:
Witnesses appearing before the committee frequently voiced their concerns about the current or future state of the market for malpractice insurance coverage. Given what we already know, there are some reforms we can look at right now that can increase the competitiveness and efficiency of that market.

1. Require the Injured Patients and Families Compensation Fund (IPFCF) to regularly submit to an "actuarial audit" of reserves. The most recent actuarial audit by Towers Perrins' Tillinghast consultants indicated that the IPFCF's assumptions as to future liabilities were extremely conservative, arguably resulting in excess accumulation of reserves adding to premium costs. Accumulation of excess reserves is not in the insured's or the public's interest. Regular actuarial audits will encourage the managers of the fund to keep their rates and reserves for future losses at appropriate levels.

   The recent dramatic cuts in rates by the IPFCF seem to be a reaction to that audit and Legislative Audit Bureau review.

2. Give the IPFCF the authority to create an insurance subsidiary to offer first dollar coverage in competition with private insurers if necessary.

- continued -

STATE CAPITOL: P.O. BOX 8953, MADISON, WI 53708-8953 • (608) 266-0315
TOLL FREE: 1-888-529-0025 • FAX (608)-266-0316 or (608) 282-3625 • E-MAIL: bob.ziegelbauer@legis.state.wi.us
DISTRICT: 1213 S. 8TH STREET, P.O. BOX 325, MANITOWOC, WI 54221-0325
MANITOWOC OFFICE: (920) 684-6783 • HOME: (920) 684-4362

There has been a great deal of discussion about future rates for malpractice coverage by private insurers. While many have indicated that the marketplace is operating efficiently now, both sides have expressed concern about how well it might work in the future. Allowing the IPFCF to create an independently funded subsidiary, if necessary, to offer primary coverage in competition with the other private insurers will add another competitive element that can incrementally keep them honest.

II. **Prevention of Malpractice Occurrences**:

To keep the long run cost of malpractice insurance coverage as low as possible it would seem to be in everyone's interest for us to consider strategic reforms now that might operate as preventative measures to avoid these undesirable outcomes. In 1999 there was a Legislative Council Special Study Committee that studied these issues and developed a broad consensus package of proposals dealing with regulation and discipline of Health Care Professionals.

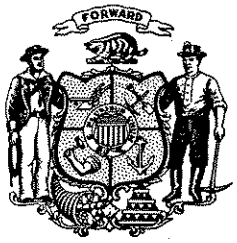
(The Legislative Council Committee developed two bills, 1999 SB 317 and SB 318, which were never fully considered by the full Legislature during the 1999-2000 session.)

I suggest that our committee take a closer look at the Legislative Council "Report No. 14 to the 1999 Legislature" (RL 99-14) with an eye to encouraging the Legislature to use it as a beginning point to again seriously consider the kinds of preventative accountability that can reduce occurrences.

Thank you for your consideration. As always, please do not hesitate to call on me if you would like to discuss this or any other recommendations further.

# # #

END



END

MEMORANDUM

TO: REPRESENTATIVE GIELOW; MEMBERS OF SPEAKER'S TASK FORCE ON MEDICAL MALPRACTICE

FROM: DAVID STRIFLING

SUBJECT: POTENTIAL RECOMMENDATIONS TO ASSEMBLY

DATE: 09/28/2005

CC:

Rep. Gielow:

After reviewing the testimony and documents submitted to our task force, and performing some additional research and analysis of my own, I hereby respond to your request for ideas via this memo summarizing my thoughts as to what recommendations our task force should send the Assembly.

This memo is divided into three parts. Part I contains my ideas and recommendations relating to the proposed cap on noneconomic damages in medical malpractice actions. Much of the testimony we heard and the information we received addressed the question of whether Wisconsin should have a cap, and whether caps in general are effective. However, given the directions our task force received from the Speaker, that is not the question with which this task force is concerned. Our mission is not to decide whether caps are necessary; rather, it is to come up with a form of the cap that is acceptable and fair. Accordingly, this memo does not attempt to address whether Wisconsin should have a cap, or whether caps have a positive effect on the overall health care climate. Nevertheless, I stress that in my opinion, if the legislature decides to re-enact the cap in some form, it must support that decision with a substantial amount of legislative history justifying the cap, as the absence of such justification was one of the grounds on which the Ferdon court struck down the cap.

Part II of this memo contains my thoughts relevant to the situation of medical residents vis-à-vis Chapter 655 of the Wisconsin Statutes, the noneconomic damages cap, and the Injured Patients and Families Compensation Fund (Fund). Part III covers the collateral source rule and Wis. Stat. § 893.55(7). Certainly, the information presented to us has focused almost exclusively on the cap, and not on the medical resident issue or the collateral source rule. Nonetheless, at our first session we briefly discussed the possibility of providing information on those issues as well, and so I have.

Before beginning my discussion of potential legislative options, however, I feel that it would be worthwhile to address the goal of medical malpractice tort reform. In short, I believe the goal of such reform should not solely be to attract and retain physicians; rather, the goal should be to attract and retain the best doctors, so that Wisconsin is not only an excellent environment in which to practice health care, but is also an excellent environment to receive health care.

With this in mind, I undertook a brief statistical analysis to see whether previous tort reforms in this state had had such an effect. I analyzed publicly available data to determine, on a state-by-state basis, the number of physicians per successful malpractice claim.[1]

My conclusion: Wisconsin doctors are among the best in the country. My study revealed that as of 2000, there were 105 Wisconsin physicians for every one successful malpractice claim. By far, this was the best ratio in the nation. In the lowest ranked state under my methodology, West Virginia, there was one successful malpractice claim for every 13 physicians!

In my view, the Wisconsin medical profession may have done too little to inform Wisconsin's residents about the high quality of health care available in this state. My inexact study could be replicated on a much larger scale to prove that Wisconsin's doctors are among the nation's best. In order to keep this "cream of the crop" at home, Wisconsin should do all it can to ensure that it remains a favorable environment to both practice and receive health care. With that in mind, I move on to my thoughts regarding the three issues facing our task force:

I. Cap on noneconomic damages in medical malpractice actions

If the legislature reenacts the cap, it must do so in a form that addresses the constitutional concerns discussed in the Wisconsin Supreme Court's opinion in Ferdon v. Wisconsin Patients Compensation Fund. First, the new legislation must address the majority opinion's conclusion that the former cap violated the Wisconsin Constitution's guarantee of equal protection of the laws in three ways: 1) By discriminating against the most severely injured claimants; 2) By discriminating against the youngest claimants; 3) By discriminating against claimants with families.

In assessing the constitutionality of a future cap, it must be remembered that much of the majority opinion is dedicated to attacking the effectiveness of caps as a whole. It is doubtful that Chief Justice Shirley S. Abrahamson – the author of the majority opinion – or Justice Ann Walsh Bradley – who joined the opinion without comment – could ever vote to find any cap constitutional in light of the majority opinion. The three dissenting Justices – Jon P. Wilcox, David T. Prosser, and Patience D. Roggensack – would likely vote that a future cap is constitutional. The two key votes may be those of the concurring Justices – N. Patrick Crooks and Louis B. Butler.

In a somewhat cryptic concurring opinion, Justice Crooks (joined by Justice Butler) noted that caps "can satisfy the requirements of the Wisconsin Constitution." This simple statement is out of step with much of the majority opinion, and it deserves further attention. The problem, according to Justice Crooks, is that the current cap is too low, and further that the legislature arbitrarily set the cap

[1] My methodology was as follows: first, I recorded the population of each state, as reported in the 2000 United States Census. Second, I determined the number of practicing physicians in each state. I used the data provided to our task force by the Wisconsin Academy of Trial Lawyers (WATL) in the report entitled "The Impact of State Laws Limiting Malpractice Awards on the Geographic Distribution of Physicians." This report provided the number of physicians per 100,000 residents in all 50 states as of the year 2000. Next, I recorded the number of successful malpractice claims during the year 2000 in all fifty states, as reported by the United States Department of Health and Human Services "National Practitioners' Database 2003 Annual Report," which is publicly available on the Internet. Finally, I divided the total number of physicians in each state by the total number of malpractice claims in that state, all with respect to the year 2000. Complete results are contained in the attached spreadsheet. Using this admittedly inexact science, Wisconsin ranked first in the nation in least malpractice claims per number of physicians.

amount at $350,000. Justice Crooks noted that in 1995, the cap amount was changed from $250,000 to $350,000 at the last minute, with no explanation.

Each of these concerns must be addressed.

The first question the legislature must answer is what form the cap should take. In this regard, it is useful to examine what other states with similar caps have done. My research revealed 27 other states that have enacted some form of damage caps applicable to medical malpractice actions. In five of these states, the caps cover all damages, not just noneconomic damages – a situation decidedly different from Wisconsin's. Accordingly, I restricted my analysis to the 22 states with caps on noneconomic damages alone. (A summary table displaying the salient features of these caps is attached as a separate spreadsheet.) The caps enacted by those states generally took five forms:

- An immutable cap, not adjusted for inflation, with no allowances for the severity of the claimant's injury or the claimant's age (8 states)
- A cap that is adjusted yearly for inflation, but contains no allowances for the severity of the claimant's injury or the claimant's age (5 states)
- A base cap that is adjustable based on the severity of the claimant's injury (9 states) (some of these caps are also adjustable for inflation)
- A cap that is based on the claimant's age (1 state - Alaska, which has a $400,000 base cap, alternatively allows the claimant to receive the higher of $400,000 or $8000 multiplied by the claimant's life expectancy).
- A cap that is based on the amount of economic damages received (1 state – Ohio, which has a $250,000 base cap, alternatively allows the claimant to receive the greater of $250,000 or 3 times economic damages up to $350,000 per plaintiff).

I suggest incorporating several of these ideas, as follows:

Set a base cap on noneconomic damages at $500,000. In the 22 states mentioned above, the cap amount ranges from a low of $250,000 (California, Idaho, Kansas, Montana, Texas, and West Virginia) to a high of $650,000 (Maryland). The average cap amount is about $390,000. In Wisconsin, the pre-Ferdon cap (as adjusted for inflation) was $455,755. This represented an increase of about $23,000 over last year's cap amount of $432,352.[2] Accordingly, one might have expected the cap level to be about $475,000-$480,000 in 2006. A $500,000 cap would be greater than the caps in 14 of the 22 other states that have enacted caps, and it would be equal to 6 other states' caps. Only 2 of the 22 caps would be higher than Wisconsin's (Maryland ($650,000) and Missouri ($565,000 as adjusted for inflation)).

This information is especially informative in light of the Ferdon concurrence. Justice Crooks expressed surprise that Wisconsin's cap could bounce from $1,000,000 to nothing to $350,000, finding this arbitrary. The statistics from other cap states reveal that the $1,000,000 cap was quite high in comparison with caps in other states.

Adjust the base cap yearly to allow for inflation. This feature, carried over from the old cap, will allow the cap amount to remain fair over longer periods of time without requiring frequent legislative adjustment.

[2] Source: materials submitted to the Task Force by the Wisconsin Commissioner of Insurance.

Increase the cap in cases involving minor children by indexing the cap based on life expectancy. As noted above, this approach is practiced in only one other state (Alaska). However, the Ferdon decision calls for unusual measures. In Wisconsin, the current life expectancy for a newborn baby is about 78.8 years (statistic provided by the Wisconsin Department of Health and Family Services, available online at www.dhfs.state.wi.us/stats/01-03life.htm). If Wisconsin followed Alaska's example and set the cap at $8000 multiplied by one's life expectancy, the results would be as follows:

Age Group	Average Life Expectancy	Noneconomic Damage Cap
0	78.8	$630,400
1-4	78.3	$626,400
5-9	74.4	$595,200
10-14	69.5	$556,000
15-18	64.6	$516,800
18 and over	-	$500,000

This provision would attempt to address the Supreme Court's concern that the existing cap discriminates against younger claimants.

Create a secondary cap for severely injured claimants. Consider creating a secondary cap (perhaps at $750,000) to compensate the most severely injured claimants. This approach is practiced in several other states. The statutory language triggering the secondary cap could be very simple ("severe and catastrophic injuries") or extremely specific, spelling out particular injuries. For example, in Florida, the secondary cap is automatically triggered when negligence results in a permanent vegetative state, and may be invoked by the trier of fact if the negligence caused a spinal cord injury involving severe paralysis; an amputation; a severe brain injury; severe burns; blindness; or loss of reproductive organs. A provision like this would attempt to address the Supreme Court's concern that the existing cap discriminates against severely injured patients. As with the base cap, this secondary cap could also be indexed for inflation, and could also be adjustable based on the claimant's life span (perhaps at $12,000 multiplied by the expected life span?). Of course, no matter how high the cap is set, some injuries will not be fully compensated. That is the fundamental nature of a cap.

Do not provide for adjustment of the cap based on a percentage of economic damages. This option, used as an alternative method in Ohio, has some attraction if only because Justice Butler repeatedly raised it as a possibility during oral argument in the Ferdon case. (A digital audio file of the Ferdon oral argument is online and available to the public at www.wicourts.gov.) However, such a cap is really no cap at all, because in a case with huge economic damages, the available noneconomic damages would also be very large. In other words, such a cap would not protect the Fund from the feared "one big case" that could severely hamstring it. From a practical standpoint, because of the limited availability of data, it might be difficult to fairly set the percentage of economic damages at which to set the noneconomic damage cap.

Do not alter the cap for a particular claimant based on the size of the claimant's family. Few other states allow modification based on the number of claimants. Such modification opens claims of equal protection violation no matter what is done; for example, if the cap is increased for claimants with multiple family members, does that discriminate against claimants with little or no family? This part of the Ferdon majority opinion may prove very difficult to address.

Consider an "escape hatch" for health care providers in high-risk areas such as emergency care or OB-GYN care. The legislature might consider special provisions applicable to certain high-

risk classes of health care providers – perhaps these providers would not be subject to the secondary cap?

Do not make the new cap retroactive. The idea of making the new cap retroactive may be appealing in order to cover the current period in which uncapped noneconomic damages may be had. However, the legislature should be aware that the Wisconsin Supreme Court declared a similar provision unconstitutional in Martin v. Richards, 192 Wis. 2d 156, 531 N.W.2d 70 (1995).

A constitutional amendment should be the last resort. Such an amendment would be very difficult to pass, and would probably take several years to become effective.

Do everything possible to bring all sides to a compromise. Obviously, this is much easier said than done. However, I believe it should be attempted. As Governor Doyle's spokesperson stated, "the governor has encouraged all sides and all interested parties to work together on this to try to come up with a solution that meets the concerns that the court has set out." (Quote taken from Milwaukee Journal Sentinel, 8/30/2005). The Governor would probably be more likely to support a bill that contained input from all sides. Perhaps the Wisconsin Association of Trial Lawyers could be induced to come to the table in exchange for the cap multipliers described above, or alternatively for some form of increased oversight over the insurance community or the medical community. For example, the recently-passed bill reenacting a cap on noneconomic damages in Illinois contained a provision requiring regulatory approvals for medical malpractice insurers seeking certain rate increases.

To provide some concrete examples of how the cap format I have proposed in this memo would work, the following table, adapted from the information WATL provided, displays the nine cases affected by the cap over the past ten years:

Name, Age, Date, County	Injury	Jury Award	Effect of old cap	Effect of new cap
Joseph Richard, mid-50s, 2005, Milwaukee	Unnecessary removal of rectum	$540,000	Reduced to $432,252 (20% reduction)	Reduced to $500,000 (7% reduction)
David Zak, mid-30s, 2004, Marinette	Failure to diagnose infection	$1,000,000	Reduced to $422,632 (57% reduction)	Reduced to $500,000 (50% reduction)
Helen Bartholomew, early 60s, 2004, Kenosha	Failure to diagnose heart attack	$1,200,000	Reduced to $350,000 (70% reduction)	Reduced to $500,000 (58% reduction)
Sean Kaul, infant, 2003, Ozaukee	Permanent disability due to negligent diagnosis	$930,000	Reduced to $422,632 (55% reduction)	Not reduced.[1]
Matthew Ferdon, infant, 2002, Brown	Right arm paralysis due to negligent delivery	$700,000	Reduced to $410, 322 (40% reduction)	Not reduced.[1]
Scott Dickinson, mid-30s, 2002, Dane	Rendered a quadriplegic due to negligent treatment	$6,500,000	Reduced to $410,322 (93% reduction)	Reduced to $750,000 (88% reduction)

Name, Age, Date, County	Injury	Jury Award	Effect of old cap	Effect of new cap
Kristopher Brown, 16, 2001, Eau Claire	Negligent treatment of broken leg results in amputation	$1,350,000	Reduced to $404,657 (67% reduction)	Reduced to $775,200 (43% reduction)[1]
Bonnie Richards, early 40s, 2000, Eau Claire	Damage to bile duct resulting in hernias	$660,000	Reduced to $381,428 (41% reduction)	Reduced to $500,000 (24% reduction)
Candice Sheppard, mid-20s, 1999, Portage	Permanent pain and injury due to negligent cyst removal	$700,000	Reduced to $350,000 (50% reduction)	Reduced to $500,000 (29% reduction)

[1] Assumes that this case would be subject to secondary cap, as indexed for minor child's life expectancy (12,000 * life expectancy.)

This table shows that a cap similar to the one I have proposed in this memo would have produced dramatically different results in some of these cases, and very similar results in others.

WATL and other cap opponents have pointed out that these nine cases represent such a small number of the total malpractice cases that caps really aren't necessary. In my view, the purpose of the cap is not to affect a larger number of cases – on the contrary, the smaller the number of cases affected, the better. Rather, the caps are intended to provide predictability; in other words, to serve as a safety valve that protects the whole system – and especially the Fund – from one extremely large award.

In selecting the above provisions, it was my intention to arrive at an equitable compromise that would ensure fairness for legitimate victims of medical malpractice while protecting health care providers and the Fund from the huge awards that have deleteriously affected the medical climate in other states. The dollar amounts discussed above are certainly debatable, and may be edited by the task force or the legislature. However, whatever final number is agreed upon must be supported by hard data to avoid the Ferdon concurrence's concern of arbitrariness.

II. Medical Residents

In Phelps v. Physicians Insurance Company, a case decided earlier this year, the Wisconsin Supreme Court ruled that unlicensed first-year medical residents are not health care providers, and therefore are not subject to the protections of Chapter 655 (such as the Fund) or the noneconomic damage cap, unless those unlicensed first-year residents are "borrowed employees" of a health care provider such as a hospital.

Our task force has heard very limited testimony on this issue. Certainly, the Phelps decision has not created the same level of consternation as has the Ferdon decision. It is, however, an ancillary issue. We may wish to present the Assembly with some information about it.

Chapter 655 of the statutes, which provides Fund coverage and certain other protections for health care providers, contains provisions governing the applicability of that chapter. Currently, the main applicability provision limits the Chapter's coverage to physicians, registered nurses, and certain

businesses such as hospitals. Wis. Stat. § 655.002. Another provision extends coverage to employees of health care providers. Wis. Stat. § 655.005.

Of course, many residents are employed by the hospitals they work in, and are therefore clearly covered by the "employee" provision. Residents working in state-owned hospitals might also be covered by the cap on damages in actions against state employees. The brunt of the Phelps decision falls on unlicensed first-year residents in programs administered by the Medical College of Wisconsin Associated Hospitals (MCWAH). These residents are employed by MCWAH, but it is questionable whether MCWAH (a purely administrative nonprofit corporation) is a health care provider. The key issue is whether the MCWAH residents are also "borrowed employees" of the actual hospitals in which they work. This question is resolved on an individual, case-by-case basis.

MCWAH employs about 140 first-year residents in 25 disciplines. (http://www.mcw.edu/display/router.asp?docid=2422). These are the residents most at risk as a result of the Phelps decision. The legislature may also wish to consider the effect this decision might have on Wisconsin's ability to attract medical residents who would eventually become Wisconsin doctors.

At first glance, it might appear that if the legislature wished to provide cap and/or Fund coverage to unlicensed first-year residents, the easiest way to do so would be to amend Wis. Stat. § 655.002(1) to include unlicensed first year residents.

However, this issue is not as simple as it seems. Theresa Wedekind, Director of the Fund, informed me that unlicensed first-year residents do not pay into the Fund. It would seem inequitable for the Fund to provide coverage without receiving an assessment from these residents. This could be handled by adjusting the Fund regulations to collect such an assessment, but that is not something the legislature could do on its own.

Another option would be to amend Wis. Stat. § 893.55(4)(b), the statute enumerating who is covered by the cap, to specifically include unlicensed first-year residents. This would give those residents the benefit of cap coverage, but would not allow them to tap into the Fund.

III. Collateral Source Rule

The third issue before us concerns the applicability of the collateral source rule in medical malpractice actions. This issue stems from the Wisconsin Supreme Court's decision in Lagerstrom v. Myrtle Werth Hospital, in which the court largely eviscerated Wis. Stat. §893.55(7), which provides:

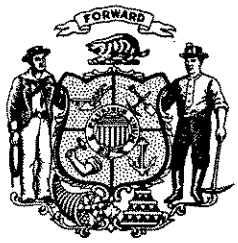
(7) Evidence of any compensation for bodily injury received from sources other than the defendant to compensate the claimant for the injury is admissible in an action to recover damages for medical malpractice. This section does not limit the substantive or procedural rights of persons who have claims based upon subrogation.

The court held that this section allows evidence of collateral source payments to be presented to the jury; however, the jury cannot reduce the plaintiff's award based on such evidence. The court essentially held that the statute gives the jury too much discretion because the text "does not inform a fact-finder what to do with the evidence." Accordingly, the court delved into legislative history and "common law concepts" to reach its conclusion.

Should the legislature wish to address this decision, it would have to modify Wis. Stat. § 893.55(7) to inform the fact-finder what it must do with evidence of collateral sources. Presumably, the intent of the change would be to force the fact-finder to reduce the plaintiff's award by any collateral source payments received. Similar provisions have been held constitutional in other states, although there is no guarantee that the Wisconsin Supreme Court would so hold. In the interest of fairness, the legislature could also amend the statute to provide that the plaintiff should be allowed to inform the fact-finder of any collateral obligations it has, such as an obligation to reimburse Medicare.

I look forward to discussing these preliminary ideas at our next meeting. As its final product, I believe our task force should produce a detailed report recording our recommendations and laying out the evidence supporting them.

END



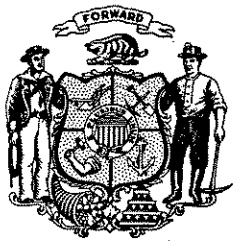
END

State	2000 Pop	Phys/100K	Total Physicians	Successful Claims	Phys/Claim
Wisconsin	5,363,675	137	7348	70	105
Virginia	7,078,515	215	15219	199	76
Hawaii	1,211,537	239	2896	40	72
Minnesota	4,919,479	126	6199	86	72
Massachusetts	6,349,097	331	21016	323	65
Oregon	3,421,399	148	5064	81	63
Vermont	608,827	231	1406	23	61
North Carolina	8,049,313	153	12315	215	57
Connecticut	3,405,565	273	9297	167	56
Alabama	4,447,100	98	4358	82	53
Delaware	783,600	203	1591	30	53
Maryland	5,296,486	239	12659	248	51
New Hampshire	1,235,786	263	3250	64	51
North Dakota	642,200	125	803	16	50
Alaska	626,932	130	815	17	48
Rhode Island	1,048,319	299	3134	67	47
California	33,871,648	187	63340	1396	45
Colorado	4,301,261	140	6022	143	42
South Carolina	4,012,012	128	5135	124	41
Washington	5,894,121	142	8370	210	40
Indiana	6,080,485	108	6567	168	39
Maine	1,274,923	196	2499	65	38
Idaho	1,293,953	95	1229	33	37
Arkansas	2,673,400	92	2460	69	36
New Jersey	8,414,350	250	21036	609	35
Tennessee	5,689,283	106	6031	179	34
Nebraska	1,711,263	113	1934	59	33
South Dakota	754,844	110	830	26	32
Georgia	8,186,453	104	8514	274	31
Pennsylvania	12,281,054	192	23580	874	27
Louisiana	4,468,976	112	5005	188	27
Wyoming	493,782	135	667	26	26
Oklahoma	3,450,654	73	2519	103	24
New Mexico	1,819,046	119	2165	89	24
Arizona	5,130,632	120	6157	263	23
Missouri	5,595,211	82	4588	196	23
Utah	2,233,169	109	2434	105	23
Mississippi	2,844,658	94	2674	116	23
Illinois	12,419,293	108	13413	589	23
Iowa	2,926,324	89	2604	121	22
Kentucky	4,041,769	99	4001	186	22
Kansas	2,688,418	97	2608	122	21
Florida	15,982,378	150	23974	1223	20
New York	18,976,457	212	40230	2103	19
Michigan	9,938,444	125	12423	659	19
Montana	902,195	131	1182	67	18
Texas	20,851,820	89	18558	1115	17
Nevada	1,998,257	96	1918	116	17
Ohio	11,353,140	120	13624	846	16
West Virginia	1,808,344	124	2242	169	13

States with caps on noneconomic damages	Cap Dollar Amount	Is cap adjusted for inflation?	Is cap otherwise adjustable?	Stat Cite	Notes
Alaska	$ 400,000	No	Can also use $8,000 x life expectancy; for "severe permanent physical impairment or severe disfigurement," use $1 million or $25,000 x life expectancy	Alaska Stat. 09.17.010	
California	$ 250,000	No	No	Cal. Civ. Code 3333.2	
Colorado	$ 300,000	No	No	Colo. Rev. Stat. 13-64-302	
Florida	$ 500,000	No	$1,000,000 if result was death or permanent vegetative state, or for certain other catastrophic injuries if equitable	Fla. Stat. Ch. 766.118	
Hawaii	$ 375,000	No	Exceptions for certain damages	Haw. Rev. Stat. 663-8.7	
Idaho	$ 250,000	Yes	No	Idaho Code 6-1603	
Illinois	$ 500,000	No	Raised to $1000000 vs hospitals	S.B. 475	(8/27/05)
Kansas	$ 250,000	No	No	Kans. Stat. Ann. 60-19a02	
Maryland	$ 650,000	Annual 15000 increase; starting in 2009	If multiple claimants, may get 125% of cap	Md. Code Ann. Cts. & Jud. Proc. 3-2A-09	
Massachusetts	$ 500,000	No	Cap does not apply in catastrophic cases as defined in statute	Mass. Gen. Laws Ch. 231, sec. 60H	
Michigan	$ 359,000	Yes - originally $280,000; figure is as of 2003	In catastrophic cases, get $500,000 adj for inflation ($641,000 as of 2003)	Mich. Comp. Laws 600.1483	
Mississippi	$ 500,000	No	No	Miss. Code Ann. 11/1/1960	
Missouri	$ 565,000	Yes - originally $350,000; figure is as of 2004	No	Mo. Rev. Stat. 538.210	
Montana	$ 250,000	No	No	Mont. Code Ann. 25-9-411	

States with caps on noneconomic damages	Cap Dollar Amount	Is cap adjusted for inflation?	Is cap otherwise adjustable?	Stat Cite	Notes
Nevada	$ 350,000	No	No	Nev. Rev. Stat. 41A.035	
North Dakota	$ 500,000	No	No	N.D. Cent. Code 32-42-02	
Ohio	$ 350,000	No	N-E damages of the greater of $250,000 or 3x economic damages up to a max of $350,000 per plaintiff or $500,000 if multiple plaintiffs. Catastrophic max may increase to $500,000 per plaintiff or $1 million for multiple plaintiffs.	Ohio Rev. Code Ann. 2323.43	
Oklahoma	$ 300,000	Yes	Only applies if there is an offer for judgment, or if care was OB or ER; cap may be lifted under some circumstances		
South Dakota	$ 500,000	No	No	S.D. Codified Laws 21-3-11	
Texas	$ 250,000	No	May recover an additional $250,000 against each involved health care institution; total limit of $500,000	Tex. Civ. Prac. & Rem. Code 74.301	
Utah	$ 400,000	Yes	No	Utah Code Ann. 78-14-7.1	
West Virginia	$ 250,000	Yes, but can't exceed 375,000	500,000 for certain catastrophic cases, adjusted for inflation but can't exceed $750,000	W. Va. Code 55-7B-8	
AVERAGE	$ 388,591				

END



END

MERCY HEALTH SYSTEM
1000 MINERAL POINT AVE.
P.O. BOX 5003
JANESVILLE, WI 53547-5003
608•756•6000
www.mercyhealthsystem.org
A System for Life

September 26, 2005

The Honorable Curt Gielow
State Representative
Room 316 North, State Capitol
Post Office Box 8952
Madison, WI. 53708-8952

Re: Medical Malpractice Task Force Proposals

Dear Representative Gielow:

Thank you for the invitation to submit suggested legislative approaches to enactment of maximum liability limits on non-economic damages in medical malpractice actions in Wisconsin. Before turning to suggested alternatives, I want to express appreciation for the work of the task force and the opportunity to serve on it. The Task Force is playing an important role in helping to restore the careful balance that helps ensure that plaintiffs in medical malpractice actions are able to receive full compensation for economic damages (e.g., lost income, medical expenses) and fair and reasonably predictable compensation for non-economic damages while, among other things, helping to preserve a stabile professional liability insurance market in Wisconsin. As the Task Force has heard, there is ample evidence from which to draw a rational conclusion that maintenance of caps on non-economic damages in medical malpractice actions helps contribute to a stabile, less costly medical malpractice insurance market.

INITRODUCTION

Unlike patients in most states, patients in Wisconsin who make successful claims for medical malpractice can be assured that they will receive financial compensation. That is because in Wisconsin, health care providers by law must obtain medical malpractice insurance, and must participate in the Injured Patients and Families Compensation Fund (the "Fund"). The combination of providers' malpractice insurance and the Fund means that in Wisconsin, successful malpractice claimants will receive their full economic damages, less costs and attorneys fees. Furthermore, plaintiffs in Wisconsin malpractice actions are assured of receiving their full non-economic damages, again, less costs and attorneys fees. As we are aware, until the recent *Ferdon* decision, there was a statutory cap on recovery of non-economic damages. Even with the cap, however, plaintiffs could recover hundreds of thousands of dollars in non-economic damages in addition to unlimited economic damages.

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

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

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

SUGGESTED LEGISLATIVE ALTERNATIVES

There are numerous potential approaches to restoration of caps on non-economic damages. The following are just a few of the approaches that the Task Force and the Wisconsin legislature may want to consider:

(A) Reinstate caps on non-economic damages.

Legitimate Government Purpose:

Improving access to health care in Wisconsin by stabilizing or increasing the supply of physicians in Wisconsin and encouraging physicians and hospitals to provide health care services in rural and urban areas.

Rational Basis:

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

The majority opinion in *Ferdon* recognized that, according to a study by the U.S. General Accounting Office, a shortage of physicians existed in rural locations in states without limitations on damage awards. Further, the majority recognized that malpractice pressures are among the factors that affect the availability of services. (See *Ferdon* at 92.)

There are a number of reports that outline Wisconsin's current and increasing shortage of physicians. Given Wisconsin's aging population and other changing demographics, the retention and recruitment of physicians are crucial in order to provide sufficient access to health care. In addition, like the report cited by Abrahamson, there are studies that have found that the retention and recruitment of physicians, especially in rural and urban areas, are more successful in states that have stable and affordable medical liability insurance rates.

As recognized by the Court in *Ferdon*, Wisconsin currently enjoys a stable and affordable medical liability environment. The Legislature, therefore, could opt to reinstate the cap or limit liability for non-economic damages in an amount that is known to support Wisconsin's stable and affordable environment, namely approximately $445,000. Based on actuarial analyses of the insurance exposure amount that would provide stable and affordable insurance rates and studies of the caps in other states, one could argue that a cap of up to $550,000 would not significantly disrupt Wisconsin's current positive environment. On the other hand, based on the same and other studies, it is reasonable to conclude that a cap or limitation in an amount above $550,000 would have a negative impact on that environment. The studies and actuarial analyses indicate that a high cap or limitation would not provide the same predictability, stability, or affordability as a low or medium cap.

Based on the above, in order to improve access to health care in Wisconsin by stabilizing or increasing the supply of physicians in Wisconsin and encouraging physicians and hospitals to provide health care services in rural and urban areas, I recommend that the Legislature reinstate a cap or limit liability for non-economic damages to an amount not to exceed $550,000.

(B) Options to implement a cap or to limit liability on non-economic damages in order to improve access to care:

1. Exemption from Liability.

The Legislature has determined that a number of activities and actions, in certain circumstances, should be exempt (immune) from liability. Exemptions from liability preclude recovery of any type of damage – economic and non-economic (in effect, a cap of $0). The Legislature has created the exemptions from liability to encourage or permit certain actions, including: the participation in recreational activities; the use of private land for recreational purposes; the donation of food; the donation of solid waste; sport shooting range activities; equine activities; providing emergency health care; and providing health care at athletic events.

In *Szarzynski v. YMCA, Camp Minikana*, 184 Wis. 2d 875 (1994), a case in which the Wisconsin Supreme Court upheld nonprofit corporations' statutory recreational immunity from liability in the face of a constitutional challenge, the State argued that immunities and other liability limitations do not deny a plaintiff equal protection. In its brief to the Wisconsin Supreme Court, the State maintained, "The question is whether the legislative objective is rationally furthered, not whether some plaintiffs are injured by immune defendants and some by non-immune defendants. Immunities and other liability limitations will be upheld even if some otherwise similarly situated plaintiffs' recoveries are affected or denied altogether. The Good Samaritan law is a classic abrogation of damage liability that will affect some plaintiffs but not others." The State, citing several examples of immunities created to encourage certain activities, concluded, "In each case, the rationality of a permissible governmental objective denies someone an otherwise full recovery" and that there are "many examples of using tort immunities to further a social policy." The Wisconsin Supreme Court agreed with the State's position in this case and, applying a rational basis standard of analysis of the statute in question, held it to be constitutional.

As with the activities listed above, providing a limited exemption from liability would encourage an activity, here the provision of health services. And, like the other exemptions from liability, this exemption from liability is rationally related to the government's legitimate interest, in this case, increasing access to health care in Wisconsin by encouraging the practice of medicine.

The statutory provision could be drafted as follows:

Create:
s. 895. 5X Liability exemption: medical malpractice. (1.) Notwithstanding s. 655.23(5), any mandatory participant in the injured patients and families compensation fund is immune from civil liability for any injury to an individual caused by the medical malpractice of the mandatory participant to the extent the non-economic damages in a medical malpractice action exceed $550,000.

(2.) This section does not apply if the death or injury was caused by intentional criminal acts or omissions.

Amend:
s. 655.27 Injured Patients and Families Compensation Fund. (1) Fund. There is created an injured patients and families compensation fund for the purpose of paying that portion of a medical malpractice claim for which a health care provider is liable which is in excess of the limits expressed in s. 655.23(4) or the maximum liability ~~limit~~ for which the health care provider is insured, whichever ~~limit~~ is greater, paying future medical expense payments under s. 655.015 and paying claims under sub. (1m). [...]

Or

Create:
s. 895. 5X Liability exemption: medical malpractice. (1) Notwithstanding s. 655.23(5), any mandatory participant in the injured patients and families compensation fund is immune from civil liability for any injury to an individual caused by the medical malpractice of the mandatory participant.

(2.) Subsection (1) does not apply to the extent the damages caused by the medical malpractice of the mandatory participant are economic damages or, if non-economic damages, the damages do not exceed $550,000.

(3.) Subsection (1.) does not apply if the death or injury was caused by intentional criminal acts or omissions.

Amend:
s. 655.27 Injured Patients and Families Compensation Fund. (1) Fund. There is created an injured patients and families compensation fund for the purpose of paying that portion of a medical malpractice claim for which a health care provider is liable which is in excess of the limits expressed in s. 655.23(4) or the maximum liability ~~limit~~ for which the health care provider is insured, whichever ~~limit~~ is greater, paying future medical expense payments under s. 655.015 and paying claims under sub. (1m). [...]

---

2. Exemption from liability tied to Medicaid.

The Legislature could refine the "legitimate government purpose" by specifically attempting to increase access to health care for the poor, elderly, disabled, children, and pregnant woman by encouraging participation in the Medicaid program. As discussed, the Legislature has determined that exemptions from liability encourage certain actions or activities and the Court has found liability exemptions constitutional. The Legislature could encourage increased participation in the Medicaid program by providing a limited liability exemption for physicians and hospitals that are certified Medicaid providers.

Create:
s. 895. 5X Liability exemption: medical malpractice. (1.) Notwithstanding s. 655.23(5), any mandatory participant in the Injured Patient and Family Compensation Fund that is certified as a Medicaid provider is immune from civil liability for any injury to an individual caused by the medical malpractice of the mandatory participant.

(2.) Subsection (1) does not apply to the extent the damages caused by the medical malpractice of the mandatory participant are economic damages or, if non-economic damages, the damages do not exceed $550,000.

(3.) Subsection (1.) does not apply if the death or injury was caused by intentional criminal acts or omissions.

Amend:
s. 655.27 Injured Patients and Families Compensation Fund. (1) Fund. There is created an injured patients and families compensation fund for the purpose of paying that portion of a medical malpractice claim for which a health care provider is liable which is in excess of the limits expressed in s. 655.23(4) or the maximum liability ~~limit~~ for which the health care provider is insured, whichever ~~limit~~ is greater, paying future medical expense payments under s. 655.015 and paying claims under sub. (1m). [...]

---

3. Full faith and credit of the State.

In order to maintain Wisconsin's stable and affordable medical liability environment, the Legislature could eliminate physicians' and hospitals' liability for non-economic damages resulting from medical malpractice. In order to provide reasonable compensation for non-economic damages, the Legislature would create a state program that compensates injured plaintiffs for non-economic damages in medical malpractice cases. This program's liability exposure would be capped at up to $550,000. This new fund would be backed by the full faith and credit of the State.

In *Ferdon*, the Court recognized that it was constitutional to cap municipal governments' liability exposure for injuries caused by road defects because "municipalities were immune from suit at the adoption of the Wisconsin constitution, and concern about public finances . . . justified the cap involved in the statute" and appeared reluctant to do anything that would disturb caps on government liability exposure (this cap would be such a cap). This option would invoke the State's sovereign immunity and, thus should be treated in the same manner as are existing liability caps that our Court has found to be as constitutional.

Under this option, the Fund would continue to exist and would be supported by provider assessments. The primary insurance requirements would not change. This option is outlined below:

- Hospitals and physicians would continue to be required to have $1 million per occurrence and $3 million annual aggregate primary liability insurance coverage and their liability would continue to be limited to the amount of the primary insurance.
- The Fund would continue to exist, but would provide compensation for economic damages only. The Fund's exposure for economic damages would continue to be unlimited.
- A new state program would be established to compensate injured patients for their non-economic damages. The awards provided by this new program would be capped at $550,000. The program would be backed with the full faith and credit

of the State. Funding of the program would, in part, rely on assessments from physicians and hospitals, with any excess assessments lapsing to the general fund and the full faith and credit of the State backing any shortfall.

(C) Abrogation of the Collateral Source Rule

Legitimate Government Purposes:

To curb the rising cost of providing medical services in Wisconsin, while still protecting the "make whole" principle central to tort law.

Background and Rationale:

The unmodified collateral source rule

The unmodified collateral source rule provides that if a plaintiff is injured by a defendant and the plaintiff receives benefits for that injury from a source such as an insurer, then information about those benefits is not admissible as evidence in a suit by the plaintiff for damages against the defendant. Thus, a plaintiff can receive damages from the defendant health care provider in the amount of the charged value of the medical expenses incurred by the plaintiff even though such expenses were not paid by the plaintiff. This windfall to the plaintiff can occur due to i) a collateral source such as an insurer paying for the medical care, or ii) all or part of the charges for the medical care being discounted by law by Medicare or Medicaid or by contract with a private insurer.

Such windfalls in the form of payments for charges incurred but not paid for by the plaintiff provide damages to the plaintiff that are in excess of what would make a plaintiff whole. These windfalls artificially increase the size of medical malpractice claims that, in turn, result in higher claims losses for medical malpractice insurers. Higher claims losses ultimately lead to higher premiums for health care providers. This phenomenon increases the cost of providing health care in Wisconsin.

Abrogation of the collateral source rule in medical malpractice claims

The abrogation of the collateral source rule in medical malpractice claims would prohibit windfall awards to plaintiffs by reducing damages awarded to a successful plaintiff in a medical malpractice action by amounts that a plaintiff has incurred, but has not paid, for health care services.

By prohibiting such windfall awards, overall health care costs in Wisconsin are not artificially increased due to artificially high medical malpractice claims. Furthermore, the abrogation of the collateral source rule would still allow plaintiffs, and those entities subrogated to principle plaintiffs, to be fully compensated for any and all economic losses they actually incur. Thus, abrogating the collateral source rule curbs the rising cost of providing medical services in Wisconsin, while still protecting the "make whole" principle central to tort law.

There are two basic types of collateral source reform throughout the United States. Mandatory abrogation of the collateral source rule requires that damages awarded to a successful plaintiff in a medical malpractice action be reduced by amounts that a plaintiff has incurred, but has not paid, for health care services. Permissive abrogation of the collateral source rule permits, but does not require, a jury to reduce the damages awarded to a successful plaintiff in a medical malpractice action by amounts that a plaintiff has incurred, but has not paid, for health care services.

Any type of collateral source reform would need to ensure that if a plaintiff's award did not include medical charges incurred but not paid by the plaintiff (and instead paid by a collateral source such as an insurer), that such plaintiff would not be required to later reimburse the collateral source. One way to address this issue would require a collateral source to seek redress for payments made on behalf of the patient (plaintiff) only from the defendant rather than the plaintiff.

*****

Thank you for the opportunity to submit these recommendations. I look forward to continuing to work with the Task Force in this important effort.

Sincerely,

Ralph Topinka