Task Force Meeting Attendance Sheet

Medical Malpractice Task Force

Date: 6 Oct 05 **Meeting Type:** Working Group

Location: 328 NW

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. 2

Handed to TF

by Rep. Hurbsch @

hearing 10/6/05

Section 1. Legislative findings. (1) The legislature finds that:

(a) The number of suits and claims for damages arising from professional patient care has increased tremendously in the past several years and the size of judgments and settlements in connection therewith has increased even more substantially;

(b) The effect of such judgments and settlements, based frequently on newly emerging legal precedents, has been to cause the insurance industry to uniformly and substantially increase the cost and limit the availability of professional liability insurance coverage;

(c) These increased insurance costs are being passed on to patients in the form of higher charges for health care services and facilities; (d) The increased costs of providing health care services, the increased incidents of claims and suits against health care providers and the size of such claims and judgments has caused many liability insurance companies to withdraw completely from the insuring of health care providers;

(e) The rising number of suits and claims is forcing both individual and institutional health care providers to practice defensively, to the detriment of the health care provider and the patient;

(f) As a result of the current impact of such suits and claims, health care providers are often required, for their own protection, to employ extensive diagnostic procedures for their patients, thereby increasing the cost of patient care;

(g) As another effect of the increase of such suits and claims and the costs thereof, health care providers are reluctant to and may decline to provide certain health care services which might be helpful, but in themselves entail some risk of patient injury;

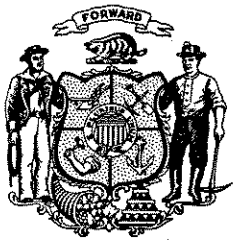
(h) The cost and the difficulty in obtaining insurance for health care providers discourages and has discouraged young physicians from entering into the practice of medicine in this state;

(i) Inability to obtain, and the high cost of obtaining, such insurance has affected and is likely to further affect medical and hospital services available in this state to the detriment of patients, the public and health care providers;

(j) Some health care providers have curtailed or ceased, or may further curtail or cease, their practices because of the nonavailability or high cost of professional liability insurance; and

(k) It therefore appears that the entire effect of such suits and claims is working to the detriment of the health care provider, the patient and the public in general.

END



END

Sawyer, Julie

From: Rep.Gielow
Sent: Friday, October 07, 2005 12:34 PM
To: Rep.Huebsch; Rep.Nischke; Rep.Fields; Rep.Ziegelbauer; 'dstrifling@hotmail.com'; 'mwolverton@pjmlaw.com'; 'cm.chumbley@ma-hc.com'; 'rtopinka@mhsjvl.org'; 'dolson@bamc.org'
Subject: Med Mal Task Force -- REVISED FINAL LETTER -- disregard earlier version

Attachments: Speaker Gard Draft Ltr 20051010.pdf

Please delete the "final draft letter" sent out earlier today. Language that had been agreed to by the Task Force yesterday was inadvertently left out of the previous draft.

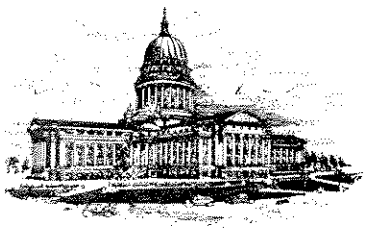
Attached is the correct version.

Speaker Gard Draft Ltr 2005101...

Please call if you have any questions.

Rep. Gielow
(608) 266-0486

Draft distributed to TF members 10/7/05.



DRAFT

Wisconsin State Assembly

P.O. BOX 8952 • MADISON, WI 53708

October 10, 2005

Speaker John Gard
Room 211 West, State Capitol
Madison, WI 53702

Dear Speaker Gard:

This letter incorporates the recommendations of the Assembly Medical Malpractice Task Force that you established following a series of Wisconsin Supreme Court decisions in June and July of this year. The recommendations are supported by the entire Task Force, except to the extent that a minority view is expressed at the conclusion of this letter. We believe that the recommendations made by the Task Force appropriately address those court decisions and forward the recommendations to you for your consideration and possible legislative action. The court decisions dealt with the cap on noneconomic damages in medical malpractice cases, coverage of medical residents under the caps and the Injured Patients and Families Compensation Fund ("the Fund"), and consideration by juries of collateral source payments for injuries to plaintiffs in medical malpractice cases. In addition, we are forwarding other recommendations that we feel will improve the medical malpractice system in Wisconsin.

Noneconomic Damage Cap

As you are aware, the Wisconsin Supreme Court declared unconstitutional the statutory cap on noneconomic damages in medical malpractice cases in *Ferdon v. Wisconsin Patients Compensation Fund*, 2005 WI 125 (2005). The majority opinion in that case held that the cap on noneconomic damages was not rationally related to the five legislative objectives summarized by the majority opinion in *Ferdon*.

In the majority opinion, Chief Justice Shirley Abrahamson summarized the five legislative objectives of a cap on noneconomic damages based on 11 findings made by the Legislature in 1975 when it enacted medical liability reform. In 1995, the Legislature enacted a cap because it believed the need for reform set forth in 1975 still existed and the Task Force believes it continues to exist today. We also believe some of the Legislature's findings were misconstrued, oversimplified or simply omitted when the summary objectives were fashioned by the court. For this reason, the Task Force believes any legislation introduced to implement a new cap on noneconomic damages should clarify the objectives embodied in the original 11 findings, including supporting data, and include them in a section related to Legislative Findings.

The Task Force recognizes that the Legislature in 1995 took a carefully balanced approach to compensating medical malpractice plaintiffs in this state. Wisconsin is the only state that

requires health care providers to purchase specified amounts of malpractice insurance coverage and also to participate in a fund that provides unlimited coverage for malpractice liability. Moreover, unlike legislative bodies in some states, the Wisconsin Legislature has set no limits on recovery for economic damages. Therefore, successful malpractice plaintiffs in this state are assured of recovery of their full economic damages. As a balance to this assurance, the Legislature placed a cap on what is assuredly the most unpredictable component of damages--noneconomic losses, largely pain and suffering. The Legislature and the Task Force recognized that this aspect of recovery is often based on emotion, not any predictable standard by which to measure damages. A reasonable cap on noneconomic damages serves as a rational balance to the Legislature's plan to ensure that successful malpractice plaintiffs are able to recover appropriate damages.

Medical liability reform is part of a broad legislative strategy designed to keep health care affordable and available in Wisconsin. The Task Force believes capping noneconomic damages for unquantifiable harms while continuing to allow unlimited recovery for economic damages is crucial to this strategy.

The Task Force is forwarding for your consideration three alternative proposals relating to noneconomic caps:

- Establish a two-tiered system under which injured minors have a higher cap than injured adults. This approach is similar to the two-tiered approach to damages in wrongful death cases.

- Establish a cap on noneconomic damages as the greater of either a base-level cap, or a set amount times each year of life expectancy of the injured patient. Since caps are applied by a judge, rather than a jury, the judge would use a table that could be developed by the Director of State Courts that sets forth life expectancy for persons of different ages. The life expectancy factor would be based solely on the age of the injured patient at the time of the act of malpractice, not on his or her specific health condition either before or after the act of malpractice.

- Cap noneconomic damages at a specific dollar amount. Immunity from liability above this dollar amount could be provided either to health care providers in general, or to health care providers that are participating in the Medical Assistance program.

The Task Force is not recommending the dollar amounts that would be used in the above proposals, but it is rather leaving that for your consideration and the consideration of the Legislature. In determining what dollar amounts to use, we recommend that you consider what other states use as a cap on noneconomic damages, previous Wisconsin Supreme Court rulings, actuarial data and studies presented to the Legislature, the amounts of noneconomic damage awards in medical malpractice cases in Wisconsin, and testimony, data and other information presented to the Task Force. The Task Force believes that this information demonstrates a rational basis for a cap on noneconomic damages because a cap will help maintain the balance described earlier as well as help to achieve legislatively stated objectives.

Any legislation that you might introduce should apply only to acts of malpractice that occur after the effective date of the legislation. The Wisconsin Supreme Court has previously declared invalid an attempt to apply caps on damages retroactively.

In addition, it is recommended that you consider whether any new cap on noneconomic damages be indexed for changes in the Consumer Price Index, as was the cap that was in effect prior to *Ferdon*.

Medical Residents

In June of this year, the Wisconsin Supreme Court rendered a 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 licensed 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 of the Task Force are as follows:

- Require all unlicensed medical residents to have a temporary educational permit starting in their first year, so that they may be considered health care providers.

- Allow sponsors of a graduate medical education program the option of participating in the Fund.

Collateral Sources

The third Wisconsin Supreme Court case that the Task Force discussed is *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.

The recommendation of the Task Force is as follows:

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Injured Patients and Families Compensation Fund

Currently, health care providers in Wisconsin are required to maintain primary medical malpractice insurance coverage in the amount of $1 million per occurrence and $3 million per year. Damages above these levels are paid from the Fund.

The recommendation of the Task Force is as follows:

- An actuarial audit of the Fund should be undertaken on a periodic basis. Currently, the Legislative Audit Bureau is required to perform a financial audit of the Fund at least once every three years. Actuaries should examine the effect that a conservative estimate of the Fund's future obligations has on premiums paid by health care providers over the long-term.

Medical Malpractice Reduction

The Task Force recommends that the Legislature set as a priority steps to reduce the incidence of medical malpractice in Wisconsin. The Legislature may wish to review recommendations made by the Joint Legislative Council's Special Committee on Discipline of Health Care Professionals in 1999 and subsequent legislation in conjunction with a review of any changes or reforms to the disciplinary system that have been made during the last six years.

Long-Range Issues

The Task Force examined other issues related to the medical malpractice system. However, since it is on a relatively short timeline, the Task Force deferred exploration of those issues to further consideration by other legislators and legislative committees.
The potential recommendations that the Task Force did not take specific action on, but rather recommended further exploration of, are as follows:

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

- Provide for legislative oversight of medical malpractice insurance premiums.

Minority Opinion

Representative Bob Ziegelbauer dissents from the recommendations for a noneconomic damage cap because of a concern that they are not sufficiently different from the previous cap that was struck down by the Wisconsin Supreme Court to enable them to survive a constitutional challenge.

Thank you for establishing the Task Force to deal with these important issues and for giving consideration to the recommendations set forth in this letter.

Sincerely,

Representative Curt Gielow, Chair
Assembly Medical Malpractice Task Force

Task Force Members:

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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

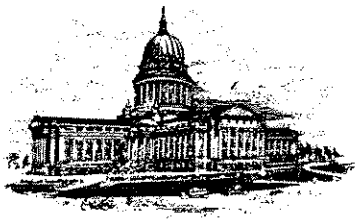
CG:jr:rr

Final Recommendation

of T.F. Sent to Gard 10/10

Distributed to members

10/10/05.



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P.O. BOX 8952 • MADISON, WI 53708

October 10, 2005

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Room 211 West, State Capitol
Madison, WI 53702

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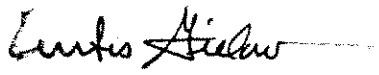

Representative Curt Gielow, Chair
Assembly Medical Malpractice Task Force

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Mr. David Strifling
Ms. Mary Wolverton
Dr. Clyde "Bud" Chumbley
Mr. David Olson
Mr. Ralph Topinka

CG:jr:rr

END

END

Sawyer, Julie

From: watl [watl@mailbag.com]
Sent: Thursday, October 06, 2005 12:07 PM
To: Rep.Gielow
Cc: Sweet, Richard; Sklansky, Ron
Subject: Response to PIC Letter
Follow Up Flag: Follow up
Flag Status: Red
Attachments: watl.vcf; 100605 Gielow Letter.pdf

Rep Gielow --

Attached is a letter responding to the letter you received from PIC Wisconsin.

If you have any questions, please do not hesitate to contact me.

Thank you.

David M. Skoglind, President
Wisconsin Academy of Trial Lawyers
Keeping Wisconsin Families Safe
Email: contact@watl.org Visit our website at: www.watl.org
Phone: 608-257-5741 Fax: 608-255-9285
Search 167,000+ depos full text at http://wwww.Trialsmith.com

Part of the general record.

Keeping Wisconsin Families Safe
www.watl.org

EXECUTIVE DIRECTOR
Jane E. Garrott
44 E. Mifflin Street, Suite 103
Madison, Wisconsin 53703-2897
Telephone: 608/257-5741
Fax: 608/255-9285
Email: exec@watl.org

Sent via email: Rep.Gielow@legis.state.wi.us

October 5, 2005

Rep. Curt Gielow
Room 316 North, State Capital
Madison, WI 53708

RE: Reducing Fund Threshold

Dear Rep. Gielow:

Physicians Insurance Company of Wisconsin (PIC) letter of October 4 contains contradictory information.

WATL is not sure how one part of PIC's letter can say they aren't likely to reduce fees if the Fund threshold is lowered to $500,000/$1,500,000, and then in another part say that the Fund threshold should be increased to $1,5000,000/$2,000,000. This appears to be nothing more than an attempt to price-gouge doctors while increasing their profits.

These statements reinforce one of the main findings in the *Ferdon v. WPCF* opinion that caps have little to no effect on malpractice insurance fees. If PIC is unlikely to reduce its malpractice fees even though its exposure is reduced 50%, how can the legislature expect them to reduce fees if there is a cap on noneconomic damages — a much smaller exposure for them. After all, only nine jury verdicts exceeded the cap on noneconomic damages from 1995-2005.

This just reinforces the very words of the insurance industry:

- "We have not promised price reductions with tort reform," said Dennis Kelly, an American Insurance Association spokesman. (Chicago Tribune, 1/3/05)
- "[M]any tort reform advocates do not contend that restricting litigation will lower insurance rates, and I've never said that in 30 years." (Victor Schwartz, General Counsel, American Tort Reform Association, *Business Insurance*, July 19, 1999)
- "Insurers never promised that tort reform would achieve specific premium savings . . ." (March 13, 2002 press release by the American Insurance Association)
- "We wouldn't tell you or anyone that the reason to pass tort reform would be to reduce insurance rates." (Sherman Joyce, President of the American Tort Reform Association, as quoted in "Study Finds No Link Between Tort Reforms and Insurance Rates," *Liability Week*, July 19, 1999)

If PIC does not lower its malpractice fees despite reducing its risk 50%, then the Insurance Commissioner's office should be empowered to investigate how PIC determines its fee levels. Based on national studies, it is apparent that claims practices have little to do with insurance rate increases. See, "FALLING CLAIMS AND RISING PREMIUMS IN THE MEDICAL MALPRACTICE INSURANCE INDUSTRY," Center for Justice and Democracy, July 2005.

While WATL has issues with many aspects of the Injured Patients and Families Compensation Fund (Fund), we believe the Fund's unique and progressive features—not the cap—have actually accounted for the decreases in malpractice premiums:

a) **Non-profit:** The Fund is not-for-profit. In contrast to private insurance corporations characterized by huge executive salaries, massive bureaucracies, and wild swings in premium rates contingent on stock and bond market investments, the Fund does not subject Wisconsin medical providers to these burdens.
b) **Universal:** The Fund is universal, covering virtually all health care providers in the state. Thus, the Fund draws upon a large pool of doctors to share the risk and hold down costs.
c) **Sharing the risk:** The Fund spreads the cost of insuring against risk across interrelated medical professions. It has only four classifications for doctors, not the 9 to 13 used by other malpractice insurers, allowing high-risk specialties not to bear an inordinately heavy burden for malpractice costs.

PIC's version of the Fund in its letter contradicts the very purpose of the Fund. Last session the legislature passed legislation which provided:

> **655.27 (6)** PURPOSE AND INTEGRITY OF FUND. The fund is established to curb the rising costs of health care by financing part of the liability incurred by health care providers as a result of medical malpractice claims and to ensure that proper claims are satisfied.

It does not say that the Fund is set aside only for "catastrophic" claims. It says that it should finance "part of the liability" costs. Above $500,000 is "part of the liability" costs.

Additionally, PIC's letter states that lowering the threshold to $500,000 would invade the "working layer" of insurance coverage. Then it states on page two that 98% of the claims it has closed over the past 18 years were attributable to payments of $500,000 or less. It would appear to us that having the Fund cover only 2% of the malpractice claims, would certainly meet the Fund's purpose.

The language used by PIC regarding defense costs follows in line with their very aggressive stance in defending claims. In fact, the Injured Patients and Families Compensation Fund (Fund) had to sue PIC-Wis because of their intransigence. *Wisconsin Patients Compensation Fund v. Wisconsin Health Care Liability Insurance Plan,* Appeal No. 95-0865, 200 Wis. 2d 599, 547 N.W.2d 578 (1996). Because of PIC's stance and the requirements of various Court opinions, the Fund has to hire counsel in every case when named as a defendant. Attached is a table compiled by Jeff Kohlman of the Fund, which shows the dramatic increase in loss adjustment expenses (legal fees)

over the last nine years. (Exhibit 1) PIC's argument that the Fund relies on the underlying malpractice carrier to defend its interest, is no longer true in most cases.

It was staggering to read that 40% of PIC's fees go toward defense costs. In contrast, the latest figures from the Fund shows that it spent just over $4 million dollars defending claims, paying just over $20 million to injured patients and their families, about a 25% rate. (Exhibit 2)

Perhaps the legislature should be considering ways to reduce defense costs in cases. In each case, at a minimum, the defense has two different sets of lawyers sitting at the table. If there are more than one defendant, then there are multiple sets of defense lawyers. In addition, each defendant has its own experts, so there are multiple experts in each case. This greatly increases the costs of defending lawsuits. It also increases the costs for the injured patient, who must often answer multiple court papers and travel across the country to depose the multiple expert witnesses. Perhaps the law should be changed to limit the number of defense lawyers in a case, or if the Fund is named and it determines itself to be at risk, it is designated the primary defense counsel and all activity in the case would be directed by them and limit the appearance at trial to one set of defense lawyers.

Finally, the PIC letter discusses the actuarial exposure for the Fund after *Ferdon*. The Fund now has almost *$750 million in assets*. In the past few years the Fund Board has lowered fees substantially, not because the actuaries hadn't predicted large claims, but because the Fund Board did not want a huge surplus, which was $24.6 million as of June 30, 2004. The fees doctors now pay into the Fund are over 50% lower than fees from 1986. In addition, in the last two years the Fund actuaries reduced the amount needed to pay claims by $177.4 million, or 20% of the Fund's value. That is a huge amount! (Exhibit 3)

PIC's letter also contradicts the letter the Task Force received from Commissioner of Insurance, Jorge Gomez on September 27. Gomez wrote, "A reduction in the liabilities placed in the private market will not impact the administration of the Fund."

Frankly, WATL hopes the legislature takes a more active interest in what the Fund actuaries recommend. For example, where does the $120 to $180 million figure PIC uses come from? We know that in the last 10 years there were nine verdicts that surpassed the unconstitutional cap. Adding together the amount the cap was exceeded in each case equals a figure of approximately $10.5 million. The $120 to $180 million figures are not based on reality.

Lowering the Fund threshold would have a positive affect on reducing overall malpractice costs in Wisconsin and should be the goal of legislators.

Sincerely,

David M. Skoglind
WATL President

The Fund also incurs loss expenses on claims with no Fund indemnity payments. Since the Fund now hires separate counsel on all claims, the number of claims closed without incurring any loss expense is rapidly declining. The following table shows the number of claims closed with no indemnity payments, both with and without loss expense payments, during fiscal 1997 through 2005 (through June 30, 2005). Also included are the number of claims closed with indemnity payments and the percent of claims closed with no indemnity payments during each fiscal year. Approximately $1.7 million of the fiscal 1998 loss expense amount can be attributed to the Fund v. St. Mary's Hospital of Milwaukee case.

CLAIMS CLOSED WITH NO INDEMNITY

FISCAL YEAR	# WITH NO LAE	# WITH LAE	AMOUNT OF LAE	TOTAL WITH NO INDEMNITY	CLAIMS CLOSED WITH INDEMNITY	PERCENT CLOSED WITH NO INDEMNITY
1997	176	39	$831,244.91	215	29	88.1%
1998	193	37	$2,386,783.73	230	18	92.7%
1999	138	28	$387,706.28	166	11	93.8%
2000	128	42	$835,313.34	170	33	83.7%
2001	142	39	$606,242.99	181	14	92.8%
2002	51	196	$1,298,895.79	247	25	90.8%
2003	15	207	$2,288,909.35	222	13	94.5%
2004	7	169	$2,849,229.00	176	12	93.6%
2005	2	140	$1,645,290.39	142	11	92.8%
ALL-TIME				4,321	612	87.6%

PATIENTS COMPENSATION FUND
FISCAL YEAR 2005 LOSSES AND LOSS EXPENSES PAID

(1) MONTH	(2) LOSSES PAID*	(3) LOSS ADJUSTMENT EXPENSE PAID**	(4) TOTAL
JULY 2004	$1,639,223.73	$525,415.31	$2,164,639.04
AUGUST 2004	$223.73	$188,143.35	$188,367.08
SEPTEMBER 2004	$436,849.46	$454,096.86	$890,946.32
QUARTER SUBTOTAL	$2,076,296.92	$1,167,655.52	$3,243,952.44
OCTOBER 2004	$1,738,364.49	$201,489.02	$1,939,853.51
NOVEMBER 2004	$223.73	$393,176.47	$393,400.20
DECEMBER 2004	$7,200,223.73	$362,450.10	$7,562,673.83
QUARTER SUBTOTAL	$8,938,811.95	$957,115.59	$9,895,927.54
JANUARY 2005	$2,800,223.73	$329,557.60	$3,129,781.33
FEBRUARY 2005	$223.73	$206,618.22	$206,841.95
MARCH 2005	$2,200,223.73	$507,043.72	$2,707,267.45
QUARTER SUBTOTAL	$5,000,671.19	$1,043,219.54	$6,043,890.73
APRIL 2005	$4,300,223.73	$177,846.71	$4,478,070.44
MAY 2005	$223.73	$276,523.73	$276,747.46
JUNE 2005	$223.73	$402,901.07	$403,124.80
QUARTER SUBTOTAL	$4,300,671.19	$857,271.51	$5,157,942.70
CUMULATIVE TOTALS	$20,316,451.25	$4,025,262.16	$24,341,713.41

*NET OF CONTRIBUTIONS RECEIVED. FUTURE MEDICAL EXPENSE AND INTEREST ON LOSSES PAID ARE INCLUDED IN THIS AMOUNT.
**INCLUDES ALLOCATED, UNALLOCATED, AND ATTORNEY FEES.

8/3/2005JK

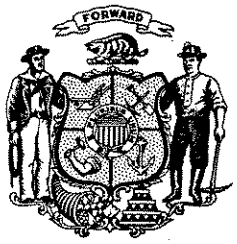
Exhibit 2

Wisconsin Injured Patients and Families Compensation Fund
History of Milliman Recommended Reserve Changes

(1)	(2)	(3)	
Financial Statement Date	Fund Published Reserve For Unpaid Losses and LAE	Subsequent Recommended Reserve Changes* $	% of (2)
June 30, 1988	$ 231,097,803	$ (13,760,945)	(6.0) %
June 30, 1989	258,248,357	830,732	0.3
June 30, 1990	290,323,281	5,773,156	2.0
June 30, 1991	335,093,478	(2,967,433)	(0.9)
June 30, 1992	362,988,314	(6,189,565)	(1.7)
June 30, 1993	390,171,374	(15,651,893)	(4.0)
June 30, 1994	440,322,232	(7,838,467)	(1.8)
June 30, 1995	497,979,560	4,253,498	0.9
June 30, 1996	544,791,109	(7,505,152)	(1.4)
June 30, 1997	594,630,074	(10,233,297)	(1.7)
June 30, 1998	638,730,618	(10,356,122)	(1.6)
June 30, 1999	693,118,316	(13,995,242)	(2.0)
June 30, 2000	748,661,611	(20,157,640)	(2.7)
June 30, 2001	786,453,837	(32,518,192)	(4.1)
June 30, 2002	818,994,479	(32,028,815)	(3.9)
June 30, 2003	873,139,152	(82,904,318)	(9.5)
June 30, 2004	880,444,510	(94,414,088)	(10.7)

* Based on one year of development

END



END

Sawyer, Julie

From: Smith, Bill [Bill.Smith@NFIB.ORG]
Sent: Thursday, October 06, 2005 4:51 PM
To: Rep.Gielow
Subject: Statement by David Skoglind, President, WI Academy of Trial Lawyers
Attachments: atra.cjd-air-medmal.doc

Rep. Gielow:

Today, the Wisconsin Academy of Trial Lawyers issued a news release that included statements by representatives of the American Tort Reform Association. As President of the Wisconsin Coalition for Civil Justice, I have worked closely for many years with ATRA's President Sherman Joyce and General Counsel Victor Schwartz, who were quoted in the release.

Unfortunately, the release from WATL failed to accurately embrace the facts about ATRA's position and the relationship between medical liability reform and health insurance costs and access.

Therefore, I am forwarding ATRA's response to these "intellectually dishonest" claims that seem to get repeated as fact by the opponents to medical liability reform.

Bill

<<atra.cjd-air-medmal.doc>>

Bill G. Smith
State Director
NFIB
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Madison, WI 53703

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Fax (608) 255-4909

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Web http://www.nfib.com/WI

Part of the general record.

ATRA **American Tort Reform Association**
1101 Connecticut Ave, NW ■ Suite 400 ■ Washington, DC 20036
(202) 682-1163 ■ Fax: (202) 682-1022 ■ www.atra.org

FOR IMMEDIATE RELEASE

Contact: Gretchen Schaefer
202-682-0084
gschaefer@atra.org

TORT REFORM OPPONENT ATTACK IS INTELLECTUALLY DISHONEST

Washington, DC, July 27, 2005—American Tort Reform Association (ATRA) President Sherman Joyce issued the following statement in response to a report issued by Americans for Insurance Reform and statements by members of Congress relying on that report:

"Americans for Insurance Reform, along with their affiliates who are closely tied with the personal injury bar, have consistently taken comments made a number of years ago about a totally different matter out of context in a desperate attempt to have a voice in the medical liability debate.

"Our nation is in the midst of a growing medical liability crisis. Nothing less than access to affordable healthcare for Americans is at stake. It is no coincidence that the crisis is most pronounced in those states that have not enacted meaningful medical liability reforms. Anyone with common sense would appreciate that placing rational limits on liability will cut the cost of claims. That, in turn, will reduce the cost of insurance. Presenting contrary information to the public and Congress is intellectually dishonest. Our position on medical liability and the effect of insurance and access to healthcare is clear and has been consistent.

"Limits on noneconomic damages for medical liability will help keep doctors where their patients need them. H.R. 5, which is scheduled to be considered by the U.S. House of Representatives this week, includes a $250,000 limit on noneconomic damages and is modeled after California's successful Medical Injury Compensation Reform Act. That law, which was enacted in 1975, has helped to keep California's medical liability insurance rates among the lowest and most stable in the nation. This, in turn, keeps doctors in the state.

"In states without medical liability reform, the cost of litigation has resulted in higher and often unaffordable medical liability premiums, which has forced doctors to retire early, cease performing high-risk procedures or move to more stable states. This has resulted in an access to healthcare crisis in 20 states, according to the American Medical Association, although Texas was removed from that list this year due to its medical liability law enacted in 2003.

"Since passing the 2003 reforms in Texas, which includes MICRA-style provisions, 13 new insurance companies have entered the state, the state's largest medical liability insurer reduced premiums by 17 percent, and the number of doctors being recruited to the state is increasing. Meanwhile, in Mississippi, where a similar law was enacted in 2004, medical liability premiums have stabilized after rising as much as 20 percent in prior years.

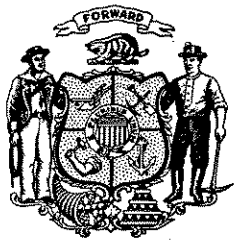
"We need a solution to the medical malpractice crisis, and it must include medical liability reform. If our opponents continue to twist our words to their advantage, we will continue to respond, but their dishonest approach fails to get to the heart of this debate," Joyce concluded.

# # #

The American Tort Reform Association (ATRA) is the only national organization dedicated exclusively to tort and liability reform through public education and the enactment of legislation. ATRA's membership includes nonprofits, small and large companies, as well as state and national trade, business, and professional associations.

www.atra.org

END



END

THE DOCTORS COMPANY

Government Relations Department Memo

TO: **Public and Private Sector Members of ALEC's Joint Civil Justice and Health and Human Services Subcommittee on Medical Liability Reform**

FROM: **Sal Bianco, Director**
Government Relations Department of The Doctors Company and Joint Subcommittee Private Sector Chair

CC: **Kristin Armshaw, Civil Justice Task Force Director**
Christie Raniszewski Herrera, HHS Task Force Director

DATE: **11/3/05**

RE: **Further Explanation of the Proposed Provisions of an ALEC Model Act on Medical Liability Reform**

- **INTRODUCTION**

In June of 2004, I submitted a lengthy memorandum on a proposed ALEC Model Act addressing medical liability reform to the HHS Task Force. Under separate cover, a copy of the memorandum has been revised and addressed to you – the Joint Subcommittee members. It, along with this memo, is being distributed prior to our Joint Subcommittee November 8th Telephone Conference Call.

In further preparation for the November 8th Telephone Conference Call, I have prepared this memorandum to provide you with a further explanation of the September 27th Memo on the proposed Model Act provisions that was sent to you.

- **PROPOSAL**

With the myriad of legislative proposals on medical liability reform, it is not a difficult task to "take from the best" and develop a model act on medical liability reform. Reliance on current laws, many of which have been determined to be constitutional, and on legislative measures enacted by state legislatures serve as the basis for the language in the proposed model act.

- **"TAKING FROM THE BEST" – A PROPOSED PROCESS FOR DEVELOPING THE MODEL ACT SECTION BY SECTION**

1. We can start with Texas and its successful medical liability reform statute, which was strengthen by a statewide vote of the people on limitation of damage awards. This section would not limit

economic damage awards. However, it places a limit of $500,000 on economic damages in a wrongful death action and is adjusted annually for inflation. The cap on punitive damage would not apply in cases for certain felonies, including fraudulent destruction or concealment of written or electronic records.

2. We can add to its statutory provisions using reforms from California that will enhance the model. This section gives us the basic ingredients for effective medical liability reform.
   - First, there is a limitation of $250,000 without exception for payment of non-economic damage awards.
   - Second, periodic payments of future economic damage awards in excess of $50,000 are permitted. Either party is allowed to request such an order from the court. If the plaintiff dies, the court must modify the future economic damage award. Damage awards for future loss of earnings cannot be reduced because the plaintiff dies.
   - Third, a collateral source offset using the evidentiary standard to prevent "double dipping" is established. Both the plaintiff and defendant can offer evidentiary evidence to prove receipt of benefits or prove costs to secure the benefits. No provider of benefits can recover from the plaintiff or through subrogation from the defendant.
   - Fourth, an attorney contingency fee schedule is established. The schedule limitation applies whether the recovery is based upon a settlement, arbitration or judgment.
   - Fifth, an alternative dispute resolution process can occur based upon a contract. There is no requirement that a medical malpractice claim be arbitrated prior to litigation.
3. Looking to Maine will provide the language on a pre-litigation medical screening & mediation panel. This section provides that before a claim is filed, a complaint must be filed with the pre-litigation screening and mediation panel. All the parties may agree to waive the pre-trial screening process. And, all parties may agree in writing to submit the claim to a binding decision of the panel. The parties may agree to hear some issues by the panel and some issues by the court. Regarding dispositive issues, the panel can not decide them and the panel chair may request a court to hear the issues prior to the panel's hearing. Panel findings and disclosures during the hearing remain confidential, unless the panel decision is unanimous in favor of either party.

4. Washington or Arizona could provide language on dealing with a state constitutional prohibition against limiting damage awards. The section states that if a state constitution prohibits a limitation on damages, the legislature by majority vote may place a ballot measure before the statewide voters at the next primary or general election which allows the legislature to enact a statute limiting the award of damages.
5. Expert witness standards could come from Alabama or from Texas. In this section, the plaintiff must prove medical negligence through the use of expert testimony. Foreign objects left in the body after surgery or an injury remote from the part of the body that received medical treatment do not require such testimony. An individual is a qualified expert witness if the individual is a physician with board certification or other substantial experience relevant to the claim and is practicing or teaching medicine in an area that is relevant to the medical malpractice claim. Within 90 days of claim filing, the plaintiff must post a bond or file an expert witness report for each defendant. Within 180 days of claim filing, the plaintiff must provide to the defendant the expert witness report(s) and the curriculum vitae for each expert.
6. Statute of limitation language could come from Kansas. This section requires a medical malpractice action be brought within two years after the injury becomes reasonably ascertainable but no more than four years can elapse. If the plaintiff is a minor, incapacitated, or imprisoned, an action must be brought within a year from the date that the disability is removed but no more than eight years can elapse. In wrongful death actions, there is a two-year limitation but the period commences to run at the date of the injury or its discovery which can occur prior to the date of death.
7. Joint and several liability provisions could come from Arizona. This section abolishes the doctrine of joint and several liability. A defendant is only severally liable for the amount of the plaintiff's damages equal to the percentage of fault. Exceptions are where the defendant(s) is in a principal-agent relationship, act in concert, or pursue a common plan or design to commit a negligent act and actively takes part in the act.
8. Dealing with various forms of immunity from sovereign to rendering emergency care could come from Nevada, Virginia, Alaska, and Florida and from Oklahoma. In this section:
   - State institutions and its employees are only liable for $50,000 in damages exclusive of pre-judgment interest. The damage

award cannot include amounts for exemplary or punitive damages. A government entity does not waive its sovereign immunity through the purchase of insurance coverage. A plaintiff must file an action within two years after the cause of action accrued.

- The state and its academic institutions cannot be sued if the action is based upon an act or omission by a state employee exercising due care in performing a discretionary function or duty.
- Municipalities are immune in their performance of governmental functions, which includes the operation of a city or county hospital or medical facility.
- A charitable entity is not liable for negligent acts of its agents, including rendering charitable medical services.
- A person or hospital that renders emergency care to a person in immediate need is not liable for damages as a result of an omission or act in rendering the emergency care.
- A plaintiff who obtains an unenforceable judgment above the monetary limit can petition the state legislature for a "claim bill" granting the payment of public monies to pay the amount above the limit.

9. Prejudgment interest calculation language could come from Washington and from Massachusetts. In this section, prejudgment interest accrues from the time of the loss and is paid upon the entire jury verdict award.
10. Placing a limit on punitive damage awards could be provided by North Carolina and by Texas. This section provides that punitive damages are capped at three times the amount of economic damages not to exceed $250,000, whichever is greater. This cap does not apply for specific felonies – murder, capital murder, aggravated kidnapping and assault, sexual assault, injury to a child, elderly or disabled person, forgery, commercial bribery, theft, intoxication assault or manslaughter.
11. Handling the issue of comparative and/or contributory negligence could be provided by Connecticut, Delaware and Arizona. This section could provide two choices:
    - Adopting a modified comparative negligence doctrine would mean that a plaintiff's recovery is barred if his or her negligence exceeds the combined negligence of all defendants. If not, then the plaintiff's recovery is reduced in proportion to his or her degree of negligence.

- Adopting a pure form of comparative negligence doctrine would mean that the plaintiff's award is reduced in proportion to his or her relative degree of fault. A court or jury has discretion to bar recovery if the plaintiff willfully or wantonly caused or contributed to the death or injury.

12. Addressing the issue of ostensible agency could come from Indiana. In this section, a hospital may be liable for physician negligence who is acting as an known independent contractor. Hospital liability rests on whether or not the hospital provided a written notice at the time of the plaintiff's admission that the physician is an independent contractor and not an employee of the hospital.
13. Looking forward, we can incorporate provisions designed to reduce litigation, such as Oklahoma's recent legislative enactment and usage by physicians entitled "I'm sorry" where the patient and/or family learns of the circumstances surrounding the injury. In this section, all "I'm sorry" gestures are inadmissible as evidence of an admission of liability. Gestures are defined to include all statements, affirmations, gestures, or conduct by a health care provider or a provider's employee that express sympathy, condolence, and benevolence regarding pain, suffering, or death which follows an unanticipated medical care outcome.
14. The September 27, 2005 document sets forth Texas statutes on comparative negligence, joint and several liability which have already been addressed in other sections of the proposed model act. However, Texas statutes on right of contribution and alternative dispute resolutions offer potential language. This section can be divided into three parts.
    - First, it can provide that all joint defendants have a right of contribution in medical malpractice actions.
    - Second, it can authorize counties to establish alternative dispute resolution systems with standards for mediation, mini-trials, moderated settlement conferences, summary jury trials, and arbitration to be established by state statute.
    - Third, health care providers are prohibited for requiring or requesting a patient sign an arbitration agreement without providing to the patient a prescribed written notice form. The form must provide for a signature by the patient's attorney to be valid.
15. Reducing the number of frivolous lawsuits can come from Louisiana's medical review panel revised statute. This section is

coordinated with Section 3 on a pre-litigation medical screening and mediation panel.

- In this section 15, a medical review panel is established with four members – an attorney and three health care providers holding unlimited licenses to practice medicine in the state. The key to frivolous lawsuit filing is a requirement that the plaintiff has forty-five days from the mailing date of the confirmation of receipt of a request for review to pay a filing fee of $100 per named defendant. The filing fee can be waived if an affidavit is received signed by a physician with an unlimited license to practice in the state which certifies that adequate medical records have been obtained and reviewed which constitute a claim for breach of the applicable standard of medical care for each named defendant. Failure to comply renders the request to the panel invalid. If the plaintiff identifies other defendants, the $100 per defendant filing fee applies. There are specific procedures for the operation of the medical review panel.

16. Section 2 proposes the use of California's contingency fee schedule which means the following: in a $1 million judgment the plaintiff's attorney receives $221,000 plus payment for all reasonable expenses in handling the case; in a $250,000 judgment where there is only a noneconomic damage award and no economic damage award, the plaintiff's attorney receives $70,000 plus payment for all reasonable expenses.
    - If a more restricted approach is preferred, then we can look to Florida. This section 16 would replace Section 2's provision on a contingency fee schedule as follows: The plaintiff is entitled to no less than 70% of the first $250,000 in all damages received, exclusive of reasonable and customary costs, whether received by judgment, or otherwise, and regardless of the number of defendants. The plaintiff is entitled to 90% of all damages in excess of $250,000, exclusive of reasonable and customary costs regardless of the number of defendants. This means that in a $1 million judgment the plaintiff's attorney receives $150,000 plus payment for all reasonable expenses in handling the case; in a $250,000 judgment where there is only a noneconomic damage award and no economic damage award, the plaintiff's attorney receives $75,000 plus payment for all reasonable expenses.
17. Reducing pre-trial costs and ensuring qualified specialists can come from a strong and effective certificate of merit procedure.

Texas has been one of the states to look to in this regard along with input from experienced claims handling experts.

- This section is coordinated with Section 5 on expert witness standards. In this Section 17, the court must appoint a qualified specialist within 30 days of filing a lawsuit. Both parties must agree upon a qualified specialist from either side. Failure to agree, allows the court discretion to make the appointment.
- The plaintiff's attorney must be given 90 days to obtain the certificate of merit/affidavit in cases where the period to file the claim is due to expire because of the statute of limitations.
- The qualified specialist has 45 days to submit to the court an affidavit containing an opinion on the merits of the pending case. The merit opinion affidavit must be submitted for each defendant in the lawsuit. The affidavit must set forth specific breaches in the standard of care and outline the negligence causation. The signer of the affidavit must be subject to discovery. If the plaintiff decides to withdraw the expert(s), the defendant remains entitled to discover what the individual(s) would have opined. The affidavit is not admissible in trial, arbitration or any court proceeding.
- A qualified specialist is defined. The qualified specialist must be of the same medical specialty or subspecialty as the defendant and board certified. The qualified specialist must sign the affidavit. This applies to a defendant who is a general practice physician or a physician practicing in a medical specialty or subspecialty.
- If the qualified specialist's affidavit finds there is no reasonable or meritorious case and the plaintiff does not substantially prevail by judgment, settlement, mediation, arbitration or other form of alternative dispute resolution, the court must order the plaintiff or plaintiff attorneys to pay the defendant(s)' costs and reasonable attorney fees. The plaintiff and his or her attorneys must share in the liability to pay the incurred costs and fees.
- The court is required to enforce the certificate of merit/affidavit procedure. If a case if filed without a certificate of merit/affidavit, dismissal of the case is automatic without an extension permitted under the applicable statute of limitation exemption provision.

- **PROPOSED TIMELINE**

The Committee would be able to complete its work within a time period which would allow for the draft model act to be distributed to the HHS Task Force in advance of ALEC's December 2004 Meeting. This would allow for full consideration by our Task Force and action in December. If adoption of the model act would occur, ALEC's Board of Directors would have the opportunity to consider adoption in time for ALEC public sector members to utilize its provisions for introduction and consideration in state legislative sessions occurring within the initial six months of calendar year 2005.