WISCONSIN STATE LEGISLATURE COMMITTEE HEARING RECORDS

2005-06
(session year)

Assembly
(Assembly, Senate or Joint)

Task Force on Medical Malpractice (ATF-MM)

Sample:

Record of Comm. Proceedings ... RCP
- 05hr_AC-Ed_RCP_pt01a
- 05hr_AC-Ed_RCP_pt01b
- 05hr_AC-Ed_RCP_pt02

- *Appointments ... Appt*
- **

- *Clearinghouse Rules ... CRule*
- **

- *Committee Hearings ... CH*
- **

- *Committee Reports ... CR*
- **

- *Executive Sessions ... ES*
- **

- *Hearing Records ... HR*
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- *Miscellaneous ... Misc*
- **05hr_ATF-MM_Misc_pt26**

- *Record of Comm. Proceedings ... RCP*
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WISCONSIN PATIENTS COMPENSATION FUND

REPORT TO THE JOINT LEGISLATIVE AUDIT COMMITTEE

EXECUTIVE SUMMARY

PREPARED BY: SPECIAL COMMITTEE OF THE BOARD OF GOVERNORS

JUNE 13, 1994

WISCONSIN PATIENTS COMPENSATION FUND

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REPORT TO THE JOINT LEGISLATIVE AUDIT COMMITTEE

INTRODUCTION

At its meeting of February 24, 1993 the Board of Governors of the Wisconsin Patients Compensation Fund (Fund) formed a Special Committee to respond to the findings of the Joint Task Force formed by the State Medical Society of Wisconsin (SMS) and the Wisconsin Hospital Association (WHA) to study the Fund's purpose and operations.

At its meeting of September 22, 1993 the Board expanded the charge of the Special Committee to include responding to concerns raised by the Wisconsin Legislative Audit Bureau in its report on the Fund's financial condition as of June 30, 1992.

The Special Committee was comprised of six members, all of whom also serve on the Fund's Board of Governors:

- Wayne Ashenberg, Chairperson
  Insurance Industry Representative
- Mark Adams
  State Medical Society
- William McCusker
  Wisconsin Academy of Trial Lawyers
- Michael Shoys
  Wisconsin Hospital Association
- Sondra Streckert
  Public Member
- Jack Strong, M.D.
  Public Member

Also participating in the Special Committee meetings were Danford Bubolz, Andrea Nelson and Thomas Ryan (representatives of the Fund), Nancy Rottier (Research Director for the Wisconsin Academy of Trial Lawyers), Thomas Daley (Wausau Insurance Group, the claims administrator for the Fund), and Robert Sanders and Chad Karls (representatives of the Fund's consulting actuaries, Milliman & Robertson, Inc).

The Special Committee met seven times in preparing its report to the Joint Legislative Audit Committee:

- October 13, 1993;
- November 17, 1993;
- February 9, 1994;
- March 23, 1994;
- April 26, 1994;
- May 24, 1994; and
- June 9, 1994 (via teleconference).

Minutes of these meetings are attached as Appendix A.

This report is intended to summarize the Committee's findings and recommendations, and to highlight the key points of its deliberations. Additional background information and supporting documents are available from Fund management.

SUMMARY & RECOMMENDATIONS

During its discussion, the Committee was guided by two major considerations. The first was the SMS/WHA Joint Task Force recommendation that the basic structure of the Fund be maintained, as reflected in the following excerpt from their report:

> "Our Task Force recommends that in today's environment, considering the Fund's deficit and the status of tort reform efforts, the existing basic structure of the Patients Compensation Fund be continued. While it is not our recommendation to discontinue the Fund, we did discuss the implications of doing so. We believe the benefits of the Fund currently outweigh the deficiencies. We believe that the deficiencies can and should be addressed within the Fund structure as it exists today. We also recognize that enactment of meaningful tort reform could impact on the need for the Fund or allow significant changes to be made to it at some time in the future."

The Committee's second major consideration was previous actions taken by the Board of Governors regarding the intent of the Fund, including:

- Maintaining an injured party's right of recovery, which includes the unlimited nature of the Fund;
- Recognition of the national concern regarding the inflationary nature of health care costs;
- Providing full funding for all current and future liabilities of the Fund, recognizing that the Fund deficit is to be addressed as a long-term issue; and
- Minimizing the administrative burden and the cost to the citizens of the state of Wisconsin in the operation of the Fund.

Within this framework, the Committee is making four recommendations, each intended to reduce the Fund deficit and/or improve the Fund's operations:

Recommendation 1: **Implement a 25 year Amortization Schedule to Retire the Deficit**

In recommending that the Fund implement a 25 year amortization schedule, the Committee proposes an approach that would include long-term consistent and direct deficit reduction. By implementing an amortization schedule the Fund would be able to continue to offer occurrence coverage. Furthermore, the administrative requirements of implementing an amortization schedule would be manageable given the Fund's current staffing constraints. The Special Committee voted unanimously in recommending the amortization schedule.

Recommendation 2: **Introduce a Cap on Non-Economic Damages of $250,000**

In recommending that a cap of $250,000 be imposed on non-economic damages, the Committee proposes a change in the statutes that they believe would address an elemental and necessary change in the tort system for resolving medical malpractice claims. In changing the statutes to impose a cap on all claims that have not yet been *filed*, this provision would reduce the existing published deficit which reflects all claims that have *occurred* regardless of whether or not they have been filed. The Special Committee voted to support recommending a cap on non-economic damages of $250,000 with Mr. McCusker casting a dissenting vote.

Recommendation 3: **Pursue Statutory Changes to Allow for Periodic Payments of Future Medical Expenses**

In recommending that future medical expenses be paid on an as incurred basis, the Committee proposes a change in the statutes that they believe would benefit both the patient and the Fund. The patient would benefit by receiving medical payments for as long as needed, and thereby not taking on the risk of exhausting the amount received via a settlement. The Fund should benefit by not having to pay out future medical expenses in a lump sum payment and thus preserving its asset base (and potential investment income). Furthermore, if the patient does not live as long as anticipated or actual medical expenses fall short of expected levels, the amount of money that is set aside to pay for the patient's anticipated future medical expenses would revert back to the Fund. The Special Committee voted unanimously in recommending the periodic payment provision for future medical expenses.

Recommendation 4: **Pursue Statutory Changes to Impose a Minimum Fee Level**

In recommending that a minimum level be set on Fund fees, the Committee proposes a statutory change that would help to ensure that the deficit would not increase in the future. The minimum fee level would be set equal to the actuarially determined break-even fee level as approved by the Board of Governors. The Special Committee voted unanimously in recommending to impose a minimum fee level.

BACKGROUND

The first charge of the Special Committee was to address the issues raised by the State Medical Society/Wisconsin Hospital Association Joint Task Force Report.

In early 1991, the State Medical Society (SMS) and the Wisconsin Hospital Association (WHA) formed a Joint Task Force to study the Wisconsin Patients Compensation Fund. The Task Force was broadly charged to examine all aspects of the purpose and operations of the Fund.

In January of 1992, the Task Force released its "Report and Identification of Issues for Study" (attached as Appendix B). While the Task Force recommended that the basic structure of the Fund be maintained, it also identified 17 issues for potential improvement in the Fund's operation. This list of 17 issues was categorized into four major areas of concern:

- Tort reform is a key system modification essential to stabilize medical liability premiums and awards and should be strongly supported. Specifically, a cap on non-economic damages, a shortened statute of limitations to two years, and a system of periodic payments should be

pursued. In addition, the Board should re-evaluate the value and acceptability of some form of panel system for resolution of disputes;

- The Board should address inequities and inconsistencies in Fund costs and access to Fund coverage. Specifically, the Board should examine the following areas from the perspective of fairness, social impact and actuarial soundness:
  - ► The availability and cost of Fund coverage to part-time and temporary practitioners;
  - ► The discount provided to certain classes of providers (example: MCW physicians);
  - ► The applicability of mandatory Fund coverage to currently ineligible classes of providers;
  - ► The availability and cost of Fund coverage for governmental entities or their employees;
  - ► The justification for four versus more fee categories for physician providers; and
  - ► The availability and cost of Fund coverage for those providers covered by Fund corporate coverage but who are not individually assessed;
- The Board should study the benefits and adverse implications of making changes to the Fund structure, specifically:
  - ► Moving the primary coverage levels from $400,000 to $1 million; or
  - ► Imposing caps on Fund coverage; and
- The Board should seek regular customer input about the administrative effectiveness and responsiveness of the Fund. Sufficient financial and support resources should be provided to enable the Fund to meet and anticipate its customer needs and expectations.

The second charge of the Special Committee was to prepare a report responding to the Wisconsin Legislative Audit Bureau's concern regarding the Fund deficit.

By statute, the Wisconsin Legislative Audit Bureau (LAB) is responsible for conducting a financial audit of the Fund at least once every three years. In July of 1993, the LAB released its report (attached as Appendix C) covering the Fund's three fiscal years July 1, 1989-90, July 1, 1990-91 and July 1, 1991-92. While the LAB was able to issue an unqualified auditor's report on the Fund's financial statements' fairness of presentation, it did express concerns regarding the Fund deficit:

"One of the most significant concerns facing the Fund is an accounting deficit, which reflects the approximate amount that would not be available to pay estimated claims if the Fund were to cease operations and collect no additional fees. Although the deficit declined to $71.7 million at the end of fiscal year 1990-91 after reaching a high of $122.7 million in fiscal year 1987-88, it again reversed direction and increased to $79 million in fiscal year 1991-92, and it is likely to continue increasing in the future unless additional steps are taken.

Some argue the Fund's financial picture is not as bleak as the accounting deficit would suggest because the Fund had a cash and investment balance of over $197 million as of June 30, 1992. However, the Fund's continued ability to increase or even maintain investment balances in the long term becomes uncertain as annual amounts paid out in claims increase. The Fund paid almost $44 million in claims and related expenses in fiscal year 1991-92 and is expected to pay almost $49 million during fiscal year 1992-93. Previously, the largest amount of claims and related expenses paid in one year totaled $26 million. Settlements of $7.6 million, $8.5 million, and $18 million within the last two years, compared to a previous high of $4.8 million, increase the likelihood of larger claim payments in the future.

Although it is difficult to predict the Fund's future cash flows because of the inability to predict future claim settlements, we project the Fund's cash and investment balance could begin declining within the next 10 years and the Fund could experience cash flow problems within the next 15 to 20 years, if current claim trends continue and the health care providers' annual fees remain at the fiscal year 1993-94 fee level. Although potential cash flow problems appear to be a long-term concern, they will be difficult to address in the future unless additional steps are taken soon to control the accounting deficit. Further, it is unclear what effect national health care and medical malpractice reform efforts may have on the Fund. However, if the reform efforts eliminate the need for the Fund, the ability to pay the Fund's existing liabilities could become a more immediate concern.

Therefore, it is important that the Board of Governors and the Legislature continue to monitor and assess the need for measures to address the deficit. The Board is establishing a study group, which will consist of members of the Board and Fund staff, to evaluate different alternatives for addressing the deficit. The study group will be expected to report to the full Board by March 1994, at which time the Board will consider what steps to pursue. *We recommend the Board of Governors report the results of its study committee and the Board's planned steps to address the deficit to the Joint Legislative Audit Committee by June 30, 1994.* "

As a point of reference, the Special Committee noted that the LAB's observations were based on the Fund deficit as of June 30, 1992 of $79.0 million. Since that time, the Fund deficit has declined to $69.7 million, as summarized below:

Financial Statement Date	Published Fund Deficit
June 30, 1992	$78,982,681
June 30, 1993	70,455,165
June 30, 1994	69,688,796*

*Estimated

The Special Committee also noted that the Board of Governors approved a 7.1% increase in the fee levels for the Fund's July 1, 1994-95 fiscal year, which represents the actuarially indicated break-even fee level. Thus, no increase in the deficit is anticipated during the July 1, 1994-95 fiscal year.

ACTIONS TAKEN BY THE BOARD TO REDUCE THE DEFICIT

At the Committee's request, Fund management prepared an historical summary of actions the Board of Governors has taken to monitor and reduce the deficit. This summary included actions the Board has taken with regards to:

Fee level increases

In nine of the last 14 years the Board has adopted a fee level increase in excess of the actuarially determined break-even level in an attempt to reduce the deficit.

Investment activity

In February of 1990, the Board sought and received statutory changes which allowed the Fund greater flexibility in its investment practices. Prior to this change, the Fund's assets were invested in short-term, fixed-return, interest-bearing instruments. Since initiating a long-term portfolio in September of 1990, it is estimated that the Fund's investment returns through March 31, 1994, were $28.3 million higher (including $8.6 million of realized capital gains) than what would have been earned if all assets had continued to be invested in the short-term account.

Tort reform

The Board has monitored the effect of the 1985 Wisconsin Act 340 provisions as it relates to a noneconomic damage cap and increases in the Fund's threshold.

Risk Management

As a long-term quality improvement and deficit reduction initiative, the Fund entered into a contract for risk management consultation in 1990. The Board has recently approved clinical

strategies for emergency, perinatal, and anesthesia specialties. The risk management program is actively reviewing practice areas resulting in high frequency or severity of claims. The purpose is to develop risk management strategies to effectively modify provider practices or behavior to minimize or eliminate these claims. Reduction or elimination of these claims will help to improve the Fund's financial position while at the same time improving the quality of care for Wisconsin patients.

Other Administrative Actions

The Special Committee noted that Fund staffing levels increased in 1992 by two permanent positions to assist the Fund with its administrative duties, primarily billing and certificate compliance matters. Further, the Fund's operations were converted in 1992 to a state-of-the-art, on-line, computerized provider/claims system. This new system has greatly improved the Fund's operations, including quicker access to information necessary for management analysis and decision-making.

Based on the above, it is the opinion of the Special Committee that the Board has acted reasonably and responsibly in its attempts to address the deficit.

HISTORICAL PERSPECTIVE ON THE FUND DEFICIT

At the Committee's request, Milliman & Robertson (M&R) prepared an historical summary of the published Fund deficit as of the close of each fiscal year (attached as Appendix D). In interpreting the history of the published Fund deficit, changes in the deficit from one year to the next are influenced by at least four factors:

- The relative adequacy of the assessment levels approved by the legislature;
- Changes in previous actuarial projections of the Fund's ultimate claim costs;
- Changes in interest rate assumptions; and
- Catastrophes (i.e., large claims such as the Ready v. Yap case).

In order to provide the Committee with a more consistent history of the deficit, M&R prepared a "hindsight" restatement of the deficit, which reflects:

- A consistent set of actuarial projections used across all years (specifically, the M&R projections as of September 30, 1993);
- A consistent yield assumption for discounting the unpaid claim liabilities (specifically, the 7.0% yield adopted by the Board for the Fund's financial reporting as of June 30, 1994); and
- The impact of large claims assigned to the fiscal year in which they occurred, rather than the fiscal year in which their impact emerged.

The hindsight restatement of the Fund deficit indicates that the Fund deficit peaked at $122.6 million as of June 30, 1986 and steadily declined from that point through June 30, 1992. While the hindsight deficit did increase by $5.2 million during the July 1, 1992-93 Fund year and is projected to increase by $5.8 million during the July 1, 1993-94 Fund year, it is M&R's opinion that the projected Fund deficit of $69.7 million as of June 30, 1994 is primarily attributable to the Fund's first 11 years of operation (i.e., from inception through June 30, 1986).

M&R identified at least four factors that led to the accumulation of the hindsight deficit of $122.6 million as of June 30, 1986:

- At inception, the Fund's financial statements were maintained essentially on a "cash flow" basis. In March of 1980 the statutes were revised to require the Fund's balance sheet to reflect a full accrual of its unpaid claim liabilities, discounted to their present value. Thus, it is important to recognize that until March of 1980, the Fund's financial statements did not reflect any deficit due to the then-perceived "pay as you go" nature of the Fund. M&R's analysis indicates that, on a hindsight basis, and based on the current accounting guidelines, the Fund deficit had grown to $48.9 million by June 30, 1980;

- At inception, the Fund's fee levels were established based on a percentage of the rates charged by the Wisconsin Health Care Liability Insurance Plan (WHCLIP) for primary coverage. The fee levels had two constraints:

  - They could not exceed 10% of the WHCLIP rates; and

  - The Fund could not accumulate more than $10 million in assets.

  These statutory restrictions were removed in March of 1980, but M&R believes they contributed to the accumulation of the hindsight deficit;

- The claims experience for medical malpractice in Wisconsin deteriorated significantly from the Fund's inception through June 30, 1986. Excluding the impact of the Ready v. Yap case, M&R's projections indicate that the Fund's claim costs increased by nearly 500% during its first 11 years, representing an annual increase of 19%. This was driven by an unexpected surge in the number of malpractice claims filed in Wisconsin, which increased by 200% between 1975 and 1983. This phenomenon was not isolated to Wisconsin, as countrywide summaries of medical malpractice experience reflect a similar pattern; and

- The Ready v. Yap claim was settled in May of 1993 for $19.1 million (including defense costs), which is the largest claim in the Fund's history. This claim occurred during the July 1, 1985-86 Fund year, and thus also contributed to the accumulation of the hindsight deficit of $122.6 million through June 30, 1986.

After peaking at $122.6 million as of June 30, 1986, the M&R analysis indicates that each of the next six Fund years' operations (i.e., the July 1, 1986-87 through July 1, 1991-92 Fund

years) made a significant contribution toward reducing the deficit. M&R attributes this improvement to at least three factors:

- A dramatic shift in the claims environment for medical malpractice coverage in Wisconsin, highlighted by a decline in the number of claims being filed. This reduction in claim frequency was also occurring on a countrywide basis;

- The benefit of the statutory increases in the Fund threshold that occurred on July 1, 1987 and July 1, 1988 as part of the 1986 tort reform (Wisconsin Act 340); and

- The statutory changes in February of 1990 which allowed the Fund greater flexibility in its investment practices. M&R has estimated that the Fund earned $28.3 million of additional investment income through March 31, 1994 due to this statutory change.

M&R's analysis indicates that this pattern of steady reduction in the Fund deficit was reversed in the latest two Fund years (July 1, 1992-93 and July 1, 1993-94). M&R attributes this to the final fee levels adopted for both of these years being below the "break-even" fee level indications.

Finally, in six of the last nine years the final fee levels approved by the legislature were less than those recommended by the Board of Governors, and the Committee asked that M&R estimate what the current Fund deficit would be if the legislature had approved fees during these years based on:

- The M&R "break-even" recommendations;

- The M&R recommendations to the Underwriting & Actuarial Committee;

- The Underwriting & Actuarial Committee recommendations to the Board of Governors; and

- The fee levels approved by the Board of Governors.

The table below shows the combined impact that the additional assessment income and investment income under each set of recommendations would have had on the Fund deficit, which is estimated to be $69.7 million as of June 30, 1994:

Fund Fees Based On	Projected Fund Surplus/(Deficit) @June 30, 1994
M&R Break-Even	$(65,877,000)
M&R Recommendation	23,046,000
Committee Recommendation	28,817,000
Board Recommendation	29,450,000
Legislative Approval	(69,689,000)

In order to properly interpret the table above, a distinction must be made between the M&R break-even recommendations versus the other three recommendations. The fees implicit in the M&R break-even recommendation each year were intended to keep the deficit at its *then current* level and did not contemplate any deficit reduction. The table above shows that, had the Fund fees since July 1, 1985 been based on the M&R break-even recommendations, M&R estimates the Fund would currently be in a deficit position of $65.9 million. Assuming no change in the other factors driving the deficit (e.g., actuarial projections, interest rate assumptions, or large claim settlements), M&R would expect that the projected deficit of $65.9 million be near the published deficit as of June 30, 1985 of $79.6 million. M&R attributes the difference to changes that have occurred over the nine year period to the actuarial projections, interest rate assumptions and recent large claim activity.

In reviewing the M&R analysis, the Committee concluded that the impact of legislative oversight did not contribute to the deficit. However, the Committee believes that it did impede the Board's ability to retire the deficit.

EVALUATION OF OPTIONS FOR RETIRING THE DEFICIT

In addressing the issue of deficit reduction, the Joint Task Force Report served as the basis for the Special Committee's discussions. With this report as their foundation, the Committee identified eight options for retiring the Fund deficit which are discussed below.

Discussion of Recommended Options

The Board of Governors has consistently taken the position that the deficit is a long-term issue, and the four options recommended by the Committee for retiring the deficit are consistent with the Board's position:

- Collect additional fees each year for deficit reduction based on a long-term amortization schedule;
- Introduce a cap on non-economic damages;
- Pursue statutory changes to enable the Fund to pay out future medical expenses on a periodic basis as opposed to a lump sum; and
- Pursue statutory changes so that Fund fees must reflect at least the actuarially determined break-even fee level.

Three of the four recommended options received the unanimous support of the Special Committee, while the recommendation relating to capping non-economic damages reflects the

majority opinion of the Committee. The Committee's discussion of each of these recommended options is summarized below.

Amortization Schedule to Retire the Deficit

The Committee felt that the first option for retiring the deficit to be evaluated should be the easiest to understand and the easiest to implement. Because of this, the Committee asked M&R to prepare the following amortization schedule to retire the deficit over several timeframes:

Years to Retire the Deficit	Annual Contribution for Deficit Reduction*
1	$47,458,070
5	10,817,366
10	6,314,917
25	3,805,983
50	3,213,836

*Based on the projected Fund deficit of $69.7 million

To put these additional fee levels in perspective, in order to retire the deficit in twenty-five years the $3.8 million of additional fees each year represents a 7.4% increase over the current fee levels. In other words, if the twenty-five year amortization of the deficit would begin on July 1, 1994 the break-even fee levels would have required a 14.5% increase instead of the 7.1% that was adopted by the Board of Governors.

If the Fund were to implement an amortization schedule to retire the deficit, the Committee noted the following advantages:

- Maintains occurrence coverage;
- Consistent progress towards deficit elimination; and
- Ease of implementation.

The Committee also noted the following disadvantages of an amortization schedule:

- Collecting fees in excess of the actuarially determined break-even fee level; and
- Future generations of physicians paying for past generations' accumulation of the deficit.

In recommending that the Fund implement a 25 year amortization schedule, the Committee proposes an approach that would include long-term consistent and direct deficit reduction. By implementing an amortization schedule the Fund would be able to continue to offer occurrence coverage. Further, the administrative requirements of implementing an amortization schedule would be manageable given the Fund's current staffing constraints.

Introduce a Cap on Non-Economic Damages

Of the various tort reform measures discussed, the Committee recommends supporting statutory changes that would introduce a cap of $250,000 on non-economic damages in medical malpractice cases.

The Committee felt that such a change in the statutes should be based on the language which introduced a similar cap of $1 million in 1986. That is, the Committee discussed as a second option for reducing the deficit imposing a cap on non-economic damages of $250,000 on all claims that have not yet been *filed* with the Fund.

The Committee asked M&R to evaluate the impact of a cap of $250,000 on non-economic damages on the Fund deficit and on Fund fees (see Appendix E for details). With respect to the impact on Fund fees, M&R's analysis indicated that the fees to be effective July 1, 1994 (which were established at the actuarially determined break-even level) could be reduced by 19.0% if a cap of $250,000 on non-economic damages were to be effective by June 30, 1994. The table below shows the estimated impact by major provider type:

Fund Class	Break-Even Fund Fees @ 7/1/94	Savings From a Cap	Revised Break-Even Fund Fees @ 7/1/94
1	$3,150	19.0%	$2,552
2	6,300	19.0%	5,103
3	15,750	19.0%	12,758
4	18,900	19.0%	15,309
Acute Care Bed	208	19.0%	168

With respect to the impact on the Fund deficit, M&R's analysis indicated that the projected deficit of $69.7 million as of June 30, 1994 would be reduced by between $14.6 million to $29.6 million if a cap of $250,000 on non-economic damages were in place by June 30, 1994 that applied to all actions filed on or after that date.

Finally, M&R estimated that, if a cap of $250,000 were effective by June 30, 1994 and the Fund fees were not reduced to reflect the anticipated cost savings, then the deficit could be further reduced by $17.6 million. This reduction would be in addition to the estimated reduction of $14.6 million to $29.6 million described above.

The Committee noted the following advantages of introducing a cap on non-economic damages:

- Reduces the deficit without collecting fees in excess of the actuarially determined break-even level;
- Reduces the future anticipated payments of the Fund; and
- May allow for claims to be settled more expeditiously.

The Committee also noted the following disadvantages to imposing a cap on non-economic damages:

- Limiting a claimant's right to recovery for damages such as pain and suffering, loss of consortium, etc.;
- Recognition that the greatest impact of a cap would occur on the most severely injured patients; and
- Probable constitutional challenges.

In recommending that a cap of $250,000 be imposed on non-economic damages, the Committee proposes a change in the statutes that they believe would address an elemental and necessary change in the tort system for resolving medical malpractice claims. In changing the statutes to impose a cap on all claims that have not yet been *filed*, this provision would reduce the existing published deficit which reflects all claims that have *occurred* regardless of whether or not they have been filed.

Periodic Payment of Awards

From inception of the Fund in 1975 through 1986, Wisconsin statutes required that if a settlement included future medical expenses, any such expenses in excess of $25,000 must be paid into the Fund by the primary insurer, organization or person responsible for such payment.

This amount would be placed into an account and disbursed to the claimant as the expenses are determined by the Commissioner to be reasonable and necessary. The payments would continue until the account is exhausted or until the injured person is deceased. It should be noted that this statute affected only a small minority of the Fund's claims, as most settlements were not impacted.

Under Wisconsin Act 340, this provision was modified to apply only to settlements, awards and judgments before June 14, 1986. Thus, unless the parties otherwise agree, future medical expenses are currently paid in a lump sum.

It was the consensus of the Committee that the statutes should be modified to again allow the Fund to pay out future medical expenses on a periodic basis. The Committee felt that statutory changes should be drafted so as to include the following provisions:

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

The Committee in evaluating this option identified the following advantages:

- Patient would receive funds for as long as needed; and
- May allow for claims to be settled more expeditiously.

The Committee also identified the following disadvantages of this option:

- Administrative burden of determining what are reasonable and necessary medical expenses; and
- Adverse impact on the claimant due to loss of control of funds and medical expense decisions.

In recommending that future medical expenses be paid on an as incurred basis, the Committee proposes a change in the statutes that they believe would benefit both the patient and the Fund. The patient would benefit by receiving medical payments for as long as needed, and thereby not taking on the risk of exhausting the amount received via a settlement. The Fund should benefit by not having to pay out future medical expenses in a lump sum payment and thus preserving its asset base (and potential investment income). Furthermore, if the patient does not live as

long as anticipated or actual medical expenses fall short of expected levels, the amount of money that is set aside to pay for the patient's anticipated future medical expenses would revert back to the Fund.

While the Committee did not quantify the potential impact of this recommendation on the Fund deficit, it did discuss the recent settlement of the Ready v. Yap claim to illustrate the uncertainty inherent in estimating a claimant's anticipated future medical expenses. Specifically, this claim was settled for $19.1 million (including defense costs), of which roughly $15 million represented anticipated future medical expenses.

Statutory Requirement for Minimum Fee Level

Chapter 655.27 of the Wisconsin statutes provides for the following cap in establishing overall assessment levels for the Fund:

> "Limit on Fees. Every rule setting fees for a particular fiscal year..... shall ensure that the fees assessed do not exceed the greatest of the following:
>
> 1. The estimated total dollar amount of claims to be paid during that particular fiscal year.
>
> 2. The fees assessed for the fiscal year preceding that particular fiscal year, adjusted by the commissioner of insurance to reflect changes in the consumer price index for all urban consumers, U.S. city average, for the medical care group, as determined by the U.S. department of labor.
>
> 3. Two hundred percent of the actual total dollar amount of claims paid during the calendar year preceding that particular fiscal year."

While the statutes define a maximum level on Fund fees, they are silent as to a minimum level. The Committee noted that in five of the nine fiscal years since July 1, 1985-86, the final fee levels approved by the legislature were below the break-even fee level estimated by M&R at the time. It was the consensus of the Committee that this impedes the Board's ability to reduce the deficit, and that consideration be given to establishing a statutory minimum level for Fund fees, to be set at the actuarially determined break-even level.

The Committee noted the following advantages to implementing a minimum requirement on fee levels:

- Should not allow the deficit to increase; and
- Should help focus the Underwriting & Actuarial Committee to more closely examine the actuarial projections.

The Committee also recognized the following disadvantages to implementing a minimum level on fees:

- Less flexibility in the fee setting process; and
- The minimum level would be based on a set of future projections.

In recommending that a minimum level be set on Fund fees, the Committee proposes a statutory change that would help to ensure that the deficit would not increase in the future. The minimum fee level would be set equal to the actuarially determined break-even fee level as approved by the Board of Governors.

Discussion of Options Considered but not Recommended

The second set of options discussed by the Committee for reducing/retiring the deficit can be characterized as options which would require structural change to the Fund as it exists today. These options were discussed in response to the assumption set forth by the LAB report, which is that the deficit is more of an immediate concern. In response to the LAB's view of the deficit, the Committee identified four options for retiring the deficit in a shorter length of time. These options included:

- Convert the Fund coverage from occurrence to claims-made;
- Increase the threshold of the Fund;
- Limit the amount of Fund coverage; and
- Establish a two-tier fee level, with the fees based upon how long the provider has participated in the Fund.

The Committee's discussions of each of these options is summarized below.

Convert the Fund to Claims-Made Coverage

The Fund currently provides unlimited coverage in excess of primary insurance limits to most healthcare providers in the state. The per occurrence primary limit has been $400,000 since July 1, 1988, with an annual aggregate primary limit of $1,000,000. Chapter 655 of the Wisconsin statutes specifies that the Fund shall provide coverage on an occurrence basis.

One of the options discussed by the Committee for retiring the Fund deficit would be to convert the Fund to claims-made coverage, coupled with an explicit provision in the Fund fees during the transition period to reduce the deficit.

If the Fund were to convert to claims-made coverage, the Committee noted the following advantages:

- Clarifies the Fund's funding needs;
- Should allow for deficit reduction;
- Should facilitate the fee setting process; and
- Should allow for some fee reduction in the early years of the conversion process.

The Committee also noted following disadvantages of converting to claims-made coverage:

- Magnitude of the structural changes needed;
- Collecting fees in excess of the actuarially determined break-even fee level;
- Acceptance of claims-made coverage by health care providers;
- Mobility of health care providers into and out of Wisconsin;
- Tail policy considerations; and
- Administrative concerns.

In discussing these potential disadvantages, it was felt that the concept of converting to claims-made coverage would be more acceptable to providers if it were coupled with a reduction in Fund fees. Another possible feature would be to freeze fees at some level during the transition period.

It was also suggested that the Fund should consider the waiver of the tail premium for providers under certain conditions. Many primary carriers writing claims-made coverage in Wisconsin currently provide a similar feature in the event of death, disability or normal retirement. In order to waive the premium for tail coverage, the fees would have to incorporate an explicit load to provide this waiver. In effect, the Fund would pre-fund the cost of the tail coverage across all providers uniformly.

The key administrative concern would be monitoring compliance with respect to tail policies, particularly for providers that leave the state. One option discussed was to offer a waiver of the premium for tail coverage for anyone leaving the state who has participated in the Fund for at least five years.

As a result of the Committee's discussions, M&R was asked to explore the impact on Fund fees and the Fund deficit of converting to claims-made coverage (see Appendix F for details). Specifically, M&R was asked to develop indicated claims-made "step factors" based on the historical emergence patterns of the Fund's losses by report year contribution. M&R was also asked to estimate the impact on the Fund deficit if Fund fee levels were established above the "break-even" level for claims-made coverage, but below the current levels. Finally, M&R was to incorporate into their analysis the cost of pre-funding tail coverage in the event of death, disability or retirement, as well as for providers who leave the state after participating in the Fund for at least five years.

In their analysis, M&R assumed the Fund would convert to claims-made coverage on July 1, 1994 with a five year timeframe to retire the deficit. Under this scenario, the 1994-95 funding level would be reduced to $30.2 million versus the $54.8 million level approved by the Board for occurrence coverage. Increases would be needed over the next four years in order to continue to reduce the deficit, and to phase in the conversion to mature claims-made coverage by the end of the fifth year. Funding levels for subsequent years would then contemplate only claims expected to be reported during the year that occurred after July 1, 1994. The projected funding levels under this scenario are summarized below:

Fiscal Year	Projected Assessment Income	% Change	Projected Ending Deficit
July 1, 1993-94	$51,149,000	---	$69,689,000
July 1, 1994-95	30,202,000	(41.0)%	35,804,000
July 1, 1995-96	34,219,000	13.3	14,971,000
July 1, 1996-97	38,770,000	13.3	3,707,000
July 1, 1997-98	44,805,000	15.6	373,000
July 1, 1998-99	52,033,000	16.1	0
July 1, 1999-00	57,961,000	11.4	0

The indicated percentage changes in funding levels shown above overstate the impact on an individual provider, as the M&R analysis assumed a 3% annual growth in the Wisconsin physician population. For example, while the overall assessment increase for Fund Year 1999-2000 represents an 11.4% increase, the impact on an individual provider is only 8.2%. The following table shows the current class 1 physician Fund fee along with the projected fees under this option:

Fiscal Year	Projected Class 1 Fund Fee	% Change
July 1, 1993-94	$2,941	---
July 1, 1994-95	1,737	(41.0)%
July 1, 1995-96	1,911	10.0
July 1, 1996-97	2,102	10.0
July 1, 1997-98	2,359	12.2
July 1, 1998-99	2,659	12.7
July 1, 1999-00	2,876	8.2

The Special Committee concluded that restructuring the Fund to provide claims-made coverage provides the most immediate method of reducing the deficit with the least short-term effect on provider fees. However, the Committee believes that retention of the occurrence form of coverage along with adopting a 25 year amortization schedule is the preferred option due to several reasons:

- Consistent with original intent of the Fund;
- Maintains the current structure of the Fund; and
- Spreads the costs of deficit reduction over a longer time frame and more providers.

If the Board of Governors determines that there is a compelling need to address the deficit in a more immediate fashion, then the option of converting to claims-made coverage should be reconsidered.

Increase the Threshold of the Fund

From inception of the Fund in 1975 through 1987, the threshold for penetrating the Fund coverage was $200,000 per occurrence. One of the provisions of the 1986 tort reform activity (Wisconsin Act 340) was to increase the Fund's threshold to $300,000 per occurrence on July 1, 1987 and to $400,000 per occurrence on July 1, 1988. The threshold has remained at $400,000 since July 1, 1988.

As one option for reducing the Fund deficit, the Committee discussed increasing the Fund threshold to either $500,000, $750,000 or $1,000,000 per occurrence while freezing fees at their current level during the transition.

The Committee identified the following advantages of this option:

- Maintains occurrence coverage;
- Transfers more of the exposure into the competitive market;
- Consistent with the original intent of the Fund to provide high-layer excess coverage; and
- Reduces the number of claims penetrating into the Fund.

The Committee also identified the following disadvantages of this option:

- Collecting fees in excess of the actuarially determined break-even level;
- Will reduce but not eliminate the deficit;
- Increases the total medical professional liability expenses of providers; and
- May adversely impact the capacity of the primary market.

M&R was asked to estimate the impact of a change in the Fund threshold on Fund fees and on the Fund deficit (see Appendix G for details). In addition, Fund management surveyed the primary carriers and self-insureds to assess their reaction to such a change.

The first part of M&R's analysis focused on the indicated reduction in the break-even Fund fee levels if the Fund threshold were increased on July 1, 1994, which is summarized in the table below:

Fund Threshold On July 1, 1994	Indicated Break-Even Fee Level	Indicated Reduction	
		$	%
$ 400,000	$54,785,000	$ 0	0.0%
500,000	51,878,000	2,907,000	5.3
750,000	46,063,000	8,721,000	15.9
1,000,000	41,487,000	13,297,000	24.3

To interpret this table, the second row shows that if the threshold were increased to $500,000 on July 1, 1994 the break-even fee level would be $51,878,000, a reduction of $2,907,000 from the current fee level of $54,785,000. This represents a potential reduction in Fund fees of 5.3%. However, upon reviewing the impact on the primary market of a change in the threshold, the increase in the primary market's rates would more than offset the indicated reduction in Fund fees, thereby actually increasing the total medical professional liability expenses of providers.

The second part of M&R's analysis focused on the estimated impact on the Fund deficit if the threshold were increased but Fund fees remained unchanged. That is, rather than reducing Fund fees by the amounts shown above to reflect the change in threshold, the Committee's intent would be to direct the indicated cost savings toward retiring a portion of the deficit. The table below summarizes the results of M&R's analysis:

(1) Fund Threshold on July 1, 1994	(2) Indicated Contribution to the Deficit	(3) Indicated Impact on the Deficit	(4) Projected Deficit on June 30, 1995
$ 400,000	$ 0	$ 0	$(69,689,000)
500,000	2,907,000	4,269,000	(65,420,000)
750,000	8,721,000	12,806,000	(56,882,000)
1,000,000	13,297,000	19,526,000	(50,163,000)

To interpret this table, M&R has estimated that the Fund deficit as of June 30, 1994 will be $69.7 million. If the legislature approves the break-even fee levels for the July 1, 1994-95 fiscal year, M&R estimates no change in the deficit as of June 30, 1995. Thus, the starting point for their projections was a baseline deficit forecast of $69.7 million.

The second row in the table above shows the projected impact on the deficit if the threshold were increased to $500,000 on July 1, 1994. Column (2) shows that the Fund fees could be reduced by $2,907,000 and still maintain a break-even posture (this is identical to the amount shown in the first table). However, if Fund fees remained unchanged, this amount would be available to reduce the deficit.

The Fund's financial statement recognizes future investment income that is expected to be earned on the Fund's assets before the assets are discharged as claim payments. When the impact of future investment income is recognized, a $2,907,000 contribution toward the deficit translates into a $4,269,000 reduction in the deficit during the July 1, 1994-95 fiscal year (shown in column (3) above). This would reduce the projected deficit as of June 30, 1995 from $69.7 million to $65.4 million (shown in column (4)).

Similar interpretations can be given to the potential impact of increasing the threshold to $750,000 or $1,000,000.

M&R also examined the potential impact on the Fund deficit if the threshold were to be increased to $1,000,000 in three stages, with Fund fees remaining at their current level:

- $500,000 on July 1, 1994;
- $750,000 on July 1, 1995; and
- $1,000,000 on July 1, 1996.

Under this scenario, M&R estimates that the Fund deficit would be reduced by $21.9 million during the three-year transition period. In addition, the Fund fees could remain flat for the fourth year and still adequately cover the Fund's projected loss costs for the July 1, 1997-98 fiscal year.

The Special Committee concluded that increasing the Fund threshold while freezing fees provides an immediate method of reducing the deficit. However, the Committee believes that amortizing the deficit over 25 years is the preferred option due to several reasons:

- Spreads the cost of deficit reduction over a longer timeframe and more providers; and
- Less volatility in the total medical professional liability expenses of providers.

If the Board of Governors determines that there is a compelling need to address the deficit in a more immediate fashion, then the option of increasing the threshold while freezing fees should be reconsidered. The Committee also believes that consideration should be given to increasing the threshold in the future so as to position the Fund more appropriately as a high-layer excess insurer.

Limit the Amount of Fund Coverage

The Fund currently provides unlimited coverage in excess of primary insurance limits to most healthcare providers in the state. As another option to retire the deficit, the Committee discussed the impact on the deficit of limiting the amount of Fund coverage. It should be emphasized that the Committee's intent would be to only limit the amount of Fund coverage, with no limitation on the total amount awarded to a claimant.

In evaluating this option the Committee noted the following advantages to limiting the amount of coverage provided by the Fund:

- May affect the settlement considerations or verdict expectations; and
- Transfers more of the exposure into the competitive market.

The Committee also identified several disadvantages of this option:

- May shift the liability of claims to providers who purchase higher limits of coverage;
- Availability of excess coverage; and
- The probability would now exist where a claimant may not be fully compensated.

The Committee asked M&R to estimate the impact on the deficit if the Fund were to provide limited coverage but freeze fees at their current level (see Appendix H for details).

The first part of M&R's analysis focused on the reduction in the break-even Fund fee levels if the Fund had introduced limits on the amount of coverage on July 1, 1994. The table below summarizes the indicated Fund fees for the July 1, 1994-95 fiscal year for a class one physician under four options:

		Indicated Reduction in Fee	
Amount of Excess Coverage	**Indicated Fund Fee @7/1/94**	**$**	**%**
$ Unlimited	$3,150	$ 0	0.0%
20,000,000	3,024	126	4.0
15,000,000	2,961	189	6.0
10,000,000	2,835	315	10.0
5,000,000	2,489	661	21.0

The second part of M&R's analysis focused on the estimated impact on the Fund deficit if coverage limits were introduced but Fund fees remained unchanged. That is, rather than reducing Fund fees by the amounts shown above to reflect the change in Fund coverage, the Committee's intent would be to direct the indicated cost savings toward retiring a portion of the deficit. The table below summarizes the results of M&R's analysis:

(1) Amount of Excess Coverage	(2) Indicated Contribution to the Deficit	(3) Indicated Impact on the Deficit	(4) Projected Deficit on June 30, 1995
$ Unlimited	$ 0	$ 0	$(69,689,000)
20,000,000	2,257,000	3,314,000	(66,375,000)
15,000,000	3,178,000	4,667,000	(65,022,000)
10,000,000	5,229,000	7,679,000	(62,010,000)
5,000,000	11,502,000	16,890,000	(52,799,000)

To interpret this table, M&R has estimated that the Fund deficit as of June 30, 1994 will be $69.7 million. If the legislature approves the break-even fee levels for the July 1, 1994-95 fiscal year, M&R estimates no change in the deficit as of June 30, 1995. Thus, the starting point for their projections was a baseline deficit forecast of $69.7 million.

The second row in the table above shows the projected impact on the deficit if the Fund coverage were limited to $20 million on July 1, 1994. Column (2) shows that the Fund fees could be reduced by $2,257,000 and still maintain a break-even posture (this is identical to the percentage savings shown in the first table). However, if Fund fees remained unchanged, this amount would be available to reduce the deficit.

The Fund's financial statement recognizes future investment income that is expected to be earned on the Fund's assets before the assets are discharged as claim payments. When the impact of future investment income is recognized, a $2,257,000 contribution toward the deficit translates into a $3,314,000 reduction in the deficit during the July 1, 1994-95 fiscal year (shown in column (3) above). This would reduce the projected deficit as of June 30, 1995 from $69.7 million to $66.4 million (shown in column (4)). Similar interpretations can be given to the potential impact of other limits on Fund coverage.

The Special Committee concluded that limiting Fund coverage while freezing fees provides an immediate method of reducing the deficit. However, the Committee believes that retention of

the unlimited form of coverage along with amortizing the deficit over 25 years is the preferred option due to several reasons:

- Spreads the costs of deficit reduction over the longer time frame and more providers; and
- Consistent with the original intent of the Fund to ensure that claimants would be fully compensated.

If the Board of Governors determines that there is a compelling need to address the deficit in a more immediate fashion, then the option of limiting Fund coverage should be reconsidered.

Establish a Two-Tier Fee Level

The final option discussed by the Committee for reducing the deficit would be to introduce a two-tier funding mechanism whereby physicians that have been in the Fund for X years would pay a higher fee than equivalent physicians who haven't been in the Fund as long. The rationale behind this alternative is that physicians who have been in the Fund are the ones who accrued the deficit and therefore should be responsible for retiring it.

In evaluating this option, the Committee identified the following advantages of establishing a two-tier funding mechanism:

- Places responsibility of retiring the deficit onto those who accrued it; and
- May facilitate the need to attract younger physicians into the state.

The Committee also noted the following disadvantages to establishing a two-tier funding mechanism:

- Determination of which physicians are responsible for the deficit;
- Collectibility of those funds levied against the responsible physicians; and
- Administrative concerns.

The Special Committee concluded that establishing a two-tier fee level mechanism would impose too great a burden on an ever-decreasing population of providers to retire the deficit. The Committee also believed that the other disadvantages listed above outweighed the advantages and because of this concluded that this option should not be recommended.

RESPONSE TO THE JOINT TASK FORCE REPORT

In addition to identifying options for retiring the deficit, the other main charge of the Special Committee was to respond to the Joint Task Force Report which identified 17 issues for potential improvement in the Fund's operation. The Committee's discussion of each of the 17 recommendations of the Joint Task Force is summarized below.

Task Force Recommendation 1. Pursue tort reform, specifically a cap on non-economic damages, as a key system modification essential to stabilize medical liability premiums and awards. A shortened enforced statute of limitations (2 years) and the institution of periodic payments would also be beneficial.

Special Committee Response: **The preceding section of this report summarized the Committee's recommendation that a cap on non-economic damages of $250,000 be introduced (Recommendation 2), and that mandatory periodic payments for future medical expenses be reinstated (Recommendation 3). The Committee also examined the Fund's experience with regard to claims that have been reported after the statute of limitations has expired. Upon reviewing these claims, the Committee recommends referral of this issue to the Claims Committee and the Underwriting and Actuarial Committee to continue to monitor the development of such claims.**

Task Force Recommendation 2. Delineate in statute the obligations of the primary carrier, definitions of coverage and exclusions so as to facilitate a better fit between primary and Fund coverage.

Special Committee Response: **Fund management informed the Special Committee that the Fund's Claims Committee has held seminars comprised of claims representatives from primary insurers and self-insurers to improve coordination of defense efforts. Furthermore, the Ad Hoc Insurance Underwriting Committee recommended that an administrative rule be promulgated to require disclosure of limited coverage to both the health care provider and the Fund. The rule has been promulgated and was effective October 1, 1993. Based on this, the Special**

Committee decided that no further discussion was necessary on this recommendation.

Task Force Recommendation 3. Correct inequities in participating and paying into the Fund. Examples: health care providers currently not paying individually into Fund (e.g., oral surgeon on hospital staff, psychologists, social workers) but covered by blanket corporate coverage; MCW physicians paying a reduced rate. Also, health care providers not eligible for Fund coverage.

Special Committee Response: **Fund management informed the Committee that the Board had previously considered assessing employees of health care providers (i.e., chiropractors, oral surgeons, podiatrists, and optometrists) but withdrew the request pending the development of actual claims experience by these employees. Furthermore, the Ad Hoc Insurance Underwriting Committee recommended creation of a standing insurance subcommittee to address such issues. Based on this, the Committee decided that no further discussion was necessary on this recommendation.**

Task Force Recommendation 4. Institute better claims coordination between primary carriers and Fund.

Special Committee Response: **The Special Committee discussed the issue of claim coordination between primary insurers, self-insurers and the Fund. One area of dispute relates to the primary insurer's fiduciary responsibility to provide a defense to the Fund pursuant to statutory requirements. Another area of dispute relates to whether or not a potentially catastrophic case should be settled or tried in court. The primary insurer may wish to try the case, while the Fund may wish to attempt settlement since it is subject to the risk of a catastrophic award should the case be tried and lost. Still other disputes may arise as to the Fund's pursuit of contribution on behalf of "negligent" providers even if they were not named in the suit by the plaintiff. Fund staff provided the Committee with information on actions that have been instituted to address these issues. For example:**

- **In 1992, and 1993, the Fund sponsored a 2-day "claims relationship" program to discuss and resolve claims handling issues of mutual concern between insurers, self-insurers and the Fund. Claims staff from primary insurers, self-insurers and the Fund attended these programs to discuss the Fund's claims handling practices and statutory requirements. The Fund plans to sponsor regular annual "relationships" meetings;**

- **The Fund is in the process of working with primary insurers to develop an alternative dispute resolution (ADR) program to resolve disputes between insurers and the Fund for cases involving multiple defendants. Currently, these parties must resort to lawsuits to settle their differences;**

- **The Claims Committee has become more actively involved in claim settlement issues, particularly as they relate to requests for contribution from primary insurers or self-insurers; and**

- **The Fund has made an effort to solicit input from both primary insurer and self-insurer representatives on special claims projects, issues and committees.**

Based on the above actions, the Special Committee determined that reasonable efforts have been taken to respond to the recommendation contained in the Task Force report.

Task Force Recommendation 5. Make claim management less political.

Special Committee Response: **The Special Committee noted that the Fund's Claims Committee membership had been increased to add two more members from an insurance company and self-insured claims department giving greater representation to insurers.**

The Special Committee also considered the possibility of the Fund discontinuing the contracting of claims services and handling claims internally.

As background for the Committee's discussion, Fund management reported that the number of full-time equivalent (FTE) claim handlers used by Wausau to handle the Fund's claims were as follows:

- **Fiscal year 1991 - 2 FTEs**
- **Fiscal year 1992 - 2 FTEs**
- **Fiscal year 1993 - 3 FTEs**

In discussing how the Fund's claims are currently handled, the Committee considered the Office of the Commissioner of Insurance's reasons for maintaining a claims contract:

- **The state has no established training opportunities for claims handlers and, based upon the relatively small number of claims handlers involved, it may be cost prohibitive to design and maintain a program to keep these file handlers adequately trained;**

- **The state has less flexibility in adding employees to the payroll than a private company does (for example, to keep up with increases in number of claim files to be handled); and**

- **The state's salary scale is less competitive than private industry.**

Because of this, the Committee recommended continuation of the current practice of contracting for the day-to-day claims management of the Fund.

Task Force Recommendation 6. Revise the mediation system; institute binding arbitration system for smaller claims.

Special Committee Response: **The Committee discussed the existing Medical Mediation Panel (Panel) process, to which every filed claim is subject. The Panel is operated out of the director of state courts' office of the Supreme Court. Its decisions are nonbinding; however, 25% to 30% of the claims mediated do not go on to circuit court.**

The Committee also noted that a new Supreme Court rule effective July 1, 1994 grants a judge the power to require parties to submit to an alternative dispute resolution method of their choice. The rule does not differentiate between medical malpractice cases and other types of civil cases.

The Committee, in evaluating the strengths and weaknesses of the mediation panels, decided that the panels do help to filter out the smaller, sometimes frivolous lawsuits but only hindered and slowed the legal process for the larger, non-frivolous lawsuits. Due to the number of issues and complexities related to the mediation panel system, the Special Committee recommends referral of an evaluation of the effectiveness of the mediation panels to the Claims Committee.

Task Force Recommendation 7. Limit amount of Fund coverage.

Special Committee Response: **The Committee's discussions regarding this recommendation were summarized in the preceding section of this report (see page 24).**

Task Force Recommendation 8. Restructure classes for Fund coverage (i.e., more classes).

Special Committee Response: The **Committee reviewed information showing the compression of the nine Wisconsin Health Care Liability Insurance Plan (WHCLIP) classes into the four classes created by Act 340. The experience of the Fund showed that the relativity by class for each of the nine classes, as defined by WHCLIP, collapse reasonably well into the four classes of the Fund.**

The Committee also discussed the following issues:

- **The economic/insurance equity of nine classes; and**
- **The social equity of four classes.**

The Special Committee recommends referral of the actuarial indications to the Underwriting & Actuarial Committee, noting that the Committee reviewed Task Force Recommendation 8 and concluded that restructuring the classes would not affect the Fund deficit.

Task Force Recommendation 9. Implement more consistent coding of physician specialty by primary carrier.

Special Committee Response: **It was the consensus of the Committee that, since Task Force Recommendation 9 had been addressed by the Ad Hoc Insurance Underwriting Committee and a rule has been promulgated, no further discussion was required.**

Task Force Recommendation 10. Expedite claims processing where Fund's liability is evident.

Special Committee Response: **The Special Committee acknowledged that the Claims Committee is continuing to closely monitor and suggest improvements to the claims process. Because of this, the Committee decided that no further discussions were needed regarding this recommendation.**

Task Force Recommendation 11. Establish proper long-term and short-term approaches to reserving the Fund.

Special Committee Response: **The Committee, in discussing the case reserving philosophy of the Fund, acknowledged that until recently the Fund did not have the resources needed in order to closely monitor its case reserves development. The Special Committee noted that the Claims Committee has been more active in recent years and with the Fund's new computer system the reserves will continue to be monitored closely.**

Task Force Recommendation 12. Evaluate trip insurance where patients would buy protection for a given procedure.

Special Committee Response: **The Committee discussed the value of making trip (per visit) insurance available to patients, either as a supplement to mandatory Fund coverage or as optional coverage if the Fund were not mandatory. This**

insurance could be purchased by the patient if and when desired, similar to flight insurance.

The Committee believed that the idea of trip insurance may be ahead of its time and not for immediate consideration. Furthermore, the Committee foresaw extensive administrative problems associated with implementing this type of product.

Task Force Recommendation 13. Evaluate tiered limits for Fund coverage.

Special Committee Response: **The Committee discussed Task Force recommendation 13 concurrently with Task Force recommendation 7. The Committee's discussions were summarized in the preceding section of this report (see page 24).**

Task Force Recommendation 14. Evaluate addition of coverage for punitive damages.

Special Committee Response: **Punitive damages are defined to include damages awarded by a court in addition to compensatory damages. They are intended to punish the negligent party for willful and wanton misconduct and to serve as a deterrent for such actions that have given rise to the claim. Consistent with previous Board actions, the Committee recommended that the Fund should not offer coverage for punitive damages.**

Task Force Recommendation 15. Evaluate Fund premium structure and how it impacts on the supply of primary care and OB practitioners.

Special Committee Response: **The Committee discussed Task Force recommendation 15 concurrently with Task Force recommendation 8. As was previously noted, the Committee recommended referral to the Underwriting & Actuarial Committee of this issue.**

Task Force Recommendation 16. Raise base coverage limits to $1 million.

Special Committee Response: **The preceding section of this report summarized the Committee's recommendation with respect to increasing the Fund threshold (see page 20).**

Task Force Recommendation 17.	Adequately address administrative resource needs of Fund staff so Fund can be more responsive to providers.
Special Committee Response:	**The Committee acknowledged that the Fund has added two permanent staff positions and implemented a new computer system to address its administrative needs. Furthermore, the former Investment Committee has been recently enlarged to cover finance and audit matters and will become more involved in monitoring the resource needs of the Fund. Because of this, the Committee decided that this recommendation has been addressed sufficiently and that no further discussion was necessary.**