WISCONSIN STATE LEGISLATURE COMMITTEE HEARING RECORDS

2005-06
(session year)

Senate
(Assembly, Senate or Joint)

Committee on Agriculture and Insurance (SC-AI)

File Naming Example:

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

COMMITTEE NOTICES ...

- *Committee Hearings ... CH* (Public Hearing Announcements)
- **

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

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

- *Record of Comm. Proceedings ... RCP*
- **

INFORMATION COLLECTED BY COMMITTEE CLERK FOR AND AGAINST PROPOSAL

- *Appointments ... Appt*
- **

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

- *Hearing Records ... HR* (bills and resolutions)
- **05hr_ab0765_SC-AI_pt02**

- *Miscellaneous ... Misc*
- **

CURT GIELOW

State Representative

Testimony on AB 764, AB 765, and AB 766
To the
Senate Committee on Agriculture and Insurance

October 27, 2005 – Room 411 South, State Capitol

Mr. Chairman and Members,

The Speaker's Task Force on Medical Malpractice Reform has completed its work and presents three pieces of legislation for consideration - **AB 764**; **AB 765**; and **AB 766** - as the product of our efforts.

We believe these bills recognize and reflect the necessary balance between fairness, affordability and availability in the area of medical malpractice insurance coverage.

The bi-partisan Task Force heard testimony from interested parties for two full meetings and then held two more meetings to debate and consider an appropriate course of action. These bills have all been passed by the Assembly in its action on Tuesday, October 25th.

AB 766 creates a two-tiered award benefit structure similar to current law in wrongful death cases. The award cap for persons under age18 would be set at $550,000, 23% higher than under the previous cap while the award cap for persons age 18 and over would be set at $450,000, essentially the same as the recent cap. The majority of the Task Force believes this differentiation, with justifications and legislative findings, is therefore responsive to the court's finding that the old caps failed constitutionality under the equal protection clause of our constitution. AB 766 passed 64-30.

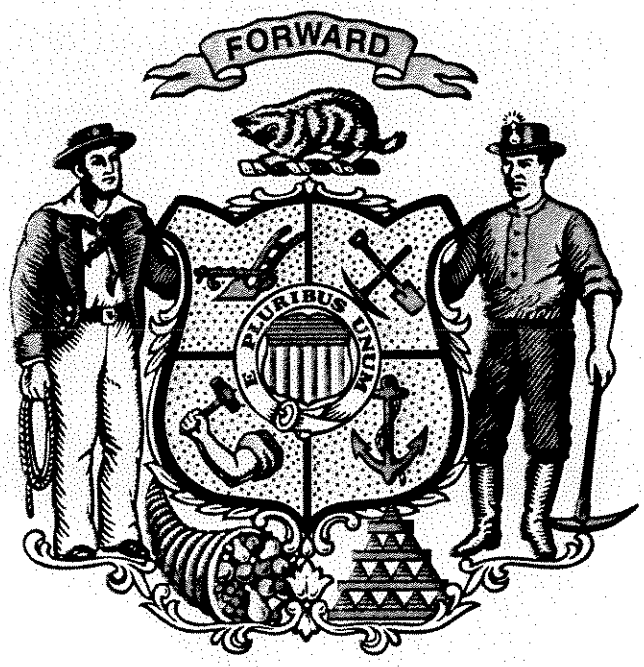
AB 765 simply closes a loophole in current law that did not provide coverage under our healthcare liability requirements to individuals that completed medical school and were doctors but had not yet completed the required first year of post-graduate medical residency, commonly called their internship, to become licensed Wisconsin physicians. AB 765 passed the Assembly with a vote of 96-0. We adopted AA1 which I introduced with Rep. Wasserman to simplify the bill to its immediate intent, which is to correct the oversight in law affecting residents.

AB 764 clarifies current law on the issue of collateral sources of payments to compensate individuals in medical malpractice cases. The bill provides for the reduction of medical malpractice awards by the amount of collateral source payments, offset by any subrogation or reimbursement resulting from those collateral source payments. The Assembly passed AB 764 on Tuesday on a vote of 60-34. We passed ASA1 to the bill, which was introduced to clarify misunderstandings by the drafter.

I would note that in all of these bills the effective date is prospective and not retroactive.

I urge the committee's support for these critical pieces of legislation.

State Capitol: P.O. Box 8952 • Madison, Wisconsin 53708-8952 • (608) 266-0486 • Toll-Free: (888) 534-0023 • Rep.Gielow@legis.state.wi.us
District: P.O. Box 504 • Mequon, Wisconsin 53092 • (262) 242-2728


FORWARD
E PLURIBUS UNUM

TO: Members of the Senate Agriculture and Insurance Committee

FROM: Janice Schreiber

DATE: October 27, 2005

RE: Testimony against caps on noneconomic damages

In June 25, 1988, my daughter Kimberly Schreiber was born in Rhinelander, Wisconsin. During the course of my delivery my uterus ruptured depriving Kimberly of oxygen. Kimberly was born a spastic quadriplegic and she cannot move below her neck or speak.

Our case involved the issue of informed consent. Kimberly was my third child and the two previous births were done by cesarean section. I had agreed to have either a vaginal delivery or cesarean section during the course of my labor. After my labor started, I requested a cesarean section several times during the course of my delivery because of the intense pain I was in. The doctor who delivered Kimberly refused my request even though the cesarean section was medically indicated and I had had two previous cesarean sections. However, by the time a cesarean was done my uterus had ruptured. It took eleven years to resolve our case going all the way to the Wisconsin Supreme Court. During that time, our family cared for Kimberly continuously.

Kimberly requires 24-hour care every day all year long. She can't be left alone. We must do everything for her — feed, dress, diaper and bathe. She cannot eat through her mouth and must be fed through a G feeding tube. She is confined to a wheelchair or bed and suffers a seizure disorder. She requires physical therapy and breathing treatments on a regular basis.

While she doesn't speak, she can communicate in her own way with her own language. She can understand things and listens well. She has her favorite books, movies and loves to go places. But we always must have someone to help her. Sometimes two people are required to help her with her activities.

For our experience going through a lawsuit was very challenging. As I stated, Kimberly was 11 year old when we settled our case. The money received in the lawsuit has helped improve Kimberly's quality of life. We have been able to provide care that was otherwise unavailable to her. Up until that time, this burden fell primarily on family members. This is a difficult burden because it physically and mentally can burn you out. However, money for medical expenses and lost wages usually are paid to someone else — nurses, doctors, therapists — it doesn't go to the injured person.

It is only the award above the out-of-pocket loss that is available to compensate in some way for the pain, suffering, physical impairment or disfigurement that Kimberly must endure for the remainder of her life. It also assures Kimberly of some quality of life. That she may do things she enjoys. These damages are very important and go to compensate Kimberly and our family for the very real losses we have suffered. The loss

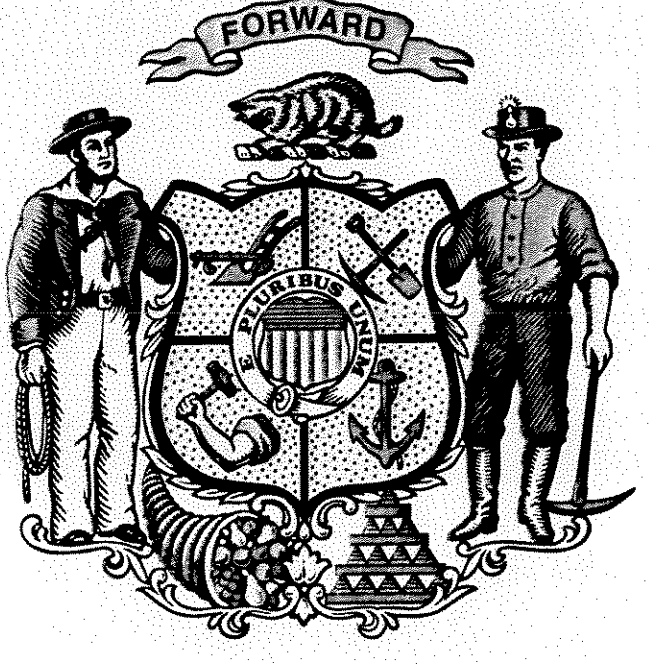
of noneconomic damages in any amount is significant because they are essential to Kimberly.

I have two older children, so I understand how different Kimberly's life is from other children. She has a great memory and understands many things, but because of her condition she will never experience all the simple things we take for granted — walking, talking and touching things. She just turned 17, but will never drive a car. This year she would be a senior in high school, but she will never graduate and become an independent citizen.

In many ways we are very lucky to have Kimberly with us today. When we were going through our court case, some of the defense experts said she wouldn't live this long. Kimberly has proven them wrong, but we want to make sure the money she has received can continue to pay for her needs as she ages.

I urge this Committee not to adopt a new cap on noneconomic damages. Caps seek to "fix" the civil justice system at the sole expense of those most seriously injured. That is neither fair nor equitable. A person whose noneconomic damages are below a cap recovers 100 percent of his or her noneconomic loss, while a person whose noneconomic are above the cap, receive only a fraction of the amount necessary to compensate them. The Supreme Court held that there is nothing rationale for treating the most seriously injured patients of medical malpractice less favorably than those less seriously injured. I must agree. People who are permanently injured like Kimberly should not be deprived of full compensation for all their injuries.

Thank you.


FORWARD
PLURIBUS UNUM

Froedtert Memorial
Lutheran Hospital
9200 West Wisconsin Avenue
Milwaukee, WI 53226-3596

October 27, 2005

Froedtert Hospital

Froedtert &
Community Health

414-805-3000
www.froedtert.com

Senator Dan Kapanke
Chair, Senate Committee on Agriculture and Insurance
Wisconsin State Senate

Chairman Kapanke and Members:

I am writing in support of 2005 Assembly Bill 765, related to coverage of medical residents by the Injured Patients and Families Compensation Fund. This legislation would affect residents who participate in training programs at Froedtert Hospital and who are employed by the Medical College of Wisconsin Affiliated Hospitals ("MCWAH"). The bill fills a gap in the Patient Compensation Fund statutory structure and codifies current practice used by the Fund.

Background

Under current law, the Injured Patients and Families Compensation Fund ("Fund") covers certain identified health care providers, primarily licensed professionals such as physicians and registered nurses, along with employees of hospitals and other health care providers. In the recent Wisconsin Supreme Court ruling in *Phelps v. Physicians Insurance Co,* 2005 WI 85, the court concluded that residents who are not yet licensed physicians are not health care providers covered by the Fund. The Court did not determine whether these residents could be considered employees of a hospital, for purposes of Fund coverage.

Residents involved in the programs of The Medical College of Wisconsin and MCWAH are not traditional hospital employees. Rather, these residents are employed by MCWAH, which has employment contracts with the residents and provides the payroll, benefits, and liability insurance for the residents.

In 2003, the Fund issued an administrative determination that these residents can be considered employees of an affiliate of a hospital providing health care services to the patients of that affiliated hospital. We feel that a statutory clarification would be better protection for these physicians-in-training.

Proposed Change

The change to Chapter 655 contained in Assembly Bill 765 adds another entity that can be covered by the Fund: a "graduate medical education program." MCWAH would qualify as such a program and as such could *statutorily* obtain coverage under the Fund for its employees. Even if a court were to over turn the administrative decision of the Fund to cover the MCWAH residents, the statute would provide coverage.

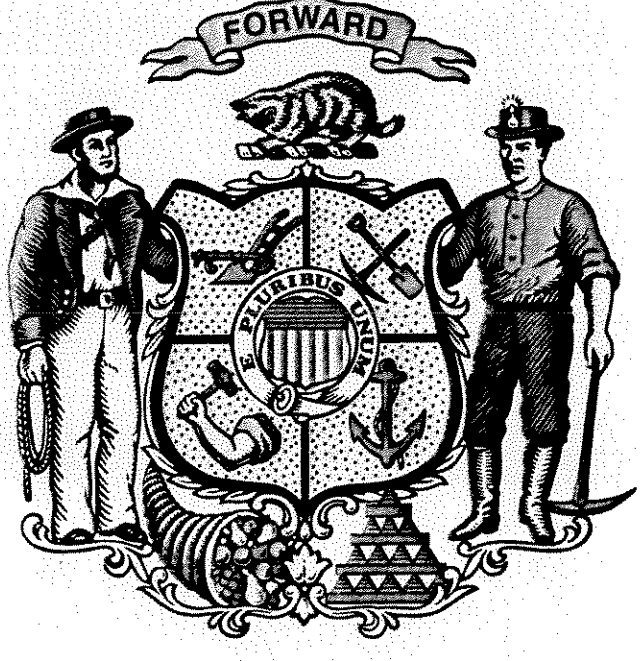
We support 2005 Assembly Bill 765 because it codifies current practice with respect to Fund coverage and will protect Wisconsin as a good location for residency programs. These benefits will help the state continue to attract quality residents to train here and eventually provide care to Wisconsin residents.

Thank you for your consideration.

Sincerely,

Maureen McNally

Maureen McNally
Director, Government and Community Relations
Froedtert & Community Health


FORWARD
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WISCONSIN HOSPITAL ASSOCIATION, INC.

October 27, 2005

TO: Senate Committee on Agriculture and Insurance

FROM: Laura Leitch, Vice President and General Counsel

SUBJECT: Support for SB 393, AB 764, 765, and 766

Chairperson Kapanke and members, my name is Laura Leitch and I am General Counsel for the Wisconsin Hospital Association (WHA). Thank you for this opportunity to speak today in support of SB 393, AB 764, 765, and 766. Our 130 member hospitals appreciate your commitment to address the recent Supreme Court decisions that found Wisconsin's cap on non-economic damages unconstitutional, changed the interpretation of the statute related to the collateral source rule, and found that first year medical residents are not health care providers for purposes of the Fund. We believe these decisions will damage the unique and balanced medical liability system that this legislature created more than 10 years ago and which has served Wisconsin well.

If you work in the health care system, that is, if you struggle with recruiting physicians to rural or urban areas, if you are a rural family practice doctor who also delivers babies, or more importantly, if you are a patient who may not have access to the care you need, you know that an adequate response to the recent court decisions, to rebalance the system especially by restoring the cap on awards for pain and suffering, is crucial.

Yet, today you will hear all sorts of reasons why Wisconsin should not restore a cap on non-economic damages. Some will tell you that the damage cap made no difference in Wisconsin and that liability insurance premiums will not go up due to its loss. But you have received compelling evidence to the contrary from Pinnacle Resources, authors of the September 2005, actuarial analysis of Wisconsin's medical malpractice environment.

Some will attempt to distract you by claiming malpractice premiums are a minuscule percentage of overall health care costs. But this is not about some misleading comparison to overall health care spending -- it is about the patients put at risk when individual physicians' skyrocketing liability premiums force those physicians to leave Wisconsin or retire too soon.

The fact that malpractice premiums amount to a fraction of overall health care spending won't make much difference to the pregnant mother who has to travel 150 miles to deliver her baby because the last OB/GYN left town.

Some will tell you to ignore what happened in other states without a well-balanced medical liability system -- but what has happened in Illinois, Oregon, Washington, Nevada, Ohio, and many other states without caps simply cannot be ignored or minimized:

- In Oregon, liability premiums for family practice physicians that deliver babies have increased 332% since caps on non-economic damages were struck down in 1999. By 2002, 34% of all physicians delivering babies in Oregon had quit performing deliveries.

- In Washington, where their short-lived caps were struck down in 1988, fewer doctors are delivering babies and more women are arriving in Washington hospitals never having received prenatal care.

- In Illinois, were in 2002 uncapped non-economic damages accounted for 91% of the average jury award, OB-GYNs have fled the state, many coming to Wisconsin. Southern Illinois is devoid of neurosurgeons and without head trauma coverage.

- In Ohio, where caps were struck down in 1991 and again in 1995, a 2004 survey of physicians conducted by the Ohio Department of Insurance indicated that nearly 40% of those who responded said they had retired, or planned on retiring in the next three years due to rising insurance costs. Only 9% of the respondents were over age 64.

We cannot dismiss what has happened in these and other states, and we cannot ignore the stories from the dozens and dozens of skilled physicians who have left these states to come practice medicine in Wisconsin. In fact, you will hear from some of them today.

Frankly, we don't need to speculate, or wait and see what the impact of losing the cap will be in Wisconsin, because our members are dealing with it right now.

We have received numerous reports of how much more difficult it already has become to recruit physicians to Wisconsin, particularly to rural areas. New physicians considering practicing in Wisconsin, or those thinking of relocating here are very concerned about what has happened here and, more importantly, what will be done about it. They simply aren't buying the notion that without a cap, Wisconsin will be just fine. They have seen and experienced what has happened in other states and know that unchecked, the system can spiral out of control.

Through our own physician workforce studies (see attached), we know that even with a cap, Wisconsin is facing serious challenges to recruit and retain new physicians. We must to do everything we can to attract and keep the young doctors we will all need to care for us in the future.

Some will have you believe that Wisconsin is somehow immune from the escalating damages and increasing out of court settlements that have taken hold in states without caps. They will try to sidetrack this debate by pointing to the few Wisconsin jury verdicts in the last ten years that exceeded the then existing cap. But make no mistake, without a cap on non-economic damages, we will see more lawsuits, higher damages and, more importantly (but less noticed), higher out of court settlements – all of which add to instability within the system, increased liability premiums, and reduced access to care.

In fact, within days of court's decision, there were plaintiff's attorneys in Wisconsin doubling their pre-decision settlement demands. We don't need to speculate about the long-term negative impact of the decision – it is happening already.

Until very recently, Wisconsin had one of the most balanced, and frankly envied, medical liability systems in the country -- the sum of an equation that included three key factors – the Wisconsin Injured Patients and Families Compensation Fund, unlimited economic damages, and a cap on non-economic damages.

Indeed, on May 12, 2005, just six weeks before the court's decision, Wisconsin Commissioner of Insurance Jorge Gomez reported on the impact of 1995 Act 10 ($350,000 cap on non-economic damages plus inflation). In his report, the Commissioner described a then favorable medical liability climate, and the impact it has had on access to health care.

> *"To conclude ... Wisconsin's malpractice marketplace is stable. Insurance is available and affordable, and patients who are harmed by malpractice occurrences are fully compensated for unlimited economic losses. Tort reform of 1995, along with well regulated primary carriers and a well managed and fully funded Injured Patients & Families Compensation Fund has resulted in the stable medical malpractice environment,* ***and the availability of health care in Wisconsin."*** (emphasis added)

In the same report, again issued roughly two months before the Supreme Court overturned our cap on non-economic damages, Commissioner Gomez indicated that medical liability carriers were predicting premiums would remain roughly the same in Wisconsin over the coming year. However, he also made it very clear that, and again I quote:

> *"... rate stability could be dramatically impacted for both the Fund and primary carriers should the caps be removed and insurers face unlimited non-economic damages."*

A fair system, one that balances the rights of injured parties with the basic need for an accessible health care system, is what we had in Wisconsin, and what we must strive to restore through this legislation. A system in which liability premiums do not drive out of business, out of the state, or into retirement, the very doctors we count on the most when we need them the most.

To accomplish this, we must have a well-reasoned and rational cap on non-economic damages. A cap that is meaningful, and that is not so high that it essentially does not exist. And, a cap that does not stand alone, but rather as the key component of Wisconsin's comprehensive medical liability system – a system that already includes:

- Unlimited economic damages.
- Mandatory periodic payments.
- And, unlike any other state, guaranteed recovery of damages through mandatory $1 million/$3 million primary coverage for physicians and hospitals and mandatory participation in the Fund.

Now missing from this system is a cap on non-economic damages, which would be addressed by the legislation before you.

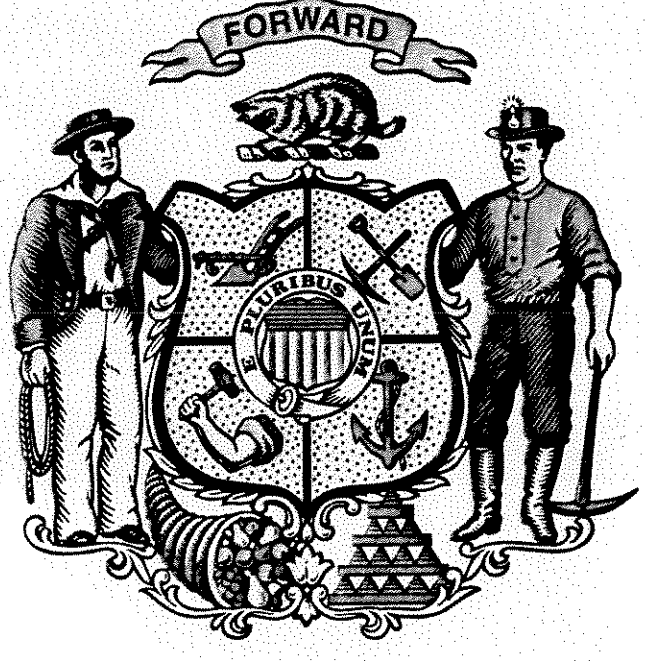
On April 7, 2005 the Illinois Hospital Association told their legislature the following:

> *"The medical liability crisis in Illinois is causing an unprecedented health care access crisis throughout the state. While some areas of Illinois may be suffering more than others, the systemic problems driving these crises exist all over Illinois and show no signs of abating. In the areas hardest hit, we are finding an absence of obstetricians willing to treat "high risk" babies, emergency care physicians unwilling to provide trauma care, and neurosurgeons refusing to provide complex and high-risk procedures."*

On August 25, 2005, after passing the Illinois Assembly and Senate, the Illinois Governor signed Illinois's new cap on non-economic damages into law.

We do not need to experience the dismantling of a health care system experienced in other states; we need to prevent it from happening.

WHA believes a balanced and equitable system can be preserved in Wisconsin but it will require the Legislature and Governor to act. We believe Wisconsin's balanced system must include a cap on non-economic damages and other important reforms, including recognition of recovery from collateral sources and Fund coverage for medical residents. We urge you to support the medical liability reform bills before you.


FORWARD
E PLURIBUS UNUM

Hospital Sisters
Health System

Belleville, IL
St. Elizabeth's Hospital

Breese, IL
St. Joseph's Hospital

Decatur, IL
St. Mary's Hospital

Effingham, IL
St. Anthony's Memorial Hospital

Highland, IL
St. Joseph's Hospital

Litchfield, IL
St. Francis Hospital

Springfield, IL
St. John's Hospital

Streator, IL
St. Mary's Hospital

Chippewa Falls, WI
St. Joseph's Hospital

Eau Claire, WI
Sacred Heart Hospital

Green Bay, WI
St. Mary's Hospital Medical Center
St. Vincent Hospital

Sheboygan, WI
St. Nicholas Hospital

My name is Sister Jomary Trstensky and I am President of Hospital Sisters Health System, a multi-hospital system located in Springfield, Illinois with eight hospitals in Illinois and five hospitals inWisconsin. Our organization has been involved in active health ministry in Illinois and Wisconsin since 1875. We constitute a tightly managed regional system of acute care hospitals. (Slide 1)

In Wisconsin we operate the following hospitals: Sacred Heart Hospital- Eau Claire, St. Joseph's Hospital – Chippewa Falls; St. Vincent Hospital – Green Bay; St. Mary's Hospital Medical Center – Green Bay; and St. Nicholas Hospital – Sheboygan. As a demonstration of our collective presence in Wisconsin, I offer some statistics from our recent audited financial statements showing evidence of the work we do with the people of this fine state.(Slide 2) On an annual basis we treat 34,000 people in our hospitals and another 456,277 as outpatients. We believe that we are, not only essential providers of state of the art health care to citizens in these communities, but also significant economic contributors because of the dollars flowing into the four communities by virtue of our hospital payrolls which came to $213,000,000 last year. (Also Slide2) We take pride in being good citizens as well as good healthcare providers.

What I have to share today is a tale of two states: Illinois and Wisconsin.(Slide 3). Our two-state location gives us a unique opportunity to compare things, in this case, medical malpractice expense for the hospitals. I present myself, not as the accounting wizard or an insurance professional, but as a steward of important resources put at our disposal for the care of people who come to us.

Because Wisconsin has had a limit on pain-and-suffering damages and Illinois has not, the two states have been a case study on controlled versus uncontrolled liability costs.

(Slide 4) Wisconsin hospitals have purchased primary coverage from WHKLIP or form commercial companies for the past 20 years. Excess coverage comes from the Patient Compensation Fund. Illinois, because of unfavorable insurance markets, has been self-insured for primary coverage and then protected by a purchased excess policy. (Slide 5)
Using audited data for calendar year 2005 we are able to show that Illinois costs exceed Wisconsin's costs by a factor of 3.5 to 1 on an adjusted patient day basis. If we adjust this to add the WHCLIP Rebates, the picture is even more dramatic, 4.2 – 1. It costs Illinois $35.63 per adjusted occupied bed per day to obtain medical liability coverage. The cost to Wisconsin is $8.41 per adjusted bed per day. These expenses do not include physician insurance policies, since our hospitals do not own or employ physicians. There is no plausible reason for this disparity other than the rational control in Wisconsin and the absence of that control in Illinois. The money saved in Wisconsin has been used for the development of new programs and services as well as new technology for our five Wisconsin hospitals. On the other hand, the extra expense in Illinois has been passed on to those who pay for health care, creating an extra burden.

My remarks are limited to hospital medical liability expense, but physicians have been

impacted by this phenomenon, so much so that Illinois has experienced an exodus of physicians from communities where their services are needed. For the sake of credibility, I limit my comments to the experiences of my own hospitals.

Because of the large expense associated with medical liability coverage for physicians, insurance companies have refused to write policies for doctors or have increased premiums beyond the doctors' ability to pay. (Slide 6) Doctors have left Illinois, moving to friendly markets.

A single hospital near the Missouri border in downstate Illinois, as of December, 2004, lost 30 physicians (average age 46) to this crisis. The hospital, very similar in size to St. Vincent Hospital in Green Bay, lost 1700 inpatient admissions, 12,000 outpatient admissions, 4000 surgical procedures, and $18 million dollars in revenue because of the defection of these 30 physicians. These doctors crossed the boundaries of primary care and all specialty services. Their stated reasons for leaving were: excessive premium increases or cessation of coverage entirely, coupled with the added threat of escalating tail coverage when they found an insurance company to cover them. This may sound like a problem of the insurance industry, but the root cause is excessive awards, excessive numbers of settlements which give rise to anxiety among insurers and among practitioners.

To clarify, I have said that our Illinois hospitals self-fund medical liability insurance. Because of the large awards given in court, organizations like ours have to make a calculated guess as to the merit of settling out of court versus trying the case. In many cases we opt for settlement in order to limit litigation costs. Therefore, one has to consider settlement costs as well as award costs in calculating the liability expense.

This tale of two States has direct bearing on AB 766 that recently received the support of the Assembly. I am here today to ask that you do your part to restore Wisconsin to a stable

medical liability environment. I believe that if providers make a mistake, we should be held accountable. People who feel victimized should have an avenue of recourse. But it must be reasonable. Unless a cap is reinstated on noneconomic damages, Wisconsin will experience what Illinois has endured. We used this same information in Illinois to help convince legislators there that some kind of control is necessary. We used Wisconsin's experience as a great success story! Unless action is taken to restore caps, there will be an increase in the cost of conducting business in Wisconsin, there will be a loss of needed physicians, access to care will suffer, employee compensation will be negatively affected, and funds will be diverted from new investments into paying for insurance.

Thank you for giving me the opportunity to share our story.

1

Wisconsin Legislative Hearing

October 27, 2005

Sr. Jomary Trstensky, President
Hospital Sisters Health System

2

HSHS Statistics

- Wisconsin – FYE 6/30/2005

- Salaries	$213,000,000
- Benefits	$ 63,000,000
- Hospital admissions	34,201
- Outpatient visits	456,277

3

Hospital Sisters Health System

- Two-state System
  - Wisconsin – 5 Hospitals
  - Illinois – 8 Hospitals

Provides an opportunity to compare medical malpractice cost and administration between two states.

4

General & Professional Liability Insurance

- Wisconsin hospitals have purchased primary coverage from WHCLIP or from commercial insurance company for the past 20 years. Excess malpractice coverage comes from Patient Compensation Fund.
- In Illinois, unfavorable insurance markets led us to self-insure the primary coverage and then purchase excess coverage for medical malpractice.

5

HSHS Results

- Cost per adjusted occupied bed
  - Illinois $35.63
  - Wisconsin $10.15 (3.5 to 1)
- Cost adjusted for 2005 WHCLIP Rebates
  - Illinois $35.63
  - Wisconsin $ 8.41 (4.2 to 1)

Costs are for calendar year 2005. In each state costs include general liability and professional malpractice insurance costs. General liability is a small portion of the total cost.

6

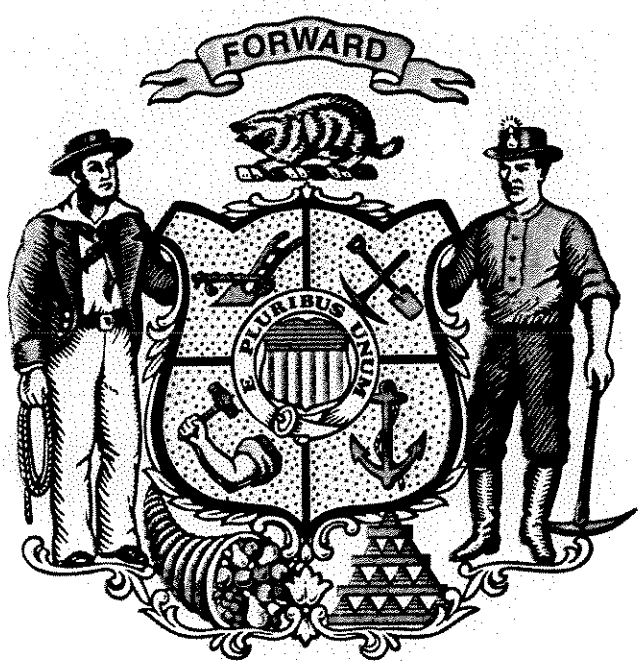
Doctors Have Left Illinois

Belleville – December 2004

Loss of 30 physicians

1700 inpatient admissions
12,000 outpatient admissions
4000 surgical procedures
$18 million in revenue

Decreased access to critical services


FORWARD
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WISCONSIN LEGISLATIVE COUNCIL
AMENDMENT MEMO

2005 Assembly Bill 765	Assembly Amendment 1
Memo published: October 26, 2005	*Contact*: Joyce L. Kiel, Senior Staff Attorney (266-3137)

As introduced, ***2005 Assembly Bill 765*** would have amended current law to do the following:

- Provide that a graduate medical education program may elect to be subject to the Injured Patients and Families Compensation Fund statute.

- With respect to licensure to practice medicine:

  (a) Remove the exemption from the requirement for licensure for the activities of a medical school graduate required for training under s. 448.05 (2), Stats. (that is, primarily the activities of first-year medical residents).

  (b) Expand the authority of the Medical Examining Board with respect to granting temporary educational permits to practice medicine and surgery to include granting such a permit to a person enrolled in a graduate medical education program at a facility approved by the Medical Examining Board, rather than limiting such a permit to persons who meet the requirements of s. 448.05 (2), Stats. (that is, rather than limiting it to those who have already completed the first year of medical residency). This change would primarily have had the effect of expanding the applicability of these temporary educational permits to include first-year medical residents.

  (c) Amend the periods for which temporary educational permits to practice medicine and surgery are valid.

Assembly Amendment 1 to Assembly Bill 765 deletes the bill's provisions relating to licensure to practice medicine noted above. Thus, the amended bill includes ***only*** the bill's provisions relating to the Injured Patients and Families Compensation Fund.

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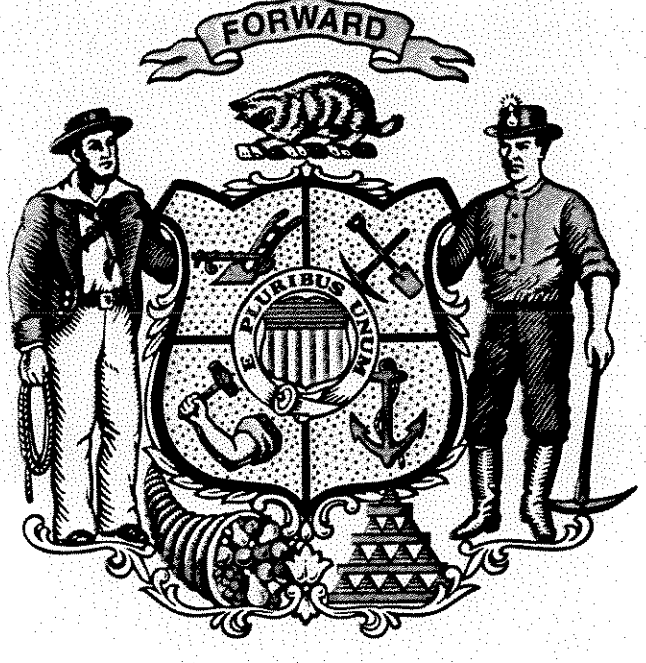
(608) 266-1304 • Fax: (608) 266-3830 • Email: leg.council@legis.state.wi.us
http://www.legis.state.wi.us/lc

Legislative History

Assembly Amendment 1 was offered by Representatives Gielow and Wasserman and was adopted by the Assembly on a voice vote. Assembly Bill 765, as amended by Assembly Amendment 1, was passed by the Assembly on a vote of Ayes, 96; Noes, 0.

JLK:rv


FORWARD
E PLURIBUS UNUM

Tap the Power SEP 01 2005 Knowledge is Power

These publications are available from the Wisconsin Legislature's Theobald Legislative Library

Medical Malpractice

Compiled by Arden Rice, Updated September 2005

http://www.legis.state.wi.us/lrb/pubs/tapthepower.htm

The Wisconsin Supreme Court recently struck down the constitutionality of Wisconsin's cap on noneconomic damages. This bibliography focuses on nationwide reforms and research findings on medical liability published since the December 2003 *Tap the Power* bibliography was released.

***Addressing the New Health Care Crisis: Reforming the Medical Litigation System to Improve the Quality of Health Care* / U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, March 3, 2003. (614.230/X4)** Examines the impact of increasing premiums on physicians' ability to practice medicine and explores various mechanisms for medical personnel to report errors without fear of litigation. http://aspe.hhs.gov/daltcp/reports-a.shtml#DALTCP31

***An Audit, Injured Patients and Families Compensation Fund, Office of the Commissioner of Insurance* / Wisconsin Legislative Audit Bureau, 2004. (614.230/W7b1)** This mandated report investigates the financial solvency of the fund. Previous audits from 2001 and 1998 are available under the former name "Patients Compensation Fund."
www.legis.state.wi.us/lab/reports/04-12Highlights.htm

***Confronting the New Health Care Crisis: Improving Health Care Quality and Lowering Costs By Fixing Our Medical Liability System* / U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, July 25, 2002. (614.230/X3)** Argues that medical malpractice insurance rates threaten access to care in many areas of the country and that inflated health costs are a result of "defensive medicine" practices by physicians intimidated by the threat of malpractice suits. http://aspe.hhs.gov/daltcp/reports-c.shtml#DALTCP25

***Containing Medical Malpractice Costs: Recent State Actions* / National Governors' Association Center for Best Practices, 2005. (614.230/N21a)** Updates a 2002 NGA brief on tactics used by states to mitigate the effects of rising malpractice insurance rates.
www.nga.org/Files/pdf/0507MALPRACTICECOSTS.PDF

***Ferdon v. Wisconsin Patients Compensation Fund (Medical Malpractice Liability Cap)* / Wisconsin Legislative Council , July 2005. (Information Memorandum 05-1). (LegisCl/2005-2007/i/05-1) (noncirculating)** Summarizes the recent Wisconsin Supreme Court case challenging the noneconomic damage caps imposed by the fund.
www.legis.state.wi.us/lc/2_PUBLICATIONS/Other%20Publications/Reports%20By%20Subject/Health/IM05_01.pdf

***Final Report on the Feasibility of an Ohio Patient Compensation Fund* / Pinnacle Actuarial Resources, Inc., May 2003. (614.230/Oh3)** Compares and contrasts the administrative and fiscal organization of PCFs in a dozen states including Wisconsin.
www.ohioinsurance.gov/Documents/05-01-03FinalReport.pdf

***Justice Capped: Tilting the Scales of Justice Against Injured Patients and Their Families: A 10-Year Review of Wisconsin's Cap On Pain and Suffering* / Wisconsin Citizen Action & Wisconsin Academy of Trial Lawyers, 2005. (614.230/W751a)** Argues that the cap discriminates against those gravely harmed by medical malpractice and does not reduce health care costs or affect the number physicians practicing in Wisconsin.
www.watl.org/watl__main_frame.htm

"Medical Liability: Beyond Caps" / *Health Affairs*, July/August 2004. (614.23/P94/2004/v.23/no.4) Contains six feature articles on medical malpractice, including "Are Damages Caps Regressive? A Study of Malpractice Jury Verdicts in California".

***Medical Liability Reform – Now! A Compendium of Facts Supporting Medical Liability Reform and Debunking Arguments Against Reform* / American Medical Association, 2005. (614.230/Am3b)** Detailed report demonstrating the impact of medical malpractice lawsuits on health care delivery.
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"Medical Malpractice" / Arden Rice, Wisconsin Legislative Reference Bureau, *Tap the Power*, December 2003. (LRB/t) (noncirculating) A previous edition of this bibliography containing additional print and electronic resources.
www.legis.state.wi.us/lrb/pubs/ttp/ttp-12-2003.html

"Medical Malpractice 'Crisis': Recent Trends and the Impact of State Tort Reforms" / *Health Affairs* (Web Exclusives), 2004. (614.23/P94a/2004/Jan-June) Investigates the extent to which rising premiums are associated with increases in claims and considers whether tort reform is more than a stop-gap solution to a flawed medical liability insurance system.
www.healthaffairs.org/WebExclusives.php

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Medical Malpractice
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***Medical Malpractice: Implications of Rising Premiums on Access to Health Care* / U.S. General Accounting Office, August 2003. (614.230/X7/pt.1)** Investigates whether "defensive medical practices" are inflating the cost of health care and how tort reform in certain states has impacted insurance premiums.
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***Medical Malpractice Insurance Report: A Study of Market Conditions and Potential Solutions to the Recent Crisis* / National Association of Insurance Commissioners, 2004. (614.230/N213)**
www.naic.org/models_papers/papers/MMP–OP–04–EL.pdf

***Medical Malpractice Liability Reform: Legal Issues and Fifty-State Survey of Caps on Punitive Damages and Noneconomic Damages* / Congressional Research Service, updated April 11, 2005. (CRS Reports). (614.230/X8)** Outlines pro and con arguments for the provisions included in 2003 H.R. 5 and H.R. 4280 relating to caps on damages, the collateral source rule, joint liability, and lawyer's contingency fees. The report also contains a table showing the caps on punitive and noneconomic damages for all fifty states.
http://digital.library.unt.edu/govdocs/crs//data/2005/upl–meta–crs–6285/RL31692_2005Apr11.pdf

***Public Medical Malpractice Insurance* / Frank A. Sloan, Pew Project on Medical Liability in Pennsylvania, 2004. (614.230/P46)** Examines the pros and cons of implementing various government interventions adopted to alleviate the malpractice insurance crisis.
http://medliabilitypa.org/research/files/sloan0304.pdf

***Report on the Impact of Act 10* / Wisconsin Office of the Commissioner of Insurance, 1997-2005. (614.230/W7c4)** This biennial report examines the number of health care providers practicing in Wisconsin, the fees that health care providers pay under s. 655.27 (3), and the premiums that health care providers pay for health care liability insurance.

***Resolving the Medical Malpractice Crisis: Fairness Considerations* / Maxwell J. Mehlman, Pew Project on Medical Liability in Pennsylvania, 2003. (614.230/P94b)** Considers the desired outcome of malpractice trials and insurance programs in terms of fair and consistent treatment of victims, medical professionals, and the public's overall access to health care.
http://medliabilitypa.org/research/mehlman0603/MehlmanReport.pdf

Related Web Sites:

www.abanews.org/issues/medmal.html – American Bar Association

www.ama-assn.org/ama/pub/category/7861.html – American Medical Association – Medical Liability Reform

www.hcla.org – Health Coalition on Liability and Access

www.ncsl.org/standcomm/sclaw/medmaloverview.htm – NCSL's Medical Malpractice Tort Reform Committee

www.rwjf.org/reports/npreports/impacs.htm – Robert Wood Johnson Foundation: Improving Malpractice Prevention and Compensation Programs

http://medliabilitypa.org/ – Project on Medical Liability in Pennsylvania funded by the Pew Charitable Trusts

State Patients Compensation Funds:

www.in.gov/idoi/medmal – Indiana

www.hcsf.org – Kansas Health Care Stabilization Fund

www.lapcf.state.la.us – Louisiana

www.doi.ne.gov/medmal/index.htm – Nebraska

Reform Efforts and Studies From Other States:

www.cga.ct.gov/olr/medicalmalpracticeER.asp – Connecticut – Lists over 50 reports on medical malpractice written by the Office of Legislative Research since 2002.

www.unf.edu/thefloridacenter/Files/Medical%20Malpractice%20Update.pdf – Florida

http://insurance.mo.gov/aboutMDI/issues/medmal – Missouri

www.leg.state.nv.us/lcb/research/library/BackBurner.cfm – Nevada

www.state.nj.us/dobi/drcorner.htm – New Jersey

http://jsg.legis.state.pa.us/Med%20Mal.HTML – Pennsylvania – Report of the Advisory Committee on Medical Professional Liability

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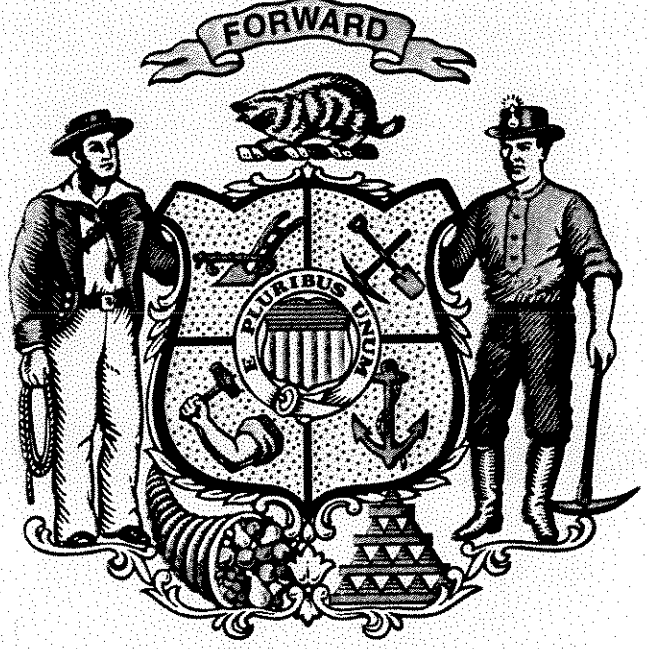
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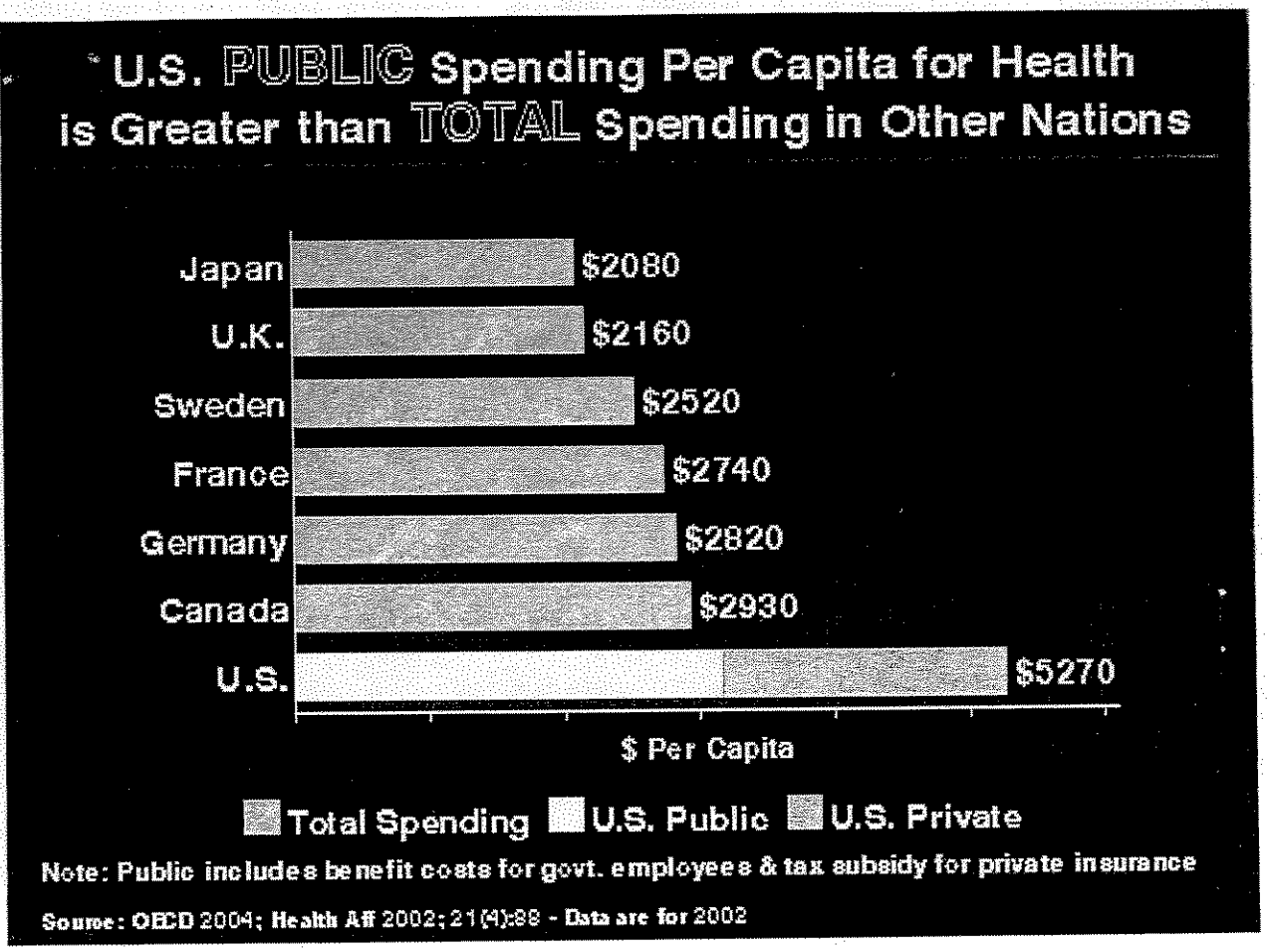

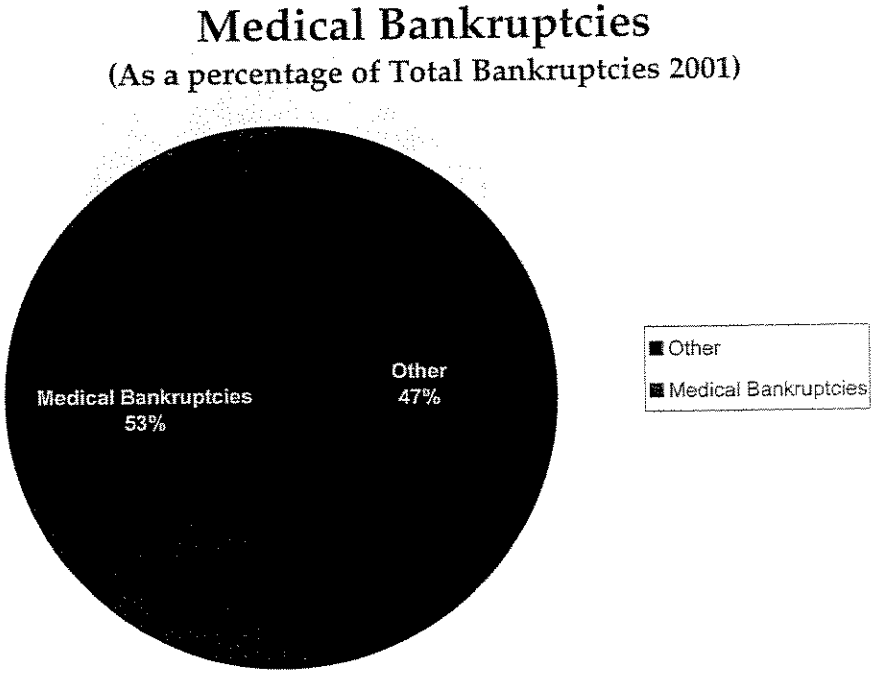

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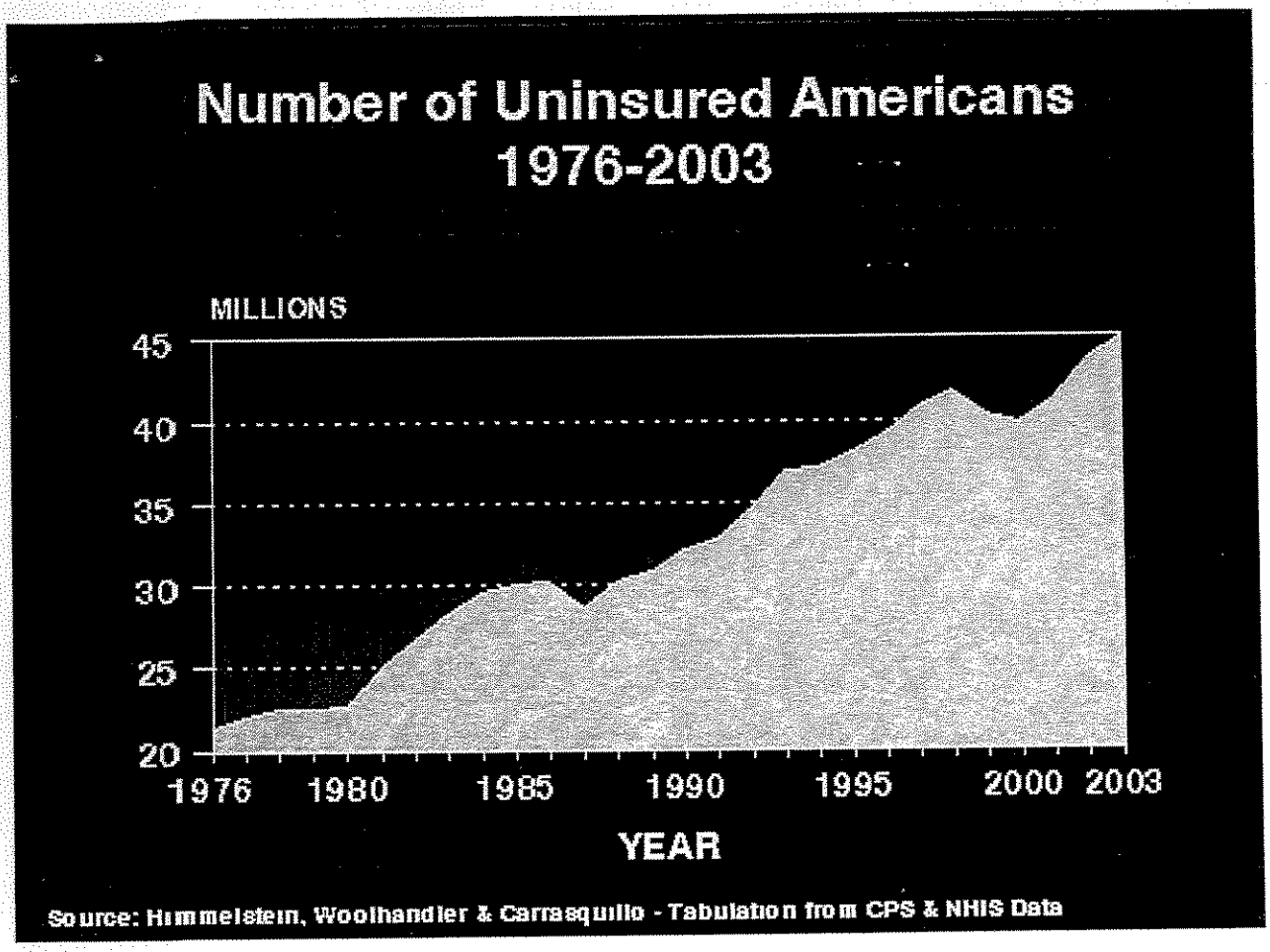
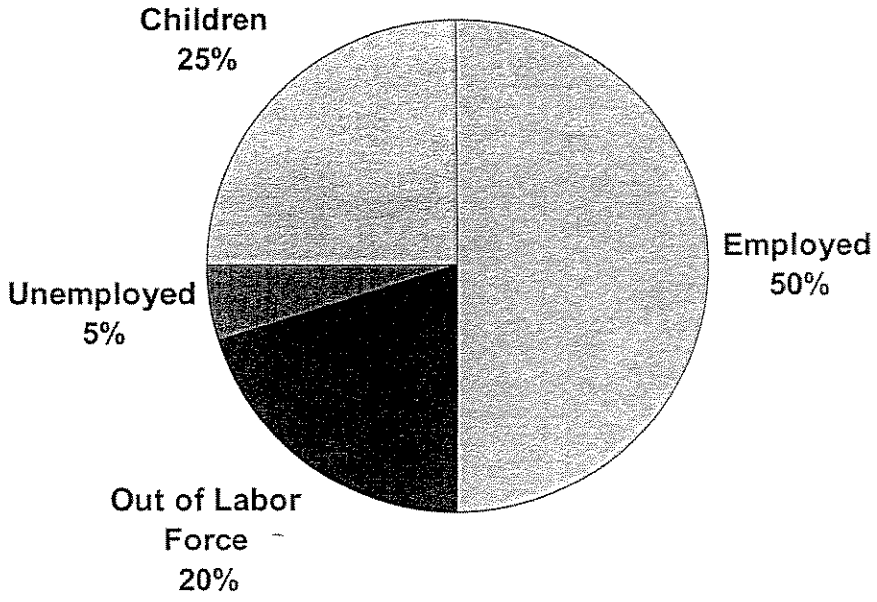
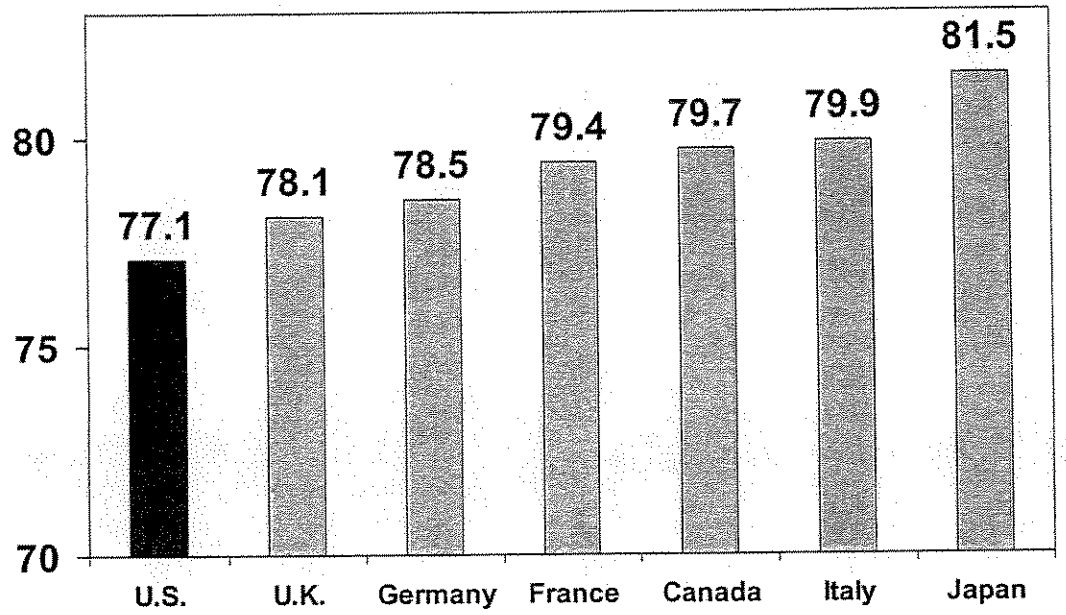


Who are the Uninsured?



Current Population Statistics, 1999

Life Expectancy



OECD, 2004, (2001 Data)

Infant Deaths by Income