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2005-06
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Record of Comm. Proceedings ... RCP

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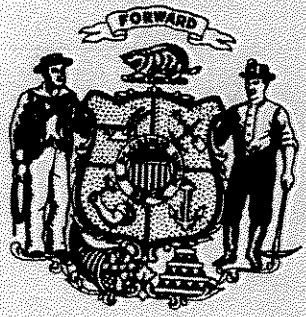

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Medical Malpractice Caps Seminar:

The Legal Issues

Sponsored by:

Wisconsin Legislative Council Staff

Wednesday, September 21, 2005

Room 417 North (GAR)
State Capitol
Madison, Wisconsin

8:30 Welcome

8:32 The Case: *Ferdon v. Wisconsin Patients Compensation Fund*
Atty. Richard Sweet, Legislative Council Staff

9:00 Historical Context of the Caps; The Patients Compensation Fund; and The State of the Law Since *Ferdon*
Attys. Jennifer Peterson & Timothy Muldowney, LaFollette Godfrey & Kahn
Atty. Ruth Heitz, General Counsel, Wisconsin Medical Society

9:35 Legal and Practical Implications of The Wisconsin Supreme Court's decision in *Ferdon* for Wisconsin Legislators
Atty. Robert Jaskulski, Habush Habush & Rottier

10:00 Seminar Concludes

WISCONSIN LEGISLATIVE COUNCIL
INFORMATION MEMORANDUM

Ferdon v. Wisconsin Patients Compensation Fund
(Medical Malpractice Liability Cap)

The Wisconsin Supreme Court's July 14, 2005 decision in the case of *Ferdon v. Wisconsin Patients Compensation Fund*, 2005 WI 125 (2005) **addresses the issue of the constitutionality of the Wisconsin statutes that place a dollar limit on noneconomic damages in medical malpractice cases.** Statutes define "noneconomic damages" as "...moneys intended to compensate for pain and suffering; humiliation; embarrassment; worry; mental distress; noneconomic effects of disability including loss of enjoyment of the normal activities, benefits and pleasures of life and loss of mental or physical health, well-being or bodily functions; loss of consortium, society and companionship; or loss of love and affection." [s. 893.55 (4) (a), Stats.]

The statutes place a limit on noneconomic damages in medical malpractice cases of $350,000, adjusted annually for inflation since 1995. Although the court's opinion refers to the "$350,000 cap" for purposes of simplicity, and this memorandum likewise does so, the current inflation-adjusted amount of the cap is $445,755.

The *Ferdon* case was a medical malpractice action that arose as a result of a physician's negligence that injured Matthew Ferdon during birth. As a result of the injury, Ferdon has a partially paralyzed and deformed right arm. A jury awarded him $700,000 for noneconomic damages and $403,000 for future medical expenses. However, because of the statutory cap on noneconomic damages, the amount of the noneconomic damage award was reduced from $700,000 to $410,322, which was the inflation-adjusted amount in effect at that time. The jury also awarded his parents $87,600 for the personal care they will render until Matthew turns 18.

The Supreme Court struck down the statutory cap on noneconomic damages by a 4 to 3 vote. The court's opinion consisted of four opinions, which are summarized in this memorandum: (1) a majority opinion by Chief Justice Abrahamson; (2) a concurring opinion by Justice Crooks (joined by Justice Butler); (3) a dissenting opinion by Justice Prosser (joined by Justices Wilcox and Roggensack); and (4) a dissenting opinion by Justice Roggensack (joined by Justices Wilcox and Prosser).

The majority opinion held that the cap violates the equal protection provision of the Wisconsin Constitution, which states in part that "(a)ll people are born equally free and independent...." [Art I., s. 1, Wis. Const.] Since the majority decided the case on this basis, it did not address the other state constitutional issues raised by Ferdon. However, the concurring opinion also held that the cap violates the state constitutional provisions on the right to a jury trial and the right to a remedy for injuries. [Art. I, ss. 5 and 9, Wis. Const.]

LEGISLATIVE OPTIONS

Some of the concerns that led the court to declare unconstitutional the statutory cap on noneconomic damages in medical malpractice cases appear to be of such a nature that they can be remedied through legislation. For example, the majority opinion raised the concern that younger plaintiffs may have to live with pain and suffering over many decades, while older

plaintiffs will not, yet both are subject to the same cap on damages. This concern might be addressed, for example, by having a variable cap that is based on the life expectancy of a person who is the same age and gender as the plaintiff.

Another concern in the majority opinion is that patients who have family members who also received noneconomic damages from the same incident of malpractice have the cap reduced since there is a single cap that covers all family members for the same incident. This concern might be addressed by having separate caps for the patient and for each family member who incurs noneconomic damages.

One concern expressed in the majority opinion that does not appear to lend itself to a legislative solution is that persons who incur damages above the cap, regardless of its level, will not be fully compensated for those damages, while persons with damages below the level of the cap will be fully compensated. However, that is the nature of a cap. Regardless of its level, someone with damages above that level will never be fully compensated.

The concurring opinion states that the current level of the cap is too low, but does not indicate a cap in order to pass constitutional muster. However, that opinion does state that statutory caps on noneconomic damages in medical malpractice cases can be constitutional.

An alternative approach that the Legislature might consider is limiting noneconomic damages to a percentage of economic damages.

Any legislation that is enacted to modify the caps on noneconomic damage will undoubtedly be challenged in court and there is no guarantee that, even with substantial changes, the cap will be upheld. Therefore, another option that the Legislature has is amending the Wisconsin Constitution to specify that the Legislature may enact legislation that sets a cap on noneconomic damages in medical malpractice cases. State constitutional amendments must be adopted by the Legislature in two consecutive sessions and then be approved by the voters of the state in a referendum.

This discussion of options is not intended to be an exhaustive list of possible options.

SUMMARY OF THE OPINIONS

MAJORITY OPINION

After reviewing the facts of the case, the court, through an opinion authored by Chief Justice Abrahamson, addressed the question of whether the $350,000 cap on noneconomic damages in medical malpractice cases is constitutional. The court initially observed:

> This court has not held that statutory limitations on damages are per se unconstitutional. Indeed, this court has recently upheld the cap on noneconomic damages for wrongful death medical malpractice actions. Just because caps on noneconomic damages are not unconstitutional per se does not mean that a particular cap is constitutional. [*Ferdon*, par. 16.]

The court discussed the statutory provisions of ch. 655, Stats., which relates to medical malpractice by a health care provider. The court noted that primary malpractice coverage for providers is $1,000,000 for each occurrence and $3,000,000 per policy year; damages above those amounts are paid by the Patients Compensation Fund (since renamed the Injured Patients and Families Compensation Fund; referred to in this memorandum as "the Fund"). The court noted that s. 655.017, Stats., states that the amount of noneconomic damages recoverable by a claimant under ch. 655, Stats., for acts or omissions of a health care provider that occur on or after May 25, 1995 are subject to the limits in s. 893.55 (4) (d) and (f), Stats., which set forth the inflation-adjusted $350,000 cap.

The court reviewed earlier decisions related to the issue, but held that they were inapplicable in this case because none reached the central issue of constitutionality of the cap on noneconomic damages in medical malpractice cases. One of the decisions discussed was a 2004 Wisconsin Supreme Court decision that rejected an equal protection challenge to the noneconomic damages cap in wrongful death actions. [*Maurin v. Hall*, 2004 WI 100, 274 Wis. 2d 28, 682 N.W.2d 866.] The court also discussed a 1995 Wisconsin Supreme Court decision that held that retroactive application of a cap on noneconomic damages in malpractice cases was unconstitutional but noted that that case did not directly determine the constitutionality of the cap itself. [*Martin v. Richards*, 192 Wis. 2d 156, 531 N.W.2d 70 (1995).]

The court then discussed the level of scrutiny that it would apply to determine whether the cap on noneconomic damage awards violates the equal protection guarantees of the Wisconsin Constitution. Generally, in reviewing a statute to determine whether it violates equal protection guarantees, a court determines whether there is a rational basis for the distinction in the statutes. However, if a statute interferes with the exercise of a fundamental right or operates to the disadvantage of a suspect class (e.g., race), the court uses a strict scrutiny analysis. The court stated that it would apply a rational basis test to the statute in question, since the malpractice statutes do not deny any fundamental right or involve a suspect classification. [*Ferdon*, pars. 65 and 66.] However, the court also referred to the level of scrutiny as "rational basis with teeth" or "meaningful rational basis." [*Ferdon*, par. 80.]

The court stated that all legislative acts are presumed constitutional and a challenger must demonstrate that a statute is unconstitutional beyond a reasonable doubt. [*Ferdon*, par. 68.]

The court observed that a person challenging a statute on equal protection grounds under the rational basis level of scrutiny bears a heavy burden in overcoming the presumption of constitutionality that is afforded to statutes. The court stated that all legislative acts are presumed constitutional and a challenger must demonstrate that a statute is unconstitutional beyond a reasonable doubt. [*Ferdon*, par. 68.]

The court expressly stated that it was not addressing the additional constitutional challenges based on a right to a jury trial and a right to a remedy under the Wisconsin Constitution, but noted "...the $350,000 cap on noneconomic damages may implicate these constitutional rights." [*Ferdon*, par. 69.]

The court found that in limiting economic damages in malpractice actions, the statutes create a number of classifications and sub-classifications. **The main classification involved in the statute is between those who suffer over $350,000 in noneconomic damages and those who suffer less than $350,000 in noneconomic damages.** Less severely injured

victims with $350,000 or less in noneconomic damages receive their full damages, while severely injured victims with more than $350,000 in noneconomic damages receive only part of their damages. **The court also noted that a main sub-classification is created by the statutes since a single cap applies to all victims of a malpractice occurrence regardless of the number of victims and claimants.** Therefore, the total award for the patient's claim for noneconomic damages, such as pain and suffering and disability, and the claims of the patient's spouse, minor children, or parents for loss of society and companionship, cannot exceed $350,000. Because of this, classes of victims are created depending on whether the patient has a spouse, minor children, or a parent.

The court identified the Legislature's objectives for enacting the $350,000 cap. In the 1975 law that created the malpractice liability chapter, the Legislature set forth 11 findings. The court summarized the legislative objectives as follows: (1) ensure adequate compensation for victims; (2) enable insurers to charge lower malpractice premiums by reducing the size of awards; (3) keep the Patients Compensation Fund's annual assessment to health care providers at a low rate and protect the Fund's financial status; (4) reduce overall health care costs for consumers of health care by lowering malpractice premiums; and (5) encourage health care providers to practice in Wisconsin, including the related objectives of avoiding the practice of defensive medicine and retaining malpractice insurers in Wisconsin.

The court stated that no rational basis exists for treating the most seriously injured patients of medical malpractice less favorably than those less seriously injured.

The court addressed whether a rational relationship exists between the legislative objective of compensating victims fairly and the classification of medical malpractice victims into two groups--those who suffer noneconomic damages under $350,000 and those who suffer noneconomic damages over $350,000. **The court noted that young people are most affected by the $350,000 cap on noneconomic damages, not only because they suffer a disproportionate share of serious injuries from malpractice, but because they can expect to be affected by those injuries over a 60-year or 70-year life expectancy.** The court stated that no rational basis exists for treating the most seriously injured patients of medical malpractice less favorably than those less seriously injured. It also stated that no rational basis exists for forcing the most severely injured patients to provide monetary relief to health care providers and their insurers. It therefore concluded that a rational relationship does not exist between the classifications of victims in the $350,000 cap and the legislative objective of fairly compensating victims of malpractice.

The court stated that the Legislature's decision fixing a numerical cap must be accepted unless the court can say that "...it is very wide of any reasonable mark." [*Ferdon*, par. 111.] For reasons set forth in the opinion, the court concluded that the $350,000 cap is unreasonable and arbitrary because it is not rationally related to the legislative objective of lowering malpractice premiums. The court cited studies that were noted in the *Martin* decision mentioned above, showing that a cap has an insignificant, if any, effect on malpractice costs. It referenced an indication by the Commissioner of Insurance that a number of factors affect malpractice premiums and that it would be difficult to draw any conclusions from premium numbers based solely on the enactment of the 1995 cap. Although the court noted that the

Commissioner of Insurance mentioned that rate stability could be dramatically impacted for both the Fund and primary insurers if the cap were removed, the court also stated that insurers do not face the possibility of unlimited noneconomic damages because their liability is limited to $1,000,000 per occurrence and $3,000,000 per year.

The court cited a General Accounting Office (GAO) study that concluding that malpractice claims payments against all physicians between 1996 and 2002 tended to be lower and grow less rapidly in states with noneconomic damage caps. However, it also noted that GAO stated the differences in both premiums and claims payments are affected by multiple factors in addition to damage caps, including state premium rate regulation, level of competition among insurers, and interest rates and income returns that affect insurers' investment returns.

The court found that the Fund has operated and been fiscally sound when there were no caps on noneconomic damages, when there was a $1,000,000 cap on noneconomic damages, and since 1995 when there has been an inflation-adjusted $350,000 cap. [*Ferdon*, par. 144.] The $1,000,000 cap was in effect from 1986 until it sunsetted in 1991, and a new $350,000 cap was not enacted until 1995. [An earlier $500,000 cap on malpractice awards was created in 1975, but was contingent on the Fund dropping below a certain dollar level, which never occurred.] In summary, **the court stated that the Fund has flourished both with and without a cap, and therefore the rational basis standard requires more to justify the $350,000 cap as rationally related to the Fund's fiscal condition.** [*Ferdon*, par. 158.]

In addressing the legislative objective of lowering overall health care costs for consumers, the court noted that medical malpractice premiums are an exceedingly small portion of overall health care costs. It observed that the direct cost of medical malpractice insurance is less than 1% of total health care costs. **Therefore, it concluded:**

> **Accordingly, there is no objectively reasonable basis to conclude that the $350,000 cap justifies placing such a harsh burden on the most severely injured medical malpractice victims, many of whom are children.** [*Ferdon*, par. 165; emphasis added.]

With regard to the issue of physician migration, the court stated that studies indicate that caps on noneconomic damages do not affect this migration. For example, the court cited the Office of the Commissioner of Insurance's reports on the impacts of the 1995 law that established the $350,000 cap and observed that the reports do not attribute either the increases or decreases that occurred in the various years in the number of health care providers to the 1995 law, much less to the $350,000 cap. Therefore, the court concluded that the $350,000 cap is not rationally related to the objective of ensuring quality health care by creating an environment that health care providers are likely to move into or less likely to move out of. **It stated: "(t)he available evidence indicates that health care providers do not decide to practice in a particular state based on the state's cap on noneconomic damages."** [*Ferdon*, par. 171; emphasis added.]

The court noted that there is anecdotal support for the assertion that doctors practice defensive medicine, but found an accurate measurement of the extent of this phenomenon is virtually impossible. It cited the finding of three independent, nonpartisan governmental agencies that

defensive medicine cannot be measured accurately and does not contribute significantly to the cost of health care. It held that the evidence does not suggest that a $350,000 cap is rationally related to the objective of ensuring quality health care by preventing physicians from practicing defensive medicine.

In conclusion, the court held that the challengers of the statute have met their burden and demonstrated that the $350,000 cap in the statutes is unconstitutional beyond a reasonable doubt. It held that the cap violated the equal protection guarantees of the Wisconsin Constitution and therefore it did not need to address the other state constitutional challenges.

CONCURRING OPINION

While the concurring opinion by Justice Crooks, joined by Justice Butler, stated that it joined the majority opinion and its holding that the $350,000 cap on noneconomic medical malpractice damages violates the equal protection guarantees of the State Constitution, the concurring opinion also stated:

> I write separately, however, to emphasize that statutory caps on noneconomic damages in medical malpractice cases, or statutory caps in general, can be constitutional. While the majority states that this case does not take issue with the constitutionality of all statutory caps, see majority op., par. 13, I want to stress that such caps can satisfy the requirements of the Wisconsin Constitution. [*Ferdon*, par. 189.]

The opinion went on to state that the legislative objectives, when reviewed in accord with a rational basis test, provide insufficient justification for that cap under the equal protection clause, and also that the $350,000 cap is "too low" to satisfy the right to a jury trial and the right to a remedy, guaranteed by art. I, ss. 5 and 9 of the Wisconsin Constitution.

The concurring opinion stated that "(i)t seems as if the $350,000 figure was plucked out of thin air."

The concurring opinion observed that the history behind the Legislature's setting of caps for noneconomic damages in malpractice actions "...demonstrates arbitrariness, and leads to a conclusion that a rational basis justifying the present cap was, and is, lacking." [*Ferdon*, par. 190; emphasis added.] The opinion noted that the caps have changed from no cap, to $1,000,000, back to no cap, and finally to $350,000 over the course of 20 years. The concurring opinion stated that "(i)t seems as if the $350,000 figure was plucked out of thin air." [*Ferdon*, par. 191.]

The concurring opinion raised the question if $1,000,000 was the appropriate figure for the cap in 1986, how can a $350,000 cap satisfy the constitutional requirements nine years later?

The concurring opinion concluded:

> In sum, I conclude that this particular cap on noneconomic damages, set arbitrarily and unreasonably low by the legislature, violates Article I, Section 1, as well as Article I, Section 5 interpreted

in conjunction with Article I, Section 9, of the Wisconsin Constitution.

Wisconsin can have a constitutional cap on noneconomic damages in medical malpractice actions, but there must be a rational basis so that the legislative objectives provide legitimate justification, and the cap must not be set so low as to defeat the rights of Wisconsin citizens to jury trials and to legal remedies for wrongs inflicted for which there should be redress. [*Ferdon*, pars. 195 and 196.]

DISSENTING OPINION

The dissenting opinion by **Justice Prosser** stated that Matthew Ferdon suffered a life-changing injury to his arm at birth as a result of medical malpractice and that he deserves fair compensation. It noted that years ago, the Legislature established a patient's compensation system, including mandatory health care provider insurance and a Patients Compensation Fund. It stated that to stabilize liability costs in this guaranteed payment system, the Legislature capped noneconomic damages "...that compensate a patient for such unquantifiable harms as pain and suffering." [*Ferdon*, par. 200.]

This court is not meant to function as a "super-legislature," constantly second-guessing the policy choices made by the legislature and governor. [*Ferdon*, par. 204.]

The dissenting opinion went on to state that some members of the court, irrespective of what they say, believe that all caps on noneconomic damages are unconstitutional. It cited the concurring opinion that contended that some damage caps are constitutional, but not the caps set by the Legislature in this case. The dissent stated: (t)his court is not meant to function as a "super-legislature," constantly second-guessing the policy choices made by the legislature and governor. [*Ferdon*, par. 204.]

The dissenting opinion concentrated on three issues: (1) the majority's adoption of a "rational basis with teeth" standard, which the dissent characterized as intermediate scrutiny without an articulation of the factors that trigger it; (2) the broad sweep of the majority's rationale in relation to the narrow issue before the court; and (3) the majority's conclusion that the Legislature had no rational basis for enacting the malpractice noneconomic damage cap.

The dissenting opinion first disagreed with the majority's ultimate determination of the applicable level of scrutiny. It noted that the majority stated it was using the rational basis test, but also mentioned "rational basis with teeth" and "meaningful rational basis." The dissent contended that perfection is not required and that the rational basis test "does not require a statute to treat all persons identically, but it mandates that any distinction must have some relevance to the purpose for which the classification is made." [*Ferdon*, par. 216, citing *Doering v. WEA Ins. Group*, 193 Wis. 2d 118, 532 N.W.2d 432 (1995).] The dissent observed that in Wisconsin, until today, there was only one rational basis test and that now there are two.

The dissent next objected to "...the exceedingly broad scope of the majority's rationale, in light of the narrow issue before us." [*Ferdon*, par. 224.] It noted that the majority held that the cap violates equal protection because persons who suffer the most injuries will not be fully

compensated for their noneconomic damages, while those who suffer relatively minor injuries with lower noneconomic damages will be fully compensated. The dissent observed:

> Such a statement would be true of any cap on damages. All caps have that effect. [*Ferdon*, par. 225.]

For example, the dissenting opinion cited the statute that limits damages against state employees to $250,000. The dissenting opinion strongly disagreed with the majority's conclusion that the Legislature did not have a rational basis to enact the noneconomic damages cap.

The dissenting opinion also criticizes the majority's attack on the effectiveness of noneconomic damage caps anywhere and its conclusion that no such cap has had any effect at all on any of the five legislative objectives summarized in the majority opinion:

> The breadth of this holding is staggering. It means that, contrary to the majority's narrow statement of the issue, it will be very difficult for Wisconsin legislators to re-enact a cap on noneconomic damages in the future. The majority has attempted to insulate its ruling from legislative reaction and redress by making its ruling so broad. [*Ferdon*, par. 236.]

The dissenting opinion stated that the cap: (1) helps ensure adequate compensation at a reasonable cost; (2) reduces the size of malpractice awards, thereby reducing premiums; (3) protects the financial status of the Patients Compensation Fund and keeps annual provider assessments to a reasonable level; (4) reduces the overall cost of health care; and (5) encourages providers to stay in Wisconsin and reduces the practice of defensive medicine. In support of its statement that the cap protects the Fund's financial status, the dissenting opinion notes that the Fund had deficits prior to the 1986 enactment of the $1,000,000 cap on noneconomic damages, and that three years after enactment of that cap, the deficits began to decrease. It then shows that three years after the passage of the 1995 law that enacted the $350,000 cap, the Fund began to show accounting surpluses.

With regard to the issue of physician retention in Wisconsin, the dissenting opinion states that the cap encourages health care providers to remain in Wisconsin. It states as follows:

> Wisconsin is not in a medical malpractice crisis because the legislature has addressed it through tort reform. By undoing the work of the legislature, the majority will drag Wisconsin back into the crisis. It is disingenuous to claim that Wisconsin is not experiencing a physician migration problem and use that as a reason to get rid of the cap, when the cap is one reason that Wisconsin has no migration problem at this time. [*Ferdon*, par. 294.]

On this issue, the dissenting opinion cites a federally commissioned study that concluded that **states with a cap average 24 more physicians per 100,000 residents than states without a cap**. This means that states with a cap have about 12% more physicians per capita

than states without a cap. The dissenting opinion states that the Legislature "...unquestionably had a rational basis to conclude" that the noneconomic damage cap would both keep physicians in Wisconsin and reduce the practice of defensive medicine. [*Ferdon*, par. 308.]

It stated that "(t)he court should not second guess the legislature." [*Ferdon*, par. 314.]

The dissenting opinion summarized by stating that in 1995, the Legislature approved comprehensive medical malpractice reform and that over the past decade, "it has been very successful." It also stated that upon reviewing validly enacted legislative acts, the court is supposed to recognize that it is the Legislature's function, not the court's, to evaluate studies and reports. It stated that "(t)he court should not second guess the legislature." [*Ferdon*, par. 314.]

DISSENTING OPINION

The dissenting opinion by **Justice Roggensack** began by stating that a statute that is challenged on equal protection grounds is presumed to be constitutional, and that any doubt about the constitutionality is to be resolved in favor of upholding its constitutionality. A party challenging a statute's constitutionality must demonstrate that the statute is unconstitutional beyond a reasonable doubt. In citing an earlier decision of the court, the dissenting opinion observed:

> We recognized that legislatively chosen classifications are matters of line-drawing that might not be precise and that at times can produce some inequities, but that our goal was simply to determine whether the statutory scheme advances a stated legislative objective or an objective that the legislature may have had in passing the statute. [*Ferdon*, par. 326.]

In citing earlier decisions, the dissenting opinion stated that under the rational basis test, which has been used for more than 30 years, a classification that is part of a legislative scheme will pass the test if it meets the following five criteria:

(1) All classifications must be based upon substantial distinctions which make one class really different from another.

(2) The classification adopted must be germane to the purpose of the law.

(3) The classification must not be based upon existing circumstances only. [It must not be so constituted as to preclude addition to the numbers included within the class.]

(4) To whatever class a law may apply, it must apply equally to each member thereof.

(5) That the characteristics of each class should be so far different from those of other classes as to reasonably suggest at least the propriety, having regard to the public good, of substantially different legislation. [*Ferdon*, par. 327.]

The dissenting opinion stated that applying the five-step rational basis test, it concluded that the cap on noneconomic damages has a rational basis and therefore does not violate the plaintiff's right to equal protection of the law.

The dissenting opinion stated that applying the five-step rational basis test, it concluded that the cap on noneconomic damages has a rational basis and therefore does not violate the plaintiff's right to equal protection of the law.

The dissent noted that when the Legislature enacted the chapter of the statutes relating to medical malpractice, it made 11 specific findings about its reasons for doing so and that these findings are entitled to great weight in the court's consideration of whether a statute has a rational basis. It noted that the majority opinion, in summarizing the 11 legislative findings into five objectives, omitted some of the legislative findings and their content.

The dissenting opinion stated that the cap is rationally related to the Legislature's goal of reducing the size of medical malpractice verdicts and settlements, so that the premiums for medical malpractice will be contained. It stated that in moving toward this goal, the Legislature made a rational policy choice that some victims of medical malpractice would not receive all of their noneconomic damages for the public good and that is a choice that any cap will have to make, no matter what the amount. It noted that **the Legislature made this choice as part of a comprehensive plan that "fully compensated all victims of medical malpractice for all the other damages they sustained.**" [*Ferdon*, par. 331, underlining in original text.]

The dissenting opinion criticized the concurring opinion which joins in striking down the noneconomic damages cap statute, but says that a cap in some higher amount might be constitutional. The dissenting opinion also asked if the cap (which is now $445,755) is too low, what is high enough and who gets to determine that?

The dissenting opinion also criticized the majority opinion for conducting a "mini-trial" to find facts that it then uses to say that reasons that the Legislature set out are not borne out by the evidence it has examined. The opinion stated that the majority conducts its trial without the benefit of witnesses, without giving each of the parties an opportunity to submit relevant evidence, and "conveniently ducks evidence that does not fit with its conclusion." [*Ferdon*, par. 346.] It stated that the process the majority employs gives no weight to the legislative findings, which are supposed to be given great weight by the court. It also stated that it does not give the benefit of any doubt to the Legislature, as the court should do if it is to accord the Legislature the respect of a co-equal branch of government.

CONCLUSION

The majority opinion in *Ferdon* held that Wisconsin's statutory cap on noneconomic damages in medical malpractice cases violates the equal protection provision of the Wisconsin Constitution. Because it decided the case on this ground, it stated that it was unnecessary to address the plaintiff's other state constitutional challenges to the statute. However, the concurring opinion stated that the statute also violates the state constitutional provisions granting the right to a trial by jury and the right to a remedy.

The Legislature could consider two options to address the court's concerns: (1) legislation; and (2) a state constitutional amendment. Although legislation might address some of the court's

concerns, there is no guarantee that modifying the statute will satisfy enough of the court's concerns to allow a new statute to pass constitutional muster.

The memorandum was prepared by Richard Sweet, Senior Staff Attorney, on July 26, 2005. The information memorandum is not a policy statement of the Joint Legislative Council or its staff.

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The History of Chapter 655 and Limits on Non-Economic Damages in Wisconsin Health Care Liability Cases

By: Timothy J. Muldowney and Jennifer L. Peterson
LaFollette Godfrey & Kahn

Ruth M Heitz, JD
General Counsel, Wisconsin Medical Society

Statutory History

- 1975: Chapter 37, Laws of 1975 creates Chapter 655 of the Wisconsin Statutes; awards are limited to $500,000 if the Fund's assets fall below certain levels.

- 1986 to 1991: Non-economic damages are limited to $1,000,000.

- 1995 to 2005: Non-economic damages are limited to $350,000, adjusted for yearly inflation.

Legislative Findings (supporting Chapter 37, Laws of 1975, § 1)

(1) The legislature finds that:

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

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

(c) These increased insurance costs are being passed on to patients in the form of higher charges for health care services and facilities;

(d) The increased costs of providing health care services, the increased incidents of claims and suits against health care providers and the size of such claims and judgments has caused many liability insurance companies to withdraw completely from the insuring of health care providers;

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

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

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

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

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

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

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

Selected Court Challenges to Chapter 655

- *State ex rel. Strykowski v. Wilkie*, 81 Wis. 2d 491, 261 N.W.2d 434 (1978). The Wisconsin Supreme Court concluded that Chapter 655 does not violate equal protection or due process guarantees, does not constitute an unlawful delegation of judicial authority, and does not impair a malpractice claimant's right of trial by jury.

- *Rineck v. Johnson*, 155 Wis. 2d 659, 456 N.W.2d 336 (1990). The Wisconsin Supreme Court held that the $1,000,000 cap superceded the lower cap for wrongful death where the death resulted from medical malpractice.

- *Martin v. Richards*, 192 Wis. 2d 156, 531 N.W.2d 70 (1995). The Wisconsin Supreme Court held that a retroactive application of the $1,000,000

statutory cap on non-economic damages in medical malpractice cases does not violate substantive due process.

- *Jelinek v. St. Paul Fire & Casualty Ins. Co.*, 182 Wis. 2d 1, 512 N.W.2d 764 (1994). The Wisconsin Supreme Court held that, in light of the sunset of the $1,000,000 statutory cap, recovery of non-economic damages in medical malpractice cases involving death was unlimited.

- *Czapinski v. St. Francis Hosp., Inc.*, 2000 WI 80, 236 Wis. 2d 316, 613 N.W.2d 120. The Court of Appeals held that the statutory cap on non-economic damages in wrongful death medical malpractice cases, Wis. Stat. § 893.55(4)(f), does not violate the equal protection clause of the Wisconsin Constitution.

- *Guzman* v. *St. Francis Hosp., Inc.*, 2001 WI App 21, 240 Wis. 2d 559, 623 N.W.2d 776. The Court of Appeals, in three separate opinions, held that the statutory cap on non-economic damages in Wis. Stat. §§ 655.017 and 893.55(4)(d) is constitutional and does not violate the right to a trial by jury, the right to a remedy clause, substantive due process or the doctrine of separation of powers.

- *Maurin v. Hall*, 2004 WI 100, 274 Wis. 2d 28, 682 N.W.2d 866. The Wisconsin Supreme Court held that the cap on non-economic damages in wrongful death medical malpractice cases does not violate the equal protection clause.

- *Ferdon v. Wisconsin Patients Compensation Fund*, 2005 WI 125, 701 N.W.2d 440. The Wisconsin Supreme Court held the statutory cap on non-economic damages in medical malpractice cases violates the equal protection clause of the Wisconsin Constitution.

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CLE ON MEDICAL MALPRACTICE

Wisconsin Legislative Council

September 21, 2005

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MYTH:

Medical malpractice costs are a substantial factor in driving up health costs.

REALITY:

Medical malpractice expenses are a tiny part of total health care spending.

EVIDENCE

Overall tort expenditures are less than the cost of medical injuries. Total national costs (lost income, lost household production, disability and health care costs) of negligence in hospitals are estimated to be between $17 billion and $29 billion each year.[1] Awards, legal costs and insurance cost an estimated $6.5 billion, or 0.46 percent of total health care spending in 2001.[2] This is at least three to four times less than the cost of medical negligence to society.

Malpractice insurance costs amount to only 3.2 percent of the average physician's revenues. According to experts at the Medicare Payment Advisory Commission (MedPAC), liability insurance premiums make up just a tiny part of a physician's expenses and have increased by only 4.4 percent over the past year.[3] The increase in this expense is noticeable primarily because of the decreases in reimbursements that doctors are receiving from HMOs and government health programs.

Malpractice insurance costs have risen at half the rate of medical inflation, debunking the myth of "out-of-control juries." While medical costs have increased by 113 percent since 1987, the total amount spent on medical malpractice insurance has increased by just 52 percent over that time—less than half of medical services inflation.[4]

Government data show that medical malpractice awards have increased at a slower pace than either malpractice premiums for doctors or health insurance premiums for consumers. According to the federal government's National Practitioner Data Bank, the median medical malpractice payment by a physician to a patient rose 35 percent from 1997 to 2000, from $100,000 to $135,000.[5] But during the same time, the average premium for single health insurance coverage has increased by 39 percent.[6] Malpractice claim payout increases have actually slowed to 1.6% a year from 2000 to 2003 — below the rate of inflation.[7]

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[1] *To Err is Human; Building a Safer Health System,* Institute of Medicine, National Academy of Science 1999.
[2] Gerald F. Anderson, et al., "Health Spending In The United States And The Rest Of The Industrialized World," *Health Affairs,* Vol. 24, Issue 4, 903-914, July-August 2005.
[3] Official Transcript, Medicare Payment Advisory Commission, Public Meeting, December 12, 2002.
[4] Office of the West Virginia Insurance Commission, *Medical Malpractice: Report on Insurers with over 5% Market Share* (November 2002)
[5] National Practitioner Data Bank Annual Reports, 1997 through 2001.
[6] Kaiser Family Foundation and Health Research and Educational Trust, Employer Health Benefits Surveys, 1998-2002; National Practitioner Data Bank Annual Reports, 1997 through 2001.
[7] Chandra, Amitabh, "The Growth of Physician Medical Malpractice Payments: Evidence From The National Practitioner Data Bank," *Health Affairs,* Vol. 24, Issue 3, W5-240-249, May-June 2005.

So-called "defensive medicine" is a red herring. Only a small percentage of diagnostic procedures — "certainly less than 8 percent" — are performed because of a concern about malpractice liability.[8] The General Accounting Office (GAO) found that (1) some defensive medicine is good medicine, (2) managed care discourages bad defensive medicine, and (3) doctors do defensive medicine because they make money from defensive medicine.[9]

Ferdon Decision

¶126 One reason that the cap does not have the expected impact on medical malpractice insurance premiums may be that a very small number of claims are ever filed for medical injuries, and even fewer of any eventual awards are for an amount above the cap. (Footnotes omitted)

¶127 Articles and studies, including a General Accounting Office study, indicated that in 1984, 57% to 70% of all claims resulted in no payment to the patient. Wisconsin statistics are similar. According to information derived from the Office of Medical Mediation Panels, from 1989 through 2004 a little more than 10% of the claims filed resulted in verdicts, with only about 30% of those favorable to the plaintiffs. In 2004, out of the 23 medical malpractice verdicts in Wisconsin, only four were in favor of the plaintiffs. (Footnotes omitted)

¶128 Victims of medical malpractice with valid and substantial claims do not seem to be the source of increased premiums for medical malpractice insurance, yet the $350,000 cap on noneconomic damages requires that they bear the burden by being deprived of full tort compensation. (Footnote omitted)

¶129 Based on the available evidence from nearly 10 years of experience with caps on noneconomic damages in medical malpractice cases in Wisconsin and other states, it is not reasonable to conclude that the $350,000 cap has its intended effect of reducing medical malpractice insurance premiums. We therefore conclude that the $350,000 cap on noneconomic damages in medical malpractice cases is not rationally related to the legislative objective of lowering medical malpractice insurance premiums. (Footnote omitted)

¶174 Three independent, non-partisan governmental agencies have found that defensive medicine cannot be measured accurately and does not contribute significantly to the cost of health care. (Footnote omitted.)

¶175 The evidence does not suggest that a $350,000 cap on noneconomic damages is rationally related to the objective of ensuring quality health care by preventing doctors from practicing defensive medicine. We agree with the non-partisan Congressional Budget Office's finding that evidence of the effects of defensive medicine was "weak or inconclusive." (Footnote omitted.)

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[8] Office of Technology Assessment, *Defensive Medicine and Medical Malpractice,* OTA-H602 pg. 74 (July 1994).
[9] GAO-03-836, "Medical Malpractice and Access to Health Care," pgs. 26-27, August 2003.

MYTH:

Wisconsin's high health costs are caused by numerous medical malpractice claims.

REALITY:

There is no medical malpractice crisis in Wisconsin.

EVIDENCE

***Expansion Magazine* has rated Wisconsin's malpractice costs as the lowest in the nation, *just 39 cents out of each $100 spent on health care*.**[10] The national average is 46 cents for every $100. Meanwhile, Wisconsin health insurance premiums are rated second highest in the nation. There is no correlation between malpractice costs and health care costs.

In Wisconsin, a state with 5.5 million people, only 240 medical negligence claims were filed in 2004 with the Medical Mediation Panels. **That is one claim for every 22,916 Wisconsin citizen.**[11]

Between 1995-2005, when the cap was in effect, there were only nine verdicts in which the jury awarded more than the cap amount to an injured patient.[12] The total amount of money that was denied to the nine people because of the cap was just over $10 million, about $1 million per year. **That comes to 18 cents per person in Wisconsin per year.**

If you compare the actual dollars, in 2003 Wisconsin doctors were spending ***less money*** on medical malpractice insurance than they did in 1989 — $118 to $112.5 million.[13]

49th in US

The frequency of awards in Wisconsin rank 49th lowest out of the 50 states on a per-capita basis, with only the state of Alabama lower.

Source: National Practitioners Databank Reports 1992-2002.

According to the National Practitioners Data Bank, in 2003 Wisconsin was the third lowest state in the number of doctors, per 1,000 doctors, for whom claims were paid to injured patients.[14] This demonstrates that many people injured by medical negligence in Wisconsin go uncompensated. Nor was that ranking due to the cap. Wisconsin was the third lowest state for the number of payments per 1,000 doctors in both 1994 and 1995, before the cap took effect.[15]

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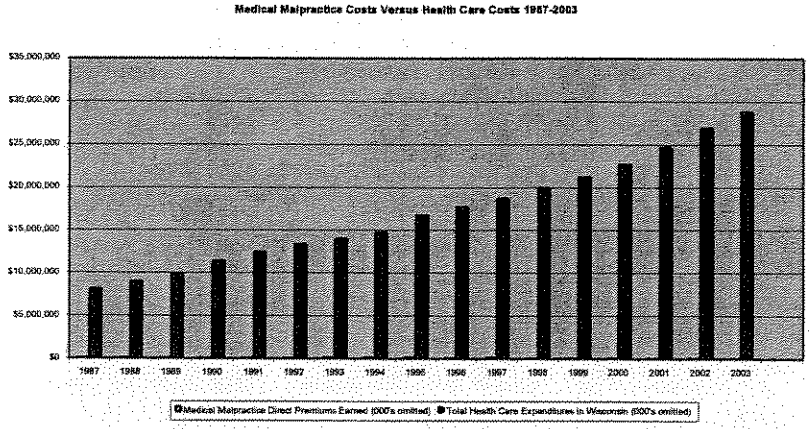
[10] From the Wisconsin Insurance Report, Office of the Commissioner of Insurance, Years 1987-2002.
[11] Randy Sproule, Medical Mediation Panels.
[12] Information obtained from Randy Sproule, Medical Mediation Panels.
[13] From the Wisconsin Insurance Report, Office of the Commissioner of Insurance, Years 1989 & 2003.
[14] 2004 National Practitioner Data Bank Annual Report.
[15] 1999 National Practitioner Data Bank Annual Report.

Medical malpractice costs are a drop in the bucket compared to health care costs in Wisconsin. In 2003, Wisconsinites spent an estimated $28.8 *billion* on health care costs compared with $112.5 *million* for medical malpractice costs.[16]



Insurers of health care providers thrive in Wisconsin. Wisconsin medical malpractice insurers had the lowest loss ratios (the percentage of each premium dollar spent in paying claims and claim expenses) in the country in 2002.[17] Physicians Insurance Company of Wisconsin, Wisconsin's largest malpractice insurer, has seen its assets increase by $92 million from 2001 to 2004.[18] It paid dividends to its stockholders averaging over $833,000 per year from 1999 through 2002.[19] Its 2003 report to the Office of the Commissioner of Insurance showed that it earned premiums of over $37 million and expected its direct losses to be a negative number, giving it a pure loss ratio of 0.0%. That profitability was not due to the cap. Wisconsin malpractice insurers had a pure loss ratio in 1994, the year before the cap was enacted, of 42.4%. That means out of every dollar collected for premiums, only 42 cents were paid out in claims. In that year, the Wisconsin insurers had premiums written in the amount of $79.4 million and paid claims of $30.1 million.[20]

Ferdon Decision

¶ 162 [M]edical malpractice insurance premiums are an exceedingly small portion of overall health care costs. (Footnote omitted.)

¶165 ... even if the $350,000 cap on noneconomic damages would reduce medical malpractice insurance premiums, this reduction would have no effect on consumer's health care costs. Accordingly, there is no objectively reasonable basis to conclude that the $350,000 cap justifies placing such a harsh burden on the most severely injured medical malpractice victims, many of whom are children.

¶166 We agree with those courts that have determined that the correlation between caps on noneconomic damages and the reduction of medical malpractice premiums on overall health care costs is at best indirect, weak, and remote. (Footnote omitted.)

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[16] U.S. Census Bureau, STATISTICAL ABSTRACT OF THE UNITED STATES: 2004-05, pages 92, 93 & 96. Years 1999-2003 are also estimated based on annual percent changes of 6.3% in 1999, 7.1% in 2000, 8.5% in 2001, 9.3% in 2002. Year 2003 is estimated based on a projected rate increase of 7.2%.

[17] Eric Nordman, et al., "Medical Malpractice Insurance Report: A study of Market Conditions and Potential Solutions to the Recent Crisis," National Association of Insurance Commissioners, page 78, September 2004.

[18] Physicians Insurance Company of Wisconsin, Inc.
https://ociaccess.oci.wi.gov/CmpInfo/GetFinancialData.oci?cmpId=0

[19] Physicians Insurance Company of Wisconsin, Inc. 2003 Annual Report, page 24.

[20] Wisconsin Insurance Report Business of 2003, page 104.

MYTH:

Rising medical malpractice costs are forcing good doctors to quit practicing or leave their states.

REALITY:

Doctors are not fleeing states in droves, despite increasingly frantic and unsupported claims from the American Medical Association, the insurance industry and their allies.

EVIDENCE

Doctors not Leaving. In 2003 the *Washington Post* reported at least 1,000 doctors had left Pennsylvania in recent years because of rising malpractice premiums caused by lawsuits. That was not true. This past April, the head of the state medical society said Pennsylvania had gained 800 more doctors the past two years. In addition, the insurance commissioner's office reported that malpractice payouts had fallen for the second year in a row and lawsuit filings were declining.[21]

Independent assessments by state officials and the media have found that the number of doctors in many states including Florida, Ohio, Pennsylvania and Washington, has remained stable and in most, has actually increased.[22]

Doctors wildly overstating claims. In 2003, the Government Accounting Office (GAO) reviewed claims by physicians that high medical malpractice premiums were causing doctors to flee states with high malpractice fees. Its review of five states concluded that the doctors have wildly overstated their case. "We also determined that many of the reported physician actions and hospital-based service reductions were not substantiated or did not widely affect access to health care" (p. 12). "Although some reports have received extensive media coverage, in each of the five states we found that actual numbers of physician departures were sometimes inaccurate or involved relatively few physicians" (p. 17). "Contrary to reports of reductions in mammograms in Florida and Pennsylvania, our analysis showed that utilization of these services among Medicare beneficiaries is higher than the national average in both [states]." (p. 21)[23]

Effect on OB/GYNs. UW Law School Professor Marc Galanter reviewed two Office of Technology Assessment studies that also fail to confirm the existence of a linkage between high malpractice premiums and doctors leaving the profession. The first study examined whether New York obstetrician/gynecologists (OB/GYNs) and family practitioners (FPs) who experienced high absolute increases in malpractice insurance premiums were more likely than physicians with lower premium increases to withdraw from obstetrics practice. The researchers found that "[m]edical malpractice insurance premium increases were not associated with physician withdrawal from obstetrics practice for either OB/GYNs of FPs." The second study

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[21] Stephanie Mencimer, "Trial and Error," Mother Jones, September/October 2004.

[22] FL, *Palm Beach Post* Editorial, 7/16/03; OH, *Toledo Blade*, 7/17/04; PA, *Allentown Morning Call*, 4/24/04; WA, *Seattle Times*, 2/23/04

[23] GAO-03-836 "Medical Malpractice and Access to Health Care," pgs. 26-27, August 2003.

looked at whether state premium levels and personal malpractice claims history accounted for whether OB/GYNs were practicing obstetrics at all. "The study found that OB/GYNs in states with greater liability threats and who reported higher personal malpractice exposure were more likely to be practicing obstetrics and had higher volumes of obstetric care than their counterparts."[24]

Effect on Rural Areas. A 1995 article reviewed a trend of worsening access to obstetrical care in some rural areas. The study concluded, "Contrary to what family physicians often claim, we found malpractice premium costs and Medicaid reimbursement rates were not associated with family physicians' likelihood of providing maternity care."[25]

REAL CAUSES OF PREMIUM HIKES

Rather than looking at medical malpractice lawsuits, perhaps the AMA should re-focus its scrutiny to the practices of insurance companies. The GAO confirms that one cause of the malpractice premium spike is that malpractice insurance firms artificially held down premiums while the stock and bond markets boomed in the late 1990s, and then got caught short when the market went sour in 2001. To make up for the shortfall, the industry jacked up rates severely in many states.[26]

The highly-conservative *Wall St. Journal* confirmed this analysis in its investigation of the malpractice premium crisis. It concluded in a front-page June 24, 2002 article:
"A price war that began in the early 1990's led insurers to sell malpractice coverage to obstetrician-gynecologists at rates that proved inadequate to cover claims...An accounting practice widely used in the industry made the area seem more profitable in the early 1990's than it really was. A decade of short-sighted price slashing led to industry losses of $3 billion last year."[27]

Ferdon Decision

¶168 Studies indicate that caps on noneconomic damages do not affect doctors' migration. The non-partisan U.S. General Accounting Office concluded that doctors do not appear to leave or enter states to practice based on caps on noneconomic damages in medical malpractice actions. (Footnote omitted.)

¶170 The Wisconsin Office of the Commissioner of Insurance's biennial reports on the impact of 1995 Wis. Act 10 examine the Act's impact on the number of health care providers in Wisconsin. The Commissioner's 2003 report shows a slight decrease in the number of providers. The Commissioner's 2005, 2001, and 1999 reports show a slight increase in the number of health care providers. The Commissioner's reports do not attribute either the increases or decreases in the number of health care providers to 1995 Wis. Act 10, much less to the $350,000 noneconomic damages cap. (Footnotes omitted.)

¶171 The available evidence indicates that health care providers do not decide to practice in a particular state based on the state's cap on noneconomic damages.

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[24] Galanter, *Real World Torts: An Antidote to Anecdote,* 55 MD. L. REV. 1093, 1144-45 (1996).
[25] D. Pathman & S. Tropman, *Obstetrical Practice Among New Rural Family Physicians,* 40 JOURNAL OF FAMILY PRACTICE, No. 5, pp. 457, 463 (May 1995).
[26] GAO-03-702, "Medical Malpractice Insurance: Multiple Factors Have Contributed to Premium Increases," June 2003.
[27] Rachel Zimmerman & Christopher Oster, "Insurers Missteps Helped Provoke Malpractice 'Crisis,'" *Wall Street Journal*, p. 1, June 24, 2002.

MYTH:

"Tort reform" and caps on damages have succeeded in holding down health care costs and medical malpractice premiums in states that have adopted them.

REALITY:

Caps on damages discriminate against the most severely injured and have not lowered health care costs.

EVIDENCE

Medical Malpractice Insurance Rates Not Reduced with Caps. The 2003 Weiss Report found that despite caps on economic damages in 19 states, "most insurers continued to increase premiums (for doctors) at a rapid pace, regardless of caps." The report found that insurers failed to pass along any savings to physicians in states with caps by refusing to lower their insurance premiums, and that caps only slowed the increase in the amount of damages insurers were required to pay out.[28]

Ironically, the Weiss study also found premiums are actually higher in states with caps than in those without. The average malpractice premium in states without caps was $35,016 in 2003. The average premium in states with caps was $40,381.[29] But despite this well-documented differential, many doctors have been stampeded into clamoring for caps as a "solution" to their sharply-rising premiums.

In recent years, at least 40 states have enacted some sort of "tort reform"; since 2002 alone, Florida, Mississippi, Nevada, Ohio, Oklahoma, and Texas have done so. Interestingly, in each state, immediately after the legislation passed, insurers sought rate increases — ranging from a minimum of 20 percent all the way up to 93 percent.

Capping Noneconomic Damages No Panacea. A recent insurance company memo explains how little noneconomic damages have to do with medical malpractice insurance. The insurer was asking for a rate increase of 27% per occurrence or 41% claims made coverage in Texas after the passage of Proposition 12, capping noneconomic damages in medical malpractice cases. The memo states:

"Noneconomic damages are a small percentage of total losses paid. Capping noneconomic damages will show loss savings of 1.0%."[30]

Instead of a frantic, ill-considered rush toward more restrictions on citizen's legal rights like caps, all the major players must seriously examine the roots of the recent epidemic of rate increases in many states. Most recently, a doctor in Connecticut signed a letter along with the state trial lawyer association and two patient groups challenging a recent rate increase of a

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[28] Martin D. Weiss, Ph.D., et al., *Medical Malpractice Caps: The Impact of Non-Economic Damage Caps on Physician Premiums, Claims Payout Levels, and Availability of Coverage,* Weiss Ratings, Inc., June 2003.
[29] *Medical Liability Monitor*, October 2003.
[30] The Medical Protective Company, Texas Physician and Surgeons Actuarial Tort Reform Memorandum, found at www.aisrc.com/caps.pdf.

medical malpractice insurer. The letter prompted the Commissioner to hire an outside actuary to review the rate hike.[31]

A One-Sized Cap is Unfair. A study from the Harvard School of Public Health indicates that caps on non-economic damages result in inequitable payouts across different types of injuries and limits patients' ability to be fairly compensated for their pain and suffering.[32]

The study analyzed a sample of jury verdicts in California that were subjected to the state's $250,000 cap on non-economic damages. They found that reductions imposed on grave injuries were seven times larger than those for minor injuries. People suffering from pain and disfigurement had particularly large reductions in their awards.

Ferdon Decision

¶82: The $350,000 cap limits the claims of those who can least afford it; that is, the claims of those, including children such as Matthew Ferdon, who have suffered the greatest injuries. Thus, the cap's greatest impact falls on the most severely injured victims. (Footnote omitted.)

¶99 According to a 1992 report by the Wisconsin Office of the Commissioner of Insurance, children from ages 0 to 2 with medical malpractice injuries comprise less than 10% of malpractice claims, yet their claims comprise a large portion of the paid claims and expenses of insurers and the Fund. That is, "[p]laintiffs with the most severe injuries appear to be at the highest risk for inadequate compensation. Hence, the worst off may suffer a kind of 'double jeopardy' under caps." (Footnotes omitted.)

¶100 Furthermore, because an injured patient shares the cap with family members, the cap has a disparate effect on patients with families.

¶101 The legislature enjoys wide latitude in economic regulation. But when the legislature shifts the economic burden of medical malpractice from insurance companies and negligent health care providers to a small group of vulnerable, injured patients, the legislative action does not appear rational. Limiting a patient's recovery on the basis of youth or how many family members he or she has does not appear to be germane to any objective of the law.

¶102 If the legislature's objective was to ensure that Wisconsin people injured as a result of medical malpractice are compensated fairly, no rational basis exists for treating the most seriously injured patients of medical malpractice less favorably than those less seriously injured. No rational basis exists for forcing the most severely injured patients to provide monetary relief to health care providers and their insurers. (Footnote omitted.)

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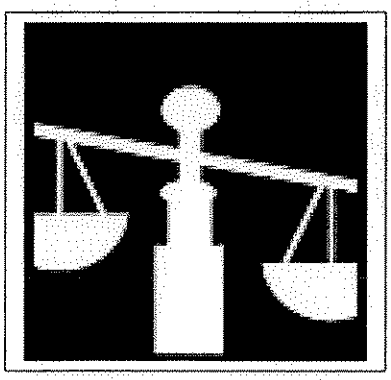
[31] Tanya Albert, AMNews staff. Oct. 18, 2004.

[32] David Studdert, Michelle Mello and Y. Tony Yang, *Journal Health Affairs*, July/August 2004, http://www.insurancejournal.com/news/national/2004/07/08/43841.htm.

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
May 2005

Wisconsin Citizen Action
&
Wisconsin Academy of Trial Lawyers

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Acknowledgements

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Executive summary

Wisconsin's cap on pain and suffering has been in effect for 10 years. This report reviews the impact of the cap on the civil justice system and whether the supposedly offsetting benefits of the cap — lower health care costs, access to doctors in underserved areas and saving the Fund from insolvency — have been realized.

The 1995 legislation capped pain and suffering awards at $350,000 (to be adjusted for inflation, and now at $445,755).[1] Yet because of the cap, the scales of justice are tilted against patients injured as a result of medical negligence who have been rendered disabled, disfigured, blind, or otherwise severely impaired.

Examining Wisconsin's 10 years of experience with the cap has had several regressive effects:

1) **The most severely disabled and disfigured patients have had their awards for lifelong pain and suffering artificially over-ruled by the Legislature's imposition of the cap.** Juries, judging the specific circumstances of each case, have levied awards in nine cases known to exceed the cap. But the jurors are never told that their decisions had been effectively overruled back in 1995 by legislators who imposed sweeping limits without regard to the particular merits of each case. While legislators may have imagined that they were somehow striking a blow at "frivolous" claims, they ironically wound up targeting precisely those victims whose claims were thoroughly investigated and fully adjudicated, and whose injuries were most severe. The cap affects those who suffer the most — individuals experiencing disfigurement, loss of a limb, paralysis, and deprivation of mental functioning.

2) **The cap arbitrarily closes the courtroom door to many Wisconsin families**. The decision to pursue malpractice damages is a difficult one for families. Families must weigh a host of often-intangible variables. At some point, the amount of potential compensation under the cap relative to the financial cost of pursuing the case must enter into the family's decision making. This is especially true for individuals with limited or no economic injury — children, stay-at-home parents, the elderly and the disabled. The cap is an arbitrary barrier to the courtroom for injured patients and their families.

3) **The imposition of the cap has perversely distorted the Injured Patients and Families Compensation Fund's purpose.** The Injured Patients and Families Compensation Fund has a mission of providing injured patients and their families with compensation while holding down malpractice fees. The Injured Patients and Families Compensation Fund has $741 million set aside for injured patients and their families. The financial capacity for "making whole" the lives of injured patients could not be more obvious. With the cap, the Fund's enormous assets are denied to patients for whom the jury has awarded compensation above the cap. Meanwhile, the Fund's assets, while barely tapped by injured patients, have been utilized to reduce Fund malpractice fees, which have been cut in **six** of the last **seven** years, most recently by 30%. The current level of malpractice fees set by the Fund is lower than in 1986.

In addition, the evidence of any so-called malpractice "crisis" should center on insurance company practices, not the judicial system. There is a wealth of data that clearly demonstrates there is a weak relationship between malpractice premiums and malpractice claims. Insurance executives themselves have bluntly admitted that the imposition of a cap on pain and suffering does not result in lower premiums.

When the cap was enacted, the citizens of Wisconsin were promised a set of benefits that would purportedly compensate for the severe restrictions imposed on the rights of injured patients. Health care would become more affordable, with the cap in place to hold down unnecessarily costly malpractice claims. The supply of doctors to under-served areas would be increased. Moreover, the projected perilous financial condition of the Fund would be stabilized to benefit doctors, injured patients and the general public.

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[1] 1995 Wisconsin Act 10.

In practice over the past decade, the tradeoff of legal rights for public benefits has proved to be disastrous. While our legal rights certainly were diminished, the promised benefits have never appeared:

- Wisconsin healthcare costs have kept escalating over the past 10 years, to the point where they rank second highest in the nation in terms of health insurance premiums. Meanwhile, malpractice costs in Wisconsin are ranked as the very lowest in the nation, clearly demonstrating that low malpractice costs do not produce affordable health care.
- The shortage of doctors in under-served rural and urban areas of Wisconsin continues, and may actually have grown more acute.
- Finally, it turns out that the Fund was never in financial jeopardy, and had actually been enjoying a surplus for five years before imposition of the cap.

By now, it is apparent that by imposing the cap, some degree of accountability for medical providers was inevitably sacrificed. In addition, families of severely injured patients are being asked to bear the burden of "fixing" the legal malpractice system alone. That is neither fair nor just.

The cap is an arbitrary barrier to the courthouse for injured patients and their families and strikes at the very heart of the civil justice system. It deprives juries of their constitutional mandate to do *justice* in individual cases. The scales of justice in Wisconsin are severely tilted against injured patients and their families as a result of a highly-restrictive cap on jury awards for pain and suffering imposed 10 years ago in 1995.

We believe there is only one solution to the current inequities: removal of the inequitable and unjust cap on pain and suffering. That solution is affordable given the Fund's enormous and steadily-growing reserves balanced against possible payouts. Most fundamentally, removal of the cap is also a moral imperative for a state that has long led the nation in progressive innovations that are both practical and compassionate.

Introduction

On May 10, 1995, Governor Tommy Thompson signed Wisconsin Act 10. The legislation capped pain and suffering damages in medical malpractice cases at $350,000 (to be adjusted for inflation, and now at $445,755),[2] it also adopted other tort "reforms" making it more difficult to bring claims against medical providers. As Gov. Tommy Thompson signed Wisconsin's cap on pain and suffering damages into effect, he declared that the new limits would help to "keep health care affordable and accessible."[3]

Major Provisions of 1995 Wisconsin Act 10

- ?? $350,000 cap on noneconomic damages, adjusted for inflation.
- ?? Periodic payments of future medical payments over $100,000 as incurred.
- ?? Periodic payment of large claims, where Fund payments exceed $1 million
- ?? Wrongful death limitation would now apply in medical malpractice cases
- ?? Admissibility of evidence of collateral sources

Ten years have passed since a cap was instituted in Wisconsin, an appropriate point in time to evaluate precisely how the cap has impacted patients and their families and whether the benefits of the cap — lower health care costs, access to doctors in underserved areas and saving the Fund from insolvency — have been realized.

The report is being presented by Wisconsin Citizen Action — the state's largest public interest organization with a long history of involvement in social and economic justice issues — and the Wisconsin Academy of Trial Lawyers — Wisconsin's largest statewide voluntary trial bar that seeks to preserve Wisconsin's civil jury trial system and whose members advocate for the legal rights of all Wisconsin citizens. The research in this report comes from the public record; it has been gleaned from articles and studies published in Wisconsin and throughout the United States.

The report pays particular attention to the impact of the cap on access to the civil jury system — especially the patients and their families bringing medical malpractice claims.

The report places the public spotlight on the condition of the Injured Patients and Families Compensation Fund (the Fund) over the past 10 years. The Fund now has more than $741 million in cash reserves and the fees recommended for health care providers for the 2005-06 fiscal year are lower than fees for 1984-85. Yet because of the cap, the designated beneficiaries of the Fund—victims of medical negligence who have been rendered disabled, disfigured, blind, or otherwise severely impaired—can only rarely benefit from the Fund.[4]

Finally, the report reviews the myths and promises proponents of caps made when they asked citizens to trade their legal rights for supposedly offsetting public benefits.

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[2] A cost of living adjustment will take place on May 15, 2005.

[3] Amelia Buragas, "Despite caps on jury awards, health premiums keep rising," *The Capital Times*, pg. 8A, Sept. 27, 2004.

[4] The Fund is defined as an "irrevocable trust for the sole benefit of health care providers participating in the fund and proper claimants." 2003 Wisconsin Act 111.

I. Denying Justice to Injured Patients and Their Families

The debate over the enactment of a cap on pain and suffering back in 1995 focused narrowly on the supposed economic benefits of tort "reform." Yet as *Business Week* recently stressed, "Tort reform, then, is more than an economic policy debate. It's also about justice—the ultimate values issue." [5]

However, these fundamental questions of justice and moral values for victims of medical malpractice were largely swept aside by a tidal wave of economically-premised arguments, which, as we will examine later, have all been proven false by a decade of experience. Concretely, the cap on pain and suffering has three major implications for Wisconsin families:

A. Caps deny compensation to the most severely-harmed patients

Caps ironically target the most severely injured patients who have a strong claim for compensation based on lifelong pain and suffering imposed by medical negligence. The cap comes into play only after a judge has found the case to have merit and permitted it to move to trial, and a jury has heard all the evidence and ruled in favor of the injured victim. A person whose noneconomic damages are less than the cap can recover 100 percent of his or her noneconomic loss. If the jury verdict exceeds the cap for pain and suffering, the cap is automatically invoked without regard to the specific circumstances of the case or the judgment of the jury. By statute, juries cannot be informed of the cap. The cap impinges on the jurors' constitutional mandate to do **justice** in an individual case because no matter what evidence is presented, no matter what injury was suffered, the damages cannot exceed the cap.

The cap impacts children injured at birth who suffer from brain injuries and physical disabilities, quadriplegics who will need life-long support for housing and transportation needs, persons injured with loss of sight, disfigurement, the inability to bear children, loss of senses or the loss of a limb, and other permanent life-altering impairments. These injuries cannot be measured in terms of lost wages or other economic calculations alone. A cap prevents severely injured patients from receiving a fair and adequate level of compensation for their substantial loss. No amount of compensation will ever make injured patients and their families' whole, but caps exacerbate an already inequitable problem.

Since the passage of the cap in 1995, we are aware of nine cases where juries took into account the full circumstances of the case and awarded pain and suffering compensation in excess of the cap.

Jury Verdict Date, County, Case #	Injured Patient and Age	Nature of injury	Noneconomic damages jury awarded, including pain and suffering	Final award	Percentage Reduced
April 2005 Milwaukee 2003CV3456	Joseph Richard mid-50's	He underwent an unnecessary removal of his rectum, with a leak of the anastomosis, ten further surgeries, and permanent bowel problems.	$540,000	$432,352	20%
May 2004 Marinette 2002CV60	David Zak mid-30s	Failure to diagnose suspicious infection causing body to shut down resulting in loss of bodily function	$1 million	$422,632	57%

[5] Mike France, et al, "How to Fix the Tort System," *Business Week*, March 14, 2005.

Jury Verdict Date, County, Case #	Injured Patient and Age	Nature of injury	Noneconomic damages jury awarded, including pain and suffering	Final award	Percentage Reduced
April 2004 Kenosha 2001CV1261	Estate of Helen Bartholomew Early 60s	Failure to diagnose heart attack causing massive heart and brain damage requiring her to live in nursing home and resulting in her death 3 years later	$1.2 million	$350,000	70%
Dec. 2003 Ozaukee 1999CV360	Sean Kaul infant	Negligent failure to provide timely and proper treatment for hypoglyceminia and hypovolemia that developed shortly after birth rendered child permanently disabled	$930,000	$422,632	55%
Dec. 2002 Brown 2001CV1897	Matthew Ferdon infant	Negligent delivery resulting in right arm being deformed and partially paralyzed	$700,000	$410,322	40%
June 2002 Dane 2000CV1715	Scott Dickinson mid-30s	Negligent treatment during a psychotic episode and rendered a quadriplegic.	$6.5 million	$410,322	93%
June 2001 Eau Claire 2000CV120	Kristopher Brown 16 years old	Negligent treatment of a broken leg resulting in part of the leg being amputated	$1.35 million	$404,657	67%
March 2000 Eau Claire 1998CV508	Bonnie Richards Early 40s	Common bile duct clipped during laproscopic cholecystectomy resulting in residual hernias requiring additional surgeries and almost dying twice.	$660,000	$381,428	41%
October 1999 Portage 1998CV169	Candice Sheppard mid-20s	Negligent surgery to remove a cyst in the vaginal area resulted in permanent pain and injury	$700,000	$350,000	50%

These nine cases show a reduction of approximately $10.2 million from what the juries determined the damages to be after hearing all the evidence compared to the damages available under the cap enacted in 1995. It is these injured patients and their families who are bearing the total burden if medical malpractice occurs and a jury awards more than the cap. It is an unfair burden since others who are less severely injured pay nothing.

B. Disparate impact

The imposition of the cap on pain and suffering is especially pernicious for women, children and the elderly who all tend to have limited or no income. The cap implies that the value of a human life is nothing more than the cost of medical care and lost earning capacity, that somehow noneconomic damages are not real. However, courts have recognized, "The loss of noneconomic damages in any

amount ... is significant because noneconomic damages are essential to a tort victim."[6] Losses above out-of-pocket losses compensate for the pain, suffering, and disability over an injured person's lifetime.

In critiquing the White House plan "to place an arbitrary $250,000 limit on pain and suffering recoveries," the staunchly pro-business *Business Week* magazine notes that such a cap "would hurt the most severely injured malpractice victims, such as those blinded or paralyzed. That would also short-change blue-collar workers, the elderly, and others who couldn't receive big compensation for lost earnings."[7]

A study from the Harvard School of Public Health indicates that a cap on non-economic damages results in inequitable payouts across different types of injuries and limits patients' ability to be fairly compensated for their pain and suffering.[8] The study analyzed a sample of jury verdicts in California that were subjected to the state's $250,000 cap on non-economic damages. They found that reductions imposed on grave injuries were seven times larger than those for minor injuries. People suffering from pain and disfigurement had particularly large reductions in their awards.

Year	Medical Mediation Claims Filed	Amount of Cap*
1986	***	$1,000,000
1987	398	$1,030,000
1988	353	$1,070,170
1989	339	$1,123,678
1990	348	$1,179,862
Total	**1438**	
Average	**359.5**	
1991	338	No Cap
1992	313	No Cap
1993	276	No Cap
1994	292	No Cap
Total	**1219**	
Average	**304.75**	
1995	324	$350,000
1996	244	$359,800
1997	240	$369,874
1998	305	$375,052
1999	309	$381,428
2000	280	$392,871
2001	249	$404,657
2002	264	$410,322
2003	247	$422,632
2004	240	$432,352
Total	**2702**	
Average	**270.2**	

** The $1 million cap went into effect on June 15, 1986 and the cap was indexed on that day each year. The $350,000 cap went into effect on May 25, 1995 and is indexed each year on May 15.*

**** No numbers for that year.*

C. The Effect on Families

The decision to pursue malpractice damages is a difficult one for families, who must weigh a host of often-intangible variables — the severity of the injury, how long it will take for the case to move forward, repeatedly reliving the situation that families' have suffered in meetings with attorneys, depositions, and court testimony.

At some point, the amount of potential compensation under the cap relative to the financial cost of pursuing the case must also enter into the family's decision-making. This is especially true for individuals with limited or no economic injury — children, parents who do not earn income with outside employment, the elderly and the disabled.

As a result, as evidenced by the number of medical malpractice cases filed, the number of people seeking to file medical malpractice claims has been steadily decreasing since the mid-80s.[9] This pattern suggests that even when there was no cap on damages from 1991-1995, there was no corresponding explosion of claims. In fact, there was a decline in filings. So, the imposition of a cap is simply an additional, but wholly arbitrary, barrier to justice for most families.

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[6] *Martin v. Richards*, 192 Wis. 2d 156, 531 N.W.2d 70 (1995).

[7] France, et al, *supra* note 5.

[8] David Studdert, Michelle Mello and Y. Tony Yang, *Journal of Health Affairs*, July/August 2004, http://www.insurancejournal.com/news/national/2004/07/08/43841.htm (last visited May 13, 2005).

[9] Information obtained from Randy Sproule, Administrator at Medical Mediation Panels. Prior to pursing a medical malpractice lawsuit, an injured patient must file a request for medical mediation, Wis. Stat. § 655.43 (2001-2002).

What is the real impact of the cap for a family? Consider a recently retired 65-year-old man, who is being treated for diabetes, where he is prescribed a medication in the wrong dosage and as a result his system shuts down and he ends up losing part of his leg. He will have a predictable medical care, which is all covered by insurance. Because of his age there is no major loss of future earnings. However, the man was an avid outdoorsman and retired specifically to live in northern Wisconsin to hunt and fish and spend more time with his children and grandchildren. With a life expectancy of 10-20 years, the man's enjoyment of life is severely reduced. The cap arbitrarily limits how much he can recover for his losses.

Another example would be a stay at home mother with three minor children in her early 40's, whose breast cancer went untreated by medical providers and her life expectancy is greatly reduced. The mother was a homemaker, so she has limited income a lawsuit could seek to recoup and her medical bills are covered by health insurance. However, what of the value to her family and the loss she will suffer? A jury can consider all the uncompensated care she provides daily to her family and the fact she may never see her children graduate and marry or enjoy grandchildren. The woman's life is severely compromised yet, pain, suffering and loss of enjoyment of life is arbitrarily capped.[10]

The cap has a different impact upon every injured patient and his or her family because a single cap applies to all of their claims, regardless of the number of family members affected. Since there is a single cap from which to recover, an injured minor child must share the amount of the cap with his or her parents. An injured married patient with a spouse and minor children must share the amount under the cap with his or her spouse and children. So, even though there is a cap on pain and suffering, the amount provided to each injured patient varies greatly and is not consistent.

[10] See also, Rachel Zimmerman and Joseph T. Hallinan, "As Malpractice Caps Spread, Lawyers Turn Away Some Cases," *Wall Street Journal*, Oct. 8, 2004.

II. Fund, not cap, holds down malpractice costs

Medical providers, insurers, trial attorneys, the Legislature, and healthcare advocates alike uniformly view the financial success of the Injured Patients and Families Compensation Fund (the Fund) in a positive light.

There is a fundamental disagreement over precisely how the Fund succeeded in both holding down malpractice premiums for doctors and amassing enormous assets. Advocates for the cap have consistently tried to assert a link between the achievements of the Fund and the existence of the cap. However, the Fund and the cap were driven by contradictory legislative philosophies.

Fund Shares Risk, Cap Shifts Risk

The establishment of the Fund represented an egalitarian reform that involved *sharing of risk* among all providers to hold down malpractice rates. Consequently, the Fund's premium structure divided the medical profession into just four categories, resulting in substantially lower rates for higher-risk specialties and somewhat higher rates for lower-risk categories. This sharing of risk helps Wisconsin to retain doctors in high-risk specialties upon whom general practitioners can rely for referring patients in need of more specialized care.

In sharp contrast, the cap on pain and suffering imposed a *shift of risk* from providers as a whole to patients and the public. Patients could no longer count on the legal system to give them full compensation for the pain and suffering caused by medical negligence. Juries were deprived of the power to fully compensate injured patients. Further, as noted in Section I, countless Wisconsin families find it impossible to get into court to seek justice when they feel that they have suffered from medical negligence.

Moreover, it is precisely the Fund's unique and progressive features—not the cap—that have actually accounted for the decreases in malpractice premiums:

Timeline of the Fund

1975 — Legislature establishes Patients Compensation Fund (Fund) and the Wisconsin Health Care Liability Insurance Plan (WHCLIP). The legislation required that all physicians carry malpractice insurance either from a private insurer or WHCLIP for up to $200,000 and then mandates participation in the Fund, which provides unlimited coverage and pays claims in excess of primary coverage. The same 13-member Board of Governors governs both. WHCLIP is run like an insurance company; the Fund is not. Fund fees were originally calculated as a percentage, not to exceed 10%, of the WHCLIP rates and the Fund was not to have more than $10 million in assets.

1980 — The fiscal nature of the Fund was changed to give the present value of all claims reserves and all incurred but not reported (IBNR) claims. IBNR claims are claims that are not presently known but are presumed to exist. This changed the Fund from a form of "pay as you go" system to a system with a potential surplus or deficit.

1986 — The Legislature adopts an indexed $1 million cap on pain and suffering. The Fund also collapsed the number of Fund classes from 9 to 4 for purposes of calculating fees.

1987 — Doctors' primary coverage increased to $300,000.

1988 — Doctors' primary coverage increased to $400,000

1991 — $1 million indexed cap sunsets.

1995 — $350,000 indexed cap adopted.

1997 — Doctors' primary coverage increased to $1,000,000.

2003 — Fund name changed to Injured Patients and Families Compensation Fund.

a) **Non-profit:** The Fund is not-for-profit. In contrast to private insurance corporations characterized by huge executive salaries, massive bureaucracies, and wild swings in premium rates contingent on stock and bond market investments, the Fund does not subject Wisconsin medical providers to these burdens.

b) **Universal:** The Fund is universal, covering virtually all health care providers in the state. Thus, the Fund draws upon a large pool of doctors to share the risk and hold down costs.

c) **Sharing the risk:** The Fund spreads the cost of insuring against risk across interrelated medical professions, so that high-risk specialties do not bear an inordinately heavy burden.

How Wisconsin doctors are insured against malpractice

Nature of malpractice claim	Source of insurance	Premiums
For claims up to $1 million	Private insurers	Set by insurance firms, highly dependent on stock and bond investments
For claims up to $1 million when private insurance is not available	WHCLIP (serves only 2.3% of doctors)	Rates are set by the Board, and are set higher than other private malpractice insurance
For claims above $1 million	Injured Patients and Families Compensation Fund	Set by Fund Board. Fees have been cut to sub-1986 levels.

Another related reform was the establishment of the Wisconsin Health Care Liability Insurance Plan (WHCLIP) to provide insurance coverage to doctors who could not find a private insurer for the "underlying" malpractice insurance. WHCLIP and the Fund work to ensure that malpractice insurance is readily *available* to Wisconsin health care providers. This meant that they would always have access to malpractice insurance no matter how the private market was faring.

No Crisis to Solve: The conventional thinking runs something like this: the Fund was in trouble in 1995; the cap was enacted in that year; the Fund is now prospering; therefore the cap produced the Fund's prosperity. This argument disintegrates upon a moment's scrutiny. In reality, the cap is utterly unrelated to the proven financial success of the Fund. Still, crediting the cap for the Fund's success has become part of the conventional wisdom around the State Capitol, despite the weakness of the logic and the abundance of contrary evidence.

In 1994 and 1995 the Fund was actually never in financial trouble. That was one of its most stable periods. Fund fees were only moderately increased from 1986 through 1994, including three years in which the fees were not increased. There was virtually no impact on fees after the $1 million noneconomic damage cap sunset on December 31, 1990 (resulting in no cap being in effect). The Fund's assets increased from $49.6 million at June 30, 1986 to $270.7 million at June 30, 1994. At no time during 1994 and 1995 was the Fund facing an imminent "crisis." If there was any hint of a "crisis" it was fed by grossly inaccurate actuarial projections from the Fund actuaries.

Grossly Inaccurate Projections Fueled Cap

As Legislators contemplated the proposal for a cap on pain and suffering verdicts, they were told there was a $67.9 million projected actuarial deficit as of June 30, 1994. The specter of such a relatively large deluge of red ink had a major impact on the pending legislation. Several legislators cited the projected deficit as a reason they thought the cap necessary.[1] However, legislators were told that the cap would not impact the actuarial deficit. On January 19, 1995, Fund Administrators testified before the Assembly Insurance Committee and stated, "the reduced estimate is not related to the 1995 adoption of the non-

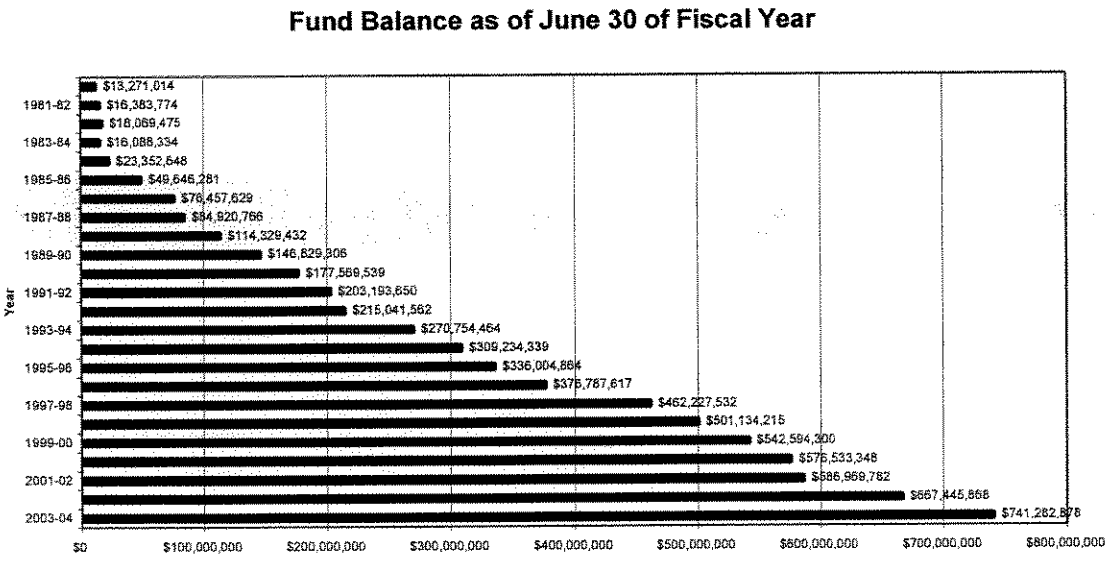
[1] Floor debate on 1995 Assembly Bill 36, January 31, 1995. (Excerpts are in Appendix A.)

economic damages cap because the cap was to be applied prospectively, which would have no impact on the Fund's actuarial deficit estimate." Despite this, the Legislature still acted as if the cap would impact the actuarial "deficit."

The actuaries incorrect estimates served to conceal a healthy surplus existing at the time the cap was enacted. Using hindsight analysis, the Fund actuaries re-calculated the condition of the Fund and discovered a spectacular miscalculation of $188 *million.*[12] Instead of a $68 million deficit there was a very healthy $120 million surplus. Overall, "Milliman USA has never correctly estimated future claims," reported the Madison *Capital Times*. Moreover, "in 12 of the last 27 years, they were off by at least $100 million."[13] (See Appendix B)

So instead of facing a ruinous actuarial deficit urgently demanding dire steps to correct it, the Fund had been in a solid surplus position for five years.[14] In fact the surplus began accumulating ***after*** the expiration of a much higher cap in 1991 (set at $1 million in 1986 for a five-year period).

If one looks at the financial history of the Fund, as of June 30, 2004, it has taken in almost $857 million in assessment income from health care providers since its inception in 1975. During the same period it has earned almost $434 million in interest, while still paying out over $601.5 million in losses and legal expenses. That now leaves the Fund with an enormous fund balance of $741 million, with most of millions of dollars in assets set aside for claims going back as far as 1989. (See Appendix C) Since many of those claims have not materialized, the Fund assets keep growing.



Fund balances come from Wisconsin Insurance Reports or Milliman Audit Reports.

[12] A long-promised audit of the Fund's financial methods is still undelivered. However, AON Risk Services did an analysis for the Wisconsin's Department of Administration of the Fund finances, and the insurer confirmed that the Fund is operating with a surplus. Aon, "Wisconsin Injured Patients and Families Compensation Fund Actuarial Report as of September 30, 2004," April 5, 2005.

[13] Amelia Buragas, "Fund's actuary wildly wrong on malpractice costs," *The Capital Times*, pg. 8A, Sept. 27, 2004.

[14] The Fund deficit peaked at $87.697 million (not $122.7 million) as of June 30, 1984. Within six years of that time, at June 30, 1990, the Fund had moved out of a deficit and into a surplus position. (See Appendix B.)

What happened can, in retrospect, be seen as a classic pendulum swing in policy: The inadequate fees and under-reserving of estimated claims in the early 1980s were replaced with excessive fees and over-reserving of claims in the late 1980s and early 1990s. The effect has been a dramatic transformation of the Fund since 1986: The Fund now has more than $741 million in cash reserves; the "actuarial" deficit has disappeared; and Fund feeassessments have been cut 6 out of the last 7 years.

Year	Change in Fund premium rates	Premiums Paid by OB-GYNs and Neurosurgeons	Fund's annual income from Assessment Income
2005-06	**-30.0%**	**$5,154***	$18.5 million*
2004-05	**-20.0%**	**$7,363**	$26,316,712*
2003-04	+5.0%	**$9,204**	$32,067,360
2002-03	**-5.0%**	**$8,769**	$29,463,735
2001-02	**-20.0%**	**$9,231**	$29,534,338
2000-01	**-25.0%**	**$11,388**	$37,052,434
1999-2000	**-7.0%**	**$15,186**	$47,879,282
1998-99	0.0%	**$16,326**	$50,621,706
1997-98	**-17.7%**	**$15,882**	$49,892,420
1996-97	+10.0%	**$19,290**	$58,259,200
1995-96	**-11.2%**	**$17,538**	$51,048,881

* The numbers are estimated based on calculations from Milliman.

On February 23, 2005, the Fund's board voted to further reduce the premiums by 30%. As seen above, the premiums charged for OB-GYN's and neurosurgeons—the highest-risk, most expensive category, have plummeted from a high of $19,290 to $5,154— an almost 70% decrease.[15] The main reason the Fund was able to lower fees was another reduction by the Fund's actuaries of their estimates of the reserves needed to pay future claims. Over the past 5 years Milliman has recommended reducing over $262 million in reserves. (See Appendix D) That is a huge amount of IBNR claims to write off and continues to demonstrate the unrealistic projections of the actuaries. (See Appendix E) In fact, as of December 31, 2004, the Fund had set aside only $17,710,410 in reserves, representing 22 claims that the Fund is aware of. That means over $720 million is set aside for claims that they think are out there, but a case has not materialized.[16] (See Appendix F)

Thus, it is impossible to credibly argue that the imposition of a drastically lower cap in 1995 suddenly "rescued" the Fund and set it on a course toward fiscal health. First, the Fund certainly did not need rescuing at that time. Second, the Fund was operating quite successfully in 1995 even after nearly a decade where the cap either stood at $1 million (today's equivalent would be $1,766,482 measured in 1986 dollars[17]) or did not exist at all. In other words, the current cap represents just 24.4% of the cap's value in 1986 dollars Third, the Fund's health in 2005 is on an entirely different, much higher plateau of financial security than at any time since its inception. Annual income from interest now exceeds payouts. With the effect of compounding interest—even at the current low rates— the annual net growth of the Fund's assets is sure to grow larger. Any sober analysis of the Fund's condition today would concede that the Fund's ongoing economic success—apart from the questions of justice raised in this report— does not depend on continuing the cap on pain and suffering. Fourth, the Fund's financial health would be even more robust if premiums for providers had not been reduced by nearly 70% over the past decade.

[15] Fund fees recommended for the 2005-06 fiscal year are lower than fees for 1984-85.

[16] Memo of Jeff Kolhman, Insurance Program Specialist for the Injured Patients and Families Compensation Fund, January 10, 2005. (Appendix F)

[17] Estimate is based on figures from Morgan Stanley.

Who Does the Fund Serve?

The Milliman actuaries' projections have fed into a pattern of keeping assets away from injured people, while health care providers alone benefit from reduction in fees and the growth in assets. Surely, the entire state benefits when doctors are provided with affordable malpractice insurance. But the imposition of the cap on pain and suffering 10 years ago has meant that injured patients and their families have not received needed benefits and suffered decreased access to the courts, even as the Fund's assets have almost tripled in the last 10 years, increasing an average of $47 million each year. During the same 10 year period, the Fund has been drawn upon an average of just 19.3 times per year and payments made to injured patients and their families averaged $28.5 million per year. That amounts to $18.5 million less than the average annual ***increase*** in Fund assets.

The 10-year record of the cap on pain and suffering limiting access to the courtroom should provoke a re-examination of these restrictions by even the most enthusiastic advocates of such a cap.

In the name of "Injured Patients and Families," the state's Fund holds assets of $741 million and is growing rapidly. But in spite of this massive reserve, the patients and families, for whom the Fund is ostensibly dedicated, find the potential source of compensation out of their reach, due to the cap enacted in 1995. The cap stands as a barrier to preventing the most severely disabled and disfigured victims of malpractie from claiming just compensation for their lifelong pain and suffering.

Injured Patients & Families Compensation Fund

Year	Number of Cases Paid	Losses Paid to Injured Patient & Families
1994-95	25	$24,098,896
1995-96	28	$51,456,670
1996-97	16	$34,679,277
1997-98	24	$18,718,458
1998-99	28	$19,929,978
1999-2000	12	$19,657,326
2000-01	22	$39,636,276
2001-02	14	$35,304,773
2002-03	11	$22,074,552
2003-04	13	$19,496,969
Total	**193**	**$285,053,175.00**
Average	**19.3**	**$28,505,318**

III. The Elephant in the Room: role of big insurers often goes unquestioned

One of the most persistent assertions about caps is that they would hold down malpractice premiums for doctors. In state after state affected by soaring malpractice fees charged by insurance companies, doctors have demanded that their legislatures enact a cap on pain and suffering awards. In Pennsylvania, for example, an AMA board member declared, "...It's the cap that will stabilize premiums the quickest."[18]

But this official would have been shocked and disappointed if he had simply checked authoritative statistics or even listened to the frank admissions of insurance executives. According to the widely-respected Weiss Report, medical malpractice premiums actually average about 10% ***more*** in states with caps than those without. States with caps averaged $46,733 in malpractice premiums in 2003, while noncap states had an average of $42,563. [19]

As noted on this page, numerous insurance executives themselves have bluntly admitted that the imposition of a cap will not result in lower premiums. In one instance, the president of Florida's largest malpractice insurance firm bluntly admitted, "No responsible insurer cancut its rates after a [malpractice cap] bill passes."[20]

Insurance execs speak up

"We wouldn't tell you or anyone that the reason to pass tort reform would be to reduce insurance rates." Sherman Joyce, President of the American Tort Reform Association, (Source: "Study Finds No Link Between Tort Reforms and Insurance Rates," *Liability Week*, July 19, 1999.)

"Insurers never promised that tort reform would achieve specific premium savings . . ." (Source: March 13, 2002 press release by the American Insurance Association (AIA).)

"[A]ny limitations placed on the judicial system will have no immediate effect on the cost of liability insurance for health care providers." (Source: "Final Report of the Insurance Availability and Medical Malpractice Industry Committee," a bipartisan committee of the West Virginia Legislature, issued January 7, 2003.)

An internal document citing a study written by Florida insurers regarding that state's omnibus tort "reform" law of 1986 said that ***"The conclusion of the study is that the noneconomic cap . . . [and other tort 'reforms'] will produce little or no savings to the tort system as it pertains to medical malpractice."*** (Source: "Medical Professional Liability State of Florida," St. Paul Fire and Marine Insurance Company, St. Paul Mercury Insurance Company.)

This theme was further bolstered by a recent rate filing by GE Medical Protective, which sought a 19% rate increase just one year after Texas voters narrowly approved a $250,000 cap on non-economic damages in medical malpractice cases. After claiming that caps would reduce malpractice premiums, the insurer admitted in its ratefiling request that "capping non-economic damages will show loss savings of 1%."[21]

When insurers are telling regulators that aps on damages don't lower premiums appreciably, then every legislator, regulator and voter should listen.

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[18] Tanya Albert," A tale of two states: Different approaches to tort reform, " *amednews.com*, May 12, 2003. Available at http://www.ama-assn.org/amednews/2003/05/12/prsa0512.htm (last visited May 13, 2005).

[19] *Medical Liability Monitor*, Oct. 2004.

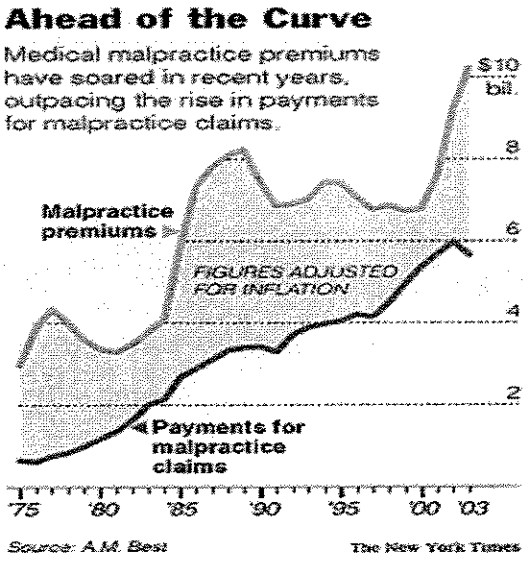
[20] "Medical Professional Liability, State of Florida," St. Paul Fire and Marine Insurance Company, St. Paul Mercury Insurance Company.

[21] The Medical Protective Company, Texas Physician and Surgeons Actuarial Tort Reform Memorandum, found at http://www.aisrc.com/caps.pdf (last visited on May 13, 2005).

Insurers: The Elephant In The Room

Perhaps the most powerful demonstration of the fact that malpractice premiums are not the direct reflection of malpractice litigation can be gleaned from the huge differential between what insurance corporations charge doctors for malpractice premiums and what they pay out in malpractice claims.

The most recent figures indicate that the industry collected over $10 billion in malpractice premiums while shelling out slightly under $6 billion in claims, suggesting a highly favorable situation for the industry. Overall, the insurance industry as a whole has recovered very strongly from the downturn of recent years. Profits soared an astonishing 1,000% between 2002 and 2003 alone.[22] CEO pay for the largest insurers has also reached astronomical levels: Among 12 U.S. health insurers, all with 2003 net sales of $1 billion or more, the median and average total pay came to $9 million and $15.2 million, respectively."[23]



The most certain conclusion on the relationship between malpractice premiums and malpractice claims is that malpractice lawsuits are not a key factor in driving the cost of premiums for doctors. There have been modest increases in payouts for malpractice claims, with such payments rising 3.1% annually, on average, between 1993 and 2003, before declining 8.9% in 2004.[24]

Academic researchers and independent analysts of the industry largely agree with the findings fo Dartmouth Economics Prof. Amitabh Chandra, who summarized the connection between malpractice lawsuits and malpractice premiums in these terms: "Surprisingly, there appears to be a fairly weak relationship."[25]

The recent state of Washington study bolsters this finding. The study reviewed 90% of the malpractice claims filed over the previous 10 years in Washington, relying on the voluntary cooperation of the five largest malpractice insurers. The study's conclusion affirmed the key points made above about th relative rarity of malpractice claims and their limited impact. Further, the study resulted in refunds of $1.3 million to Washington doctors who were overcharged by their insurers. Washington State Insurance Commissioner Michael Kreidler saw a crucial lesson in his study: "We need more reliable claims and settlement information from all of the parties providing medical malpractice coverage," information that would allow his state to "make public policy based on facts rather than anecdotes."[26]

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[22] Between the premium income and thegains from stocks, bonds and other investments, the private insurance industry increased its surplus by $61.6 billion in 2003.http://iso.com/press_releases/2004/04_14_04.html.

[23] Graef Crystal, "Well Paid Insurance CEOs vs. 45 Million Uninsured Americans,*Bloomberg*, October 6, 2004.

[24] Joseph B. Treaster and Joel Brinkley, "Behind Those Malpractice Rates," *New York Times*, Feb. 22, 2005. "The recent jump in premiums shows little correlation to the rise in claims," th*Times* stated in reviewing data from the National Practitioner Data Bank.

[25] *The Effect of Malpractice Liability on the Delivery of Health Care,* by Katherine Baicker and Amitabh Chandra, National Bureau of Economic Research, Working Paper 10709, August 2004.

[26] Thomas Shapley, "Gouging, numbersbelie medical malpractice 'crisis' claims,"*Seattle Post-Intelligencer*, March 6, 2005.

Poor management piled on top of greed

Poor financial management on the part of insurance companies is another culprit for the increase in medical malpractice insurance premiums. During good economic times, insurance companies competed with each other by offering lower premiums, but in tough times, some pulled out of the market altogether, leaving doctors with only higher-priced carriers.[27] A financial boom in the 1990s encouraged many carriers to compete for new geographic markets by relaxing underwriting criteria ad lowering premiums to a level that, in hindsight, should not have been offered because some companies did not cover their ultimate losses.

From 1998 through 2001 medical malpractice insurers experienced decreases in their investment income as interest rates fell on the bonds that generally make up around 80 percent of their investment portfolios.[28] A decrease in investment income meant that income from insurance premiums had to cover a large share of insurers' costs.[29] Reversals of fortune as the economy slowed led to pullouts and insolvencies in many states, while solvent companies rejected riskier customers and raised premiums.[30]

A close observer of insurance firms' practices, Joan Claybrook, president of the consumer watchdog group Public Citizen, noted, "We recognize that some doctors in some states have suffered from large premium increases over the past two years. But those were caused by a sour economy that resulted in investment losses or lower than expected earnings from stocks and bonds—the principal way insurance companies make money, which has nothing to do with the lawsuits and the legal system."[31]

Premiums related to insurers' investments, not litigation

In reality, the spate of soaring malpractice premiums is actually the product of a periodic and predictable shift in the business cycle of the insurance industry. During periods when insurance corporations' stock and bond investments are earning big returns on Wall Street, the firms reduce their premiums to lure in more doctors.

> ***"The recent spike in premiums—which is now showing signs of steadying—says more about the insurance business than it does about the judicial system... "The recent jump in premiums shows little correlation to the rise in claims."—NY Times, 2/23/05***

But when their investments suffer a downturn, then insurance corporations shore up their profits by raising premiums drastically, as even such precorporate news outlets as the *Wall Street Journal* explain. The *Journal* concluded in a front-page June 24, 2002 article: "*A price war that began in the early 1990's led insurers to sell malpractice coverage to obstetrician-gynecologists at rates that proved inadequate to cover claims...An accounting practice widely used in the industry made the area seem more profitable in the early 1990's than it really was. A decade of short-sighted price slashing led to industry losses of $3 billion last year.*"[32]

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[27] Michael Schostok, president of the Illinois Trial Lawyers Association, quoted in *Chicago Tribune* article, March 12, 2004.

[28] GAO-03-702, "Medical Malpractice Insurance: Multiple Factors Have Contributed to Premium Increases," p. 5, June 2003.

[29] *Id.*

[30] William M. Sage, "The Forgotten Third: Liability Insurance and the Medical Malpractice Crisis," *Health Affairs*, Vol. 23 No. 4, p. 13, July/August 2004. http://content.healthaffairs.org/content/vol23/issue4/ (last visited May 13, 2005).

[31] Public Citizen news release, Oct. 6, 2004, available at http://www.citizen.org/pressroom/ (last visited May 13, 2005).

[32] Rachel Zimmerman & Christopher Oster, "Insurers Missteps Helped Provoke Malpractice 'Crisis,'" *Wall Street Journal*, p. 1, June 24, 2002.

Other analyses have also found that the insurance industry's investment strategies have had the biggest impact in driving up malpractice rates "The recent spike in premiums—which is now showing signs of steadying—says more about the insurance business than it does about the judicial system."[33]

In Texas, where voters were persuaded to approve a $250,000 cap on pain and suffering, researchers found that soaring malpractice premiums were actually not correlated with malpractice lawsuits and settlements.[34]

A Florida study also shows no sharp increase in lawsuits in medical malpractice cases. "When we compared the number of malpractice cases to the population in Florida," said Neil Vidmar, one of the study's authors and professor at Duke's School of Law, "there has been no (large) increase in medical malpractice lawsuits in Florida."[35]

Wisconsin Insurers

Wisconsin first passed a cap of $1 million on "pain and suffering" in 1986, which sunset January 1, 1991. In retrospect, the enactment of the cap was clearly influenced by what is now widely recognized as a cyclical downturn in insurance industry investments, followed by predictable sharp increases imedical malpractice premiums for doctors. The lowering of the cap in 1995 to $350,000 (now, adjusted for inflation, at $445,755) was done at a time when there was no downturn Back in 1994, Wisconsin had the third best loss ratios in the nation.[36]

Wisconsin medical malpractice insurers continue to enjoy very substantial returns on their insurance premiums. In 2001, for example, private malpractice insurers for Wisconsin doctors (covering claims up to $1 million) collected $62.6 million in premiums and paid out only $19.9 million to patients harmed by medical negligence.[37] In addition, earnings can be considerably enhanced by investing the premiums skillfully.

Most recently the National Association of Insurance Commissioners (NAIC) released a report showing that Wisconsin had the best loss ratios in the nation in 2002.[38] Demonstrating the Wisconsin's malpractice insurers favorable position has changed little in the past decade—it was very good in 1994 and it's still very good today. This clearly shows that WHCLIP and the Fund have provided Wisconsin with stable insurance mechanisms that do not necessitate the need for a cap on pain and suffering.

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[33] Treaster & Brinkley, *supra* note 24.

[34] Bernard Black, Charles Silver, David Hyman & William Sage, "False Diagnosis,"*New York Times*, March 10, 2005. (Premium increases starting in 1999 'were not driven primarily by increases in claims, jury verdicts, or payouts.'")

[35] "Study finds tort reform not the answer for medical malpractice crisis," Stephanie Horvath,*Palm Beach Post,* March 22, 2005.

[36] NAIC, *Medical Malpractice Insurance Net Premium and Incurred Loss Summary*, July 18, 2001, page 6. http://www.naic.org/research/Research_Division/Stats/MEDMAL07-18-02.pdf (last visited May 12, 2005).

[37] *2001 Wisconsin Insurance Report*, published annually by the Office of the Commissioner of Insurance.

[38] Eric Nordman, Davin Cermak & Kenneth McDaniel, *Medical Malpractice Insurance Report: A Study of Market Conditions and Potential Solutions to the Recent Crisis,* presented to NAIC on September 12, 2004, pages 77-78. http://www.naic.org/models_papers/papers/MMP-OP-04-EL.pdf (last visited May 12, 2005).

IV. The Big Tradeoff That Failed: rights lost, health care costs soaring

The clear and consistent pattern of malpractice premiums' linkage to the insurance industry's investment cycles gets lost amid the high-volume public-relations campaign waged by the industry and its allies. As a result of the incessant repetition of attacks on the civil justice system, many citizens believe a powerful set of myths despite strong evidence to the contrary:

Myth: Malpractice costs make up a substantial part of overall health costs

Fact: Malpractice costs account for just 0.55 cents of US health care spending and 0.40 of healthcare spending in Wisconsin[39] (Appendix G)

Myth The fear of malpractice litigation forces doctors to undertake unnecessary, expensive "defensive medicine" procedures.

Fact: The General Accounting Office (GAO) found that (1) some defensive medicine is good medicine, (2) managed care discourages needless defensive medicine, and (3) to the extent doctors conduct defensive medicine, it is because they make money from additional procedures.[40] The Congressional Budget Office notes that doctors often find it profitable to undertake such procedures; that more testing may produce better outcomes, and that the actual cost is small[41]

Myth: Rising medical malpractice costs are forcing good doctors to quit practicing or leave their states.

Fact: In 2003, the Government Accounting Office (GAO) reviewed claims by physicians that high medical malpractice premiums were causing doctors to flee states with high malpractice fees. Its review of five states concluded that the doctors have wildly overstated their case.[42]

Myth: A high percentage of malpractice claims are "frivolous."

Fact: The scope of medical negligence is hardly "frivolous," as the equivalent of three jumbo jetliners full of Americans die daily due to errors by providers.[43] Meanwhile, in Wisconsin, a state with 5.5 million people, only 247 medical negligence claims were filed in 2003 with the Medical Mediation Panels. That is one claim for every 22,257 Wisconsin citizens.[44]

Myth: Wisconsin, like the rest of the U.S., has been rocked by a "litigation explosion" composed of dubious lawsuits.

Fact: Evidence from Wisconsin, other states, and the federal courts all show a noticeable *downturn* in litigation, not the proclaimed explosion. The explosion is certainly a dud[45] Wisconsin ranks 49th lowest in the frequency of awards out of the 50 states on a per-capita basis, with only the state of Alabama lower.[46]

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[39] Center for Justice & Democracy Memo with attached spreadsheet prepared by J. Robert Hunter, Director of Insurance, Consumer Federation of America, November 14, 2001; From the Wisconsin Insurance Report, Office of the Commissioner of Insurance, Years 1987-2002.

[40] GAO-03-836, "Medical Malpractice and Access to Health Care," pgs. 26-27, August 2003.

[41] CBO Economic and Budget Issue Brief, "Limiting Tort Liability for Medical Malpractice," p. 6 (January 8, 2004).

[42] GAO-03-836 *supra* note 40.

[43] HealthGrades report July 2003. *See Milwaukee-Journal-Sentinel* article, 1A July 28, 2003.

[44] Randy Sproule, Medical Mediation Panels.

[45] Ruth Simpson, "We're Not Seeing You in Court," *The Verdict*, Volume 26:2 Spring 2003, page 12.

[46] National Practitioners Databank Reports 1992-2002.

Myth: Irresponsible jackpot juries feel free to hand out huge sums of money for unworthy victims.

Fact: A Florida study showed that 92.4% of million-dollar-plus awards were reached out of court, with juries playing no role.[47] Evidently, insurers recognized that medical providers were very likely to lose if the case were presented to a jury.

The Wisconsin Experience:

The 1995 "reforms," most especially the cap, were carried along on a wave of promises regarding the improvement of health care affordability and access in Wisconsin, along with saving the Injured Patients and Families Compensation Fund (the Fund) from disastrous losses.

As shown in Part I, the enactment of the cap did in fact restrict the ability of injured victims to gain access to the courts. Part II debunks the insolvency of the Fund.

However to win enactment of the cap on pain and suffering in 1995, proponents perpetuated the biggest myth of all: ***A Cap on pain and suffering would hold down Wisconsin's fast-rising healthcare costs and improve access to doctors in underserved areas.***

But a continuing stream of evidence pours a torrent of rain upon this sunny version of healthcare affordability and access in Wisconsin.

PROMISES made about caps	ACTUAL OUTCOME since enactment
Would make health care more affordable	Wisconsin health insurance costs 2nd worst in nation
Would improve access to doctors in underserved areas	Wisconsin faces shortages of physicians in urban and rural areas.
Would protect Fund from insolvency	Fund had already been in surplus for 5 years before the 1995 cap was adopted, so no problem existed

Malpractice Costs versus Health Care Costs: Where's the Correlation?

Despite low malpractice rates, Wisconsin remains plagued by extremely high healthcare costs. An August 23, 2004 Government Accountability Office report included he Milwaukee area, and found that medical costs are 27% higher overall in Milwaukee than the national average of metro areas. Doctor prices are 33% higher in Milwaukee than the national average, and hospital costs are an astonishing 63% higher, says the GAO.[48]

Since 2000, Wisconsin workers have been hit with their share of premiums rising 4 times as fast as wages, climbing 49% while average wages have crept up by only 12.2%. The premium increases, as a multiple of worker wage growth, were higher in Wisconsn than Illinois, Iowa and Minnesota— states **without** caps on pain and suffering.[49] (See Appendix H)

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[47] "Study finds tort reform not the answer for medical malpractice crisis," Stephanie Horvath,*Palm Beach Post,* March 22, 2005.

[48] GAO-04-1000R, "Milwaukee Health Care Spending," August 18, 2004.

[49] Families USA, "Health Care: Are You Better Off Today Than You Were Four Years Ago?" September 2004.

Even more distressing data came in a Feb. 14, 2005 article in *Expansion Management* magazine, a journal aimed at corporate decision makers who control the siting of business operations. Titled, "Health Care Expenses ***Are*** a Key Site Location Factor," the article is a particularly ominous warning for Wisconsin citizens about the future of the state's economy, as Wisconsin ranks 49th (ie., second worst) in health insurance premiums in the 2005 Health Care Cost Quotient study conducted by the magazine.[50]

> Wisconsin ranks ***2nd worst*** in health insurance premiums in the U.S. Yet it ranks the ***very best*** in medical malpractice costs in the nation.
> —***Expansion Management*** magazine, Feb. 14, 2005

Yet the very same study ranked Wisconsin first (i.e., the very best) in medical malpractice costs.[51] Thus, Wisconsin citizens have witnessed health costs exploding to the second highest in the nation, while malpractice costs—1/2 of 1% of health care costs —stand as the least expensive of any state. It is impossible to imagine an outcome further away from the results promised by the advocates of the cap in 1995. Malpractice suits are clearly not a driving force behind high health care costs

Doctor Distribution

Like every other state— including those labeled by the AMA as suffering from a medical malpractice premium "crisis"—Wisconsin has enjoyed an increase in the supply of physicians practicing in the state.[52] But the state has continued to suffer from a maldistribution of doctors, with wealthy suburban areas attracting large numbers of providers while lowincome rural and central cities struggle by with an inadequate supply of doctors.

Even the most outspoken advocates of the cap concede that the state has a severe problem of doctor shortages in lower-income rural and urban areas. In 2004, the Wisconsin Hospital Association and Wisconsin Medical Society issued a report based upon a year-long study of Wisconsin's physician shortage.[53] The study showed a continuing shortage of doctors, especially in impoverished rural and urban areas. Notably, the report did not call attention to the organizations' predictions from a decade ago that the cap would resolve this problem.

> ***We have a shortage that's far more acute [in Milwaukee] than 10 years ago."***
> *—Aurora executive and former city health commissioner Paul Nannis*

According to some knowledgeable observers, the shortage of doctors in under-served areas has actually become *more* severe since the enactment of the caps. "We have a shortage that's far more acute [in Milwaukee] than 10 years ago," reported Paul Nannis, former city of Milwaukeehealth commissioner and now vice president of government and community relations at Aurora Health Care.[54]

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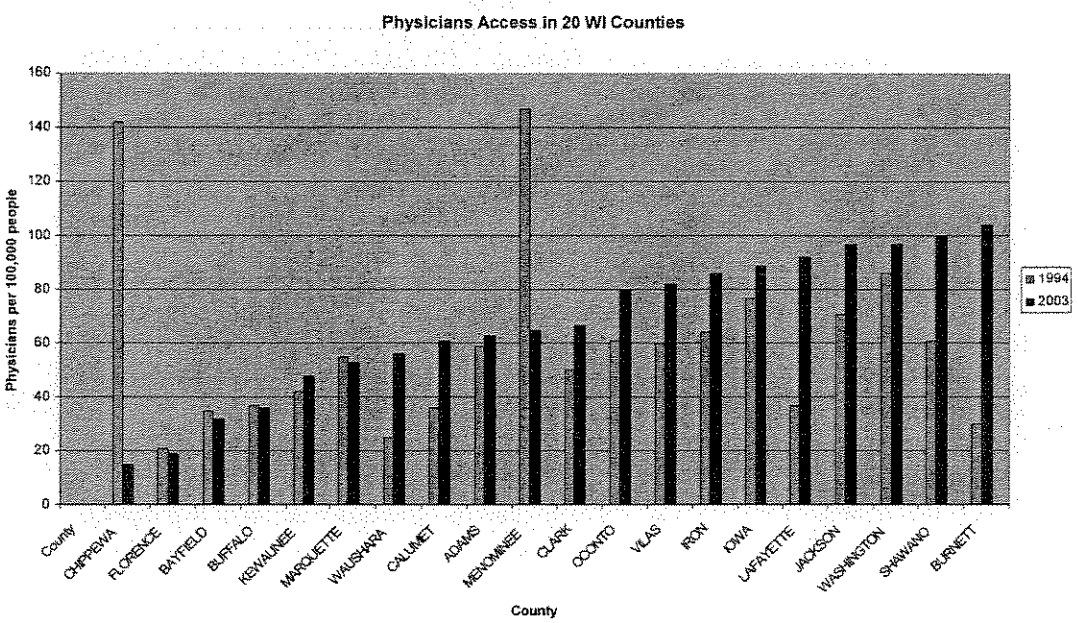
[50] Michael Keating, "Health Care Expenses Are a Key Site Location Factor,"*Expansion Management,* Feb. 14, 2005
[51] *Id.*
[52] The number of physicians are higher in Wisconsin and in every other state than in 1996, according to the American Medical Association. The number has risen in every state over the 2000-2002 period, states the AMA's "Physician Characteristics and Distribution in the U.S." publication, 2003-2004 edition.
[53] "Who Will Care for Our Patients?" report by Wisconsin Hospital Association and Wisconsin Medical Society, 2004.
[54] Czerne M. Reid, "Pressing Need: With a dearth of doctors on Milwaukee's north side, physicians and patients feel the crunch," *Milwaukee Journal Sentinel*, Nov. 15. 2004.

Physician/population ratio in rural WI



The above graph shows the number of physicians per 100,000 in the least-populated counties in Wisconsin in 1994 (before cap) and 2003. In Milwaukee County the number of physicians per 100,000 people is also considerably lower than average, with 1 physician per every 272 people. Dane County is similar with 1 per 270. The average number of physicians in Wisconsin is 1 per every 192 people.[55]

The data demonstrate clearly that there is no consistent growth in the supply of doctors for underserved areas since the cap was instituted. In some of the most rural areas, the number of providers has actually gone down significantly. Contrary to earlier promises, the advent of the medical malpractice cap has not increased rural and urban residents' access to doctors.

[55] Sources for graphs and data on Milwaukee and Dane counties include www.wisconsin.gov; population estimates; Consumer Guide to Health Care http://www.chsra.wisc.edu/physicians/search.asp. (last visited May 13, 2005)

Conclusion

The ominous implications for the Constitutional rights of Wisconsin citizens—particularly injured patients—were minimized during the legislative debate in 1995 that imposed the cap on pain and suffering in medical malpractice cases. Instead, advocates of the cap argued that this loss of legal access for a relative few would be far outweighed through a tradeoff for broader public benefits — lower health care costs, more doctors in underserved areas and a solvent and stabilized Fund for injured patients and their families.

In practice over the past decade, the tradeoff of legal rights for public benefits has proved to be disastrous. While our legal rights certainly were diminished, the promised benefits have never appeared. Moreover, it is now clear that the Fund's future success is not connected to continuing the cap on pain and suffering. If the Fund can simultaneously accumulate $741 million in cash reserves and afford to make cuts of nearly 70% in malpractice premiums for providers, as it did over the last decade, then there is surely no financial basis for maintaining the cap.

By now, it is apparent that by imposing the cap, some degree of accountability for medical providers was inevitably sacrificed. In addition, families of severely injured patients are being asked to bear the burden of "fixing" the legal malpractice system alone. That is neither fair nor just.

The cap is a barrier to the courthouse for injured patients and their families and strikes at the very heart of the civil justice system. It deprives juries of their constitutional mandate to do *justice* in individual cases. The scales of justice in Wisconsin are severely tilted against injured patients and their families as a result of a highly-restrictive cap on jury awards for pain and suffering imposed 10 years ago in 1995.

We believe there is only one solution to the current inequities: removal of the inequitable and unjust cap on pain and suffering. That solution is affordable given the Fund's enormous and steadily growing reserves balanced against possible payouts. Most fundamentally, removal of the cap is also a moral imperative for a state that has long led the nation in progressive innovations that are both practical and compassionate.

Appendix Index

Appendix A..... A-1 to A-2

Part of the Floor Debate on January 31, 1995 on the passage of 1995 Assembly Bill 36, which was enacted as 1995 Wisconsin Act 10.

Appendix B..... B-1

Comparison of Published Surplus/(Deficit) to Hindsight Deficit by Milliman USA. Since 1994 Milliman has reviewed the published deficit and then done a hindsight review. (Part of Actuarial Report of November 24, 2004.)

Appendix C..... C-1

Summary of Revenue and Expenses Inception through June 30, 2004 by Milliman USA. The bottom number is the surplus/(deficit) by year. (Part of Actuarial Report of November 24, 2004.)

Appendix D..... D-1

History of Recommended Reserve Changes by Milliman USA. (Part of Actuarial Report of November 24, 2004.) This chart indicates how much Milliman has changed its reserves on a yearly basis. In 2004, Milliman revised its reserves downward by $94.4 million, or 10.7% of the Fund's value. In 2003, Milliman recommended an almost $83 million reserve change or 9.5% of the amount of the Fund.

Appendix E..... E-1

Chart of the unrealistic projections of remaining liabilities based on Milliman's estimates of undiscounted ultimate losses and LAE expenses in 2004.

Appendix F..... F-1 to F-3

Memo of Jeff Kohlmann, Insurance Program Specialist, Patients Compensation Fund to Claims Committee, Patient Compensation Fund, dated January 10, 2005. The memo and chart notes that only $17,710,410 has been set aside for known case loss reserves.

Appendix G..... G-1

Chart reviewing medical malpractice costs, which have decreased as a percentage of total health care costs in Wisconsin.

Appendix H..... H-1

Chart showing premium increases for health care as a multiple of worker wage growth from 2000-2004 in surrounding states. Since 2000, Wisconsin workers have been hit with their share of premiums rising 4 times as fast as wages. The premium increases, as a multiple of worker wage growth, were higher in Wisconsin than Illinois, Iowa and Minnesota — states **without** caps on pain and suffering.

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Wisconsin Citizen Action is a statewide public interest organization dedicated to social, economi c and environmental justice for all. We unite the political power of our members with the power of a diverse coalition to: win improvements that matter in our daily lives, give people a sense of their own power to shape the future, and alter the relations of power to favor people over wealthy special interests. Our strategy is to build majoritarian power around issue and electoral campaigns.

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Tap the Power

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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.
www.ama-assn.org/ama1/pub/upload/mm/-1/mlrnowjune14 2005.pdf

"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: 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.
www.gao.gov/new.items/d03836.pdf

***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

Clippings: (Noncirculating; available for use in the library; clippings prior to 1981 are on microfiche)

- Physicians (malpractice): 614.230/M29Z

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Medical Malpractice

Compiled by Arden Rice, December 2003

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

The American Medical Association recently rated Wisconsin as one of only a few states not experiencing a medical malpractice insurance rate crisis. States are implementing a variety of reforms to maintain access to health care.

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

Addressing the Medical Malpractice Insurance Crisis. **(Issue Trends) National Governors' Association Center for Best Practices, 2002. (614.230/N21)** Summarizes two dozen different tactics used by states to mitigate the effects of rising malpractice insurance rates.
www.nga.org/cda/files/1102MEDMALPRACTICE.pdf

An Audit, Patients Compensation Fund, Office of the Commissioner of Insurance. **Wisconsin Legislative Audit Bureau (2001 and 1998). (614.230/W7b/1999-00 and 614.230/W7b/ 1995-97).** These two audits address recent fiscal issues surrounding Wisconsin's Patient Compensation Fund. Previous audits are available in the state documents collection.
www.legis.state.wi.us/lab/reports/01-11full.pdf and
www.legis.state.wi.us/lab/reports/98-7Summary.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

"Medical Liability Insurance". ***Congressional Digest,*** **v.82, no.2, p.33-64, February 2003. (614.230/C762)** Debates the 2002 H.R. Bill 4600 that would have capped non-economic damages at $250,000.

"Medical Malpractice". Congressional Quarterly, Inc., ***CQ Researcher,*** **v.13, no.6, p.130-151 February 14, 2003. (614.230/C761c)** Examines the trends in rising premium costs, outlines the measures states have taken to limit damages awarded in malpractice suits, and debates whether federal legislation is necessary.

"Medical Malpractice". National Conference of State Legislatures, ***State Health Lawmakers' Digest,*** **v.3, no.4, Summer 2003. (614.23/N21b)** Describes no-fault compensation plans, arbitration, and damage caps as solutions implemented by various states to reduce the cost of medical malpractice insurance.

Medical Malpractice Caps: The Impact of Non-Economic Damage Caps on Physician Premiums, Claims Payout Levels, and Availability of Coverage. **Weiss Ratings, Inc., June 2003. (614.230/W43)** Commonly known as the "Weiss report", this study faults the investment practices of insurance companies and the inability of the medical profession to police itself for the rise in malpractice insurance rates.
www.weissratings.com/MedicalMalpractice.pdf

Medical Malpractice Crisis (Trends Alert). **Council of State Governments, April 2003. (614.230/C83)** Provides an historical analysis of the medical malpractice crises in the 1970s, 1980s, and the present, and outlines the various legal, medical, and insurance reforms that states can consider to alleviate the current crisis.

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.
www.gao.gov/new.items/d03836.pdf

Medical Malpractice Insurance: Multiple Factors Have Contributed to Increased Premium Rates. **U.S. General Accounting Office, June 2003. (614.230/X7/pt.2)** The goal of this study was to analyze the extent of premium rate increases, the causes of this recent trend and how this crisis differs from previous medical malpractice insurance crises. www.gao.gov/new.items/d03702.pdf

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Medical Malpractice
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Patients Compensation Fund. **(2003-05 Budget Issue Paper #458) Wisconsin Legislative Fiscal Bureau, April 23, 2003. (LFB/b/2003-5/no.458) (noncirculating)** This brief analyzes Governor Doyle's 2003 failed budget proposal to transfer $200 million from the fund to a new "health care provider availability and cost control fund" overseen by Department of Health and Family Services. www.legis.state.wi.us/lfb/2003-05budget/2003-05BudgetPapers/458.pdf

Preliminary Report on the Feasibility of an Ohio Patients Compensation Fund. **Pinnacle Actuarial Resources, Inc., February 2003. (614.230/Oh3)** Compares and contrasts the administrative and fiscal organization of PCFs in a dozen states including Wisconsin. www.ohioinsurance.gov/Legal/REPORTS/Prelim_Patient_Compensation_Report_03-03-03.pdf

"Reforming the Medical Malpractice Insurance Market". Stephanie Norris, *NCSL State Legislative Report,* v. 27, no. 13, July 2002. (614.230/N211b) Highlights measures taken by states in 2002 to improve the condition of the medical liability insurance industry such as limiting attorney fees and awards and shortening the statute of limitations for filing claims.

The Weiss Ratings Report on Medical Malpractice Caps: Propagating the Myth That Non-Economic Damage Caps Don't Work. **Physician Insurers Association of America, July 2003. (614.230/P56)** A critical analysis of the methodology used in the Weiss report. www.thepiaa.org/text_files/WEISS070903.htm

"What's at Stake for Your Family? Maintaining Wisconsin's Delicate Medical Liability Balance". Wisconsin Medical Society, *Your Doctor, Your Health,* v.2, no.3, p.5-8, Fall 2003. (614.230/W75b) A local perspective on how the current medical malpractice crisis is impacting Wisconsin, including guest responses by Sen. Dale Schultz and Rep. Sheldon Wasserman.

Wisconsin Health Care Liability Insurance Plan (WHCLIP). **Office of the Commissioner of Insurance, 1992. (614.230/W7c1)** Examines the operation of WHCLIP, the state-sponsored malpractice insurer that provides coverage for claims too small to be covered by the Patients Compensation Fund.

Wisconsin Patients Compensation Fund: Functional and Progress Report. **Wisconsin Office of the Commissioner of Insurance, 1976-1986. (Ins/w) (noncirculating)** These legislatively mandated reports include claim reports and audits from an independent actuarial firm.

Related Web Sites:

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

www.atla.org/medmal/main.aspx – American Trial Lawyers Assoc. Medical Malpractice in America

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

www.ncsl.org/programs/insur/medmal.htm – NCSL's Medical Malpractice site

www.thepiaa.org/public_home.asp – Physician Insurers Association of America

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

www.mcandl.com/states.html – Summary of Medical Malpractice Law: Index of States

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.state.sc.us/sclac/Reports/2000/pcf.htm – South Carolina Legislative Audit Council Report

http://oci.wi.gov/pcf.htm – Wisconsin Patients Compensation Fund

Reform efforts and studies from other states:

www.cga.state.ct.us/olr/medicalmalpractice.htm Connecticut

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/HotTopics.cfm Nevada

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

www.ohcr.state.pa.us – Pennsylvania

Clippings: (Noncirculating; available for use in the library; clippings prior to 1981 are on microfiche)

- Physicians (malpractice): 623.230/M29Z