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April 23, 2003 Joint Committee on Finance Paper #458

Patients Compensation Fund (Insurance and Health and Family Services)

[LFB 2003-05 Budget Summary: Page 203, #5 and Page 276, #2]

CURRENT LAW

The patients compensation fund (PCF) was created in 1975 to provide excess medical malpractice coverage for health care providers. Under current law, health care providers must obtain primary medical malpractice insurance from private insurance companies in the amount of $1 million per occurrence and $3 million per policy year in the aggregate. PCF provides coverage in excess of the primary insurance, and fund coverage is unlimited. Participation in PCF is mandatory, unless the provider qualifies for an exemption. Exemptions include: (a) providers who do not practice in Wisconsin for more than 240 hours in a fiscal year; (b) providers employed by the state, a county, or municipality who do not expect to practice outside of that employment for more than 240 hours during a fiscal year; (c) providers whose principal place of practice is not in Wisconsin; (d) federal employees covered under the Federal Tort Claims Act who do not expect to practice outside that employment for more than 240 hours during a fiscal year; (e) retired providers; (f) providers who have never practiced in Wisconsin to date; and (g) corporations and partnerships that cease providing medical services in Wisconsin.

PCF provides coverage on an occurrence basis. Payment of the premium for a given year of practice entitles the provider to coverage for claims filed for any acts of malpractice that occur during that year, including claims that are filed subsequent to the PCF coverage cancellation date. If a claim is based on an occurrence during a covered year, then PCF is responsible for coverage regardless of when the claim is filed. Under current law, claims are paid in the order received within 90 days, unless appealed, and if there are insufficient funds, the claims are immediately payable in the following year in the order in which they were received.

PCF is funded through annual assessments paid by providers and through investment income. Under current law, PCF is held in trust for the purposes of Chapter 655 of the statutes, which currently is to regulate health care liability and patients' compensation, and may not be

used for any other purposes. As of September 30, 2002, the Office of the Commissioner of Insurance (OCI) estimated PCF's total assets to be $620.7 million, total outstanding liabilities to be $631.6 million, and the fund equity to be -$10.9 million. OCI also estimates that by June 30, 2003, PCF's fund equity will be approximately -$255,000.

GOVERNOR

Insurance

Provide $200 million SEG in 2003-04 from PCF to transfer to a new segregated fund, the health care provider and cost control fund, which would support a portion of the state's share of medical assistance (MA) costs budgeted in the Department of Health and Family Services (DHFS).

Health Care Provider Availability and Cost Control Fund. Create the health care provider availability and cost control fund in Chapter 655 of the statutes to ensure the availability of health care providers in the state and to control the cost of health care services to state taxpayers, workers, and employers. Specify that the fund could be used to: (a) assist in the education and training of health care providers; (b) ensure that health care providers who serve recipients under MA or other health care programs established by the state receive levels of payment sufficient to retain their participation in the programs and to reduce the risk of shifting costs to private sector employers; and (c) defray the cost of other health-related programs that DHFS determines are effective in ensuring the availability of health care providers in the state and controlling the cost of health care services to state taxpayers, workers, and employers.

Require OCI to administer the fund. Specify that the fund would participate in the state investment fund, and the State of Wisconsin Investment Board would have control of investments and collection of all money loaned or interest earned from the fund.

Guaranteed Payment. Create a sum sufficient GPR appropriation to pay any portion of a medical malpractice claim that PCF is required to pay but is unable to pay because of insufficient funds. Make claims payable within 90 days from PCF, but if PCF has insufficient funds, the claims are payable within 90 days from the sum sufficient GPR appropriation. The sum sufficient GPR appropriation would also be subject to the same review, assessment, and withdrawal processes as PCF.

Health and Family Services

Reduce funding for MA benefits by $200 million GPR in 2003-04 and provide $200 million SEG from the health care provider availability and cost control fund to support MA benefits in 2003-04.

Medical Assistance. Create a continuing appropriation in DHFS to disburse funds from the health care provider availability and cost control fund to support a portion of the state's share

of MA benefits costs. Modify the current MA appropriation to reflect that a portion of the state's share of MA benefit costs would be funded from the new appropriation.

DISCUSSION POINTS

1. This item would fund a portion of the state's 2003-04 MA benefits costs by using assets that have accumulated in the PCF. Because this funding would be provided in the first year of the biennium, funding from this source would not be part of the MA base for the 2005-07 biennium. This use of this funding in 2003-04 reflects the administration's intent not to have PCF be an ongoing source of funding for the MA program.

In a letter to the Co-chairs of the Joint Committee on Finance dated March 17, 2003, the DOA Secretary requested that the bill be amended to sunset the transfer mechanism and the health care provider access and cost control fund on July 1, 2005, to better reflect this intent.

Medical Malpractice

2. According to a March 3, 2003, report prepared by the United States Department of Health and Human Services, the medical malpractice environment as a whole has contributed to a health care crisis in the United States. Patients have less access to doctors as doctors have given up their practices, limited their practices to patients who do not have health conditions that are more likely to lead to lawsuits, or have moved to states where insurance can be obtained at a lower price. Some doctors are unable to obtain or afford medical liability insurance. In addition, some insurers are leaving the market. Insurance premiums in the United States, excluding California, have increased 505% from 1976 to 2000. The cost of increasing premiums for doctors is passed on to the patients.

3. The American Medical Association has listed Wisconsin as one of six states whose medical liability systems are not in crisis or showing problem signs. Attachment 1 indicates which states are in crises, which are showing problem signs, and which are not showing problems.

4. To avoid problems with a medical malpractice system, it is necessary to maintain a stable and predictable environment. To this end, Wisconsin has implemented a number of tort reform measures to stabilize the medical malpractice environment, including: (a) a statute of limitations, in most cases, of three years from the incident date or one year from the discovery date; (b) a cap on noneconomic damages of $350,000 plus a cost of living increase, currently approximately $410,000; (c) limits on attorney contingency fees; (d) mandatory professional primary liability insurance of $1 million per incident and $3 million per policy year; (e) periodic payment of damages; (f) a mediation system to resolve disputes without litigation; (g) a contributory negligence provision, which allows damages awarded to be diminished in proportion to the amount of negligence attributed to the person recovering; (h) abolition of the collateral source rule, which results in the admission of evidence, in an action to recover damages for medical malpractice, of any compensation for bodily injury received from sources other than the defendant to compensate the claimant for the injury; and (i) PCF to provide unlimited excess liability coverage.

5. The other five states that show no problem signs have also implemented a variety of tort reforms. California has passed provisions relating to: (a) a cap on noneconomic damages; (b) the collateral source rule; (c) limits on attorney contingency fees; (d) structured settlement payments; and (e) joint and several liability. Colorado has passed provisions relating to: (a) a cap on all damages; (b) joint and several liability; (c) the collateral source rule; and (d) structured settlement payments. Indiana has passed provisions relating to: (a) joint and several liability; (b) the collateral source rule; (c) a cap on all damages; (d) limits on attorney contingency fees; and (e) PCF. Louisiana has passed provisions relating to: (a) a cap on damages; (b) structured settlement payments; (c) PCF; (d) joint and several liability; and (e) prejudgment interest. New Mexico has passed provisions related to: (a) joint and several liability; (b) structured settlement payments; (c) a cap on all damages, except for punitive damages; and (d) PCF.

6. All states have implemented one or more tort reform measures in an attempt to stabilize the medical malpractice environment. Eight states other than Wisconsin have PCFs--South Carolina, Indiana, Kansas, Louisiana, Nebraska, New Mexico, Pennsylvania, and Wyoming. Four out of the six states that show no medical malpractice problem signs have PCFs. However, five out of nine states that have PCFs are either in crisis or showing problems signs.

Patients Compensation Fund

7. Each state that has a PCF operates the fund with different requirements. Participation in at least three of the states -- Kansas, Pennsylvania, and Wisconsin -- is mandatory. Coverage in at least two of the states, South Carolina and Wisconsin, is unlimited. Primary insurance coverage that is required for providers varies from state to state. Wisconsin has the highest primary insurance coverage requirement of $1 million per incident and $3 million per policy year. Wisconsin is also the only fund to have both mandatory participation and unlimited coverage.

8. When Wisconsin's PCF was established in 1975, it operated on a cash basis for the first five years. In other words, providers were assessed based on actual payout amounts for claims in a given year. During the 1980's, PCF switched from cash accounting to accrual accounting to improve the integrity of the fund. Under the accrual method, providers are assessed based on estimates of what all claims would total over time for incidents that occurred in any given year, rather than on what the payout amount was for that year. Accrual accounting ensures that PCF has sufficient assets to pay any outstanding liabilities, including claims incurred but not reported, if PCF were discontinued. The estimates of what claims would total over time are actuarially determined. Wisconsin requires insurers to be financially solvent such that their assets are sufficient to cover any outstanding liabilities. Therefore if an insurer stopped doing business, all outstanding claims would be paid. PCF is currently operated in a similar manner.

9. During the 1990's, the PCF's Board of Governors began to increase PCF's reserves to cover any outstanding claims if PCF were eliminated. The total amount of the reserves, the assessments and investment income, are PCF's total assets. Any outstanding claims since the inception of PCF, including claims incurred but not reported, are the total outstanding liabilities. The difference between the total assets and the total outstanding liabilities is the fund equity. PCF operates in a similar manner, but uses estimated future investment income earnings to discount its

total outstanding liabilities. The Board tries to avoid any deficit or surplus of the fund equity and assesses providers with that goal in mind.

10. To determine provider assessments for PCF, actuaries attempt to predict how many claims will occur in a given year and how much those claims will cost. By the actuaries' own statements, the process is highly uncertain, especially since Wisconsin's PCF is unique in the nation. The actuaries indicate that their estimates have been tracking the industry nationally as a whole. However, there is a concern that the estimates may be too conservative for Wisconsin.

11. The 13-member Board uses the actuarial information to set annual premium rates for providers, which are then established by rule. Attachment 2 shows annual provider assessments for each provider classification from fiscal years 1997-98 thru 2001-02. The Board has usually set rates that differ from the actuaries' recommendations. The Board attributes the difference to the fact that Wisconsin's medical malpractice environment is much more stable than the rest of the nation and to the fact that because assessments are mandatory, PCF has a "captured pool" to require additional assessments to make up for any underestimation in assessments from a previous year. Table 1 compares the actuaries' recommended percentage changes to premiums with the percentage changes approved by the Board in each year from 1994-95 thru 2002-03.

TABLE 1

Annual Percentage Changes to Assessment Fees
Policy Years 1994-95 thru 2002-03

Policy Year	Actuary Recommendation	Board Approved
1994-95	10.8%	7.1%
1995-96	4.9	-11.2
1996-97	17.3	10.0
1997-98	-17.7	-17.7
1998-99	5.9	0.0
1999-00	2.7	-7.0
2000-01	3.7	-25.0
2001-02	-28.6 to 28.2	-20.0
2002-03	117.4	5.0

12. Historically, actual expenditures have been much lower than projected expenditures. However, because it is difficult to predict when claims for any specific incident will be paid, expenditures could greatly increase in the future if losses incurred in previous years are finally paid. Through December 31, 2002, PCF had paid over 597 claims, totaling approximately $535.2 million, since its inception. As of that date, PCF had 32 claims reported and pending, which are estimated to require approximately $33.3 million in aggregate case reserves.

13. PCF reserves are used to pay claims for incidents that occurred in prior years. For example, a claim may be submitted to PCF for payment seven years after the incident occurred. Assessments collected from the year of the incident would have been set-aside in reserves to pay for any claims resulting from that year. Some claims could take up to 20 years after the incident date before they are paid. Although the statute of limitations for filing a medical malpractice claim is, in

most cases, three years from the incident date or one year from the discovery date, there is no limit on how long the litigation process will take. Table 2 shows for each fiscal year from 1975-76 thru 2001-02 assessments collected during that year, claims paid out during that year, the aggregate amount paid for all claims that occurred in that year, the aggregate number of claims paid for incidents that occurred in that year, and the number of estimated outstanding claims for incidents that occurred during that year. The figures are taken from an actuarial report prepared by the Board's actuarial consultant, Milliman USA, regarding PCF, dated September 30, 2002. For example, in policy year 1975-76, PCF collected $3,036,200 in assessments and paid claims totaling $51,600. However, since 1975-76, PCF has paid a total of $5,713,400 in claims for incidents that occurred during 1975-76. PCF has paid 16 claims since 1975-76 for incidents that occurred during 1975-76, and there is still one outstanding claim.

TABLE 2

Assessments and Expenditures
Policy Years 1975-76 thru 2001-02

Policy Year	Assessments	Claims Paid in the Year	Total Claims Paid for Incidents That Occurred in the Year	Number of Claims Paid for Incidents that Occurred in the Year	Number of Outstanding Claims
1975-76	$3,036,200	$51,600	$5,713,400	16	1
1976-77	3,055,000	64,500	4,977,100	21	0
1977-78	1,351,000	784,400	9,160,000	24	0
1978-79	1,416,100	328,800	11,178,600	23	0
1979-80	2,395,700	3,922,100	21,652,100	37	0
1980-81	4,412,500	2,260,500	16,273,800	34	2
1981-82	4,652,700	3,619,400	22,914,100	45	2
1982-83	7,344,300	7,661,900	19,320,200	32	1
1983-84	10,276,200	14,155,700	19,574,400	34	1
1984-85	17,417,300	13,899,200	11,772,100	26	1
1985-86	32,324,700	9,903,000	54,440,000	42	1
1986-87	30,560,000	17,572,800	23,797,800	37	1
1987-88	33,642,800	26,092,800	42,672,400	22	2
1988-89	37,969,600	16,351,200	23,540,400	18	2
1989-90	43,161,200	25,590,200	25,795,900	23	2
1990-91	43,936,700	26,747,100	29,455,200	19	4
1991-92	42,350,100	44,828,400	34,801,800	18	4
1992-93	45,063,900	47,012,000	30,394,100	21	3
1993-94	51,213,200	26,829,500	46,380,400	18	5
1994-95	55,505,700	27,582,200	30,717,900	30	8
1995-96	51,048,900	53,205,000	11,541,000	11	9
1996-97	58,270,700	37,397,300	11,188,900	11	11
1997-98	49,892,400	24,840,400	7,200,000	4	11
1998-99	50,621,700	23,544,300	16,446,000	2	20
1999-00	47,879,300	23,875,700	2,500,000	1	19
2000-01	37,052,400	41,114,800	0	0	*
2001-02	29,534,300	39,480,000	0	0	*

*Figures not available.

14. In addition to premiums, PCF invests its reserves, which earns interest. As of June 30, 2000 (the last year for which audited statements are available), PCF's cash and investment balances amounted to approximately $542 million. Investment income accounted for $275 million of this amount and more than 27% of PCF's total revenue since 1975. Investment earnings help to reduce the provider assessments that fund current and future claim payments. The investments are long-term. These funds are not cash on hand and would have to be liquidated to receive a cash amount. Liquidation could involve significant financial penalties and the remaining balance would earn less in the future. Table 3 shows expenses paid, assessments collected, total assets, total liabilities, and the fund equity for fiscal years 1994-95 thru 2001-02. The figures from 1994-95 thru 1999-00 are from the Legislative Audit Bureau's report. The figures from 2000-01 thru 2001-02 are unaudited figures provided by OCI.

TABLE 3

Patients Compensation Fund Balances
Fiscal Years 1994-95 thru 2001-02

Fiscal Year	Expenses	Assessments	Total Assets	Total Liabilities	Fund Equity
1994-95	$22,126,600	$55,505,700	$310,015,300	$367,738,100	-$57,722,800
1995-96	53,424,100	51,048,900	336,223,000	378,018,500	-41,795,500
1996-97	36,833,600	58,259,200	376,830,700	420,924,900	-44,094,200
1997-98	22,562,600	49,884,800	462,227,500	484,394,300	-22,166,700
1998-99	22,622,100	50,621,700	501,134,200	492,554,400	8,579,800
1999-00	22,862,000	47,879,300	542,613,000	515,383,300	27,229,700
2000-01	39,636,300	36,542,500	576,524,200	548,063,700	28,460,500
2001-02	39,391,900	29,751,000	588,823,400	582,219,300	6,604,100

15. OCI estimates that, as of September 30, 2002, PCF's fund equity was approximately -$10.9 million. However, OCI also estimates that by June 30, 2003, PCF's fund equity will be approximately -$255,000.

Legal Issues

16. Wisconsin Legislative Council staff have addressed potential legal issues in transferring $200 million from PCF to the health care provider availability and cost control fund. The attached memorandum, prepared by Wisconsin Legislative Council staff for Senator Schultz, provides information on the creation of PCF, major changes to PCF that have occurred since its creation, and the structure and operation of PCF, as well as the bill's proposal and potential constitutional issues. The memorandum outlines the arguments that could be made in support of and against the proposed transfer of $200 million from PCF to the new fund. The memorandum concludes that the creation of a sum sufficient GPR appropriation, which would be used to pay any portion of a medical malpractice claim that PCF is required to pay but is unable to pay because of insufficient funds, would probably be required to successfully defend against a legal challenge. The

attachment alluded to in the memorandum is not included.

17. The PCF Board of Governors indicates that it has a fiduciary responsibility to protect the integrity of PCF and has passed a resolution that indicates that as trustee, the Board opposes any attempt to withdraw funds from PCF that goes beyond the original intent that PCF be held in trust only for liability claims. In addition, the Board has indicated its intent to challenge the transfer of funds. If the Board does challenge the transfer of $200 million from PCF to the new fund, the state would incur costs in defending the challenge. If the state were unsuccessful in a legal challenge, the state would have to pay back the $200 million transferred from PCF with interest.

18. Several legislators and the PCF Board have requested an opinion from the Office of the Attorney General regarding whether transferring $200 million from PCF to the health care provider availability and cost control fund could be successfully challenged in a court of law. However, the opinion has not yet been completed.

Medical Malpractice Issues

19. Although PCF contributes to the stable and predictable medical malpractice environment, it is not known whether transferring money from the fund on a one-time basis will significantly affect Wisconsin's stable medical malpractice environment, given the other protections in place. The medical malpractice environment would still be predictable because the amount of the transfer is known, and it is on a one-time basis, so the fiscal effects could be calculated. However, if premiums significantly increase, it could contribute to a destabilization of the medical malpractice market.

20. The administration has indicated that the transfer should not affect the PCF assessments. Because the assessments are based upon a single policy year and because there is a sum sufficient GPR appropriation that will cover any claims if the PCF should be unable to do so, the Board should not have to increase assessments based on this $200 million transfer. However, Milliman indicates that assessments are not only based on the current policy year, but also on the current fund equity. In other words, Milliman would consider the deficit in making recommendations to the Board regarding increases in assessments, especially since they could not assume the existence of the sum sufficient GPR appropriation in future years. Milliman estimates that $16.6 million annually for the next 25 years in addition to the current assessments, which is a 57% increase over 2002-03 assessments, would be needed to compensate for the fund equity deficit. The Board indicates the increase in assessments would have an adverse effect on reinsurance rates and the medical malpractice environment. It is unknown to what extent this would affect the medical malpractice environment in Wisconsin.

21. The Board has also expressed concern that should the medical malpractice environment in Wisconsin become unstable as a result of transferring $200 million from PCF to the new fund, Wisconsin could have fewer practicing physicians. Wisconsin uses its stable medical malpractice environment to recruit new physicians to this state. If the medical malpractice environment became less stable, Wisconsin might become less attractive to future physicians.

Integrity of the Fund

22. Another issue regarding the transfer of $200 million involves taking a fiscally sound fund and making it less so in order to promote other public policy considerations. The Governor's bill proposes to use $200 million from PCF to substitute for GPR funding that would otherwise be needed to support MA-eligible health care costs. In addition, the bill proposes a sum sufficient GPR appropriation to pay claims if PCF cannot to ensure that PCF will not become insolvent.

23. On the other hand, the Governor's recommendation to transfer $200 million would create a fund equity deficit, which the Board has eliminated over the years. PCF would be able to endure liability over the short-term (10 years), but the actuaries predict a crisis could occur in the long-term (10 to 15 years). In addition, the Legislative Audit Bureau (LAB) indicated that PCF's fund equity deficit could affect the state's bond rating. However, any affect on bond rating would probably not surface in the short-term.

The Board also has indicated that it is concerned about what would happen in the future if GPR funds would be needed. Would the sum sufficient GPR appropriation still exist? Would a future Legislature approve supplemental GPR funding to support the fund? Would the current Board be held responsible for not increasing assessments to continue to maintain a positive fund equity? The Board indicates that the Governor's proposal to transfer $200 million from the fund would have a profound effect on the trust providers have with PCF.

24. The actuaries indicate that the withdrawal of $200 million will result in an actual deficit of $281 million due to the loss of investment income. As previously indicated, PCF's total outstanding liabilities are discounted by future investment income earnings. Withdrawal of the $200 million reduces the asset base by one-third, thereby reducing future investment income.

25. Another issue involves the accuracy of the actuaries' estimates of total outstanding liabilities. In its 2001 report, LAB expressed a concern that the actuaries' estimates in this regard have been too conservative. LAB recommended that an independent audit be done. PCF accepted the recommendation, and another actuarial consultant is doing an audit independent of Milliman. However, the audit has not yet been completed. In addition, the Board addressed PCF's previous fund equity deficit in a much shorter time frame than anticipated. The Board was prepared to make up the deficit over a 25-year period. However, the fund equity deficit was reduced in approximately 10 years. Also, the Board itself has consistently set assessment rates that differ from the actuaries' recommendations.

Transfer of Funds

26. The administration indicates that transferring $200 million would leave PCF with total assets of approximately $260.7 million at the end of ten years. This estimate does not take into consideration potential financial penalties that may result from prematurely liquidating long-term assets. In determining the amount of total assets after ten years, the administration makes several assumptions. First, assessment income is assumed to remain at the same level as 2001-02, $29,534,300, which is the lowest level since 1984. Second, other income is assumed to be $44,500,

which is the lowest level since 1984. This income consists of administrative fees and contributions from other carriers that tender their primary limits to PCF to pay claims. Third, total expenditures are assumed to be $53,205,000, which is the amount of expenditures in 1995 and is the highest amount of expenditures since PCF's inception. Finally, investment income is assumed to grow at the rate of only 3.5% annually. Because the highest expenditures since PCF's inceptions were in the amount of $53,205,000, the administration believes that the total assets in ten years will be sufficient to pay all claims and, therefore, the sum sufficient GPR appropriation will not be utilized.

27. Under current law, there is no requirement that PCF operate on an accrual accounting basis, rather than a cash basis. PCF could operate on a cash basis. As a result, PCF's total assets could be liquidated. As of September 30, 2002, PCF's total assets totaled $620,732,300. PCF would then assess providers based on the amount of claims paid during that year, rather than on the amount it would take to pay all claims in the future for incidents that occurred during that year. Based on the history of PCF's claims paid annually, PCF could expect assessments not to exceed $53,205,000. Consequently, PCF has no required level of total assets to maintain.

28. On the other hand, there is a statutory requirement that PCF be accounted for on an accrual basis. All audits of PCF are based on accrual accounting. In addition, if PCF were funded on a cash basis, premiums would fluctuate from year to year as claims are paid. Fluctuation in premiums could contribute to a destabilization in the medical malpractice environment. Also, liquidating all of PCF's assets could result in providers being assessed twice for claims associated with incidents that have already occurred.

29. The Board has increased assessments for 2003-04 by 5%. Therefore, the total assessments received in 2003-04 would be $31,011,100. With the assumption that the assessments would remain $31,011,100 for the next ten years, and with the same assumptions used by the administration, transferring $300 million from PCF in 2003-04 would leave PCF with approximately $134.2 million in total assets in 2012 (not including potential financial liquidation penalties). The total assets in ten years could be sufficient to pay all claims and, therefore, the sum sufficient GPR appropriation would not be utilized.

30. On the other hand, in an effort to minimize any medical malpractice or fund equity problems, less funding could be transferred from PCF to the new fund. With the assumption that the assessments would remain $31,011,100 for the next ten years, and with the same assumptions used by the administration, transferring $100 million from PCF would leave PCF with $426.2 million in total assets in 2012 (not including potential financial liquidation penalties). The total assets in ten years could be sufficient to pay all claims and, therefore, the sum sufficient GPR appropriation would not be utilized.

31. Finally, the Committee could delete the provision from the bill in order to avoid a potential legal challenge, to avoid any potential adverse effects to the medical malpractice environment in Wisconsin, and to maintain the integrity of PCF's fund equity balance.

ALTERNATIVES

1. Adopt the Governor's recommendation to transfer $200 million in 2003-04 from PCF to the health care provider availability and cost control fund. In addition, repeal the transfer provision and the health care provider access and cost control fund on July 1, 2005.

2. Modify the Governor's recommendation by transferring $300 million in 2003-04 from PCF to the health care provider availability and cost control fund. In addition, repeal the transfer provision and the health care provider access and cost control fund on July 1, 2005.

Alternative 2: OCI	**SEG**
2003-05 FUNDING (Change to Bill)	$100,000,000

Alternative 2: DHFS	**GPR**	**SEG**	**TOTAL**
2003-05 FUNDING (Change to Bill)	**-** $100,000,000	$100,000,000	$0

3. Modify the Governor's recommendation by transferring $100 million in 2003-04 from PCF to the health care provider availability and cost control fund. In addition, repeal the transfer provision and the health care provider access and cost control fund on July 1, 2005.

Alternative 3: OCI	**SEG**
2003-05 FUNDING (Change to Bill)	**-** $100,000,000

Alternative 3: DHFS	**GPR**	**SEG**	**TOTAL**
2003-05 FUNDING (Change to Bill)	$100,000,000	**-** $100,000,000	$0

4. Delete provision.

Prepared by: Kim Swissdorf
Attachments

ATTACHMENT 2

Annual Provider Assessments[1]

Provider Types	1997-98	1998-99[2]	1999-00	2000-01	2001-02
Physician Class 1[3]	$2,647	$2,721	$2,531	$1,898	$1,518
Physician Class 2[4]	5,294	5,170	4,809	3,606	2,885
Physician Class 3[5]	11,382	11,292	10,504	7,877	6,302
Physician Class 4[6]	15,882	16,326	15,186	11,388	9,110
Nurse Anesthetist	678	678	631	475	380
Hospital -- per Occupied Bed	167	167	155	116	93
Nursing Home -- per Occupied Bed	31	31	29	22	18
Employees of a Partnership or Corporation					
Nurse Practitioner	662	680	631	475	380
Advanced Nurse Practitioner	926	952	886	664	531
Nurse Midwife	5,823	5,986	5,568	4,176	3,341
Advanced Nurse Midwife	6,088	6,258	5,821	4,365	3,492
Advanced Practice Nurse Prescriber	926	952	886	664	531
Chiropractor	1,059	1,088	1,012	759	607
Dentist	529	544	506	380	304
Oral Surgeon	3,971	4,082	3,797	2,847	2,278
Podiatrists -- Surgical	11,250	11,564	10,757	8,067	6,454
Optometrist	529	544	506	380	304
Physician Assistant	529	544	506	380	304

[1] These rates apply to providers having Wisconsin as their primary place of practice. Other rates apply to providers for whom Wisconsin is not their primary place of practice.

[2] Overall, there was no change from FY 1997-98 rates. However, there were minor rate changes for certain provider types.

[3] Includes family or general practice physicians not performing surgery, and nutritionists.

[4] Includes family or general practice physicians performing minor surgery, and ophthalmologists performing surgery.

[5] Includes most types of surgeons, such as plastic, hand, general, and orthopedic.

[6] Includes obstetric and neurological surgeons.