04-12
October 2004

An Audit

Injured Patients and Families Compensation Fund

Office of the Commissioner of Insurance

2003-2004 Joint Legislative Audit Committee Members

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From the Office of the Commissioner of Insurance

State of Wisconsin \ LEGISLATIVE AUDIT BUREAU

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October 12, 2004

Senator Carol A. Roessler and
Representative Suzanne Jeskewitz, Co-chairpersons
Joint Legislative Audit Committee
State Capitol
Madison, Wisconsin 53702

Dear Senator Roessler and Representative Jeskewitz:

As required by s. 13.94(1)(de), Wis. Stats., we have completed a financial audit of the Injured Patients and Families Compensation Fund (formerly the Patients Compensation Fund), which insures health care providers in Wisconsin against medical malpractice claims that exceed the primary malpractice insurance thresholds established in statute. We have provided an unqualified auditor's report on the Fund's financial statements for fiscal years ending June 30, 2003, 2002, and 2001. However, we highlight the uncertainty involved in estimating and reporting future loss liabilities.

As noted in our 2001 audit, interest groups continue to raise concerns about the conservative nature of the actuarial estimates of the Fund's loss liabilities, as evidenced by the actuary's annual reductions in past estimates and an accumulation of cash and investments totaling $658.9 million as of June 30, 2003. However, more than three years after we recommended that the Office of the Commissioner of Insurance contract for an audit of the actuarial methods and assumptions used in estimating the Fund's loss liabilities, an actuarial audit has not been completed. The Office concluded that a draft report prepared by the contractor in 2002 was not acceptable, and it is in the process of contracting with another vendor. We include a recommendation that the Office report to the Joint Legislative Audit Committee on the status and results of the actuarial audit by November 30, 2004.

The Fund's computerized provider system, which tracks and accounts for its operations, is aging and experiencing errors that require daily manual reviews and adjustments to correct. The condition of the system is likely to worsen, resulting in increased risk to the Fund's financial operations and additional efforts to keep the system operational. The Office is pursuing incremental enhancements to keep the system operational.

We appreciate the courtesy and cooperation extended to us by the staff of the Office of the Commissioner of Insurance and the contractors who assist in administering the Injured Patients and Families Compensation Fund program. A response from the Office's Assistant Deputy Commissioner follows the appendix.

Respectfully submitted,

Janice Mueller
State Auditor

JM/DA/ss

Report Highlights ■

The Fund maintains a sound financial position.

Questions continue regarding the conservative nature of the Fund's actuarial estimates.

The Office encountered difficulties in obtaining an actuarial audit.

The computerized provider system is aging and experiencing operational problems.

The Injured Patients and Families Compensation Fund (formerly the Patients Compensation Fund) was created to pay medical malpractice claims that exceed primary insurance thresholds established by statute. Statutes require most health care providers that operate or have permanent practices in Wisconsin to maintain primary malpractice coverage of $1 million for each incident and $3 million per policy year. In addition, these providers are required to participate in the Fund, which provides unlimited liability coverage for economic damages that exceed the primary limits.

The Fund is managed by a Board of Governors, administered by the Office of the Commissioner of Insurance, and financed through assessments on health care providers and earnings on the Fund's investments. It has paid over $553.2 million in claims from its inception through June 30, 2004. 2003 Wisconsin Act 111, which changed the Fund's name from the Patients Compensation Fund to the Injured Patients and Families Compensation Fund, established it as an irrevocable trust for the sole benefit of participating health care providers and proper claimants.

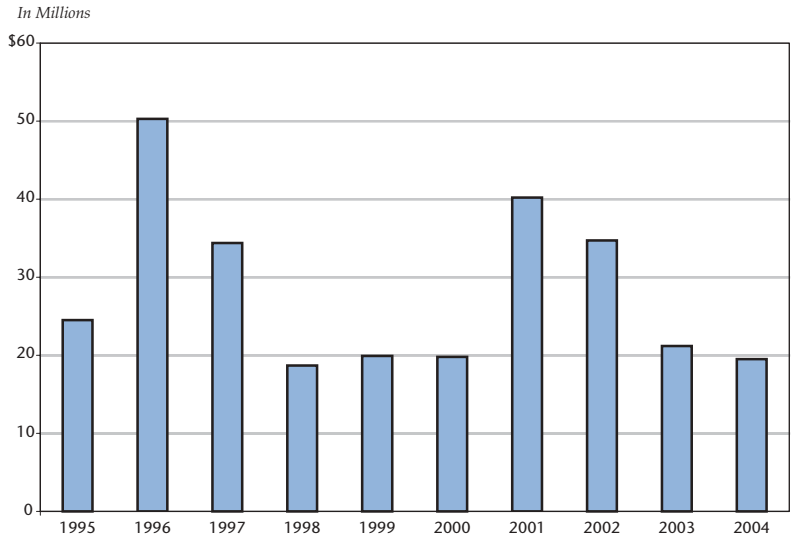
Statutes require the Legislative Audit Bureau to perform financial audits of the Injured Patients and Families Compensation Fund at least once every three years. Our audit report contains our unqualified opinion on the Fund's financial statements and related notes as of and for the years ending June 30, 2003, 2002, and 2001.

Financial Position

The uncertainty and long-term nature of medical malpractice claims make it difficult to predict the size and timing of claims that will be settled and paid from the Fund. In the past ten years, annual claims payments have varied from a low of $18.7 million to a high of $50.3 million, as shown in Figure 1.

Figure 1

Annual Claim Payments[1]



[1] For fiscal year ending June 30.

Since its creation in 1975, the Fund has typically received more in assessments and investment income than it has paid out in claims and administrative expenses. As a result, its cash and investment balances have grown to $658.9 million as of June 30, 2003. However, the Fund's financial position is also significantly affected by its loss liabilities, which are based on estimates of what it may be required to pay for malpractice incidents that have occurred but may not yet have been settled or even reported. The Board of Governors relies on a consulting actuarial firm, which it has employed since the Fund's initial years, to estimate these loss liabilities.

The Fund reported an accounting deficit for several years in the past because estimated loss liabilities exceeded the cash and investments available to pay them. Its accounting balance reached a low of -$122.7 million on June 30, 1988. The Fund's financial position has

since improved significantly. The accounting balance was $7.9 million as of June 30, 2003, and is estimated to be $21.0 million as of June 30, 2004.

Actuarial Estimates

Annual actuarial adjustments to the Fund's estimated claims have contributed to the improvement in its financial status in recent years. Because a medical malpractice claim may be filed years after an incident, and there is no limit on the amount of economic losses the Fund may be required to pay, the actuary reviews and revises individual and total loss liability estimates each year, based on subsequent experience and information.

The Fund's actuary indicates that annual adjustments have been within the normal range of variability for actuarial projections, especially considering the uncertainties surrounding medical malpractice cases. Nevertheless, in nine of the ten years from fiscal year (FY) 1993-94 through FY 2002-03, the actuary's initial estimate of loss liabilities has been decreased one year later, following actuarial review of subsequent experience and information. Furthermore, the actuary's original loss estimates for the last 20 policy years have been reduced over time by $217.3 million, which represents 13.9 percent of the original losses estimated for these years.

Some interested parties continue to be concerned that the actuary may be overly conservative in estimating the Fund's loss liabilities. For example, interest groups representing patients and trial lawyers suggest that over the years, conservative actuarial estimates have exaggerated medical malpractice costs in Wisconsin and, consequently, contributed to 1995 legislation that re-established limits on non-economic damages awarded to patients and their families for pain and suffering, embarrassment, mental distress, and the loss of companionship and affection that results from medical malpractice. As of May 15, 2004, these awards are limited to $432,532.

On the other hand, from both an actuarial and an accounting perspective, conservative actuarial estimates are considered more prudent than overly optimistic ones, not only because of uncertainties surrounding long-term medical malpractice claims, but also because of the unlimited coverage for economic damages available under the Fund. While several other states have medical malpractice funds, only a few provide unlimited coverage. Therefore, relatively limited experience pertaining to unlimited coverage is available in the industry.

Prudent estimates are also important because of the significant role that medical malpractice funds can play in a state's medical malpractice environment. The Injured Patients and Families Compensation Fund is often cited as an important factor in Wisconsin's relatively stable environment for health care providers in comparison to other states. Its solid financial position provides flexibility to readily respond to changes that may occur in the medical malpractice environment in the future.

Actuarial Audit

In light of questions raised about the actuarial estimates, we recommended in June 2001 that the Office of the Commissioner of Insurance contract for an audit of the actuarial methods and assumptions used in estimating the Fund's loss liabilities. A comprehensive review by an independent actuary is likely not only to suggest refinements to the actuarial analyses, but also to promote broader acceptance of the analyses by the various interested parties.

However, more than three years after our 2001 recommendation, an actuarial audit of the Fund has not been completed. The Office contracted with an actuarial firm in August 2002, but after reviewing a draft report and working with the firm for several months, the Office and the Board's Finance, Investment, and Audit Committee concluded that the contractor's work and the original request for proposals did not meet the original intent of the Audit Bureau's recommendation and that further analysis and discussion of the nature, structure, and funding of the Fund was needed. The Office paid the first contractor a total of $23,183 and issued a second request for proposals in April 2004. Five proposals were received and rejected. Subsequently, the Office has obtained proposals from other actuarial firms it has determined to be experts in the area of medical malpractice.

A contract for another actuarial audit is expected to be issued in October 2004 and completed in November 2004. In addition, the Board recently established a policy to obtain an actuarial audit of the Fund once every three years.

Provider System

Another continuing challenge for the Fund is the decreasing effectiveness of its aging computerized provider system. Since the system was first developed in the early 1990s to track medical malpractice claims, it has been expanded to incorporate other aspects of the Fund's operations, including billings and provider

compliance with liability coverage requirements. However, the provider system has not been able to easily accommodate the changes that have occurred over time. As a result, errors in health care provider accounts have occurred, including incorrect bills and noncompliance notices. As a result of these regularly occurring errors, staff must, on a daily basis, review the account information in the system, bills and notices generated by the system, and system reports to ensure that information is complete, accurate, and current.

The regular occurrence of errors and the need to manually identify and correct them increase the risks associated with the Fund's operations and, consequently, required additional audit effort before we could issue an opinion on the fairness of the Fund's financial statements. The condition of the system is likely to worsen, resulting in increased risk to the Fund's financial operations and requiring additional efforts to keep the system operational.

In its 2003-05 biennial budget proposal, the Office requested authority to spend $607,800 from the Fund for a new provider system. Like other budget requests for systems work, the Office's request for additional resources for a new provider system was denied by the Legislature. The Office is now more fully documenting problems with its provider system and assessing its ability to internally complete incremental enhancements. As part of our ongoing financial audit work at the Fund, we will continue to monitor the Office's status in addressing problems with its provider system.

Recommendation

Our recommendation addresses the need for the Office of the Commissioner of Insurance to:

- ☑ report to the Joint Legislative Audit Committee by November 30, 2004, on the status and results of the actuarial audit expected to be completed in November *(p. 21).*

■ ■ ■ ■

Introduction ■

The Injured Patients and Families Compensation Fund (formerly the Patients Compensation Fund) insures health care providers in Wisconsin against medical malpractice claims that exceed the primary malpractice insurance thresholds established in statutes. It was created in Chapter 37, Laws of 1975 in response to concerns over the cost and availability of medical malpractice insurance. The Fund is managed by the 13-member Board of Governors, which is chaired by the Commissioner of Insurance and also oversees the Wisconsin Health Care Liability Insurance Plan, a public health care liability risk-sharing plan. The Office of the Commissioner of Insurance has statutory responsibility for administering the Fund and contracts with Wausau Insurance Companies, which was paid $813,474 for claims administration in FY 2002-03, and the Physicians Insurance Company of Wisconsin, Inc., which was paid $23,172 for risk management services in FY 2002-03. Since 1978, the actuarial firm of Milliman USA has served as a consultant, providing actuarial services for which it was paid $117,233 in FY 2002-03.

Most health care providers in Wisconsin are required to purchase secondary medical malpractice insurance from the Fund.

Statutes require most health care providers that operate or have permanent practices in Wisconsin to maintain primary malpractice coverage of $1 million for each incident and $3 million per policy year. In addition, they are also required to participate in the Fund, which provides unlimited liability coverage for economic damages that exceed the primary limits established in statutes. Health care providers that are insured by the Fund include individuals, such as physicians and nurse anesthetists; institutions such as hospitals, ambulatory surgery centers, and nursing homes; and entities that

are owned or controlled by hospitals, as well as entities such as medical partnerships, corporations, and cooperatives.

Assessment rates vary by provider type.

As of June 30, 2003, 13,466 health care providers were assessed $29.5 million for coverage in FY 2002-03. Assessment rates vary by provider type and specialty. For example, among individual providers, rates are higher for physicians than for nurses, and higher for physicians who perform surgery than for those who do not. The appendix lists annual assessment rates for various providers from FY 1997-98 through FY 2003-04. Statutes limit the overall level of fees the Board of Governors may assess in any one year. In FY 2003-04, the limit was set at $92.5 million.

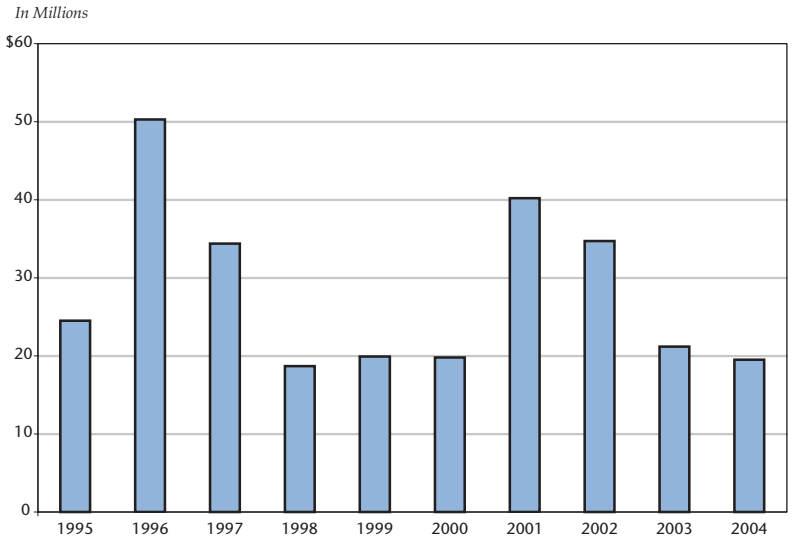
The Fund paid over $553.2 million for 612 claims from its inception through June 30, 2004.

A medical malpractice claim may be filed years after an incident occurs, and there is no limit on the amount of economic losses the Fund may be required to pay. Coverage for providers is based on participation at the time an event that results in a claim occurred, rather than at the time the claim is made. The Fund paid over $553.2 million in claims from its inception through June 30, 2004. More than 77 percent of the 612 claims paid have been for amounts less than $1 million. These claims account for 28 percent of total claim payments. In contrast, there have been 18 claims for $5 million or more each. These claims represent 27 percent of total claim payments.

A small number of large-value claims can significantly affect the Fund's operations and cash flow, but the uncertainty and long-term nature of medical malpractice claims makes it difficult to predict if or when large claims will be settled and paid from the Fund. For example, the Fund paid an $8.6 million claim in December 1999 for an incident that occurred over 11 years earlier. In 2001, the Fund paid a $6.6 million claim for an incident that occurred over nine years earlier. The variability of annual claim payments is further illustrated in Figure 2. While annual claim payments averaged $28.3 million per year over the last ten years, they ranged from $18.7 million to $50.3 million.

Figure 2

Annual Claim Payments[1]



[1] For fiscal year ending June 30.

In response to the balance of cash and investments accumulated to pay the Fund's claims, the Governor's 2003-05 biennial budget proposed establishing a new segregated fund to support a portion of the State's share of Medical Assistance costs, along with a $200 million transfer from the Patients Compensation Fund to the new fund. The Legislature deleted this provision from the enacted budget and subsequently enacted 2003 Wisconsin Act 111, which changed the Fund's name from the Patients Compensation Fund to the Injured Patients and Families Compensation Fund and established it as an irrevocable trust for the sole benefit of participating health care providers and proper claimants.

By law, the Legislative Audit Bureau is responsible for performing financial audits of the Injured Patients and Families Compensation Fund. As necessary parts of our financial audit, we reviewed the Fund's controls, assessed the fair presentation of its financial statements for FYs 2002-03, 2001-02, and 2000-01, and reviewed compliance with statutory provisions. We also reviewed the financial status of the Fund and followed up on prior recommendations.

■ ■ ■ ■

Financial Operations of the Fund ■

Although their interests and priorities differ, health care providers, consumers of health care services, and trial lawyers all benefit by having confidence in the reliability and appropriateness of the Fund's financial information and decisions. The Fund's financial status has improved in recent years. However, questions continue regarding the reasonableness of the actuarial estimates used in the Fund's financial operations. In our previous audit, we had recommended the Office of the Commissioner of Insurance obtain an actuarial audit to help assuage concerns with the Fund's actuarial loss estimates. During our current audit, we followed up on the status of the actuarial audit. In addition, we note problems the Fund is experiencing with its computerized provider system, which is integral to all aspects of its operations.

Financial Status of the Fund

The Fund had $658.9 million in cash and investments as of June 30, 2003.

Since its creation in 1975, the Fund has typically received more in assessments and investment income than it has paid out in claims and administrative expenses. As a result, its cash and investment balances have grown to $658.9 million as of June 30, 2003. Investment income, which has been a significant component in the investment balance growth, accounts for $410.8 million, or 33 percent, of the Fund's total revenue since 1975. Investment earnings help to reduce the provider assessments that fund current and future claim payments.

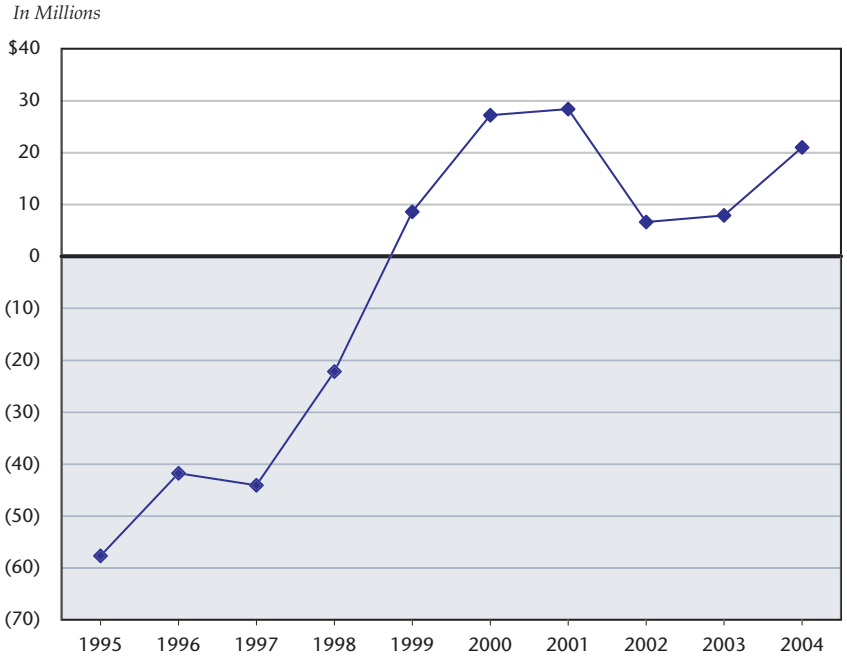
However, the Fund's financial position is also significantly affected by its loss liabilities, which are based on estimates of what it may be required to pay for malpractice incidents that have occurred but may not yet have been settled or even reported. The Board of Governors relies on the consulting actuarial firm to estimate the Fund's loss liabilities and to provide analysis for the Board to consider in establishing the annual fees paid by health care providers.

The Fund has reported a positive financial position since FY 1998-99.

For several years, the Fund reported an accounting deficit because estimated loss liabilities exceeded the cash and investments available to pay them. The Fund's accounting balance reached a low of -$122.7 million on June 30, 1988. As shown in Figure 3, the Fund's financial position has subsequently improved. Beginning in FY 1998-99 it has been reporting a positive accounting balance, which was $7.9 million as of June 30, 2003, and is estimated to be $21.0 million as of June 30, 2004.

Figure 3

June 30 Accounting Balances[1]



[1] Balance for 2004 is estimated by staff of the Office of the Commissioner of Insurance.

A number of actions by the Board and the Legislature have affected the Fund's financial position. For example:

- Various changes have been made to allow increased flexibility for the Fund's investments, which has helped to increase investment returns. Statutory changes in 1990 allowed the State of Wisconsin Investment Board to make long-term investments for the Fund. Beginning in 2000, the Board of Governors authorized the Fund to invest up to 20 percent of its portfolio in equity index funds. In 2004, legislation was enacted that allows the Investment Board to hire external managers to actively invest the Fund's fixed-income securities.

- Legislative action in 1995 re-established a limit on awards for non-economic damages, such as pain and suffering, embarrassment, mental distress, and the loss of companionship and affection. These damage awards had been limited to $1 million from June 14, 1986, through December 31, 1990. The re-established limit was set to begin at $350,000 for medical malpractice incidents that occurred on or after May 25, 1995, and to be adjusted at least annually to reflect changes in the consumer price index. The limit for current non-economic damage awards is $432,532 as of May 15, 2004. The constitutionality of this limit and other statutory requirements of the Fund is being challenged in over 90 court cases, although the limit was affirmed by the Wisconsin Supreme Court in July 2004.

- The statutory thresholds at which secondary coverage by the Fund is to begin have been raised as the primary insurance requirement has increased over time. Initially, primary medical malpractice coverage limits were $200,000 for each incident and $600,000 per policy year. As noted, they are currently $1 million for each incident and $3 million per policy year.

Actuarial Estimates

Annual actuarial adjustments to the Fund's estimated loss liabilities also have significantly affected the Fund's financial status. Because a medical malpractice claim may be filed years after an incident and there is no limit on the amount of economic losses the Fund may be required to pay, the actuary reviews and revises individual and total loss liability estimates each year, based on subsequent experience and information. For the last ten years, annual adjustments to previously reported total loss liabilities have ranged from an increase of $4.3 million to a decrease of $82.9 million.

The Fund's actuary indicates that the magnitude of the annual adjustments are within the normal range of variability inherent in any set of actuarial projections, especially considering the uncertainty surrounding medical malpractice cases. However, in nine of the ten years from FY 1993-94 through FY 2002-03, the actuary's initial estimate of loss liabilities has been decreased one year later, following actuarial review of subsequent experience and information. Further, the most recent reduction of $82.9 million in loss liabilities as of June 30, 2003, represents the largest reduction amount and percentage made in the past 18 years.

The actuary reduced original loss estimates by a net of $217.3 million for the last 20 policy years.

The aggregate effect of revised actuarial estimates is illustrated in Table 1, which compares the most recent estimate of ultimate losses and legal defense liabilities to the original estimates for each policy year since FY 1984-85. For example, the actuary originally estimated that medical malpractice events that occurred in FY 1986-87 would ultimately result in loss and legal costs to the Fund of $49.0 million. However, the actuary's most recent estimate of the Fund's loss and legal liabilities for medical malpractice events that occurred in FY 1986-87 is $25.5 million, or $23.5 million less than the original estimate. The actuary's original loss estimates for the last 20 policy years have been reduced over time by a net amount of $217.3 million, which represents 13.9 percent of the original total losses estimated for these years.

Table 1

Actuarial Revisions to Ultimate Loss Estimates

Policy Year	Original Estimate	Most Recent Estimate[1]	Increase (Reduction)
FY 1984-85	$ 28,067,902	$ 13,021,849	$ (15,046,053)
FY 1985-86	34,150,248	58,714,804	24,564,556
FY 1986-87	49,021,792	25,483,812	(23,537,980)
FY 1987-88	55,106,186	46,389,103	(8,717,083)
FY 1988-89	56,896,321	32,683,015	(24,213,306)
FY 1989-90	56,402,240	43,984,698	(12,417,542)
FY 1990-91	64,553,518	49,084,429	(15,469,089)
FY 1991-92	74,169,162	58,353,300	(15,815,862)
FY 1992-93	83,375,724	63,009,557	(20,366,167)
FY 1993-94	91,338,273	84,155,208	(7,183,065)
FY 1994-95	91,668,669	81,333,169	(10,335,500)
FY 1995-96	87,341,100	65,521,813	(21,819,287)
FY 1996-97	100,739,270	87,351,557	(13,387,713)
FY 1997-98	83,750,340	68,703,506	(15,046,834)
FY 1998-99	87,917,582	78,864,065	(9,053,517)
FY 1999-2000	92,519,004	85,999,601	(6,519,403)
FY 2000-01	98,736,961	93,004,312	(5,732,649)
FY 2001-02	103,061,970	93,943,777	(9,118,193)
FY 2002-03	110,520,559	102,412,557	(8,108,002)
FY 2003-04	110,304,577	110,304,577	0
Total	**$1,559,641,398**	**$1,342,318,709**	**$(217,322,689)**

[1] The most recent estimates are based on the actuary's September 30, 2003 report to the Underwriting and Actuarial Committee, dated November 26, 2003.

The Fund's claim experience has been more favorable than projected.

The actuary indicates the ultimate loss estimates were reduced because claim experience was more favorable than originally expected. The Fund's claim experience also is favorable when compared to medical malpractice claim activity nationally. For example, in comparison to large verdicts in excess of $50 million that have occurred in some states, the largest claim paid by the Fund has been $18.0 million, paid in 1993 for an incident that occurred in 1986. As shown in Table 2, only three claims payments made by the Fund since its inception have exceeded $10.0 million. Further, the Fund has experienced a decrease in the number of new claims in recent years. For the 12 months ending September 30, 2003, only 152 new claims were reported, compared to

239 new claims for the 12 months ending September 30, 2000. The reasons for the significant decrease in new claims are not entirely clear, although recent claim experience may have been affected, in part, by potential claimants' delays in settling claims or bringing them to trial pending resolution of recent challenges to the constitutionality of the limit on non-economic damages.

Table 2

Claims Payments Greater than $5 Million through June 2004

Amount (In Millions)[1]	Calendar Year of Incident	Calendar Year of Payment	Claimant Allegations
$18.0	1986	1993	Diet pills prescribed without a complete physical evaluation, causing cardiac arrest and resulting in brain damage
15.6	1993	1996	Negligent treatment caused quadriplegia
13.6	1993	2000	Initial surgery and follow-up treatment of pinched nerve were negligent, causing continuing pain
9.6	1998	2001	Negligent prescriptions caused brain damage
9.5	1989	1990	Improperly administered anesthesia caused brain damage during cardiac surgery
8.6	1988	1999	Negligent treatment caused brain damage, and lack of informed consent
7.9	1985	1995	Failure to diagnose a hematoma caused brain damage, and lack of informed consent
7.3	1987	1992	Failure to identify high bilirubin level in a timely manner, resulting in brain damage
7.1	1990	1995	Failure to promptly deliver baby, causing cerebral palsy
6.9	1992	2000	Negligent delivery caused brain damage
6.8	1992	1995	Negligent treatment of brain aneurysm
6.6	1992	2001	Failure to diagnose blood disorder in infant caused brain damage
6.1	1999	2002	Failure to restrain patient during psychiatric care resulting in quadriplegia
6.0	1999	2002	Negligent delivery caused brain damage
5.8	1990	1996	Surgery caused brain injury, and lack of informed consent
5.6	1995	1998	Negligent treatment caused brain damage
5.6	1993	1999	Negligent treatment caused brain damage
5.1	1982	1984	Failure to diagnose and treat meningitis

[1] Includes interest on losses paid.

The reasonableness and acceptance of the actuarial estimates are important not only for financial reporting, but also in the assessment-setting process. Until FY 2002-03, the actuary made annual

recommendations to the Board regarding changes in assessment levels needed for the next policy year. Typically, the recommended assessment changes were based on the actuary's estimate of assessment levels required to fund claims for incidents that would occur during the upcoming period, with adjustments for any existing positive or negative accounting balance.

The Board has approved assessment rates lower than those recommended by the actuary.

However, as shown in Table 3, the Board frequently approved assessment levels lower than those recommended by the actuary. A noteworthy difference between the actuary's recommendation and the change approved by the Board occurred in FY 2000-01, when the actuary recommended a 3.7 percent increase and the Board approved a 25 percent decrease in total assessments. The Board's decision appeared to be affected, in part, by the actuary's adjustments to past loss estimates. In addition, the Board noted that the Fund's large investment balance and the positive accounting balance would provide flexibility to respond to unfavorable experience in the future by increasing rates.

Table 3

Annual Percentage Changes to Assessment Fees

Policy Year	Percentage Change Recommended by Actuary	Percentage Change Approved by Board	Actual Assessments Revenues
FY 1992-93	13.2%	4.0%	$45,063,934
FY 1993-94	16.8	10.0	51,213,220
FY 1994-95	10.8	7.1	55,505,730
FY 1995-96	4.9	(11.2) [1]	51,048,881
FY 1996-97	17.3	10.0	58,259,200
FY 1997-98	(17.7) [2]	(17.7) [2]	49,884,839
FY 1998-99	5.9	0.0	50,621,706
FY 1999-2000	2.7	(7.0)	47,879,282
FY 2000-01	3.7	(25.0)	36,795,064
FY 2001-02	(28.6) to 28.2 [3]	(20.0)	29,555,966
FY 2002-03	n/a [4]	(5.0)	29,463,735
FY 2003-04	n/a [4]	5.0	32,900,629
FY 2004-05	n/a [4]	(20.0)	26,300,000 [5]

[1] Adoption of limit on non-economic damages enacted by the Legislature affected the change approved.
[2] Fees were reduced because the Fund's threshold increased from $400,000/$1 million to $1 million/$3 million.
[3] The actuary provided four rate recommendations ranging from a decrease of 28.6 percent to an increase of 28.2 percent, based on four different scenarios for eliminating the positive balance.
[4] The actuary did not provide a recommended assessment change, but rather estimated a break-even funding level.
[5] Projected based on FY 2003-04 assessments, adjusted for changes approved by the Board.

Beginning with FY 2002-03 assessments, the actuary no longer recommends an assessment change, but instead provides the Board a break-even funding level, which is an estimate of assessment changes that would be needed to cover estimated losses for the year. However, the Board has approved assessment changes that were significantly less than the break-even funding levels estimated by the actuary.

Some interested parties believe the actuarial loss estimates are too conservative.

Some interested parties are concerned that the actuary may be overly conservative in estimating the Fund's loss liabilities, as evidenced by the regular reduction of past estimates. Interest groups representing patients and trial lawyers suggest the conservative nature of the actuarial estimates over the years exaggerated medical malpractice insurance costs in Wisconsin and, consequently, contributed to 1995 legislation that re-established limits on the amount that can be awarded for non-economic damages. As noted, non-economic damages are limited to $432,532 as of May 15, 2004.

On the other hand, from both an actuarial and an accounting perspective, conservative estimates are considered more prudent than overly optimistic ones, especially when considering the uncertainties involved with the long-term nature of medical malpractice claims and with providing unlimited excess liability coverage for economic damages. While several states have medical malpractice funds, only a few provide unlimited coverage. Therefore, relatively limited experience pertaining to unlimited coverage is available in the industry. Similarly, prudent estimates are important because of the significant role the medical malpractice funds can play in a state's medical malpractice environment.

An actuarial audit was recommended in June 2001.

The Injured Patients and Families Compensation Fund is often cited as an important factor in Wisconsin's relatively stable environment for health care providers in comparison to other states. The Fund's solid financial position provides it flexibility to readily respond to changes that may occur in the medical malpractice environment in the future. However, in light of questions being raised about the actuarial estimates, we recommended in our preceding audit, completed in June 2001, that the Office of the Commissioner of Insurance contract for an audit of the actuarial methods and assumptions used in estimating the Fund's loss liabilities.

Actuarial Audit

Actuarial audits have become fairly common for critical actuarial analyses, and they can be useful and effective oversight mechanisms. An actuarial audit may be especially useful for the Fund because of the long-term nature of medical malpractice claims,

increased unpredictability resulting from the Fund's coverage, and the significant effect actuarial analyses have on the Fund's financial decisions and operations. Further, a comprehensive review of the Fund's actuary's methods and assumptions by an independent actuary could provide suggestions to the consulting actuary for refining its actuarial analyses, and it could be useful in promoting broader acceptance of the analyses by the various interested parties.

The Office does not yet have a finalized actuarial audit.

However, more than three years after our 2001 recommendation, an actuarial audit of the Fund still has not been completed. The Office contracted with an actuarial firm in August 2002, and the firm provided the Office a draft report in fall 2002. However, after working with the firm for several months, the Office and the Board's Finance, Investment, and Audit Committee concluded that the actuary's draft report did not meet the original intent of the Audit Bureau's recommendation and that it lacked critical analysis and discussion about the Fund's nature, structure, and funding. In response, the Office and the Board concluded business with the actuarial firm in March 2004 without the release of a final public report. The Office paid the actuarial firm a total of $23,183.

The Office and the Finance, Investment, and Audit Committee also determined that the original request for vendor proposals had problems, including lack of specificity regarding experience requirements, which contributed to concerns with the actuarial auditor's work. In April 2004, the Office issued a second request for vendor proposals, which included experience in conducting actuarial audits of medical malpractice as a mandatory requirement. The five proposals received were all rejected because, in the Office and the Committee's view, the firms did not meet the qualification requirements. The requests for vendor proposals were issued following the Office's normal procurement procedures, using the state bidders list on the VendorNet system. However, the Office did not ensure that firms qualified to conduct actuarial audits of medical malpractice insurance received the requests for vendor proposals. The Office has recently obtained proposals from firms it has determined are experts in performing actuarial audits of medical malpractice. The Office expects that a contract for another actuarial audit will be issued in October 2004, with an expected completion date in November 2004. In addition, the Board recently established a policy to obtain an actuarial audit of the Fund once every three years.

☑ Recommendation

We recommend the Office of the Commissioner of Insurance report to the Joint Legislative Audit Committee by November 30, 2004, on the status and results of the actuarial audit.

Provider System

Another continuing challenge for the Fund is the decreasing effectiveness of its aging computerized provider system. In the early 1990s, a computer system was developed for the claims portion of the Fund's operations. Since that time, additional applications were added to assist with maintaining primary insurance coverage information and for billing health care providers. Further, the Fund's operations have evolved to include more comprehensive procedures related to compliance issues that have placed increasing demands on the provider system.

Problems with the provider system regularly result in errors with provider information.

The current provider system has not been able to easily accommodate the changes that have occurred over time and, as a result, errors have occurred in health care provider accounts. To continue operating, the provider system has required numerous "patches," with some of the attempts to fix a specific problem resulting in errors in other areas. For example, Office staff note:

- incorrect bills have been produced;
- incorrect noncompliance notices have been generated for providers that are actually in compliance; and
- histories for providers' accounts have disappeared from the system, requiring the information to be recreated on the system.

As a result of these regularly occurring errors, staff conduct daily manual reviews of account information in the system, bills and notices generated by the system, and system reports to ensure that information is complete, accurate, and current. Further, staff review noncompliance information to ensure it is correct before it is provided to the Department of Regulation and Licensing. The accuracy of noncompliance information is important because the Department of Regulation and Licensing can place a hold on the license of a provider who does not pay required assessments or is otherwise noncompliant. Further, the regular occurrence of errors and the need to manually identify and correct them increase the risks associated with the Fund's financial operations and, consequently, required additional audit effort before we could issue an opinion on the fairness of the Fund's financial statements. The condition of the system is likely to worsen, resulting in increased risk to the Fund's financial operations and requiring additional efforts to keep the system operational.

Because of the Fund's unique operations, standard software is not available. Therefore, the Office planned to contract with two programmers to develop a new system over an 18-month period, and in its 2003-05 biennial budget proposal included a request for budgetary authority to spend $607,800 from the Fund for a new provider system. Like other budget requests for systems work, the Office's request for additional resources for a new provider system was denied by the Legislature. In June 2004, the Office requested $753,700 for the new provider system under s. 13.10, Wis. Stats. However, the Joint Committee on Finance denied the request because it was not deemed an emergency and, therefore, did not meet the requirements of a s. 13.10 request.

The Office is more fully documenting problems and considering interim steps to keep the system operational.

In response to continuing problems with the provider system and denied requests for budgetary authority to develop a new system, the Board of Governors suggested the Office more fully document problems occurring with the system and identify other potential alternatives that could be pursued. The Office is currently assessing the ability of its internal information systems staff to work on the provider system and complete incremental enhancements as a short-term response to the system problems. As part of our ongoing financial audit work at the Fund, we will continue to monitor the Office's status in addressing problems with its provider system.

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Audit Opinion ■

Independent Auditor's Report on the Financial Statements of the Wisconsin Injured Patients and Families Compensation Fund

We have audited the accompanying financial statements of the Wisconsin Injured Patients and Families Compensation Fund as of and for the years ended June 30, 2003, 2002, and 2001. These financial statements are the responsibility of the management of the Wisconsin Injured Patients and Families Compensation Fund. Our responsibility is to express an opinion on these financial statements based on our audit.

We conducted our audit in accordance with auditing standards generally accepted in the United States of America and the standards applicable to financial audits contained in *Government Auditing Standards*, issued by the Comptroller General of the United States. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements. An audit also includes assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall financial statement presentation. We believe that our audit provides a reasonable basis for our opinion.

As discussed in Note 1, the financial statements referred to in the first paragraph present only the Wisconsin Injured Patients and Families Compensation Fund and do not purport to, and do not, present fairly the financial position of the State of Wisconsin and the changes in its financial position and its cash flows, where applicable, in conformity with accounting principles generally accepted in the United States of America.

In our opinion, the financial statements referred to in the first paragraph present fairly, in all material respects, the financial position of the Wisconsin Injured Patients and Families Compensation Fund as of June 30, 2003, 2002, and 2001, and the changes in its financial position and its cash flows for the years then ended in conformity with accounting principles generally accepted in the United States of America.

As discussed in Note 11 to the financial statements, the Wisconsin Injured Patients and Families Compensation Fund implemented Governmental Accounting Standards Board Statement Number 34, *Basic Financial Statements—and Management's Discussion and Analysis—for State and Local Governments*.

As discussed in Note 4 to the financial statements, the Wisconsin Injured Patients and Families Compensation Fund's projected ultimate loss liability is an estimate based on recommendations of a consulting actuary. The Wisconsin Injured Patients and Families Compensation Fund's management and Board of Governors believe that the estimated loss liabilities are reasonable and adequate to cover the cost of claims incurred as of the end of the fiscal year. However, uncertainties inherent in projecting the frequency and severity of large medical malpractice claims, the Fund's unlimited liability coverage, and extended reporting and settlement periods make it likely that amounts paid will ultimately differ from the recorded estimated liabilities. These differences cannot currently be quantified.

Our audit was conducted for the purpose of forming an opinion on the financial statements of the Wisconsin Injured Patients and Families Compensation Fund. The supplementary information included as Management's Discussion and Analysis on pages 27 through 33 is presented for purposes of additional analysis and is not a required part of the financial statements referred to in the first paragraph. We have applied certain limited procedures, which consisted principally of inquiries of management regarding the methods of measurement and presentation of the supplementary information. However, we did not audit the information and express no opinion on it.

In accordance with *Government Auditing Standards*, we have also issued a report dated September 3, 2004, on our consideration of the Wisconsin Injured Patients and Families Compensation Fund's internal control over financial reporting and on our tests of its compliance with certain provisions of laws, regulations, and contracts. The purpose of that report is to describe the scope of our testing of internal control over financial reporting and compliance and the results of that testing, and not to provide an opinion on the internal control over financial reporting or on compliance. That report is an integral part of an audit performed in accordance with *Government Auditing Standards* and should be considered in assessing the results of our audit.

LEGISLATIVE AUDIT BUREAU

September 3, 2004 by

Diann Allsen
Audit Director

Management's Discussion and Analysis ■

Prepared by Management of the Wisconsin Injured Patients and Families Compensation Fund

This section presents management's discussion and analysis of the financial performance of the Wisconsin Injured Patients and Families Compensation Fund during the fiscal years ended June 30, 2003, 2002 and 2001. This discussion should be read in conjunction with the accompanying financial statements and notes. The financial statements, notes, and this discussion are the responsibility of the management of the Fund.

Overview of the Fund

The Fund was created in 1975 to provide excess medical malpractice insurance for Wisconsin health care providers. Under broad authority granted to it by s. 655.27(2), Wis. Stats., the Fund is governed by a 13-member Board of Governors. The Board consists of three insurance industry representatives; a member named by the Wisconsin Academy of Trial Lawyers; a member named by the State Bar Association; two members named by the State Medical Society of Wisconsin; a member named by the Wisconsin Hospital Association; four public members appointed by the Governor; and the Commissioner of Insurance, who serves as the chair. The Fund's administrative staff is provided by the Office of the Commissioner of Insurance.

The Board is assisted by an Underwriting and Actuarial Committee; a Legal Committee; a Claims Committee; a Finance, Investment, and Audit Committee; a Risk Management Steering Committee; and a Peer Review Council. The Board and its committees meet quarterly.

The Fund operates on a July 1 through June 30 fiscal year basis. Administrative costs and operating costs, including claim payments, are funded through assessments on participating health care providers.

Financial Statements

The financial statements of the Fund have been prepared in a format prescribed by the Board of Governors in accordance with generally accepted accounting principles. Financial statements for each of the past three years follow this discussion and analysis.

Assets

The Fund's assets consist primarily (over 95 percent) of investments, which are managed by the State of Wisconsin Investment Board (SWIB) in accordance with directives of the Board of Governors and its Investment Committee. The Board has established investment guidelines to be followed by SWIB; compliance with these guidelines is reviewed quarterly by the Investment Committee. Approximately 12 percent of the Fund's total investments are in equities, in compliance with the investment guidelines. Investments are reported at market value.

As shown in Table A, assets have grown significantly in recent years, although FY 2001-02 reflects a $14 million loss on the sale of WorldCom investments. The overall growth in assets is due to the assessment revenue and investment income exceeding expenses. These revenues are invested, resulting in increases in the total assets.

Table A

Total Assets

As of:	Total Assets	Change from Prior Year
June 30, 2001	$576,709,136	6.3%
June 30, 2002	588,823,428	2.1
June 30, 2003	667,448,545	13.4

The Investment Committee has been working with SWIB in an attempt to hire an outside manager to provide more in-depth day-to-day management of the Fund's assets to maximize its return on investment. During the 2003-05 session, the Wisconsin Legislature approved a bill that would permit SWIB to hire a manager for the Fund's assets (2003 Wisconsin Act 299).

Liabilities

The loss liabilities account for nearly all of the liabilities of the Fund. The loss liabilities include amounts for individual case estimates for reported losses and estimates for incurred but not reported losses, based upon actuarially determined ultimate losses. Loss liabilities also include a provision for the estimated future payment of claim adjustment costs associated with the outstanding claims.

Table B

Total Loss Liabilities

As of:	Total Loss Liabilities	Change from Prior Year
June 30, 2001	$547,489,688	6.5%
June 30, 2002	580,140,565	6.0
June 30, 2003	656,315,300	13.1

The loss liabilities are the amounts expected to be paid in the future for incidents that have already occurred. An increase in loss liabilities is expected each year, as there is another year of activity to be added to the ultimate potential losses paid. This amount varies based upon actuarial studies. In addition to the increase for each new year, the Fund's outside actuary also reviews each year of loss activity and makes adjustments to any outstanding liabilities for each year as deemed appropriate.

The uncertainties inherent in projecting the frequency and severity of claims because of the Fund's relatively short history, unlimited liability coverage for economic damages, and extended reporting and settlement periods make it likely that the amounts ultimately paid will differ from the recorded estimated liabilities. These differences cannot be quantified.

Section Ins. 17.27(3), Wis. Adm. Code, requires the liability for losses and loss adjustment expenses to be maintained on a present value basis. The discount factors for FYs 2002-03, 2001-02 and 2000-01 were 0.750, 0.707, and 0.694, respectively.

Net Assets

The Fund's net assets, or the balance of assets in excess of liabilities, for the past three years are shown in Table C. Changes in the net assets are attributable to the difference between revenues collected and expenses paid, in addition to the

changes made to loss liabilities estimates for previous years as determined by the actuary.

Table C

Net Assets

As of:	Net Assets	Change from Prior Year
June 30, 2001	$28,448,652	4.5%
June 30, 2002	6,604,102	(76.8)
June 30, 2003	7,935,026	20.2

The Board of Governors has made a decision to maintain surplus levels as near to zero as possible, and that a need does not exist to maintain any significant surplus level within the Fund. This decision was based upon the nature of the Fund: it is a risk-sharing fund with no stockholders, and participation is mandatory. Therefore, assessments can be levied to make up any shortfalls should they occur in the future.

Revenues

The Fund's revenue consists primarily of assessments and investment income. All Fund participants are billed annually in accordance with an assessment rate determined annually by the Board of Governors with the advice of the Fund's consulting actuary. Investment income varies due to factors including the economy in general, the operating experience of the Fund, and the amount of new money available for investing.

As shown in Table D, the amount of total revenue fluctuated a great deal over the last three years. Contributing factors included the changes in assessments rates and changes in investment income due to market factors.

Table D

Total Revenues

Fiscal Year	Total Revenues	Change from Prior Year
2000-01	$ 77,428,274	13.4%
2001-02	51,099,019	(34.0)
2002-03	104,211,475	103.9

Assessments are collected from all Fund participants. The Board of Governors decreased assessments rates by 25 percent, 20 percent, and 5 percent in FY 2000-01, FY 2001-02, and FY 2002-03, respectively. However, as shown in Table E, these decreases were partially offset by increases in the number of health care providers participating in the Fund.

Table E

Assessment Revenues

Fiscal Year	Assessment Revenues	Change from Prior Year
2000-01	$36,795,064	(23.2)%
2001-02	29,555,966	(19.7)
2002-03	29,463,735	(0.3)

Physicians are classified into one of four classes based upon risk assessment of their specialty. Hospitals are assessed based upon number of beds and outpatient visits. As of June 30, 2003, the vast majority of Fund participants were physicians, at 85 percent. Corporations made up another 10 percent, and the remaining 5 percent consisted of various other participant types. At June 30, 2003, Fund participants totaled 13,466, including 11,402 physicians, 1,342 corporations, 489 nurse anesthetists, 111 hospitals with 30 affiliated nursing homes, 51 partnerships, 22 hospital-owned or controlled entities, 18 ambulatory surgery centers, and 1 cooperative.

Investment income, which includes bond interest and capital gains and losses, is shown in Table F. Investment income in FY 2001-02 was low due to economic and market factors, and a $14 million loss on a WorldCom investment. The market improved in FY 2002-03, which resulted in unrealized gains of $39 million. The Fund's investment strategy is to invest approximately 85 percent of its assets in fixed-income securities that have a reasonable degree of safety of principal, as well as income-paying ability. High priority is given to matching the maturity of assets with the liquidity needs of the liabilities. Generally, with the increase in the investments noted previously, an increase in investment income is expected.

Table F

Investment Income

Fiscal Year	Investment Income	Change from Prior Year
2000-01	$40,222,422	101.7%
2001-02	20,993,042	(47.8)
2002-03	74,502,092	254.9

Underwriting Expenses

The Fund's underwriting expenses consist of loss and loss adjustment expenses paid, plus changes to the liabilities for unpaid claims. The changes to the liabilities can be either positive or negative amounts, depending upon the annual actuarial analysis of the outstanding reserves on a year-by-year basis. Expenses can vary widely depending upon both paid and reported claims during any given year, as well as changes in actuarial assumptions used in determining loss liabilities.

As shown in Table G, underwriting expenses increased significantly in FY 2002-03, largely due to a change in the discount rate applied to the loss liabilities. The discount rate is used in determining the present value of the reserves held for future payment of claims that have already occurred. Prior to FY 2002-03, the discount rate was 7 percent. Due to the low-interest environment, the Board voted to reduce the discount rate to 6 percent to more accurately reflect the long-term return on investments. A decrease in the discount factor results in an increase in the amount of funds needed to be held in reserve for the payment of claims.

Table G

Underwriting Expenses

Fiscal Year	Underwriting Expenses	Change from Prior Year
2000-01	$ 75,425,964	54.9%
2001-02	72,120,287	(4.4)
2002-03	101,935,410	41.3

Summary

The Injured Patients and Families Compensation Fund, a segregated fund administered by the Office of the Commissioner of Insurance, operates as a risk-sharing fund. Assessments are collected from participating health care providers and are used to pay underwriting and administrative expenses. The Fund's Board of Governors determines the assessment rates annually, based on actuarial advice in conjunction with the Board's philosophy to maintain net assets at or near zero.

Investments are predominantly conservative (approximately 88 percent in A-rated bonds and 12 percent in equities), with the intent to match assets with liabilities while maximizing return.

Contacting the Fund's Financial Management

This financial report is designed to provide the Legislature, the executive branch of government, the public, and other interested parties with an overview of the financial results of the Fund's activities and to show the Fund's financial position. If you have questions about this report or need additional information, contact the Wisconsin Injured Patients and Families Compensation Fund director at the Office of the Commissioner of Insurance, 125 South Webster Street, Post Office Box 7873, Madison, Wisconsin 53707-7873.

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Financial Statements ■

Statement of Net Assets
June 30, 2003, 2002, and 2001

	June 30, 2003	June 30, 2002	June 30, 2001
ASSETS			
Current Assets:			
Cash and cash equivalents (Note 3)	$ 6,071,293	$ 17,132,081	$ 8,138,572
Investments (Note 3)	13,327,150	7,709,820	10,099,143
Investment income receivable	8,404,308	8,688,955	8,999,413
Assessments receivable	145,952	200,002	364,900
Other receivables	24,763	1,871,210	13,782
Supplies inventory and other assets	7,818	7,914	7,610
Total Current Assets	27,981,284	35,609,982	27,623,420
Noncurrent Assets:			
Investments (Note 3)	639,461,220	553,196,986	549,063,216
Capital assets, net of accumulated depreciation	6,041	16,460	22,500
Total Noncurrent Assets	639,467,261	553,213,446	549,085,716
TOTAL ASSETS	**667,448,545**	**588,823,428**	**576,709,136**
LIABILITIES			
Current Liabilities:			
Loss liabilities—current portion	58,250,000	54,330,000	75,000,000
Assessments received in advance (Note 2E)	2,831,910	1,643,638	305,230
Provider refunds payable	191,974	230,095	180,588
General and administrative expense payable	80,061	43,748	68,052
Medical mediation panel fees payable (Note 7)	2,910	3,998	4,304
Vouchers payable	60,178	133,031	187,443
Compensated absences	8,679	7,784	7,554
Total Current Liabilities	61,425,712	56,392,294	75,753,171
Noncurrent Liabilities:			
Loss liabilities (Note 4):			
Loss liability for incurred but not reported losses	800,026,833	748,722,897	701,500,418
Loss liability for reported losses	31,966,378	35,421,362	52,516,954
Loss liability for loss adjustment expense	41,145,941	34,850,220	32,436,465
Estimated loss liabilities	873,139,152	818,994,479	786,453,837
Amount representing interest	(218,284,788)	(239,965,382)	(240,654,874)
Discounted loss liabilities	654,854,364	579,029,097	545,798,963
Liabilities for future medical expenses (Note 5)	1,060,936	486,468	490,725
Contributions being held liability (Note 6)	400,000	625,000	1,200,000
Total loss liabilities	656,315,300	580,140,565	547,489,688
Less: loss liabilities—current portion	(58,250,000)	(54,330,000)	(75,000,000)
Noncurrent loss liabilities	598,065,300	525,810,565	472,489,688
Compensated absences	22,507	16,467	17,625
Total Noncurrent Liabilities	598,087,807	525,827,032	472,507,313
TOTAL LIABILITIES	**659,513,519**	**582,219,326**	**548,260,484**
NET ASSETS			
Net Assets:			
Invested in capital assets, net of related debt	6,041	16,460	22,500
Restricted for injured patients and families	7,928,985	6,587,642	28,426,152
TOTAL NET ASSETS	**$7,935,026**	**$6,604,102**	**$28,448,652**

The accompanying notes are an integral part of this statement.

Statement of Revenues, Expenses, and Changes in Fund Net Assets for the Years Ended June 30, 2003, 2002, and 2001

	Year Ended June 30, 2003	Year Ended June 30, 2002	Year Ended June 30, 2001
OPERATING REVENUES			
Assessments (Note 2E)	$ 29,463,735	$ 29,555,966	$ 36,795,064
Investment Income	74,502,092	20,993,042	40,222,422
Assessment Interest Income (Note 8)	127,967	295,687	362,005
Total Operating Revenues	**104,093,794**	**50,844,695**	**77,379,491**
OPERATING EXPENSES			
Underwriting Expenses:			
Net losses paid	21,247,353	34,675,660	40,177,424
Loss adjustment expenses paid	4,225,616	4,087,172	2,800,086
Risk management expenses	21,407	60,264	55,055
Medical expenses paid	643,498	125,427	159,112
Change in liability for incurred but not reported losses	51,303,936	47,222,479	30,683,632
Change in liability for reported losses	(3,454,984)	(17,095,592)	6,053,669
Change in liability for loss adjustment expense	6,295,721	2,413,756	1,054,925
Change in amount representing interest	21,680,594	689,492	(5,575,128)
Change in liability for future medical expense	(27,731)	(58,371)	17,189
Total Underwriting Expenses	101,935,410	72,120,287	75,425,964
General and Administrative Expenses	940,763	823,282	783,368
Total Operating Expenses	**102,876,173**	**72,943,569**	**76,209,332**
OPERATING INCOME (LOSS)	**1,217,621**	**(22,098,874)**	**1,170,159**
NONOPERATING REVENUES (EXPENSES)			
Administrative Fee Income	43,632	39,384	46,268
Miscellaneous Revenue	74,049	214,940	2,515
Loss on Disposal of Capital Assets	(4,378)	0	0
Total Nonoperating Revenues (Expenses)	**113,303**	**254,324**	**48,783**
CHANGE IN NET ASSETS	**1,330,924**	**(21,844,550)**	**1,218,942**
NET ASSETS			
Net Assets—Beginning of the Year	6,604,102	28,448,652	27,229,710
Net Assets—End of the Year	$ 7,935,026	$ 6,604,102	$ 28,448,652

The accompanying notes are an integral part of this statement.

Statement of Cash Flows
for the Years Ended June 30, 2003, 2002, and 2001

	Year Ended June 30, 2003	Year Ended June 30, 2002	Year Ended June 30, 2001
CASH FLOWS FROM OPERATING ACTIVITIES			
Cash Received from Providers for Assessments	$ 31,268,846	$ 32,365,524	$ 38,124,481
Cash Received from Primary Malpractice Insurers	1,955,240	6,852,809	2,478,597
Cash Received from Other Sources	383,598	899,046	978,364
Cash Paid for Losses	(23,427,594)	(42,103,469)	(41,956,022)
Cash Paid for Loss Adjustment Expenses	(4,225,616)	(4,087,172)	(2,800,086)
Cash Paid for Other Expenses	(964,579)	(975,534)	(742,733)
Cash Paid to Providers for Refunds of Fund Fees	(605,066)	(1,268,239)	(1,884,438)
Cash Paid for Medical Mediation Panel Fees	(207,733)	(392,259)	(377,090)
Net Cash Provided by (Used for) Operating Activities	**4,177,096**	**(8,709,294)**	**(6,178,927)**
CASH FLOWS FROM INVESTING ACTIVITIES			
Interest Received	21,972,517	33,451,627	34,329,316
Cash Received as Proceeds from Sales of Investments	186,582,144	140,687,001	137,600,420
Cash Paid for Purchase of Investment Securities	(223,820,027)	(156,424,053)	(173,874,523)
Increase (Decrease) in Market Value	27,482	(11,772)	40,813
Net Cash Provided by (Used for) Investment Activities	**(15,237,884)**	**17,702,803**	**(1,903,974)**
NET INCREASE (DECREASE) IN CASH AND CASH EQUIVALENTS	**(11,060,788)**	**8,993,509**	**(8,082,901)**
Cash and Cash Equivalents—Beginning of the Year	17,132,081	8,138,572	16,221,473
Cash and Cash Equivalents—End of the Year	$ 6,071,293	$ 17,132,081	$ 8,138,572
RECONCILIATION OF OPERATING INCOME TO NET CASH PROVIDED BY (USED FOR) OPERATING ACTIVITIES			
Operating Income	$ 1,217,621	$ (22,098,874)	$ 1,170,159
Adjustments to Reconcile Operating Income to Net Cash Provided by Operating Activities:			
Depreciation expense	6,040	6,040	6,040
Operating income (investment income) classified as investing activity	(74,502,251)	(20,993,574)	(40,222,422)
Miscellaneous nonoperating income	117,681	254,324	48,783
Changes in assets and liabilities:			
Decrease (Increase) in assessments receivable	54,051	164,897	(53,132)
Decrease (Increase) in other receivables	(10,334)	(646)	(1,927)
Decrease (Increase) in supplies inventory and other assets	96	(304)	(3,586)
Increase (Decrease) in loss liabilities	76,174,735	32,650,877	33,364,644
Increase (Decrease) in other liabilities	1,119,457	1,307,966	(487,486)
Total Adjustments	2,959,475	13,389,580	(7,349,086)
Net Cash Provided by (Used for) Operating Activities	**$ 4,177,096**	**$ (8,709,294)**	**$ (6,178,927)**
Noncash Activities:			
Net change in unrealized gains and losses	$ 39,585,000	$ (421,000)	$ 5,855,000

The accompanying notes are an integral part of this statement.

Notes to the Financial Statements ■

1. Description of the Fund

The Injured Patients and Families Compensation Fund is part of the State of Wisconsin financial reporting entity and is reported as a major enterprise fund in the State's Comprehensive Annual Financial Report. The Fund, formerly the Patients Compensation Fund, was created in 1975 for the purpose of paying that portion of a medical malpractice claim exceeding the legal primary insurance limits prescribed in s. 655.23(4), Wis. Stats., or the maximum liability limit for which the health care provider is insured, whichever limit is greater. Most health care providers permanently practicing or operating in the State of Wisconsin are required to pay annual assessments.

Management of the Fund is vested with the 13-member Board of Governors, which is chaired by the Commissioner of Insurance. The Board has designated the Commissioner of Insurance as the administrator of the Fund. Similarly, under s. 655.27(2), Wis. Stats., the Commissioner shall either provide staff services necessary for the operation of the Fund or, with the approval of the Board, contract for all or part of these services. During FY 2002-03, FY 2001-02, and FY 2000-01, the Board contracted for the Fund's actuarial, risk management, and claims administration services.

2. SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

A. Fund Accounting and Basis of Presentation

The financial statements of the Injured Patients and Families Compensation Fund have been prepared in conformance with generally accepted accounting principles (GAAP) for proprietary funds. The accompanying financial statements were prepared based upon the flow of economic resources focus and full accrual basis of accounting, with revenues recognized when earned and expenses recognized when incurred.

The Statement of Revenues, Expenses, and Changes in Fund Net Assets classifies the Fund's fiscal year activity as either operating or nonoperating. Because the Fund is an enterprise fund, which is a type of proprietary fund, it accounts for operations in a manner similar to private businesses in which operating revenues are derived from exchange transactions. Assessments, which are received from health care providers in exchange for coverage under the Fund, represent a significant component of operating revenues. Investment income is also classified as operating revenues because it is considered a significant and integral source of revenue in the Fund's operations. Operating expenses include underwriting and administrative expenses.

Certain revenues and expenses that are not related to the Fund's primary purpose, such as gain or loss on the disposal of capital assets, are reported as nonoperating revenues and expenses.

The Fund applies all applicable Governmental Accounting Standards Board (GASB) pronouncements. Financial Accounting Standards Board (FASB) statements effective after November 30, 1989, are not applied in accounting for the operations of the Fund.

B. Accounting Estimates

The preparation of financial statements requires management to make estimates and assumptions that affect the amounts reported in the financial statements and accompanying notes. Actual results could differ from those estimates. Estimates that are particularly susceptible to significant change in future years are the liabilities for unpaid losses and loss adjustment expenses. In estimating these liabilities, management uses the methodology discussed in Note 4 on ultimate and discounted loss liabilities.

C. Cash and Cash Equivalents

All cash is deposited with the State and is required to be invested in the State Investment Fund. The State Investment Fund is a short-term pool of state and local funds managed by the State of Wisconsin Investment Board with oversight by its Board of Trustees. Since shares in the State Investment Fund are purchased in $1,000 increments, cash balances below $1,000 are deposited in the State's bank.

D. Investment Valuation

Investments of the Fund consist of high-grade fixed-income securities managed by the State of Wisconsin Investment Board, and shares in two equity index funds. Fixed-income obligations and index fund shares are reported at fair value consistent with the provisions of GASB Statement 31, *Accounting and Financial Reporting for Certain Investments and for External Investment Pools*. When available, fair value information is determined using quoted market prices. However, when quoted market prices for certain securities are not available, fair values are estimated.

E. Assessments

Assessments are billed and recognized as revenues on a fiscal year basis, which is also the policy year. Assessments received for the upcoming fiscal year are treated as deferred revenue and reported as assessments received in advance. Accounts of providers are automatically credited and reported as provider refunds payable when primary insurance lapses.

F. Loss Liabilities

Loss liabilities are estimated based on recommendations of a consulting actuary and are discounted to the extent that they are matched by cash and invested assets. The uncertainties inherent in projecting the frequency and severity of claims, the Fund's unlimited liability coverage for economic damages, and extended reporting and settlement periods make it likely that the amounts ultimately paid will differ from the recorded estimated liabilities.

G. Policy Acquisition Costs

Since the Fund has no marketing staff and incurs no sales commissions, acquisition costs are minimal and charged to operations as incurred.

H. Capital Assets

The Fund capitalizes all office furniture and equipment with a useful life of two or more years and a purchase price of $5,000 or more. Capital assets are depreciated under the straight-line method over the estimated useful lives of the assets. Accumulated depreciation as of June 30, 2003, 2002, and 2001, was $24,161, $57,525, and $51,485, respectively.

I. Employee Compensated Absences

The Fund's compensated absence liability consists of accumulated unpaid leave, compensatory time, personal holiday hours, and Saturday/legal holiday hours earned and vested as of June 30.

3. DEPOSITS AND INVESTMENTS

A. Deposits

All cash is deposited with the State and is invested by the State of Wisconsin Investment Board through the State Investment Fund. The State Investment Fund is not registered with the Securities and Exchange Commission as an investment company. Shares in the State Investment Fund are reported as cash equivalents and are reported at fair value as of June 30. The various types of securities in which the State Investment Fund may invest are enumerated in ss. 25.17(3)(b), (ba), and (bd), Wis. Stats. Holdings of the State Investment Fund include certificates of deposit and investments consisting primarily of direct obligations of the federal government and the State, and unsecured notes of qualifying financial and industrial issuers. Interest income, gains, and losses of the State Investment Fund are allocated monthly.

The fair value of shares in the State Investment Fund was $4,780,000 (no mark-to-market adjustment) as of June 30, 2003; $16,903,518 (net of negative mark-to-market of $27,482) as of June 30, 2002; and $7,903,291 (net of negative mark-to-market of $15,709) as of June 30, 2001. Shares in the State Investment Fund are not required to be categorized under GASB Statement 3.

B. Investments

The Fund's investments are managed by the Investment Board, whose objectives are to invest moneys held in the Fund in investments with maturities and liquidity that are appropriate for the needs of the Fund. Permitted classes of investments include bonds of governmental units or of private corporations, loans secured by mortgages, preferred or common stock, real property, and other investments not specifically prohibited by statute. In FY 1999-2000, the Investment Board began investing a portion of the Fund's portfolio in equity index funds. The Fund's current investment guidelines limit equity investments to 20 percent of the total portfolio.

All of the Fund's fixed-income investments required to be categorized by GASB Statement 3 meet the criteria for risk category 1. Investments in risk category 1 are insured or registered, or are held by the State or its agent in the State's name. Shares in the equity index funds are not required to be categorized. The market values of the Fund's investments at year-end are as follows:

	June 30, 2003	June 30, 2002	June 30, 2001
Fixed Income:			
Government and Agency	$ 197,412,133	$ 167,299,851	$ 163,694,575
Industrial	198,080,787	181,168,465	201,065,623
Transportation	10,702,492	4,964,376	5,092,794
Finance	82,426,961	75,906,283	50,485,728
Utilities	62,957,318	51,526,482	61,550,019
Sovereign	22,281,658	10,657,630	5,263,944
Subtotal	573,861,349	491,523,087	487,152,683
Equities:			
Russell 3000 Index Fund	44,343,356	34,137,083	38,013,476
Russell 2000 Index Fund	34,583,665	35,246,636	33,996,200
Subtotal	78,927,021	69,383,719	72,009,676
Total Investments	$652,788,370	$560,906,806	$559,162,359

4. ULTIMATE AND DISCOUNTED LOSS LIABILITIES

A. Loss Liabilities

Loss liabilities include individual case estimates for reported losses and estimates for losses that have been incurred but not reported (IBNR) based upon the projected ultimate losses recommended by a consulting actuary. Individual case estimates of the liability for reported losses and net losses paid from inception of the Fund are deducted from the projected ultimate loss liabilities to determine the liability for IBNR losses as follows:

	June 30, 2003	June 30, 2002	June 30, 2001
Projected Ultimate Loss Liability	$1,372,113,120	$1,302,384,138	$1,237,484,791
Less:			
Net Loss Paid from Inception	(540,119,909)	(518,239,879)	(483,467,419)
Liability for Reported Losses	(31,966,378)	(35,421,362)	(52,516,954)
Liability for IBNR Losses	$ 800,026,833	$ 748,722,897	$ 701,500,418

Loss liabilities also include a provision for the estimated future payment of costs to settle claims. These ultimate loss adjustment expenses (LAE) are estimated at 5.75 percent of the projected ultimate loss liabilities as of June 30, 2003, at 5.25 percent as of June 30, 2002, and at 5.00 percent as of June 30, 2001. The LAE paid from inception of the Fund is deducted from the projected ultimate LAE provision to determine the liability for LAE as follows:

	June 30, 2003	June 30, 2002	June 30, 2001
Projected Ultimate LAE Liability	$78,896,504	$68,375,167	$61,874,240
Less:			
Net LAE Paid from Inception	(37,750,563)	(33,524,947)	(29,437,775)
Liability for LAE	$41,145,941	$34,850,220	$32,436,465

B. Re-estimated Loss Liabilities

The loss liability and liability for LAE are continually reviewed as adjustments to these liabilities become necessary. Such adjustments are reflected in current operations. As of June 30, 2003, the actuary estimated that the liabilities for losses and LAE through June 30, 2002, would be $32.0 million (3.9 percent) less than the amount estimated for this period as of June 30, 2002. In a similar fashion, the total losses as of June 30, 2001 and 2000, were estimated one year later to be $32.5 million (4.1 percent) less and $20.2 million (2.7 percent) less, respectively, than originally estimated.

C. Discounted Loss Liabilities

Section Ins 17.27(3), Wis. Adm. Code, requires the liability for reported losses, liability for IBNR losses, and liability for LAE be maintained on a present-value basis, with the difference from full value being reported as a contra account to the loss reserve liabilities. The loss liabilities are discounted only to the extent that they are matched by cash and invested assets. However, beginning with FY 1998-99, the Fund has held sufficient cash and invested assets to fully match the discounted loss liabilities. Therefore, the loss liabilities presented in the financial statements are fully discounted. The actuarially determined discount factor was 0.750 for FY 2002-03, 0.707 for FY 2001-02, and 0.694 for FY 2000-01.

D. Loss Liabilities Balances and Activities

Loss Liabilities	July 1	Additions	Deductions	June 30	Current Portion
FY 2000-01	$514,125,044	$ 82,076,394	$48,711,750	$547,489,688	$75,000,000
FY 2001-02	547,489,688	89,213,985	56,563,108	580,140,565	54,330,000
FY 2002-03	580,140,565	105,971,186	29,796,451	656,315,300	58,250,000

5. FUTURE MEDICAL EXPENSE LIABILITY

Section 655.015, Wis. Stats., requires accounts to be established for future medical expense awards in excess of $25,000 that were entered into or rendered before June 14, 1986, or in excess of $100,000 that were entered into or rendered on or after May 25, 1995.

6. CONTRIBUTIONS BEING HELD LIABILITY

A primary insurer may voluntarily present a nonrefundable payment to the Fund generally equal to the amount of primary coverage in effect for the related claim. This payment from the primary insurer is negotiable with the Fund in exchange for a release of payment for any future defense costs that may be incurred on the claim.

7. MEDICAL MEDIATION PANEL

Section Ins 17.27(3), Wis. Adm. Code, requires the fees collected for administration of the Medical Mediation Panel to be included in the Fund's financial reports, but that they should not be regarded as assets or liabilities or otherwise taken into consideration in determining assessment levels to pay claims. The Fund collected $208,511 in fees in FY 2002-03, $402,228 in FY 2001-02, and $379,158 in FY 2000-01.

8. ASSESSMENT INTEREST INCOME

Fund participants choosing payment plans other than annually are assessed interest on the deferred assessment amounts. Section Ins 17.28(4), Wis. Adm. Code, prescribes the interest rate to be assessed on the deferred assessments as the average annualized rate earned by the Fund on its short-term funds for the first three quarters of the preceding fiscal year, as determined by the Investment Board. Interest was assessed at the rate of 2.6830 percent for FY 2002-03, 6.2150 percent for FY 2001-02, and 5.1428 percent for FY 2000-01.

9. CLAIM ANNUITIES

The settlement of a claim may result in the purchase of an annuity. Under specific annuity arrangements, the Fund may have ultimate responsibility for annuity payments if the annuity company and the reassignment company default on annuity payments. One of the Fund's annuity providers defaulted on $84,079 in annuity payments through June 30, 2003, which the Fund subsequently paid. The annuity provider is currently making the majority of these annuity payments, but the Fund continues to make monthly annuity payments of $224 to cover defaulted payments. The Fund has received reimbursement for these payments, including interest, of $60,578 through June 30, 2003. It is unclear when the annuity provider will be able to make the remaining annuity payments and whether the Fund will be able to recover the remaining annuity payments made on the behalf of the annuity provider. The total estimated replacement value of the Fund's annuities as of June 30, 2003, 2002, and 2001, was $133.3 million, $132.8 million, and $126.8 million, respectively. The Fund reserves the right to pursue collection from state guarantee funds.

10. EMPLOYEE RETIREMENT PLAN

Permanent full-time employees of the Injured Patients and Families Compensation Fund are participants in the Wisconsin Retirement System, a cost-sharing, multiple-employer, defined benefit plan governed by Chapter 40 of Wisconsin Statutes. State and local government public employees are entitled to an annual formula retirement benefit based on: 1) the employee's final average earnings; 2) years of creditable service; and 3) a formula factor. If an employee's contributions, matching employer's contributions, and interest credited to the employee's account exceed the value of the formula benefit, the retirement benefit may instead be calculated as a money purchase benefit. The Wisconsin Retirement System is considered part of the State of Wisconsin's financial reporting entity. Copies of the separately issued financial report that includes financial statements and required supplementary information may be obtained by writing to:

Department of Employee Trust Funds
P.O. Box 7931
Madison, WI 53707-7931

The report is also available on the Department of Employee Trust Funds' Web site, *http://etf.wi.gov*.

Generally, the State's policy is to fund retirement contributions on a level-percentage-of-payroll basis to meet normal and prior service costs of the retirement system. Prior service costs are amortized over 40 years, beginning January 1, 1990. However, in December 2003 the State issued bonds and subsequently fully liquidated its prior service liability balance as of January 2003. The liquidation of the State's prior service liability resulted in credits being granted to state agencies for amounts already paid in 2003. In addition, state agencies will be required to make future contributions to fund the bond payments.

The retirement plan requires employee contributions equal to specified percentages of qualified earnings based on the employee's classification, plus employer contributions at a rate determined annually. The Injured Patients and Families Compensation Fund's contributions to the plan were $51,750 for FY 2002-03, $48,717 for FY 2001-02, and $50,337 for FY 2000-01. The relative position of the Injured Patients and Families Compensation Fund in the Wisconsin Retirement System is not available because the Wisconsin Retirement System is a statewide, multiple-employer plan.

11. CHANGE IN ACCOUNTING PRINCIPLE

The Injured Patients and Families Compensation Fund implemented a new financial reporting model for FY 2001-02, as required by the provisions of GASB Statement Number 34, *Basic Financial Statements—and Management's Discussion and Analysis—for State and Local Governments*. The primary changes under GASB Statement 34 were the classification of assets and liabilities into current and noncurrent, reclassification of retained earnings to net assets, and presentation of management's discussion and analysis. The provisions of GASB Statement 34 were applied to the Fund's financial statements for FY 2000-01 for comparative presentation purposes.

12. SUBSEQUENT EVENTS

There are currently over 90 cases in Wisconsin courts challenging the State's limit on non-economic damages in medical malpractice cases and other statutory requirements. In a July 1998 ruling from the Milwaukee County Circuit Court, the non-economic damages limit was found to be unconstitutional. This case was then accepted directly on appeal by the Wisconsin Supreme Court, without first going through the Court of Appeals. In May 2000, the Wisconsin Supreme Court deadlocked 3-3 on the constitutionality of the limit, with one justice abstaining. On December 19, 2000, the 1st District Court of Appeals, in a 2-1 vote, ruled the limit to be constitutional. According to the Fund's actuaries, if this limit were to be overturned and deemed retroactive to the effective date of May 25, 1995, the Fund's undiscounted unpaid claim liabilities could increase by as much as $144 million as of June 30, 2003. In July 2004, the Wisconsin Supreme Court affirmed the constitutionality of the non-economic damages limit.

13. AUDIT ADJUSTMENTS

The unaudited financial statements presented in the Commissioner of Insurance's annual reports to the Governor and the Legislature have been adjusted to reflect recommended audit adjustments.

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Report on Compliance and Control ■

Independent Auditor's Report on Compliance and on Internal Control over Financial Reporting Based on an Audit of Financial Statements Performed in Accordance with Government Auditing Standards

We have audited the financial statements of the Wisconsin Injured Patients and Families Compensation Fund as of and for the years ended June 30, 2003, 2002, and 2001, and have issued our report thereon dated September 3, 2004. We conducted our audit in accordance with auditing standards generally accepted in the United States of America and the standards applicable to financial audits contained in *Government Auditing Standards*, issued by the Comptroller General of the United States.

COMPLIANCE

As part of obtaining reasonable assurance about whether the Wisconsin Injured Patients and Families Compensation Fund's financial statements are free of material misstatement, we performed tests of its compliance with certain provisions of laws, regulations, and contracts, noncompliance with which could have a direct and material effect on the determination of financial statement amounts. However, providing an opinion on compliance with those provisions was not an objective of our audit and, accordingly, we do not express such an opinion. The results of our tests disclosed no instances of noncompliance that are required to be reported under *Government Auditing Standards*.

INTERNAL CONTROL OVER FINANCIAL REPORTING

In planning and performing our audit, we considered the Wisconsin Injured Patients and Families Compensation Fund's internal control over financial reporting in order to determine our auditing procedures for the purpose of expressing our opinion on the financial statements and not to provide assurance on the internal control over financial reporting. However, we noted a certain matter involving the internal control over financial reporting and its operation that we consider to be a reportable condition. Reportable conditions involve matters coming to our attention relating to significant deficiencies in the design or operation of the internal control over financial reporting that, in our judgment, could adversely affect the Fund's ability to record, process, summarize, and report financial data consistent with the assertions of management in the financial statements. Specifically, as further discussed in the audit report section titled "Provider System," the aging and decreasing effectiveness of the Fund's provider system is resulting in regularly occurring errors that require manual adjustment. The occurrence of the errors and the need to manually identify and correct them increase the risks associated with the Fund's financial operations. Further, the condition of the system is likely to worsen, resulting in increased risk to the Fund's financial operations and requiring additional effort to keep the system operational.

A material weakness is a condition in which the design or operation of one or more of the internal control components does not reduce to a relatively low level the risk that misstatements in amounts that would be material in relation to the financial statements being audited may occur and not be detected within a timely period by employees in the normal course of performing their assigned functions. Our consideration of the internal control over financial reporting would not necessarily disclose all matters in the internal control that might be reportable conditions and, accordingly, would not necessarily disclose all reportable conditions that are also considered to be material weaknesses. However, we do not believe the problems with the Fund's provider system noted above are a material weakness.

This independent auditor's report is intended for the information and use of the Wisconsin Injured Patients and Families Compensation Fund's management, the Board of Governors, and the Wisconsin Legislature. This independent auditor's report, upon submission to the Joint Legislative Audit Committee, is a matter of public record and its distribution is not limited. However, because we do not express an opinion on compliance or provide assurance on internal control over financial reporting, this report is not intended to be used by anyone other than these specified parties.

LEGISLATIVE AUDIT BUREAU

September 3, 2004 by

Diann Allsen
Audit Director

Appendix

Annual Provider Assessments[1]

Provider Types	Fiscal Year						
	1997-98	1998-99[2]	1999-2000	2000-01	2001-02	2002-03	2003-04
Physician Class 1[3]	$ 2,647	$ 2,721	$ 2,531	$ 1,898	$ 1,538	$ 1,461	$ 1,534
Physician Class 2[4]	5,294	5,170	4,809	3,606	2,769	2,630	2,761
Physician Class 3[5]	11,382	11,292	10,504	7,877	6,385	6,063	6,366
Physician Class 4[6]	15,882	16,326	15,186	11,388	9,231	8,766	9,204
Nurse Anesthetist	678	678	631	475	378	359	377
Hospital—per Occupied Bed	167	167	155	116	93	88	92
Nursing Home—per Occupied Bed	31	31	29	22	17	16	17
Employees of a Partnership or Corporation:							
Nurse Practitioner	662	680	631	475	385	365	384
Advanced Nurse Practitioner	926	952	886	664	538	511	537
Nurse Midwife	5,823	5,986	5,568	4,176	3,385	3,214	3,375
Advanced Nurse Midwife	6,088	6,258	5,821	4,365	3,538	3,360	3,528
Advanced Practice Nurse Prescriber	926	952	886	664	538	511	537
Chiropractor	1,059	1,088	1,012	759	615	584	614
Dentist	529	544	506	380	308	292	307
Oral Surgeon	3,971	4,082	3,797	2,847	2,308	2,192	2,301
Podiatrists—Surgical	11,250	11,564	10,757	8,067	6,538	6,209	6,520
Optometrist	529	544	506	380	308	292	307
Physician Assistant	529	544	506	380	308	292	307

[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 opthamologists performing surgery.
[5] Includes most types of surgeons, such as plastic, hand, general, and orthopedic.
[6] Includes obstetric and neurological surgeons.

State of Wisconsin / OFFICE OF THE COMMISSIONER OF INSURANCE

Jim Doyle, Governor
Jorge Gomez, Commissioner

Wisconsin.gov

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September 24, 2004

JANICE MUELLER STATE AUDITOR
LEGISLATIVE AUDIT BUREAU
22 EAST MIFFLIN STREET SUITE 500
MADISON WI 53703

Dear Ms. Mueller:

We are in receipt of the Legislative Audit Bureau's draft audit report of the Injured Patients and Families Compensation Fund and would like to respond to the following recommendation:

"It is recommended that the Office of the Commissioner of Insurance report to the Joint Legislative Audit Committee by November 30, 2004, on the status and result of the actuarial audit."

As we stated in our response to the recommendation regarding an actuarial audit in the previous LAB audit, we agree that such an audit would be prudent. In addition, the Fund's Board of Governors passed a motion which will require such an audit to be conducted at least once every three years.

Fund staff, and OCI, drafted requests for proposals (RFPs) subsequent to the original recommendation and eventually a contract was awarded. The draft work was reviewed by the Fund Board's Audit Committee and it was determined to be inadequate in that it did not address any of the issues which make the Fund unique. A second RFP was drafted with the assistance of the Audit Committee to assure that the necessary requirements were addresses. The members of the Audit Committee reviewed the proposals received in response to the second RFP and deemed them all unacceptable as none of them included specific responses to some of the mandatory requirements.

Subsequently, OCI after discussions with the Department of Administration assisted Fund staff in developing alternative procedures to ensure that an experienced medical malpractice actuarial firm would be hired to perform the audit. Those procedures are currently under way, and it is expected, barring any protests from earlier proposers, that a report will be available by the November 30, 2004 date.

In conclusion, the Fund's Board through its Audit Committee has taken an active role in obtaining the actuarial audit of the assumptions and methodology used by the fund's contract actuarial firm, and continues to monitor the process currently underway.

Sincerely,

Eileen Mallow

Eileen Mallow
Assistant Deputy Commissioner
Office of the Commissioner of Insurance