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An Audit:

Injured Patients and Families Compensation Fund

October 2004

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.

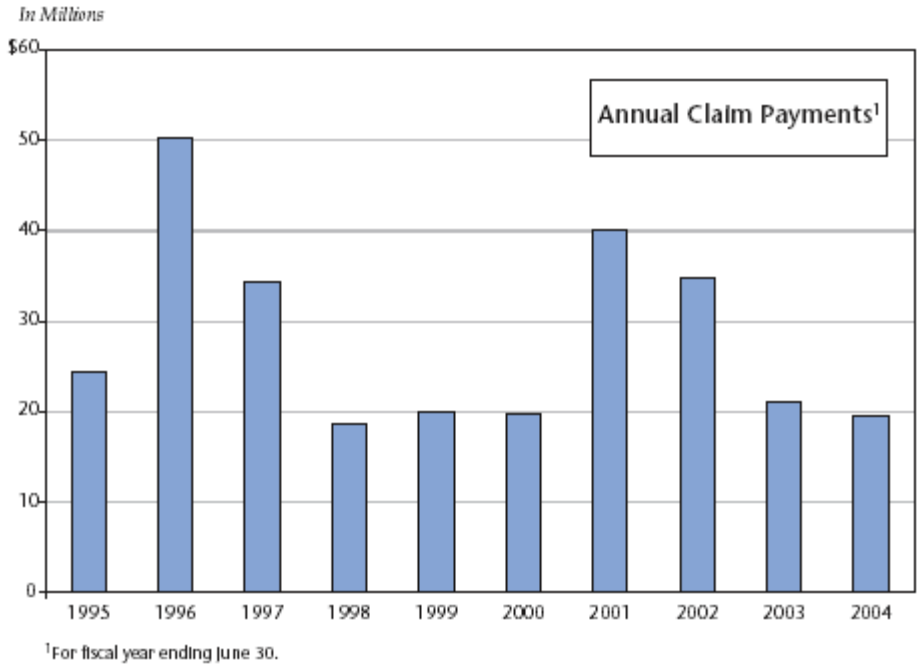
Key Facts and Findings

The Fund reported an accounting balance of $7.9 million as of June 30, 2003.

Cash and investment balances totaled $658.9 million as of June 30, 2003.

The Fund has paid over $553.2 million for 612 medical malpractice claims since its inception.

An actuarial audit is expected to be completed by November 30, 2004.



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 noneconomic 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**)*.

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