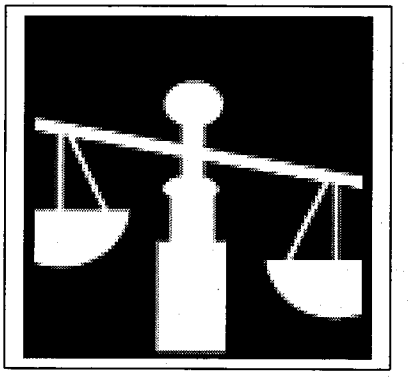
Justice Capped

Tilting the Scales of Justice Against Injured Patients and their Families



A 10-year review of
Wisconsin's cap on pain and suffering
May 2005

Wisconsin Citizen Action
&
Wisconsin Academy of Trial Lawyers

Table of Contents

Acknowledgements

We would like to thank Wisconsin Citizen Action intern Bonnie Broeren for her work in providing research assistance for this report.

Executive summary

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

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

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

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

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

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

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

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

---

[1] 1995 Wisconsin Act 10.

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

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

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

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

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

Introduction

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

Major Provisions of 1995 Wisconsin Act 10

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

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

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

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

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

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

---

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

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

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

I. Denying Justice to Injured Patients and Their Families

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

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

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

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

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

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

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

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

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

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

B. Disparate impact

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

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

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

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

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

** The $1 million cap went into effect on June 15, 1986 and the cap was indexed on that day each year. The $350,000 cap went into effect on May 25, 1995 and is indexed each year on May 15.*
**** No numbers for that year.*

C. The Effect on Families

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

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

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

---

[6] *Martin v. Richards,* 192 Wis. 2d 156, 531 N.W.2d 70 (1995).
[7] France, et al, *supra* note 5.
[8] David Studdert, Michelle Mello and Y. Tony Yang, *Journal of Health Affairs*, July/August 2004, http://www.insurancejournal.com/news/national/2004/07/08/43841.htm (last visited May 13, 2005).
[9] Information obtained from Randy Sproule, Administrator at Medical Mediation Panels. Prior to pursing a medical malpractice lawsuit, an injured patient must file a request for medical mediation, Wis. Stat. § 655.43 (2001-2002).

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

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

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

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

II. Fund, not cap, holds down malpractice costs

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

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

Fund Shares Risk, Cap Shifts Risk

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

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

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

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

Timeline of the Fund

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

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

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

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

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

1991 — $1 million indexed cap sunsets.

1995 — $350,000 indexed cap adopted.

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

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

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

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

How Wisconsin doctors are insured against malpractice

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

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

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

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

Grossly Inaccurate Projections Fueled Cap

As Legislators contemplated the proposal for a cap on pain and suffering verdicts, they were told there was a $67.9 million projected actuarial deficit as of June 30, 1994. The specter of such a relatively large deluge of red ink had a major impact on the pending legislation. Several legislators cited the projected deficit as a reason they thought the cap necessary.[11] However, legislators were told that the cap would not impact the actuarial deficit. On January 19, 1995, Fund Administrators testified before the Assembly Insurance Committee and stated, "the reduced estimate is not related to the 1995 adoption of the non-

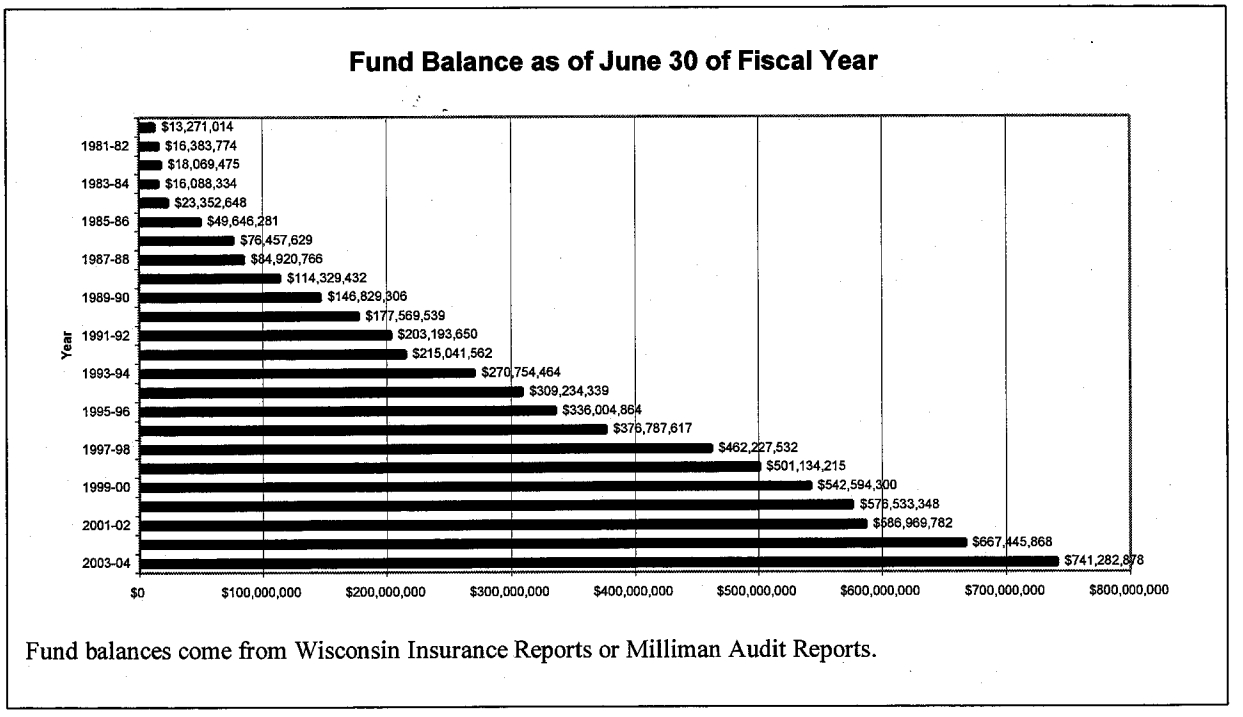
[11] Floor debate on 1995 Assembly Bill 36, January 31, 1995. (Excerpts are in Appendix A.)

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

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

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

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



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

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

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

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

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

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

* The numbers are estimated based on calculations from Milliman.

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

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

[15] Fund fees recommended for the 2005-06 fiscal year are lower than fees for 1984-85.
[16] Memo of Jeff Kolhman, Insurance Program Specialist for the Injured Patients and Families Compensation Fund, January 10, 2005. (Appendix F)
[17] Estimate is based on figures from Morgan Stanley.

Who Does the Fund Serve?

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

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

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

Injured Patients & Families Compensation Fund

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

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

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

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

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

Insurance execs speak up

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

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

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

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

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

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

---

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

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

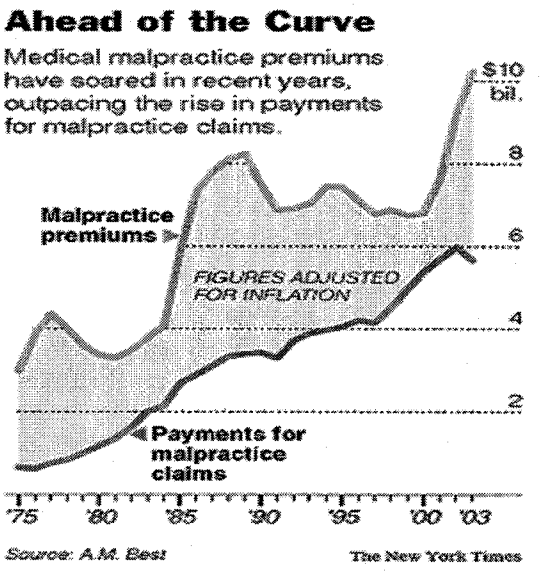
[20] "Medical Professional Liability, State of Florida," St. Paul Fire and Marine Insurance Company, St. Paul Mercury Insurance Company.

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

Insurers: The Elephant In The Room

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

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



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

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

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

---

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

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

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

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

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

Poor management piled on top of greed

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

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

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

Premiums related to insurers' investments, not litigation

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

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

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

---

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

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

[29] *Id.*

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

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

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

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

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

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

Wisconsin Insurers

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

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

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

---

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

---

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

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

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

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

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

[44] Randy Sproule, Medical Mediation Panels.

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

[46] National Practitioners Databank Reports 1992-2002.

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

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

The Wisconsin Experience:

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

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

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

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

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

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

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

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

---

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

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

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

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

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

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

Doctor Distribution

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

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

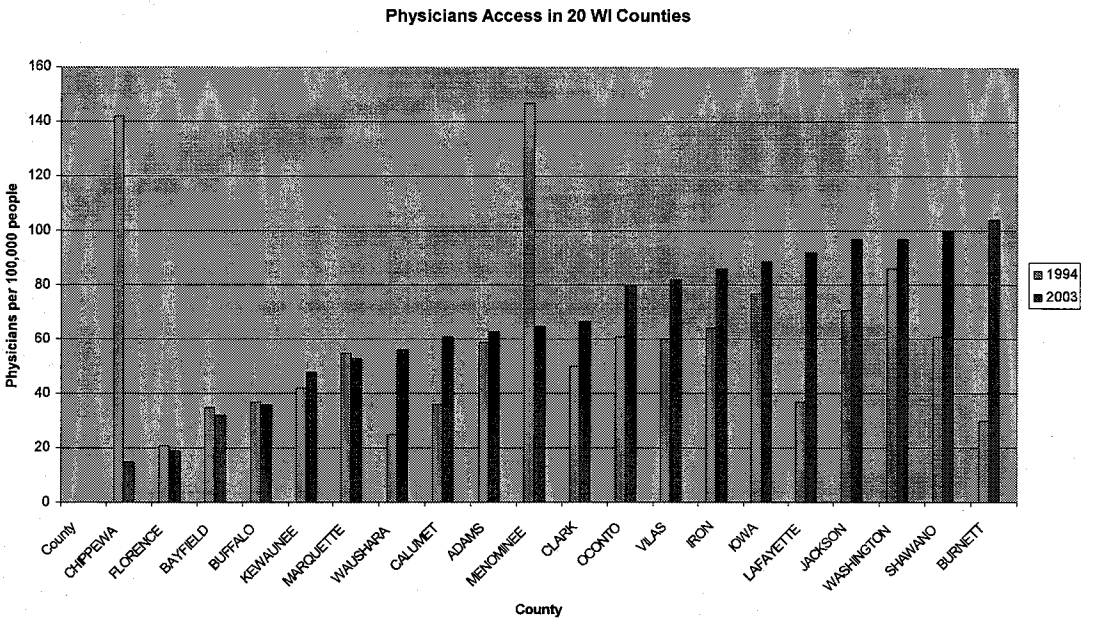
> ***We have a shortage that's far more acute [in Milwaukee] than 10 years ago."***
> *—Aurora executive and former city health commissioner Paul Nannis*

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

---

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

Physician/population ratio in rural WI



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

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

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

Conclusion

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

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

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

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

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

Appendix Index

WISCONSIN CITIZEN ACTION

1202 Williamson Street
Madison, WI 53703
(608) 256-1250
www.wi-citizenaction.org

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

Wisconsin Academy of Trial Lawyers

44 E. Mifflin Street, Suite 103
Madison, WI 53703
(608) 257-5741 FAX (608) 255-9285
www.watl.org

The Wisconsin Academy of Trial Lawyers (WATL) is a voluntary trial bar and a non-profit corporation under the laws of Wisconsin. Members of the Academy are attorneys who represent consumers seeking to hold wrongdoers accountable for injuries arising from unsafe products or procedures. The Academy's objectives are to promote continuing legal education for the betterment of the trial bar profession and to preserve Wisconsin's civil jury trial system by working with the state legislature and other governmental bodies as an advocate for the legal rights of all Wisconsin citizens.