
WISCONSIN MEDICAL SOCIETY, INC.
AND DAVID M. HOFFMAN, M.D.,

Plaintiffs,

Case No. 07-CV-4035

v.

MICHAEL L. MORGAN,

Defendant.

**BRIEF OF AMICUS CURIAE
WISCONSIN HOSPITAL ASSOCIATION
IN SUPPORT OF PLAINTIFFS' MOTION FOR SUMMARY JUDGMENT**

Wisconsin Hospital Association (“WHA”) respectfully submits this brief as amicus curiae in support of plaintiffs’ motion for summary judgment. The unprecedented action of the state legislature—removing funds paid by hospitals and other health care providers into a statutorily created trust and directing their use for other purposes—is not simply poor policy that jeopardizes the integrity of Wisconsin’s medical malpractice system. It is as well an unconstitutional impairment of the State’s contractual obligations to health care providers.*

INTEREST OF AMICUS CURIAE AND INTRODUCTION

WHA is a voluntary organization, established in 1920 and dedicated to helping ensure that its health care provider members are able to provide high-quality health care services to Wisconsin’s communities. WHA thus has a strong interest in suits that involve the health and integrity of Wisconsin’s health care system and, more specifically, the medical malpractice statutory scheme set forth in Chapter 655 of the Wisconsin Statutes.

* WHA concentrates its amicus curiae brief on the State’s unlawful impairment of its contract with health care providers, but WHA supports as well the other causes of action raised by plaintiffs.

Chapter 655's comprehensive structure for handling medical malpractice claims forms the context of this lawsuit. A vital part of the system is "the Fund" (viz., the Injured Patients and Families Compensation Fund). By virtue of the statutory scheme, various actors in the system have rights and obligations with respect to the Fund. These include not only the plaintiff, who brings a claim against a health care provider (and, in certain cases, the Fund) to recover damages "on account of malpractice" (Wis. Stat. § 655.007), but also the health care provider, whether a doctor, nurse anesthetist, or hospital, who pays into and receives coverage from the Fund. They include as well the State of Wisconsin, which is charged with protecting the Fund.

To begin with the Fund itself: The Fund is the statutorily created means by which health care providers obtain excess coverage in situations where injured patients and their families maintain significant medical malpractice claims. Specifically, the statute provides in part as follows:

There is created an injured patients and families compensation fund for the purpose of paying that portion of a medical malpractice claim which is in excess of the limits expressed in s. 655.23(4) or the maximum liability limit for which the health care provider is insured, whichever limit is greater, paying future medical expense payments under s. 655.015, and paying claims under sub. (1m).

Wis. Stat. § 655.27(1). As the Wisconsin Supreme Court has more succinctly stated, "[t]he Patients Compensation Fund, created by sec. 655.27, Stats., pays that portion of medical malpractice awards above certain limits. Sec. 655.27(1)." *State ex rel. Strykowski v. Wilkie*, 81 Wis. 2d 491, 500, 261 N.W.2d 434, 438 (1978).

This excess coverage is no gratuitous benefit provided by the State of Wisconsin out of general revenues. Health care providers covered by the Fund not only are required to maintain primary insurance coverage (\$1,000,000 at present), *see* Wis. Stat. § 655.23(3)(a),(4)(b)(2), but to pay assessments into the Fund—that is, to fund the Fund. There thus is no question that the

Fund “is financed by assessments against health care providers.” *Strykowski*, 81 Wis. 2d at 500, 261 N.W.2d at 438. Again, the Wisconsin Supreme Court: “*From these assessments* the Fund pays the portion of a successful claim against a health care provider” *Wisconsin Patients Comp. Fund v. Wisconsin Health Care Liab. Ins. Plan*, 200 Wis. 2d 599, 607, 547 N.W.2d 578, 581 (1996) (emphasis added).

Chapter 655 regulates as well the actions of the State. It does this not merely (if such a thing could be mere) by generally committing to the “integrity of [the] fund” and by expressly providing that “[t]he fund, including any net worth of the fund, is held in irrevocable trust for the sole benefit of health care providers participating in the fund and proper claimants.” Wis. Stat. § 655.27(6). In the same provision, to effectuate the legislative commitment to the Fund’s “integrity,” Chapter 655 sets forth this unequivocal statement: “*Moneys in the fund may not be used for any other purpose of the state.*” *Id.* (emphasis added). See *Finnegan v. Patients Comp. Fund*, 2003 WI 98, ¶ 20 n. 2, 263 Wis. 2d 574, 586 n.2, 666 N.W.2d 797, 803 n.2.

ARGUMENT

A. Chapter 655 Creates a Contract Between the State and Health Care Providers.

The foregoing provisions together with other parts of Chapter 655 form a contract between the State of Wisconsin and health care providers. The health care providers forgo purchasing excess liability insurance on the private market and pay assessments into the Fund in exchange for the excess protection that the State has promised to provide through the monies of a *dedicated* Fund.

The parties’ exchange can be variously characterized. One can focus primarily on what health care providers give. For example, the Fund’s 2007 Functional and Progress Report observes that “[a]ssessments . . . are received from health care providers in exchange for coverage under the Fund.” Exhibit Q to Plaintiffs’ Motion for Summary Judgment (“Plaintiffs’

Motion”) at 18. Or one can focus primarily on what health care providers (and thus communities in Wisconsin) receive in exchange. For example, the Wisconsin Supreme Court has observed as follows: “[T]he legislative purpose of enacting ch. 655 was to induce health care providers to stay in practice in Wisconsin by reducing their operating costs. The inducement provided by the statute is limited liability and lower costs to the provider for the coverage provided by the Fund.” *Wisconsin Patients Comp. Fund v. St. Paul Fire and Marine Ins. Co.*, 116 Wis. 2d 537, 543, 342 N.W.2d 693, 696 (1984).

However characterized, the result of the exchange is a contract. Where one party (here, the State) makes a promise to another party (here, the health care provider), and in exchange that other party both promises and performs accordingly (here, in the form of each health care provider’s payment of assessments into the Fund and its forgoing of purchasing other excess insurance), there is consideration and a contract exists. This is basic hornbook law. *See Restatement (Second) of Contracts* § 17 (1981) (“the formation of a contract requires a bargain in which there is a manifestation of mutual assent to the exchange and a consideration”); *see, e.g., id.*, § 50 (manifestation of assent as acceptance), § 71 & comment b (“bargained for”), § 72 (consideration).

The State itself effectively has recognized the existence of a contract. For example, Chapter 655 speaks in classic contractual terms in this notable provision: “On and after July 24, 1975, every patient, every patient’s representative and every health care provider shall be conclusively presumed *to have accepted to be bound* by this chapter.” Wis. Stat. § 655.006(1)(a) (emphasis added). *See also* Commissioner of Insurance Document, attached as Exhibit A, at 1 (Commissioner of Insurance observation that as of July 24, 1975, it is “imperative that every health care provider in the State of Wisconsin understands the benefits which [Chapter 655] provides and the obligations which it confers”).

B. The New Legislation Unconstitutionally Impairs This Contract.

2007 Wisconsin Act 20 (the “New Legislation”), which codifies the 2007-2009 biennial budget and takes \$200 million from the Fund, unconstitutionally impairs the contract between the State and health care providers. Health care providers paid these monies into the Fund under the expectations and for the purposes set forth in Chapter 655. In enacting the New Legislation, the State has failed to abide by *its* correlative obligations under Chapter 655: viz., to follow the procedures set forth for any release of monies from the Fund and to safeguard the trust of the Fund and not use its assets for other purposes. The New Legislation thereby works an unconstitutional impairment of the State’s obligations under federal law, *see* U.S. Const., art. 1, sec. 10 (“No State shall . . . pass any . . . Law impairing the Obligation of Contracts”), and state law, *see* Wis. Const., Art. I, sec. 12 (“No . . . law impairing the obligations of contracts, shall ever be passed”).

The New Legislation takes monies from the Fund for reasons utterly unrelated to the express purpose stated in Chapter 655. Chapter 655 contains a “clear statutory directive” that the “Fund shall be held in trust for the purposes of this chapter.” *Wisconsin Health Care Liab. Ins. Plan*, 200 Wis. 2d at 615, 547 N.W.2d at 584. This purpose, which is stated in Wis. Stat. § 655.27(6), is to pay for resolving medical malpractice claims: “The fund is established to curb the rising costs of health care by *financing part of the liability incurred by health care providers* as a result of medical malpractice claims and to ensure that proper claims are satisfied.” Wis. Stat. § 655.27(6) (emphasis added). Yet the stated purpose of the New Legislation is to “[i]ncrease funding for MA and Badgercare benefits by \$71,500,000 SEG in 2007-08 and by \$128,500,000 SEG in 2008-09 from the MA trust fund and reduce GPR funding by a corresponding amount.” Legislative Fiscal Bureau Summary Document at 354, Exhibit N to Plaintiffs’ Motion. That matter could be scarcely more plainly stated: “The additional funding

would be available due to a provision that would transfer these amounts from the injured patients and families compensation fund to the MA trust fund.” *Id.* In short, the legislature wanted to provide benefits to other programs without using general revenue funds, and it did so (literally) at the expense of health care providers.

By its actions, the State *substantially impaired* its contract with health care providers. The State is obligated under Chapter 655 to ensure that the statutory procedures are followed before monies are removed from the Fund. For that reason, there are mandatory “claims procedures” (Wis. Stat. § 655.27(5)(a)) and a provision, consistent with those procedures, that “[m]oneys shall be withdrawn from the fund by the commissioner [of insurance] only upon vouchers approved and authorized by the board of governors” (*id.* § 655.27(4)(a)). The New Legislation did not change these procedures. Indeed, it expressly stated (New Legislation § 9225) that it was transferring the monies “[n]otwithstanding section 655.27(6) of the statutes.” *See Relevant Excerpt of 2007 Wis. Act 20, found in Exhibit M to Plaintiffs’ Motion.* The statutory claims procedures and removal procedures exist to ensure the integrity of the full net worth of the Fund. Yet the State not only failed to protect that integrity, but was the violating party. In short, the State diverted monies from the Fund in a manner inconsistent with the statutory procedures of Chapter 655 and the settled expectations of health care providers.

The constitutional contract clauses proscribe such an action by the State. As long ago as the time of the still-leading academic exegesis of the clause, it could be said that the Contract Clause “has been frequently invoked to prevent a state or local area of government from attempting to evade its contractual financial obligations.” Benjamin Wright, *The Contract Clause of the Constitution* 249 (1938) (and collecting cases at 224-227). The State of Wisconsin simply cannot jettison statutory contracts any time that it desires to make its budgetary life easier.

The State's action has a significant effect on health care providers. The State offers no recompense for its action, no provision for replacing the monies in the Fund or compensating health care providers if they somehow must pay to replenish the Fund—no extrajudicial remedy for the State's impairment. The health care providers' assessments thus will be consumed for other purposes. This is especially troubling because the assessments were based upon actuarial assumptions made with respect to the experience of the health care providers and the Fund (assumptions that have been found to be "reasonable but conservative," Commissioner of Insurance Gomez Letter dated September 27, 2005, attached as Exhibit B, at 1) and because, as the Former Commissioner of Insurance, Jorge Gomez, has remarked, "if the Fund ran out of money there is no easy source of additional funds." *Id.*

No exceptions to the Contract Clause are applicable here. For example, the State cannot argue that its actions were justified by "a significant and legitimate public purpose, such as remedying a broad and general social or economic problem," *Chappy v. Labor & Industry Review Comm'n*, 128 Wis. 2d 318, 326, 318 N.W.2d 552, 556 (Ct. App. 1985); *see also United States Trust Co. of New York v. New Jersey*, 431 U.S. 1, 22 (1977), and were "reasonable and necessary to serve [that] purpose." *United States Trust Co. of New York*, 431 U.S. at 25; *see also State ex rel. Cannon v. Moran*, 111 Wis. 2d 544, 561, 331 N.W.2d 369, 378 (1983). To be sure, the State can point out that the monies were taken to assist in funding medical assistance and Badgercare benefits, but that does not end the inquiry. Funding different public programs not within the province of the original contract (and with the health care providers' dedicated monies) is not a reasonable and necessary basis for ignoring the State's obligations to health care providers under Chapter 655.

So much is established by *United States Trust Co. of New York v. New Jersey*, 431 U.S. 1 (1977). In *United States Trust Co. of New York*, the State of New Jersey sought to repeal by

statute a covenant with holders of Port Authority bonds; the covenant acted as security for the bonds by limiting the Port Authority's ability to take on additional deficits from passenger railroad services. *See id.* at 3, 9-10. The United States Supreme Court refused to permit the State to repeal the covenant because, it concluded, the new terms sought by the State were an unconstitutional impairment of contract, even though the State sought the repeal for a number of financial, energy, and environmental reasons. *See id.* at 28-32.

As the Court explained, "a State cannot refuse to meet its legitimate financial obligations simply because it would prefer to spend the money to promote the public good rather than the private welfare of its creditors." *Id.* at 29. Just so here: The State would take the monies paid to the Fund by health care providers, including individual doctors and nurse anesthetists, in the nature of assessments and use them for what it considers another legitimate purpose. But in doing so, it substantially depletes the monies available in the Fund, for reasons unrelated to the purpose of the Fund. That is unlawful.

It should be observed as well that the State—in diverting money from the Fund—damages an important part of what has been a well-functioning medical malpractice system. The American Medical Association stated in its 2007 medical liability map report that Wisconsin was one of eight stable states in the country with regard to its medical liability system. *See AMA State of Liability Report*, attached as Exhibit C. *See also* Legislative Fiscal Bureau Joint Committee on Finance Paper #450 dated May 17, 2005, at 8-9, Exhibit E to Plaintiffs' Motion. And maintaining the integrity of the Fund to ensure its ability to provide excess coverage for medical malpractice claims is critical to the operation of the medical malpractice statutory scheme. Indeed, Former Commissioner Gomez emphasized the important role of the Fund in the medical malpractice system: "the Fund has been a noted success in helping make Wisconsin


medical malpractice market a viable environment where companies compete for business, doctors receive affordable coverage, and patients receive the protections.” Exhibit B at 1.

The integrity of the Fund is critical as well to the operation of hospitals and other health care providers. Hospitals provide a broad range of high quality and affordable care, from primary-care treatment to life-saving treatment, in communities all over Wisconsin. The treatment provided by these hospitals depends, in large part, on the hiring and retention of first-rate professionals for whom a stable medical malpractice environment is important. That stability, which the legislature sought when it passed Chapter 655, has existed precisely because the integrated parts of the Chapter 655 statutory scheme (as described above) function as they should. The State’s actions thus not only violate its contractual obligations under Chapter 655 to health care providers but imperil the well-being of the entire statutory system.

CONCLUSION

For the reasons stated, plaintiffs’ motion for summary judgment seeking declaratory and equitable relief should be granted.

Respectfully submitted,



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EXHIBIT A



State of Wisconsin \ OFFICE OF THE COMMISSIONER OF INSURANCE

RECEIVED

Lee Sherman Dreyfus
Governor

SEP 9 1980

LEGISLATIVE REFERENCE
BUREAU

Susan Mitchell
Commissioner

123 WEST WASHINGTON AVENUE
MADISON, WISCONSIN 53702

(608) 266-3585

On July 24, 1975, Wisconsin's malpractice law became effective. Because of its potential impact on the budgets, licenses and professional circumstances of health care providers, it is imperative that every health care provider in the State of Wisconsin understands the benefits which this law provides and the obligations which it confers.

1) What is a Health Care Provider Under Chapter 655?

A) Physician - Any person licensed as a physician under Chapter 448, Wisconsin Statutes, who practices the profession of medicine, or medicine and surgery, or osteopathy and surgery or osteopathy in this state, either part-time or full-time for more than 240 hours in a fiscal year, July 1 thru June 30.

B) Nurse Anesthetist - Any person licensed as a professional nurse under Chapter 441, Wis. Stats., who engages in the administration of anesthesia in this state either part-time or full-time for more than 240 hours in a fiscal year, July 1 thru June 30.

C) Partnerships comprised of such physicians, nurse anesthetists or podiatrists and corporations owned by such physicians, nurse anesthetists or podiatrists and operated for the purposes of providing medical services and operational cooperative sickness care plans organized under ss. 185.981 to 185.985 which directly provides services through salaried employes in their own facilities.

D) Hospitals as defined by s. 50.33 (1) (a) and (c); but excluding state, county or municipal employes or federal employes covered under the federal tort claims act as amended while acting within the scope of their employment and those facilities exempted by s. 50.39 (3) or operated by any governmental agency.

E) State, county or municipal employes or facilities excluded under D) above may petition the Commissioner of Insurance to become subject to the provisions of Chapter 655.

F) Any podiatrist licensed under Chapter 448, Wis. Stats. (Effective May 7, 1980, Laws of 1979.)

*The term "hospital" wherever used in this bulletin means a health care facility as defined by section 50.33 (1) (a) and (c), Wisconsin Statutes, but excluding those facilities exempted by section 50.39 (3), Wisconsin Statutes.

2) Who Can Be Exempt?

Chapter 655 provides for certain exemptions from the mandatory provisions. They are:

- A) Physicians, nurse anesthetists or podiatrists who do not "treat the sick" in this state either full-time or part-time for more than 240 hours a fiscal year. (Optional exemption)
- B) Licensed physicians, graduate medical students or podiatrists acting only within the scope of their residency or fellowship program. (Optional exemption)
- C) Physicians, nurse anesthetists or podiatrists who are employed by the federal government, the state, a county or a municipality.
- D) Licensed physicians, nurse anesthetists or podiatrists whose principal place of practice is NOT in Wisconsin.
- E) Hospitals owned and operated by a governmental agency. (See (I.E.) preceding).

An Affidavit of Exemption form is attached to this bulletin. Health care providers who are exempt should complete the form and return it. For those who may claim an exemption (items A & B above), the form should be completed only if an exemption is desired. Persons who file an exemption are not entitled to any benefits or limitations which are provided under Chapter 655.

3) What are health care providers required to do in order to comply with the law?

- A) Every health care provider subject to the law must have malpractice insurance protection of at least \$100,000 per claim/\$300,000 per year and file a certificate of insurance with the Office of the Commissioner of Insurance.

Every health care provider subject to Chapter 655 who does not have professional liability coverage of at least \$100,000/\$300,000 will be subject to the penalties provided by statute. This coverage may be obtained either from the state risk-sharing pool (The Wisconsin Health Care Liability Insurance Plan) or from a private insurer*.

*Or, under certain circumstances, a health care provider can satisfy the requirement through other means, such as a surety bond. In practical terms, however, it is unlikely that these are real alternatives for health care providers that are not large institutions. Anyone seeking further information on these alternatives under the law should contact the Office of the Commissioner of Insurance directly.

Information on application procedures for the Wisconsin Health Care Liability Insurance Plan is attached to this bulletin. The Plan is required to offer health care liability insurance to all health care providers on an occurrence basis, up to limits of \$200,000/\$600,000. It should be understood by all Wisconsin health care providers that unless they obtain coverage up to these limits (\$200,000/\$600,000) there will be a gap in their protection (the Patients Compensation Fund established under Chapter 655 only covers claims over \$200,000/\$600,000). In other words, just meeting the minimum insurance requirement of the statute (\$100,000/\$300,000) will not protect health care providers for the resulting "gap" between the limits of their primary coverage and the limit of their liability afforded them by the Patients Compensation Fund.

B) Every health care provider subject to the law must pay an annual fee into the Patients Compensation Fund established under Chapter 655. This fee covers the cost of administering the system of informal and formal panels (Patients Compensation Panels) created by the law for the handling of malpractice claims. It will also cover the cost of administering the Patients Compensation Fund, and all claims made against that fund (i.e., all claim settlements in excess of \$200,000 - or a \$600,000 annual aggregate per provider - for incidents in which a health care provider who has complied with the requirements of Chapter 655 is involved).

Every health care provider who is not exempt from the provisions of Chapter 655 will be billed on an annual basis for his share of the cost of supporting the Patients Compensation Fund. License or certificate renewal is contingent upon the health care providers' payment of fees to the Patients Compensation Fund (and compliance with the mandatory sections of the statute).

Health care providers must comply with Chapter 655 before entering non-exempt practice. The law further provides penalties up to \$1,000 for each week of non-compliance.

Newly licensed physicians, nurse anesthetists and podiatrists will be billed when they become licensed. A pro rata assessment has been established for those who enter private practice in the State of Wisconsin during the coverage period.

The Fund participation period is from July 1 to June 30 on an annual basis. Fees or assessments are determined by the Board of Governors prior to each July 1.

Health care providers who feel that their assessments are incorrect may appeal to:

Patients Compensation Fund
123 West Washington Avenue, 7th Floor
Madison, WI 53702

There is no additional assessment for partnerships, service corporations or cooperatives for the Patients Compensation Fund.

SOME QUESTIONS AND ANSWERS ABOUT THE
WISCONSIN HEALTH CARE LIABILITY INSURANCE PLAN

4) What Benefits Does the Law Provide?

Health care providers who comply with the requirements of Chapter 655 will have their liability for acts of malpractice limited to \$200,000 per occurrence and \$600,000 for all claims in any single year. Payments for claims above these liability limits will be made by the Patients Compensation Fund. The Fund will issue no "policies", but it will pay valid claims in excess of \$200,000/\$600,000 on behalf of health care providers who are subject to and who have complied with Chapter 655.

In addition, the law assures that primary insurance protection for professional liability will be available on an occurrence basis to all health care providers who require it, through the Wisconsin Health Care Liability Insurance Plan.

5) What Do I Do Now?

If you do not have the primary insurance required under this law, you should obtain it immediately, either from the Wisconsin Health Care Liability Insurance Plan, or from the voluntary market.

If you want to be exempt from the requirements of the law, (because you do not "treat the sick" in Wisconsin on a part-time or full-time basis for more than 240 hours in a fiscal year) you should file an affidavit of Exemption with the Office of the Commissioner of Insurance.

There is no provision for installment payment of Fund fees or assessments. Therefore, these assessments should be budgeted as an operating expense.

If you presently have excess or umbrella coverage, you should review it carefully with your agent to determine whether or not - or in what way - it duplicates the limits of liability provided by the Patients Compensation Fund. The Fund is excess to any other malpractice liability insurance carried which exceeds \$200,000/\$600,000.

1. What is the Wisconsin Health Care Liability Insurance Plan?

It is a nonprofit insurance mechanism which makes available medical malpractice insurance for physicians, surgeons, osteopaths, podiatrists, and nurse anesthetists licensed to practice in Wisconsin; general acute care hospitals may obtain malpractice insurance through the Plan as well.

The Health Care Liability Insurance Plan was made possible by the enactment of Chapter 2, Laws of 1975, and responds also to the mandate of Chapters 37 and 79, Laws of 1975. The Plan creates a source of professional liability insurance for eligible health care providers who cannot or choose not to obtain this insurance coverage in the voluntary market.

2. How may coverage under the Plan be obtained?

All licensed insurance agents and brokers throughout the state will be supplied with application forms and detailed information. In addition, the state offices of the National Association of Independent Insurers (NAII), the American Insurance Association (AIA), and the Wisconsin Insurance Alliance can provide application forms and assistance in obtaining coverage.

Or contact the Plan administrator direct:

Wisconsin Health Care Liability Insurance Plan
2000 Westwood Drive
Wausau, WI 54401
715 842-6777

3. Who provides the medical professional liability coverage?

Wisconsin Health Care Liability Insurance Plan, (an insurance company) was created under Chapter 619, Wisconsin Statutes. Employers Insurance of Wausau, a company experienced in the malpractice field, operates the Plan under contract. The Plan is intended to be self-supporting. If losses and expenses exceed premiums paid, then companies writing coverage against liability from personal injuries are required to advance monies to maintain the Plan's solvency. This advance, however, is in the nature of a loan and is repaid by the Plan through premium increases to health care providers.

4. Who is eligible? Is a doctor with a history of malpractice claims against him eligible?

Any physician, surgeon, osteopath, podiatrist, or nurse anesthetist licensed to practice in Wisconsin and Wisconsin general acute care hospitals may obtain professional liability insurance from this Plan. Professional health care providers who have had professional liability claims made against them will be able to obtain coverage through the Plan.

5. What is the scope of the Plan's coverage?

The Plan provides medical professional liability insurance on an occurrence basis for loss, expense, and liability resulting from errors, omissions, or neglect in the performance of any professional medical service. Coverage will be available for medical groups (partnerships and corporations) under certain circumstances. The minimum limits are \$100,000 per occurrence and \$300,000 annual aggregate. The maximum limits under the Plan are \$200,000 per occurrence and \$600,000 aggregate for all claims in any one policy year.

By law, the Plan is limited to writing only professional liability coverage, for health care providers as defined by Administrative Rule, Ins 3.35. Ancillary coverage, such as general liability coverage, may be written by the Plan for hospitals only.

6. How can an exact premium quotation be obtained?

A completed application to the Wisconsin Health Care Liability Insurance Plan must be submitted to the Plan administrator. A letter of quotation will be forwarded indicating the appropriate premium charge.

7. What is the earliest effective date of coverage under the Plan?

If requested by the applicant, coverage can become effective at 12:01 a.m., standard time, the day following receipt of payment in full of the quoted premium or the agreed down payment if the premium is financed.

8. Physicians and surgeons are rated by type of practice in 7 classifications as follows:

Premium Class 1 - General Practitioners and Specialists hereafter indicated who do not perform obstetrical procedures or surgery and do not ordinarily assist in surgical procedures. Incision of boils and superficial abscesses or suturing of skin and superficial fascia are not considered as surgery.

Allergists
Cardiologists (not including catheterization)
Dermatologists
Gastroenterologists
Industrial Medicine Physicians
Internists
Neurologists

Pathologists
Pediatricians
Preventive Medicine Physicians
Psychiatrists
Public Health Physicians
Rehabilitationists--Physiatrists
Roentgenologists--Radiologists

Premium Class 2 - General Practitioners and Specialists hereafter indicated who perform minor surgery (including obstetrical procedures not constituting major surgery) or assist in major surgery on their own patients. Tonsillectomies, adenotomies and caesarean sections shall be considered major surgery.

Allergists
Cardiologists (not including catheterization)
Dermatologists
Gastroenterologists
Industrial Medicine Physicians
Internists
Neurologists

Pathologists
Pediatricians
Preventive Medicine Physicians
Psychiatrists
Public Health Physicians
Rehabilitationists--Physiatrists
Roentgenologists--Radiologists

Premium Class 3 - General practitioners who perform major surgery on their own patients or assist in major surgery on other than their own patients.

Specialties of Ophthalmology, Proctology, Cardiology, (including catheterization) and Emergency Room Physicians (who do not perform major surgery).

Premium Class 4 - Urologists and Emergency Room Physicians (who perform major surgery).

Premium Class 5 - Cardiac Surgeons, General Surgeons, Anesthesiologists, Otolaryngologists.

Premium Class 6 - Obstetricians - Gynecologists, Plastic Surgeons.

Premium Class 7 - Neurosurgeons, Orthopedists, Thoracic Surgeons, Vascular Surgeons, Weight Control Bariatrics.

Premium Class 8 - Osteopaths who only perform osteopathic manipulation.

A physician will not qualify for a General Practice category if he is a recognized surgical specialist who continues to do any major surgery.



State of Wisconsin OFFICE OF THE COMMISSIONER OF INSURANCE

Wm Sherman Dreyfus Governor

Susan Mitchell Commissioner 123 WEST WASHINGTON AVENUE MADISON WISCONSIN 53703-1001

AFFIDAVIT OF EXEMPTION

The basis for exemption is listed under 1-5 below. Please indicate the basis for exemption in the space on the Affidavit.

1. I, _____, certify that I am a registered physician, osteopath or podiatrist licensed by the State of Wisconsin and hold license # _____. I am filing this affidavit to obtain exemption from the mandatory insurance provisions of Chapter 655, Wisconsin Statutes. I am exempt under reason # _____ (below). I realize that by filing this exemption I am not entitled to any benefits or limitations provided by Chapter 655, Wis. Stats.

(Date) _____ (Signature)

(Street) _____ (City and State) _____ (Zip)

EXEMPTIONS

- 1. I do not expect to treat the sick in the State of Wisconsin for more than 240 hours during the period from July 1, current year, to June 30, next year.
2. I am employed by the state, a county, or municipality. I do not expect to have outside practice exceeding 240 hours during the period from July 1, current year, to June 30, next year.
3. I am a federal employe and covered under the federal tort claims act. I do not expect to have outside practice exceeding 240 hours during the period from July 1, current year, to June 30, next year.
4. I am a licensed physician and graduate medical student. I do not expect to treat the sick outside my training program for more than 240 hours during the period from July 1, current year, to June 30, next year.
5. My principal place of practice is not in Wisconsin. More than 50% of my hours of practice will be performed outside the State of Wisconsin during the period from July 1, current year, to June 30, next year.

EXHIBIT B



State of Wisconsin / OFFICE OF THE COMMISSIONER OF INSURANCE

Jim Doyle, Governor
Jorge Gomez, Commissioner

Wisconsin.gov

125 South Webster Street • P.O. Box 7873
Madison, Wisconsin 53707-7873
Phone: (608) 266-3585 • Fax: (608) 266-9935
E-Mail: Information@oci.state.wi.us
Web Address: oci.wi.gov

September 27, 2005

The Honorable Curt Gielow
State Representative
Chair – Medical Malpractice Insurance Task Force
316 N State Capital
Hand Delivered

Dear Representative Gielow:

When I appeared before the Medical Malpractice Task Force on September 8, 2005, I was asked about a LAB report. Let me take this opportunity to get back to you and the other members of the Task Force on the issue of the Fund being "overly conservative" in its reserving. On July 7, 2005, the Fund received the Tillinghast Second Opinion on the Milliman Actuarial Analysis as of September 30, 2004. That second opinion found the Fund reserve "to be reasonable, but conservative" [p.3]. The report also noted that conservatism is appropriate because; the coverage offered is unlimited; there is uncertainty with respect to investment results; there could be contingent liabilities; and if the Fund ran out of money there is no easy source of additional funds.

I would also like to take the opportunity to emphasize that the Fund has been a noted success in helping make Wisconsin medical malpractice market a viable environment where companies compete for business, doctors receive affordable coverage, and patients receive the protections. No other state in the union can attest to this success. Specifically:

- The medical malpractice marketplace in Wisconsin is the most stable anywhere in the country. Providers pay the least amount of premium, including Fund assessments, to receive the most coverage available anywhere in the United States.
- The approximately 20 companies now writing in medical malpractice coverage in Wisconsin create a competitive market for primary coverage. The first layer of coverage is available to any licensed physician practicing in Wisconsin at rates that are simply not available in comparable states.
- For patients who successfully prove a malpractice claim, (close to 90% of the claimants do not), the process of actually recovering an award is much more predictive than in other jurisdictions.
- Medical malpractice insurance is available to any licensed physician who wants to practice in Wisconsin. If a doctor cannot secure coverage in the private market, that doctor can secure first dollar coverage in WHCLIP, Wisconsin's residual pool.

The Honorable Curt Gielow
September 27, 2005
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- o During the past several years as other states have announced alarming rate increases and problems with availability of malpractice coverage, the assessments of doctors and other healthcare providers participating in the Wisconsin Fund have been reduced by 50%. Assessments have fallen from \$40 million to less than \$20 million in the last two years.

In 2005 the *Ferdon* decision removal of 'caps' on non-economic damages increased the exposure of the Fund to essentially unlimited liability for non-economic damages. The long-term cost of such increased exposure can be actuarially estimated and assessments adjusted accordingly to ensure adequate reserving for liabilities to be paid in the future. The Fund is well able to manage, through its contracted vendors, such a change in the risk environment.

It has been suggested that one option for a workable solution to continue to control the cost of medical malpractice insurance is that the Fund now begin coverage at \$500,000 per occurrence/\$1,500,000 annual aggregate. This would be a return to the coverage levels of the early 1990s. The threshold or point, at which the Fund starts paying claims, has increased over time. The threshold history is; \$200,000 (1975 – 1987); \$300,000 (1987 – 1988); \$400,000 (1988 – 1997); \$1,000,000 (1997 to present).

In the interests of finding workable outcomes let me observe that if \$500,000/\$1,500,000 were to be the statutory amounts now required, health care providers would obtain primary medical malpractice insurance from private insurance companies in those amounts. A reduction in the liabilities placed in the private market will not impact the administration of the Fund. As risk shifts to the Fund, payments to the Fund would increase while payments to private insurers would decrease. The bottom line for such a policy change is that the Fund through its Board of Governors has successfully made such changes before and has conservatively managed its reserves to ensure the continued financial viability of the Fund.

The Injured Patients and Families Compensation Fund has been remarkably successful in fulfilling the charge of supporting a viable medical malpractice environment in the state. As the Task Force considers alternatives, lowering the threshold to \$500,000/\$1,500,000, should be one option for the task force's consideration.

Thank you for the opportunity to speak to the Task Force. If you need any further information on the Fund please feel free to contact me.

Sincerely,


Jorge Gomez
Commissioner

EXHIBIT C

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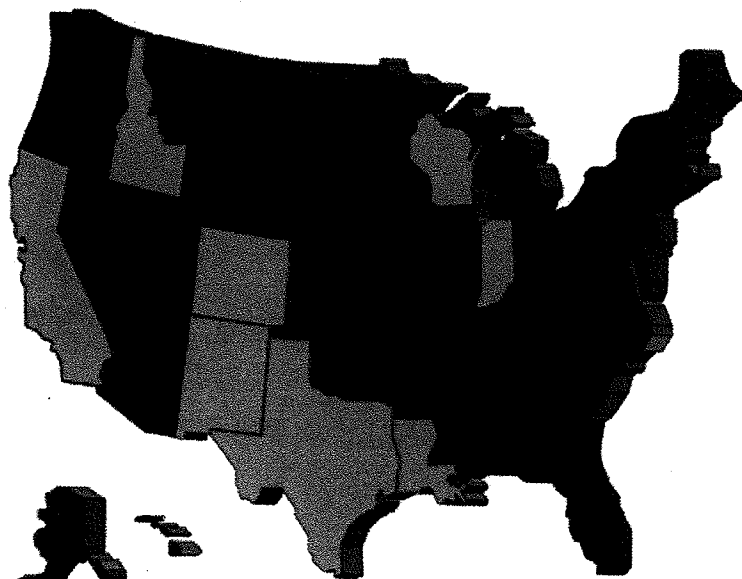
PROFESSIONAL ISSUES

State of liability

Quick View. March 5, 2007.

The AMA says four states have improved their liability standing.

■ Crisis states ■ Caution states; includes Guam ■ Stable states



The American Medical Association has updated its medical liability map for 2007. Arkansas, Georgia, Mississippi and West Virginia moved off the crisis list of states where medical liability insurance rates force physicians to retire early, eliminate high-risk procedures or leave the state. The number of states in crisis stands at 17, down from 21 a year ago.

Crisis states: Connecticut, Florida, Illinois, Kentucky, Massachusetts, Missouri, New Jersey, Nevada, New York, North Carolina, Ohio, Oregon, Pennsylvania, Rhode Island, Tennessee, Washington and Wyoming.

Caution states: Alabama, Alaska, Arizona, Arkansas, Delaware, Georgia, Hawaii, Iowa, Kansas, Maine, Maryland, Michigan, Minnesota, Mississippi, Montana, Nebraska, New Hampshire, North Dakota, Oklahoma, South Carolina, South Dakota, Utah, Vermont, Virginia and West Virginia. Also, Washington, D.C., and Guam.

Stable states: California, Colorado, Idaho, Indiana, Louisiana, New Mexico, Texas and

Wisconsin.

Source: American Medical Association

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