Wisconsin Doctors Feel Exposed by Loss of Cap

BY JENNIFER SILVERMAN
Associate Editor, Practice Trends

Christopher Magiera, M.D., said he paid $30,000 a year for malpractice insurance when he worked as a gastroenterologist in Cleveland.

Since his 2003 move to Wisconsin—a state known for its desirable practice climate, its tort reforms, and its cap on noneconomic damages—Dr. Magiera watched that premium shrink to about $5,000 a year, which included a contribution to the state's compensation fund for patients.

"Private insurers had been giving us low rates because they knew the medical liability environment was very stable," he said.

His premiums soon may go up again, due to a recent decision by the Wisconsin Supreme Court to remove the longstanding cap on noneconomic damages in malpractice cases.

The cap was instituted decades ago, but was reduced to $250,000 in 1995. With inflation adjustments, the cap had increased to $445,775 in 2005.

The case that killed the cap involved a patient who suffered a brachial plexus injury during birth, David Lowe, a partner with Jacquart & Lowe S.C., a Milwaukee firm that specializes in medical malpractice, told this newspaper. Although a lower court had sustained the cap, the Wisconsin high court ruled that the cap was unconstitutional beyond a reasonable doubt.

TALK BACK

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"We'll have to see what the climate does and how the situation changes," Mark Belknap, M.D., president of Wisconsin Medical Society, said in an interview. But without a limit on pain and suffering, physicians are already concerned that their future may involve higher claims and that plaintiff attorneys will be encouraged to file more lawsuits.

Like many physicians, Dr. Magiera and his wife, Pamela Galloway, M.D., a general surgeon, considered moving when malpractice premiums in their state shot up.

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Dr. Christopher Magiera, who moved to Wisconsin seeking lower malpractice premiums, hopes new legislation will restore stability.

Premiums in Ohio, a state the American Medical Association classifies as a "crisis state" for malpractice, were getting out of control, Dr. Magiera said in an interview. An insurance agent had told Dr. Galloway that her annual premiums were going to increase from $33,000 to $100,000.

"We didn't see a future in Cleveland. It was going to be economically unfeasible for my wife to maintain a profit, and while that's not what medicine is all about, you don't want to work for a zero balance, either," Dr. Magiera said.

Wisconsin, one of six states that the AMA classified as the best for tort reform, "had the most perfect of all conditions," he said.

The state requires that physicians carry $1 million worth of liability insurance, then contribute to a compensation fund for injured patients and their families.

"If you have a judgment against you, your insurance picks up the first million, and the fund picks up everything else," Dr. Magiera said.

A physician's contribution to the fund depends on the risk of the specialty, said Dr. Belknap, an internist in Ashland, Wis.

These favorable practice conditions had encouraged physicians to relocate to Dr. Belknap's town on Lake Superior. For example, "we recruited two general surgeons from states that didn't have good climates." Ashland had also acquired an ob.gyn. who practices obstetrics. "They wouldn't have come, had the caps been eliminated."

Shawn Hennigan, M.D., an orthopedic surgeon in Green Bay, is another transplant. In 2003 he moved from Pennsylvania, one of the liability hotbeds of the country, leaving behind a potential annual premium of $100,000.

But if claims and payouts begin to increase under this new ruling in Wisconsin, so will the premiums, Dr. Hennigan predicted.

The cap's elimination may change the way insurance companies approach these cases, Mr. Lowe said. "Until now, the insurers knew that the cap would be their worst day in court … and they'd force plaintiffs to trial, hoping there would be a result [that would be] less than the cap." Its elimination may not bode well for insurers, but from the patient's perspective, it means that meritorious claims will settle rather than being forced to trial, he said.

The cap's removal will also permit elderly, retired victims, who have less economic damages (such as wage loss) to have their cases accepted, "because their pain and suffering may now be compensated at a higher level." At the same time, attorneys may be more willing to represent these patients, because "the upside potential for compensation in these cases is somewhat greater," Dr. Belknap said.

Insurers are still assessing the situation, he said. However, "if the climate worsens, people reaching middle age or near retirement will retire early if they see the risks are going up."

Dr. Magiera said he isn't sorry he moved to Wisconsin. Because the tort reforms were approved more than a decade ago, the public in Wisconsin has not been culturally indoctrinated into the lawsuit mentality, he said. "I think there is the potential of restoring stability here."

Efforts currently are underway to have the cap reinstated.

Rep. John Gard (R-Peshtigo), speaker of the Wisconsin state assembly, recently formed a medical malpractice task force to examine the issue.

"This shortsighted ruling jeopardizes quality health care for every resident in the state, especially for folks in rural areas," Rep. Gard said in a statement. "Wisconsin was a nationwide model for medical malpractice reform. That law made us a destination state for good doctors. We will work hard this fall to regain that title."

The task force should come up with legislation in time for the fall session that would restore Wisconsin's reputation for quality health care, he said.

The key is to craft legislation that would pass the muster of the Supreme Court, Dr. Magiera said, adding that another option would be to push for a constitutional amendment that would allow reinstatement of the cap. ■

States Work on Expanding Health Insurance Coverage

BY MARY ELLEN SCHNEIDER
Senior Writer

NASHVILLE, TENN. — States' policy makers are looking for innovative approaches to expand access to health insurance.

"There seems to be renewed interest in trying to build on [employer-sponsored insurance]," Sharon Silow-Carroll, senior vice president of the Economic and Social Research Institute in Teaneck, N.J., said at the annual conference of the National Academy for State Health Policy.

Trends that have combined to spur action in this area include the decline in employer-sponsored insurance, the financial strains on state Medicaid programs, and the rising cost of health care.

States have responded with a number of different approaches:

► **Limited benefit plans.** Some states are allowing the sale of lower-cost, limited benefit plans and other options such as health savings accounts coupled with high-deductible plans.

► **Premium assistance.** Other states are offering premium assistance through Medicaid, State Children's Health Insurance Program (SCHIP), and other public programs. For example, Rhode Island offers subsidies and wrap-around benefits to those eligible for Medicaid and other state health programs. For those individuals who earn 150% of the federal poverty level or less, the state pays the employee's share of the employer-sponsored premium.

► **Reinsurance.** There has also been a lot of interest in reinsurance through indirect subsidies to employers and workers, she said. New York pays 90% of claims between $5,000 and $75,000 for eligible individuals.

► **State-negotiated health plans.** States are also using their purchasing power with or without additional subsidies to provide more affordable health insurance options.

► **Employer mandates.** State policy makers can also try to increase employer-sponsored coverage with mandates that require employers to cover workers or pay a fee to the state to arrange coverage. Such a proposal was recently defeated in California.

Such "pay-or-play" proposals "reemerge every few years in the states," Ms. Silow-Carroll said. "If a state is very serious about boosting [employer sponsored insurance] in a big way, a pay-or-play type approach really should be on the table as one of the options considered."

All of these strategies can stand alone but should be part of a comprehensive approach that deals with cost containment, cost issues, and quality issues, and various aspects of different uninsured populations, she said.

Strategies that build on employer-sponsored insurance have advantages for states, Ms. Silow-Carroll said, because they offer a way to expand access to coverage without the state bearing the full cost. For example, the Rhode Island premium assistance program allows the state to cover a family for half the cost under its traditional assistance programs like Medicaid.

But a key limitation, she said, is that under voluntary strategies there has historically been fairly low employer participation—especially among those employers who have never offered coverage in the past.

"To get them to take that step and actually begin to offer coverage, even if it's subsidized coverage, is a hard sell," Ms. Silow-Carroll said. ■