WiscRisk
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Injured Patients & Families Compensation Fund



INJURED PATIENTS AND FAMILIES COMPENSATION FUND CLAIMS EXPERIENCE

By Jeff Kohlmann, Director, Injured Patients and Families Compensation Fund

The Injured Patients and Families Compensation Fund's (Fund) mission is to provide excess medical malpractice coverage to Wisconsin health care providers and to ensure that funds are available to compensate injured patients. The Fund was created by legislative enactment in 1975. Health care providers obtain primary medical malpractice insurance from private insurance companies in an amount required by statute.

Participation in the Fund is mandatory for physicians, CRNAs, hospitals, Ambulatory Surgery Centers, and corporate entities providing the medical services of physicians and/or CRNAs. As of June 30, 2013 there were approximately 15,700 Fund participants.

The Fund is governed by a 13-member Board of Governors (Board). Administrative staff is provided by the Office of the Commissioner of Insurance. Fund staff consists of an Insurance Program Manager, and six full-time employees. Staff ensures compliance with primary insurance requirements, billing and collection of assessments, and claims oversight. The Fund contracts with outside vendors for the following services: Claims Administration, Actuarial Services, and Risk Management. Investments are managed by the State of Wisconsin Investment Board based on guidelines approved by the Board of Governors.

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

The 13-member Board of Governors is chaired by the Commissioner of Insurance or his/her delegate. The Board membership is comprised of:

- Three insurance industry representatives appointed by the Commissioner of Insurance
- Four public members appointed by the Governor (at least two of whom are not lawyers or doctors and are not professionally associated with any hospital or insurance company)
- One member named by the Wisconsin Association for Justice
- One member named by the State Bar of Wisconsin
- Two members named by the Wisconsin Medical Society
- One member named by the Wisconsin Hospital Association

A list of the current Board can be found at www.oci.wi.gov/pcf

In order for a claimant to recover from the Fund, the Fund must be a named defendant in the action and the health care provider or entity a participant in the Fund. Since the inception of the Fund in 1975 through June 30, 2013, there have been a total of 5,906 claims filed in which the Fund was named. During this period, the Fund has paid a total of 665 claims or 11.3% of all claims filed. The total amount paid for as of June 30, 2013 was approximately $833 million. Also during this period, the Fund closed 5,110 claims or 86.5% without payment.

The Injured Patients and Families Compensation Fund contracts for claims management services. The Claims Committee of the Board oversees issues involving claims and makes recommendations to the Board regarding claims handling policy and procedures. The contractor performs the day to day monitoring of cases and reports on a quarterly basis to the claims Committee.

The process for handling claims is:

1. The Fund is named in the suit by the plaintiff, which is served on the Fund
2. The Fund verifies whether the provider(s) named in the suit had Fund coverage at the time of the claim incident
3. The claims contractor establishes claim files
4. The claims contractor, with approval from the Fund director, hires outside Counsel
5. The claims contractor monitors the case progress with defense counsel
6. The claim is either settled through negotiations with the plaintiff or is decided at trial

Not all reported claims result in loss payments by the Fund. As previously mentioned, approximately 86% of the Fund's closed claims have resulted in no payment. Claims may be closed with no Fund payment for various reasons including:

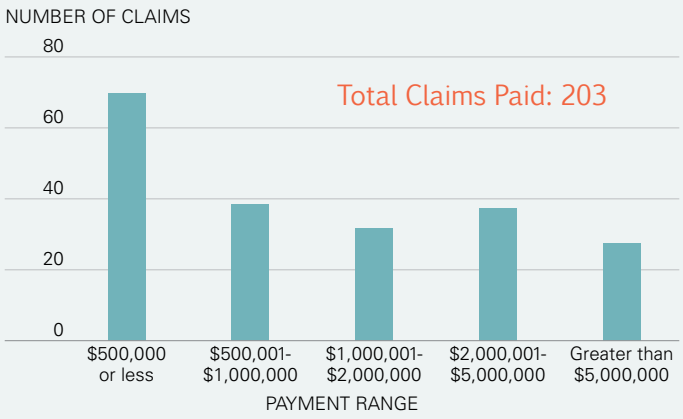
- Dismissal of claims lack of negligence or causal negligence, or plaintiffs did not pursue case
- Defense verdicts at trial
- Claim settlements negotiated within the underlying insurer limits

The Fund's experience at trial as well as claim settlement history for Claims over the last five fiscal years is reported below. Trial losses may result in no Fund payment (verdict within primary carrier limits). Settlements represent cases negotiated to resolution out of court.

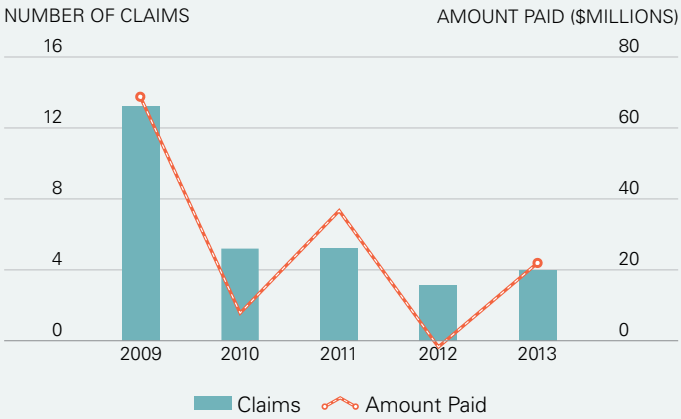
- 19 – Settled with Fund money
- 50 – Tried, Defense Verdict
- 13 – Tried, Plaintiff Verdict
- 68 – Settled within Primary Limits

Fund claim payments can vary widely due to various factors, including the unlimited nature of the Fund; the severity of the patient injuries and; the primary insurance limits in effect at the time of each incident.

Range of Fund Claim Payments July 1, 1996 – June 30, 2013



Number and Amount of Losses Paid by Fiscal Year



The frequency and severity of claims paid by the Fund on behalf of hospitals, physicians and clinics from 2009 – 2013 are shown below.

Frequency and severity of Claims Paid 2009 – 2013

FISCAL YEAR	HOSPITALS		PHYSICIANS		CLINICS	
	Claim frequency	Amount paid	Claim frequency	Amount paid	Claim frequency	Amount paid
2009	3 Claims	$23.0 M	9 Claims	$40.2 M	2 Claims	$2.5 M
2010	0 Claims	$0 M	5 Claims	$7.1 M	0 Claims	$0 M
2011	1 Claim	$4.9 M	4 Claims	$32.5 M	0 Claims	$0 M
2012	0 Claims	$0 M	3 Claims	$1.4 M	0 Claims	$0 M
2013	2 Claims	$9.3 M	2 Claims	$4.7 M	1 Claim	$9.6 M
Totals	6 Claims	$37.2 M	23 Claims	$85.9 M	3 Claims	$12.1 M

Claims are generally reported to the Fund six months to three years after the incidents giving rise to the claims occurred. The applicable statute of limitations determines the deadline for filing a medical malpractice action. The table to the right summarizes claims reported to the Fund by fiscal year since 2009.

FISCAL YEAR	NUMBER OF CLAIMS REPORTED
2009	90
2010	105
2011	74
2012	57
2013	75

It should be noted that payments reported in this article are Fund payments only, the stated amounts do not include payments made by primary carrier.

The following tables summarize claims paid during fiscal years 2009 – 2013. The payments reflect Fund payments only and do not include payments made by primary carriers.

Fiscal Year 2009 Claims Paid

$16,050,000	Settled	Negligent surgery – child – permanent brain damage
$9,447,370	Verdict	Negligent labor & delivery – brain damaged Infant
$8,563,200	Verdict	Neurotoxin injected into spine – adult
$5,000,000	Settled	Negligent labor & delivery – brain damaged infant
$5,000,000	Settled	Negligent brain surgery – adult
$5,000,000	Settled	Negligent labor & delivery – brain damaged infant
$3,250,000	Settled	Post MVA failure to diagnoses spinal fracture resulting in permanent injury
$2,948,220	Verdict	Post MVA negligent treatment – adult – resulting in amputation
$2,500,000	Settled	Negligent treatment – adult
$2,500,000	Verdict	Failure to timely diagnoses stroke
$2,000,000	Verdict	Deferred payment from 2008 claim
$1,900,000	Settled	Negligent spinal surgery
$1,500,000	Settled	Negligent back surgery
$43,121	Verdict	Failure to diagnose cauda equina

Fiscal Year 2010 Claims Paid

$3,803,627	Verdict	Failure to timely perform C-Section – brain damaged infant
$1,515,542	Verdict	Negligent treatment – adult – respiratory arrest
$1,250,000	Settled	Failure to timely diagnose cancer – adult
$341,927	Verdict	Negligent treatment – psychiatric
$200,000	Settled	Negligent treatment – adult

Fiscal Year 2011 Claims Paid

$22,000,000	Verdict	Negligent labor & delivery – brain damaged infant
$5,200,000	Settled	Misdiagnosis of brain bleed – brain damaged adult
$5,000.000	Settled	Negligent labor & delivery – brain damaged infant
$4,919,257	Settled	Medication error/overdose – brain damaged adult
$250,000	Settled	Negligent epidural injection – paralysis adult

Fiscal Year 2012 Claims Paid

$1,011,185	Verdict	Failure to diagnose impending stroke/informed consent
$280,269	Verdict	Failure to diagnose resulting in stroke
$85,000	Settled	Medication error/overdose – adult

Fiscal Year 2013 Claims Paid

$11,978,490	Verdict	Negligent management of birth – brain damaged infant
$6,891,000	Settled	Improper performance – brain damaged adult
$4,500,000	Settled	Failure to timely perform C-section – brain damaged infant
$200,000	Settled	Failure to treat fetal distress – brain damaged infant

About WiscRisk

WiscRisk is published quarterly and circulated to more than 15,000 healthcare providers statewide. Designed to keep readers informed of trends in liability claims and loss prevention, this publication is prepared by the Risk Management Steering Committee for the Injured Patients and Families Compensation Fund.

Articles published in WiscRisk contain the expressed opinions and experiences of the authors and do not necessarily represent the position of the Injured Patients and Families Compensation Fund. Authors are required to make disclosure of any relevant financial relations, which may be related to the subject matter discussed. Authors have made proper disclosure and have no relevant financial relationships that exist now or in the past 12 months.