Wyoming Healthcare Commission Meeting
August 25, 2003
Casper, Wyoming

Attendance: Chairman Chris Muirhead, Commissioners George Bryce, Ford Bussart, Carol Jenkins, Paul Lang, Dixie Roberts, John Vandel, and Dr. Robert Volz, Ex Officio Commissioners Ken Vines and Fran Cadez (designee of Dr. Deborah Fleming), Director Diane Harrop, and Assistant Emily Quarterman.

The meeting called to order by the Chairman at 8:39 a.m.

Introductions were made.

Presentations:

Dr. Robert Monger, Vice Chair, Wyoming Medical Society said the American Medical Association is the nationwide political organization for physicians. Tort reform is the number one political issue for physicians right now, he said. Malpractice tort reform has widespread support nationally, but it's controversial as well. President Bush and Vice President Cheney and Wyoming's congressional delegation support tort reform, he said. Dr. Monger provided the criteria for AMA states in crisis, which include patient access to healthcare, physician supply and medical malpractice insurance availability. According to AMA criteria, Wyoming is a state in crisis. Wyoming is the most recent state to be designated in a crisis, joining 18 other states. Wyoming is really an island in the intermountain West; none of our bordering states are in crisis, according to the AMA.

Physicians wind up leaving states in crisis for states not in crisis. Wyoming doesn't have very many doctors per capita – we rank 47th. In a rural community when physicians leave, it's a big deal. A lot of doctors in Wyoming are on the verge of retirement – 20 percent are over the age of 60. Physicians in Wyoming can still get medical malpractice insurance but Wyoming physicians pay much more than their peers in other states. One doctor who has left Wyoming paid $94,000 per year for medical malpractice insurance here. He went to Minnesota where he will pay $5,000 year for medical malpractice insurance. Another doctor paid $52,000 in Wyoming and went to Colorado where he pays $8,000 for medical malpractice insurance. It's difficult to recruit physicians to Wyoming – we have to try to find people who want to live in a rural area. Doctors make less money here; Medicare pays rural physicians – who have higher overhead -- less than urban physicians. That's a lot to overcome when you're trying to recruit somebody. As a rheumatologist in Cheyenne, Dr. Monger said he could move to Ft. Collins pay about one-third of what he pays in Wyoming for medical malpractice insurance.

The AMA's crisis designation will generate a lot of negative national publicity for Wyoming. All physicians in the country get the AMA crisis map; recruiting is more difficult when they see the state contacting them has been declared to be in crisis. In a way, Dr. Monger said, we're at a crossroads for malpractice insurance in Wyoming. If things don't change, we'll look back in two or three years and say, "when the AMA

designated us a crisis state, things went from bad to worse." On the other hand, if things do change, we'll say, "that was the best thing that ever happened because things changed." If the national publicity generates attention and helps change things, that might be a good outcome.

We are surrounded by states that have enacted effective tort reform, so we are ripe for change. All those states came through a crisis like Wyoming's, but now none of them are designated by the AMA as being in crisis. Colorado's tort reform has been the most effective. Look at the states surrounding Wyoming see what they've got and see how well it's worked. They've all done tort reform before we have. A federal government study has shown states that have tort reform have more physicians per capita than those that don't. Without tort reform, it's harder to keep insurance companies in Wyoming. Another national study showed it's not profitable to underwrite insurance in Wyoming. Without a federal overriding mandate, some states like Wyoming have fallen off the cliff and are in bad shape. It would be nice to have federal overriding legislation. But I don't mean to imply that we should wait for a federal solution. I encourage the commission to look hard at this issue and come up with some Wyoming-specific solutions.

Ex-officio Commissioner Vines asked Dr. Monger about the AMA map showing states in crisis, noting that all the states surrounding Wyoming except Colorado are states showing problem signs despite not being in crisis. Those same states have caps on damages. What is the basis of AMA's determination that a state is showing problem signs? Dr. Monger said for rural states, patient access is a major part of it. Some states --South Dakota is one -- have caps, but obviously that's not the only component of what prevents a state from being in crisis. Commissioner Volz asked about mandatory review panels, which he noted have been struck down as being unconstitutional in the past. But if such an obstruction could be set aside, how would you rate mandatory review panels vs. caps? Dr. Monger said that he thinks they're both important. One thing we need to improve on is preventing errors. The problem with the malpractice climate in Wyoming is that if a physician makes an error that injures a patient, it's in his professional interest not to tell anyone. The problem then is that a lot of errors don't get reported. We should all want a system that encourages error reporting so they don't happen again. Ideally you want a liability system that is fair, uniform, and predictable. The problem with the jury system is that lots of times, jurors don't have a medical background and can't determine whether medical malpractice has occurred or not. Professional juries could make that determination, however. We want a malpractice system that is efficient in time and money.

The overhead for malpractice insurance is over 50 percent; not many dollars paid for insurance premiums wind up in the hands of people who have been harmed, Dr. Monger said. It takes a long time for cases to resolve. The results are not predictable. One jury might award lots of money to one person while another jury might award very little money to a plaintiff for the same thing. The Wyoming Medical Society's proposal is not to cap economic damages (such as time lost from work, medical bills incurred). The problem with pain and suffering awards is that they are arbitrary. The reason caps work is that they even out the awards. The WMS also recommends some kind of guidelines for

pain and suffering awards. Commissioner Bussart: Has the AMA articulated a set of objective criteria that when added together that constitute a crisis? Dr. Monger: The AMA does not use a mathematical formula, it uses measures of patient access, physician supply, and insurance availability as its primary indicators of a crisis. Commissioner Bussart: Is it your belief that the fact that your premiums in Cheyenne are three times higher than what you would pay in Colorado is solely because Colorado has caps on damages? Dr. Monger: I do believe that. If you want to buy a life insurance policy good for $250,000, it costs a whole lot less than if you want to buy a $1 million policy. Malpractice insurance is really not much different than that. In Colorado, because of tort reform, a doctor can't be sued for more than "x" amount; in Wyoming, there is no limit on the amount you can be sued for. The cap translates into lower insurance costs. There are some small differences between Wyoming and Colorado, but much more than 90 percent of the problem is the tort system in Wyoming.

Commissioner Vandel: You mentioned the reluctance of physicians to come forth if there is an error -- what is needed to change that to get the physician to come forward and be open about it? Dr. Monger: It's tough if you make a mistake to tell people. Physicians want a good medical system, too. They want a system that corrects itself. The most interesting idea that I've seen is Wyoming Sen. Charlie Scott's idea for a medical error panel. But if you want to quickly get to the heart of problem and fix the malpractice problem, look to other states surrounding Wyoming and think about moving Wyoming from a bottoming state to a state that's doing okay to one that's going to leapfrog a lot of other states and be a leader. Look at a medical errors commission based on a worker's comp system. Physicians could report errors and not be held personally responsible. Commissioner Bryce: Is there proof that the number of medical errors have gone down in some other these other states once they've enacted this? Dr. Monger: There's no data that's looked at that one way or another.

Commissioner Bryce: If tort reform were adopted, could a managed care system be adopted at the same time? Dr. Monger: Possibly. There are a lot of challenges in rural settings for managed care, but tort reform might help. If you look at who doesn't have health insurance in the United States, it's the working poor. People who are poorer than the working poor qualify for Medicaid, while people over 65 qualify for Medicare. People who are in a higher economic bracket generally have employer-provided insurance. It's the working poor, people who are working for an hourly wage that's minimum wage, who don't have insurance. For example, rheumatoid arthritis is a fairly common condition. In recent years there has been state-of-the-art medicine that allows prevention of the disabling nature of the disease, but can't reverse the disability once it occurs. I have a patient who's a woman in her 30s who worked at McDonalds about five years ago and didn't have health insurance. She now has permanent deformities because she couldn't afford the medication needed to prevent the arthritis from progressing. She didn't qualify for Medicaid because she worked. Her employer didn't provide insurance. Now she's disabled and just qualified for Social Security Disability Income and Medicaid. It's a personal tragedy for her. Had she had health insurance, she would have normal hands. Now the state will pay a whole lot of money to her for her medical care and disability. As a taxpayer, it makes me angry that our system works like that.

Commissioner Lang: AMA's maps show that six of seven states with tort reform are having problems, and six states with tort reform are in crisis – in other words, 25 percent of states with tort reform are in crisis or show some signs of it. Dr. Monger: I would agree there is more than one issue that puts a state in crisis. If you look at the micro-package from California that's proven to work -- caps are an essential part but not the total package. Wendy Curran, Executive Director of the Wyoming Medical Society: Some of the companies providing medical malpractice nationally withdrew from the market after going bankrupt, diminishing the availability of insurance – and that impacted whether states are in trouble or crisis using AMA's classification system **(Wyoming Medical Society handouts: Wyoming Medical Society.pdf, WMS2.pdf)**

Senator Craig Thomas said that all Americans want "Cadillac" health service. In underserved areas, there may be some places that are always underserved because of low populations with long distances between them. For them, we need a system of health care delivery because we're not going to have everything in every town. There has to be coordination to move that care into underserved areas. The same is true with competition for insurance; Wyoming's small population isn't as interesting to insurance companies as other markets. Delivery of health care to our aging population is costing more. The biggest increase in medical costs is the equipment we are using now. I've heard that an MRI in Douglas costs $900, while in Casper, the same procedure is $500. That's probably an expensive machine not used as much in Douglas. There are good reasons we live here, but our low population brings us a few problems. We are unique. We have to work together. The federal government isn't going to solve all our problems; it's responsible for Medicare and Medicaid. The percentage of the population enrolled in Medicare is about 13 percent in Wyoming, which is comparable to national rates. Most people are not in federal programs.

There are caucuses in the Senate and the House looking at rural health care. I've introduced legislation this last year that addresses rural health clinics, ambulances, and hospitals, most of which is in the Medicare bill. That bill is now in committee, where they're trying to resolve differences over Medicare and pharmaceuticals allocations. If passed, the bill will provide $56 million for hospitals in Wyoming over 10 years. The bill lowers the labor-related share of the wage index from 71 percent to 62 percent; because of low numbers, our health care per person is sometimes more expensive than in urban areas. The proposed "hold harmless on outpatient" payment system creates new payments for hospitals with low volume. The Critical Access Hospital program is strengthened in the legislation. That will provide flexibility on the 25-bed limit for acute and swing beds. Payment equity for rural physicians increases the payment bonus to physicians providing healthcare in underserved areas. Congress's goal is to reduce the 2,800 areas of the nation that are classified as underserved. Medicare will require the Centers for Medicare and Medicaid to automatically give eligible providers the 10 percent bonus, if the bill is passed.

Medicare reform is a very difficult issue. The allocation for pharmaceuticals alone in the Medicare bill is $400 billion, to be spent over 10 years. Congress is trying to do some

things over time to phase in giving Medicare patients a choice between staying in the existing program and switching to a model akin to that provided to federal employees delivered in the private sector. The private sector-based model is a more efficient way of delivering Medicare prescription services. Right now, the elderly are not excited about that. If the new model is implemented, there would be a temporary Medicare program as a bridge between the new and old systems. Congress is also interested in attempting to change the direction of Medicare coverage to include prevention, in order to deal with people before they get sick. Chronically ill Medicare beneficiaries use the majority of Medicare funding.

Concerning medical liability insurance, frankly it is disturbing when a doctor who lives in Cheyenne pays substantially more than a physician living just a few miles away in Ft. Collins. What would be the down side to tort reform, other than the lawyers' resistance? What's wrong with doing it, even if it's not going to be the resolution to the issue? A tort reform bill passed in the House, but it doesn't have to be a federal thing -- do it in Wyoming if you think it's good there. I guess it takes a constitutional amendment in Wyoming and that makes it more difficult to pass. The Attorney Generals wrote a letter saying they don't want to lose jurisdiction over association insurance, when we attempted to address the availability of that. In other words, there are always a lot of reasons things we think are good for health care that somebody else blocks. We need to take a long look at that. I don't know whether tort reform will pass through Congress or not. We're going to continue to work on that. We're also continuing to work on association health plans. The House has passed a bill but the Senate doesn't have a version. It seems to me again that one of the reasons in a low population state that we have we don't have the interest from insurance providers is that the volume isn't here. Blue Cross Blue Shield is set against association health plans but I think it's something we ought to talk about. Employees in small businesses may increasingly go without insurance because small businesses are no longer able to carry insurance. It seems like it's worth some scrutiny.

I hope we can do a little better job of educating people about some things they can do to take responsibility for their own health. The question of the uninsured is a tough issue. There is discussion in Congress about providing tax incentives that would make payment of insurance premiums tax free, with the belief that money would be set-aside by those who reaped the savings. However, many people who are uninsured are low wage earners and probably aren't paying taxes, so a tax credit is of no value to them. I have no objection to making insurance premiums tax-exempt, but I don't know that it would be a good solution. In terms of health care utilization, you see in Medicaid where the user doesn't have to pay much and there are no limits on using health care provided, instances of when a child has a headache, a hospital visit is made. There has to be some user co-payment in these programs. We're doing something with income levels in Medicare because some high-income people have an advantage over low-income people in the care that's accessible. But there's a limit to how much the federal government can provide.

Commission Chairman Muirhead: What is the current status of the Medicare prescription drug bill? Senator Thomas: It's in conference committee. There are fairly substantial differences between the House and Senate versions of the bill. Congress has a

commitment to doing something about access to pharmaceuticals. The controversy is centering on setting up alternative delivery system in the private sector. It's our intention, though, that if the private sector model emerges, to continue Medicare as is with a separate program for pharmaceuticals.

Dr. Mark Levine, Region VIII Centers for Medicare and Medicaid Services (CMS), Denver Regional Office, said the distribution of residents of Wyoming and the rest of the United States is similar, in terms of the number of people covered by employer-based insurance (58 percent), Medicaid (11 percent) and Medicare (12 percent). However, Wyoming has one of the smallest nonfederal physician-to-patient ratios in the country. This state has a slightly higher number of hospital beds per capita, but hospital admissions are low. Hospital emergency room visits are perhaps a little higher in Wyoming, but whether the difference is statistically significant is not clear. Wyoming has shown appropriate use of skilled nursing facilities, in relation to other states.

Medicare has grown considerably in recent years but the growth anticipated over the next 30 years is going to dwarf the growth we have seen before. CMS has recognized that there are more and more problems with the providers of health care not being as interested in seeing Medicare and Medicaid patients. In parts of Colorado and other parts of Region VIII (particularly rural areas), providers of care have stopped seeing Medicaid patients. Some areas are in crisis. It's understandable -- why should they have a limit on the amount they can bill for services provided because the federal government compensates them at a lesser level than insurance companies? In addition, many fear being accused of fraud and abuse. In order to combat that fear, CMS is taking a more educational than regulatory approach to fraud and abuse. Some providers' perception is that Medicare is more burdensome in terms of documentation. They do have to justify the level of care provided but Medicare paperwork is no more burdensome than any other coverage provider. Physicians are required to document more, in general. CMS is making a point to host open door forums to encourage physicians, consumers, advocates and others to interact directly with staff. CMS has a physician team available to address regulatory issues that physicians feel are in the way of their enrollment in Medicare. A toll-free number is available in addition to World Wide Web access. CMS staff met 26 times in the previous year with different provider groups and others in Wyoming trying to understand issues here and how CMS and the state can best work together. CMS's state coordinator for Wyoming is Bernadette Quevedo-Mendoza, and her telephone number is (303) 844-7121. She has been an active player in Wyoming for many years. Lyla Nichols, also with CMS, said Medicare assures physicians that claims will be paid quickly – within 15 days if filed electronically and within 28 days if on paper. Hospital reimbursement is made based on a prospective payment system (PPS) or on a cost basis, depending on the hospital's classification and the procedure. Inpatient PPS is based on diagnosis while outpatient care is based on procedures done. Ms. Nichols talked about the different means of determining what health care providers and facilities are paid for the services they provide. Those delivering care in health professional shortage areas receive greater levels of compensation.

All of the institutions that provide care in Wyoming are enrolled in the Medicare program (can bill Medicare), Dr. Levine said, and all participate (accept the Medicare reimbursement rate). Virtually all practitioners are enrolled. Participation is optional. If they opt out, physicians can bill patients with Medicare who then have to collect from the federal government themselves. No providers in Wyoming have opted out. Most often CMS sees opt outs in large metropolitan areas where there are specialists with limited practices. Nichols said Medicare's structure was originally based on an insurance model but in recent years efforts began to add preventive care benefits. As the number of Medicare beneficiaries grows, disease management is increasingly a problem (diabetes, asthma, chronic obstructive pulmonary disease, coronary artery disease, obesity, depression, hypertension, end stage renal disease). The federal government is funding a number of demonstration projects on disease management.

Sophia Hinojosa, also of CMS's Region VIII office in Denver, talked about the different populations served and the services provided under Medicaid and the State Children's Health Insurance Program in Wyoming. She reviewed what other states are doing – including cutting back on services provided to offer some coverage to a greater number of people. In Utah, an employer-sponsored insurance component has been added that allows people to participate in some federally subsidized coverage if they pay an annual fee and their employers provide some funding as well. Commissioner George Bryce asked whose job it is to request a waiver. Ms. Hinojosa said it is different in different states – requests for waivers may be via the Legislature, or may go through a state Department of Health. CMS has waiver project officers who provide applications and guidelines. Once waivers are approved, they can be in effect for three to five years. They must pass through tests for cost neutrality or cost effectiveness prior to approval. Commissioner Dr. Volz asked how long the waiver approval process takes. Ms. Hinojosa said waivers are being expedited and some have been approved in two to three months. In the past two years, 90 days would be the average time. When a waiver application is submitted the CMS office has three months to review it. If CMS wants to make additions or comments, the three-month clock is stopped and negotiations begin. Commissioner Dr. Volz: Can waivers become permanent? Ms. Hinojosa: Some areas can, some can't. A lot of waiver programs are permanent, although that might change with Medicaid reform and greater future flexibility. The majority of the waivers have been in existence for over 20 years. They are renewed after three to five years. Commissioner John Vandel: Please elaborate on the employer-sponsored component that Utah has -- how many states are doing that? Ms. Hinojosa: The availability of that option has only been in place for about two years, so no more than 20 have started. They are available especially in those states have a lot of small businesses that struggle a lot with health insurance. Ms. Hinojasa said she would be happy to provide more information to the Commissioners, and encouraged them to visit the CMS web site, www.cms.hhs.gov, where information on employer-sponsored waiver components are detailed: click on Medicaid, click on waivers, click on the map which provides information on each state and waiver proposal listings. Commissioner Dr. Volz: What does Medicaid require consumers to pay, in the way of a co payment? Ms. Hinojosa: There are regulations that prohibit states from charging more than a $2 co-payment or 5 percent coinsurance. Some states have in times of budget crisis

switched from a co-payment system to coinsurance permitting them to charge more to the beneficiaries without changing the benefit package or eligibility group.

The State Children's Health Insurance Program (SCHIP) was created in 1997 and provides a higher level of reimbursement than Medicaid to encourage a greater number of states to participate. The federal regulations are minimal for enrollment: children have to be uninsured or can't be Medicaid eligible, cannot be residing in a public institution, and/or their parents must lack insurance. SCHIP's coverage must equal what a state's employees are offered. Commissioner John Vandel: There has been discussion about a waiver to include the parents of SCHIP children who are not covered by insurance. Is that possible? Ms. Hinojosa: Yes, a lot of states do these for parents, and especially pregnant women. The difference between Medicaid and SCHIP is that 10 percent more federal money is allocated for an SCHIP and states can waive SCHIP requirements to target almost any population. However, there has been some controversy about covering just adults with SCHIP money because of congressional intent: Congress passed SCHIP for children, not for adults, originally. Nationally, 80 percent of uninsured people work. Wyoming reflects that. Commissioner Carol Jenkins: Is there evidence of adverse selection within SCHIP? Ms. Hinojosa: Generally there is more adverse selection in Medicaid than in SCHIP. Medicaid children are poorer and uninsured longer, and then sicker. In our region, we haven't heard any concern about that. Wyoming's Kid Care is exemplary. Wyoming is participating in the Robert Wood Johnson initiative to enroll children in available health coverage and has been effective in outreach. Commissioner George Bryce: Have you seen combination of SCHIP and employer-sponsored insurance components? Ms. Hinojosa: Not in our region. Some states back East have seen that the Arkansas waiver certainly includes that, but just for the children's population. I could check for you. Commissioner George Bryce: Where does the coverage get provided -- under the employer plan or under Medicaid provisions? Ms. Hinojosa: Usually it is under the Medicaid package and the coverage provided is not usually the full Cadillac.

Dr. Levine talked about utilization review: CMS wants to pay the right provider for the right service to the right beneficiary. CMS does random reviews and focused reviews to detect problems in billing patterns or inappropriately billed procedures. Prospective payment turns utilization review back onto institutions themselves, in terms of reducing patients' length of stay. Inpatient hospital claims are reviewed not by fiscal intermediaries or by the carriers but by the quality improvement organization CMS contracts with. The questions answered in a medical review determine when Medicare pays for a new procedure or under what circumstances should Medicare pay for specialized care. For example, after medical review CMS has decided under certain circumstances to pay for controversial lung reduction surgery for people with emphysema. That has been controversial because the procedure costs $33,000 and will benefit only a minority of the people who have emphysema -- but for those people who benefit, the procedure is very important. Data analysis is to detect errors, but before taking administrative action, CMS embarks on a course of provider education and feedback. Dr. Levine talked about Leapfrog, a quality of care improvement organization. He said Leapfrog was started by a business coalition that launched a quality-based purchasing group contract for care with an eye toward requiring use of evidence-based

practices. Reporting hospitals perform procedures that they're equipped to do and are discouraged from doing just any procedure in order to be reimbursed. Leapfrog is not active in Wyoming because the organization considers the state's population base to be too small and there is no local champion in the state. However, hospitals can report themselves to Leapfrog, which will make that perspective available to the large national companies buying healthcare around the country.

The Administration has committed itself to providing choice to people on Medicare, moving from HMOs to provider options. The Administration is enormously supportive of efforts to make the performance reports from skilled nursing facilities, home health agencies, and hospitals more available. Efforts are being made to offer better benefits, including greater access to prescription drugs and to preventive care. CMS must address the long-term viability of its programs in relation to the anticipated vast increase in beneficiaries, however. The inevitable expense of providing better benefits has already squeezed an awful lot of the viability of the program, out of payments to providers, and that strategy cannot be maintained. Increasingly, there is a commitment to rewarding excellence in quality of care. A group of hospitals reporting on several defined measures of care have agreed to take money from poorer performing hospitals with which to reward hospitals improving on their performance. Greater attention is being given to prevention, to deal with chronic disease management. The Medicare population's average age is higher, as people are living longer, but 55 percent of Medicare costs are expended on 5 percent of the program's beneficiaries – usually at end of life. Commissioner Dr. Volz: It is my understanding that there's a different rate of reimbursement for sole community hospitals depending on the number of beds they have? Am I also correct in understanding that physician payments are being reduced? Dr. Levine: As the charges for physician care go up, then the amount of reimbursement per charge goes down. There are more and more costly high tech procedures in Medicare coverage. Conversion factor is being lowered to maintain budget neutrality. A 4.2 percent decrease in physician reimbursement is projected in 2004. However, the current bill that's before Congress in the conference committee having to do with Medicare modernization and prescription drug benefit has just a 1.5 percent increase in the House version while the Senate version simply says there will be no decrease. Where the conference committee is going to come out on that remains to be seen. In 2003, the physician payment was scheduled to go down but Congress intervened and it did go up.

Commissioner Bryce: I've heard the cost of Medicaid is $340 million a year. Are Medicare and Medicaid expenditures close to same number? Dr. Levine: Are you referring to the Wyoming expenditure? (Affirmed.) We can research that and get it to you by the end of the day. Nationally speaking ,Medicare is comparable to Medicaid. In terms of the growth of expenditure, Medicaid has been growing faster than Medicare. Medicare pays about 60 percent of all long-term care cases nationally. Ex-Officio Department of Health Commission Designee Cadez: Discuss the difference in reimbursement rate for practitioners who bill for services provided in Critical Access Hospitals. Ms. Nichols: None of it is happening in our region. The CMS bonus for CAH hospitals turned out to be a real administrative nightmare when it first was initiated. Hospitals' computer systems were not designed to handle the physician payment and all the little nuances like the

shortage bonus and how anesthesia is paid. Those things are getting ironed out now but that's why Critical Access Hospitals started to do that when it first was available then word got around it wasn't worth the hassle. It's getting a lot better now. Commission Chairman Muirhead: Explain the difference in reimbursement for Critical Access Hospitals. Ms. Nichols: Critical Access Hospitals receive cost-based reimbursement, not prospective payment. They also have the possibility of 115 percent physician reimbursement. Rep. Jerry Iekel: Clarify with regard to disease management, which seems imminently sensible, what's happening. Ms. Nichols: It's not a Medicare benefit except through demonstration projects. Rep. Iekel: With regard to the burgeoning elderly population that has chronic disease factors, is there any special attention paid to Alzheimer's, which has a tremendous progressive rate of increase in the next 25 years. Dr. Levine: There are some demonstration projects that address that population, which also is one ripe for disease management. I'm not sure they have started that yet or are simply in the proposal stage.

Jan Bloom of the Mountain Pacific Quality Health Foundation (QHF) said her organization is the quality improvement organization (QIO) contracting with CMS for initiatives in Wyoming, Montana, Hawaii and the Western Pacific. QHF was established in 1973 and works with health care organizations on improving quality of care in general but contracts with CMS specifically to ensure people with Medicare receive quality health care. The QIO also wants to ensure Medicare pays for services deemed reasonable and necessary. QHF is working primarily in Wyoming: nursing homes, home health agencies, hospitals, physicians' offices, and with underserved and rural beneficiaries. The organization's strategies include providing technical assistance to health care professionals and health care organizations. The goal of the nursing home quality improvement initiative is to collaborate with nursing homes to improve the quality of care in nursing homes by providing training to personnel. QHF is working on three quality measures in Wyoming: to reduce the percentage of long term residents with pain, reduce the percentage of short stay residents with pain, and reduce the percentage of residents with loss of activities in daily living. QHF is collaborating with home health agencies, training staff to discuss quality improvement activities, helping with outcome-based quality improvement reports, and helping them identify how they are doing in comparison to their counterparts in other states. They also are providing assistance with action plan development; 22 of 29 home health agencies in Wyoming have plans with target outcomes for improvement. Facilities welcome the QHF because individualized technical assistance is provided. The QHF has 38 physicians lined up to work on quality improvement in Wyoming and others have asked to participate in looking at quality of care measures. Presently, the QHF is working with physician offices to improve quality indicators in diabetes. The QHF is also working with consumers to help make them aware of their rights, provides materials to them to promote healthful lifestyles, and encourages utilization of preventive care. Other materials help people learn how to select a nursing home. The QHF uses health fairs and the Medicare web site to inform people about their medical rights. Health care organizations are being prepared for the federal requirement that their reports are to be made public; nursing homes' reports went public in November 2002, home health care agencies were made public as of October 2003, and hospitals' reports go public in 2004. Already, through the American Hospital

Association, 14 of 24 Wyoming hospitals have chosen to voluntarily share their data. Down the line, reimbursement will be tied to quality. Commissioner John Vandel: Many home health agencies went away in the last few years. How many are left in the state and how many are free standing (not connected to a hospital)?. Ms. Bloom: There are currently 29 active home health agencies in the state that we are aware of, with a third or less being attached to a hospital. **(CMS handouts: CMS.pdf).**

Tom Stroock, Chairman of the SPG Taskforce, chairman of the 1993 Healthcare Reform Commission, former U.S. Ambassador to Guatemala, and former Wyoming legislator, told the Healthcare Commissioners that they are about to embark on something very hard, challenging, absorbing, and beneficial to sick people. He said he first wanted to talk about the SPG Uninsured Task Force study being funded by a $1 million federal grant determine the best ways to extend health care coverage to the most number of people in Wyoming. Wyoming was one of 10 states chosen to do this kind of study. With our small population, we hope the $1 million goes further in Wyoming than it does in the other nine states conducting similar studies. The Uninsured Task Force has until March to make its report. The Task Force has contracted with the University of Wyoming and Wyoming health care providers to run an exact survey. The Health Reform Commission was forced to guess how much money we would have to spend per person for various kinds of treatments, how many would be covered, and how many would be eliminated. As a result of the current study, the Uninsured Task Force will know within 5 percent what it will cost to offer coverage. His main concern is that the Commission and Task Force don't duplicate each other's work. He asked the Commission to withhold work and judgment on how to increase the access of Wyoming residents to healthcare insurance and medical treatment until the SPG report is made.

We think that for considerable numbers of people we don't have to change very much concerning the quality and the location of the health care delivered. We think that although access to healthcare is very much regional, the state through rural health development has expanded the physical side of the healthcare delivery system. The cost of health care, however, is driving people out of the system and raising insurance rates. Although this is Wyoming, we're going to have to make any system recommended a required system. Businesses will have to enroll. If we don't make insurance coverage mandatory; there are too many folks who think they are invincible and immortal and won't sign up for coverage, and too many businesses that don't want to take on the expense. Asking people to take on liabilities meets resistance, as does asking citizens to take on issues they haven't had to before. We need certain numbers of bodies in the system to spread the risk. Here in Wyoming, we're dealing with only 500,000 total people. We are barely a blip on insurance companies' radars and we have to get everybody in this together. We taking as our model for administration the worker's compensation commission that grew from the new worker's comp law passed within the last five or ten years. Worker's comp has demonstrated efficient and effective administration. If we were to combine the worker's comp administration with health care insurance and use it to contract with private industry, we could get many benefits to Wyoming health care.

Commission Chairman Muirhead: The Commission has no intention of duplicating or imposing on the good work the SPG grant is doing, and we look forward to hearing that report back. Commissioner Bussart: Who else will receive information that the Uninsured Task Force is generating? Mr. Stroock: The federal government. The guy with the gold makes the rules. The report is addressed to them, but the Task Force has promised the Wyoming Department of Health that the results will be forwarded to them so that they will have the information and be able to disperse it. We intend to inform every single legislator and we are going to make sure every one of you gets a copy. We want the largest circulation possible. I would think that certainly by December you all should know what we're recommending. Commissioner Bussart: What's the federal goal? Mr. Stroock: They're wanting various state recommendations to come into them. They are seriously considering using information states generate as a pilot for a federal government program. That's why we're so concerned that the Wyoming pilot be based on the best of information. Commissioner Dr. Robert Volz: Describe the legislative impact of such a recommendation. Mr. Stroock: I'm no longer a legislator but when I was there, I think they would have listened long and hard. Legislatures are interesting things; the mindset of 94 different people is reflected. I would think the effort put into this, the expertise being brought to bear, would cause people to seriously reconsider their beliefs, but beyond that I would dare not predict.

The Health Reform Commission had a fascinating and interesting time in the early 1990s. Much of what we thought would be accepted was not and what we thought wouldn't be, was. We came out with 49 recommendations. I would recommend the Health Reform Commission report (*available upon request*) to you as something to use as background. Of the 49 recommendations the Health Reform Commission made, 31 of them one way another have come to fruition. Our biggest failure was in tort reform. If you address it you will have the same sort of horrid fight we did. I hope you come out ahead if you address it. It's something that has to come. The cost of malpractice suits is unknown to insurance companies. The awards in Wyoming have not been out of line, it's the fact that when the insurance company covers somebody it doesn't know what might come down the road. If we have no limit on potential damage awards, the charge for medical malpractice coverage goes through the roof. Many attorneys -- the entire plaintiffs bar -- will oppose you with all its might, influence, and lobbying ability. I think you're going to have to persevere. I suggest to you that you have fallback positions that will not draw so much opposition. If you persuade the governor to take an active role and help push this thing forward, you will get a lot accomplished. If the governor is not interested, you will find yourself rowing upstream.

We recommended, and I suggest you consider recommending, that alcohol taxes be increased and specifically earmarked. Tobacco taxes were increased, as we proposed. But alcohol and drugs are an equal public health nemesis. They cause untold heartache, social costs, medical costs, out of pocket costs. They are destructive – not just in relation to impaired driving but also with respect to diseases. The increase in tax is not to raise money because it won't raise but a couple of million bucks, but in the context of changing behavior, it will make a difference. The libertarians among us believe you don't want to change behavior. I don't share that belief. I hope you, as members of the

commission don't share that belief. I think we have to change behavior. I think the best method in the health field we have is to tax alcohol. The Health Reform Commission also asked for a state government goal of universal health care coverage in Wyoming in seven years. That didn't happen. Mr. Stroock suggested that the Wyoming Healthcare Commission follow the Health Reform Commission's lead and also recommend universal healthcare coverage implementation within six to eight years.

He said the commission should attach timelines to recommendations and ensure that progress is made by overseeing action taken during the specified time allotments. There should be a continuing commission in place, he said. I don't care whether it's this commission or some totally separate commission, but some commission must do it. When we were addressing healthcare reform, we said, "sunset us, have a whole new group but have someone responsible." The more you can involve the Legislature in your results, the more successful you will be. We are least successful where we have not involved legislators. He noted that some successful Health Reform Commission recommendations didn't have the intended affect. For example, the Commission's call for providing for a health insurance purchasing cooperative was heeded. It's a mechanism that hasn't been used. There aren't very many HMOs in Wyoming. He advised the Healthcare Commission to look at how that mechanism could be strengthened and health insurance cooperatives could be effective in Wyoming, then. One place we thought we would score a big win and struck out was trying to improve physical education for youngsters. We recommended youngsters have a required PE activity five days a week. That surely hasn't happened. We recommended the state provide for nutritionists who would supervise the food kids take in every day in the school. That didn't happen. That doesn't cost the state much, but does cost the school districts. To provide for PE, the school districts have to pay. For better nutrition, they have to jerk out candy and Coke machines. Don't educate kids where the good nutrition lies while giving approval to that kind of nutrition in the schools. That's why children are obese and out of shape.

As Mr. Stroock reviewed his commission's findings, he noted that no change has occurred in the expenditure of the fund created to pay for the care of miner's sickened by their work. There's over $30 million in the Miner's Hospital Fund earmarked for a miner's hospital by the federal government, but there is no miner's hospital in Wyoming. Most Wyoming hospitals treat miners. In Sweetwater and Campbell counties, where most Wyoming miners reside, miners' diseases are now handled mostly through the regular medical system. The special needs of miners are no longer as dramatic or as drastic as they were in the era when the Miner's Hospital Fund was created. We believe that $30 million can intelligently be spent on health care, but thus far, the Legislature has been unwilling to reallocate those funds. The Health Reform Commission did not get the Legislature to change the status quo. Money keeps coming in while only small amounts appropriated out: $500,000 goes to Sweetwater County Memorial Hospital annually while Campbell County gets even less. That's money that's just sitting there. Now that isn't smart, especially in a state that needs to spend it on health care – spend it by changing one letter: minors' health, rather than miner's health.

The last thing is alternative dispute resolution, which is part and parcel to tort reform. There are ways of resolving disputes between medical deliverers and patients. The state needs to change the current rules so anyone requesting a hearing could get one, but that requires action by the Supreme Court, which has thus far been unyielding. If they don't become willing to make that change, let's have the Legislature mandate it and say they shall. This is not intervening with anyone's right to sue or appeal. Legislation should be passed that directs the legal system as follows: if someone asks for mediation or alternative dispute resolution, you *shall* do it.

Dealing with health care isn't going to make you politically popular, he told the current commissioners, in fact it ain't going to make you popular at all. But be assured that in a group like this, you will come out with the right decisions. I am absolutely positive a group of Wyoming citizens with your backgrounds will come up with something. Anything you do should and will be vetted by the governor and should go to the Legislature.

Chairman adjourned the meeting for lunch, 12:10 p.m.

Chairman called the meeting to order at 1:30 p.m.

Stephen Northrup, Sen. Mike Enzi's office, said Sen. Enzi wanted to be present but is in Africa because he worked on and voted for the landmark legislation to accelerate the fight against HIV/AIDS in Africa. He's in Africa to see firsthand the impact of HIV/AIDS in Africa and to make sure the taxpayers' money is spent wisely on a network to get the medication that helps stem the HIV/AIDS tide that is creating a generation of orphans in Africa. His goal is to keep mothers and fathers alive and keep families together, which results in a more stable Africa and a more stable world. Sen. Enzi wanted to appear before the Commission to talk about the Reliable Medical Justice Act he introduced. When I joined his staff in January, his top healthcare priority for this year was medical liability reform. The Patients First Act is still in progress in Congress and while Sen. Enzi continues to support that piece of legislation, he sees it as only a first step toward corralling the skyrocketing medical malpractice insurance premiums that are forcing doctors to move their practices to other states and that are endangering the availability of critical healthcare services in rural Wyoming. The Patients First Act was debated in July and a majority of senators voted to begin working on the bill. They will take up a new version of that bill in the fall, but the odds are stacked against it already – they'll begin the session about 11 votes short of those needed to shut down a bill-stalling filibuster. If Enzi has any criticism of the Patients First Act, it's that it's not audacious enough. If passed, it would help in the short term to stabilize premiums. However, even if we pass that bill, Sen. Enzi thinks we leave a fundamentally flawed system in place. Compensation is neither prompt nor fair. Some injured patients get huge jury awards while other patients get nothing at all. A series of studies found only 2 percent to 3 percent of those injured ever filed a claim. The same studies also found 80 percent of malpractice claims exhibit no evidence of malpractice. One of the studies followed a malpractice claims for a decade. The authors of the study found that in cases of no evidence of negligence, 43 percent got payment, while payment was made in only 56

percent of those cases where negligence was in fact found. While there are reports that somewhere between 44,000 and 98,000 deaths per year are caused by healthcare errors, the current litigation scheme does not provide equitable compensation or rational consequences what would serve as a deterrent to negligence. Most suits have no basis in a provider's negligence. There is no significant correlation between negligence and compensation. Tort reform alone cannot fix this. The best long-term answer to our current crisis is to create a more reliable system of medical justice, a system that is fair, predictable, and reliable for patients and providers. Justice is absent. The Reliable Medical Justice Act authorizes funding for states to test alternatives to their current medical justice systems. Sen. Enzi's intent is to foster rapid advances in healthcare by learning from system demonstrations. The intention is to create workable means of replacing tort liability with a patient centered, safety focused system. We can enable states to experiment with, and learn from long-term solutions – including a health care court, which would allow judges to make binding rulings on causation, compensation and an appropriate standard of care. Another option would be to offer medical providers immunity from lawsuits if they make timely settlement offers to patients for economic losses suffered as a result of negligence.

One thing is clear: people are demanding change. States are trying to change their medical liability systems. Congress ought to support states trying to do that. We have a constitutional limit on amounts that can be considered in compensation in Wyoming. Sen. Scott's bill would have created a commission on healthcare errors. Sen. Scott said one of his biggest obstacles was it was a new idea. No one had a schedule for compensation or knew how much such a system would cost. Sen. Enzi believes Congress ought to help develop thoughtful ideas. One reason he offered this bill is that he knows states have been policy pioneers in many areas. Medical litigation ought to be the next item for the "laboratories of democracy," as we like to call the states. Sen. Enzi's bill at its core aims to foster innovation. It can take a while for Congress to turn good ideas into laws -- probably because we have so many bad ideas we want to prevent from becoming law. I don't think it's reasonable to pass this bill and get this funded and to the states in the next legislative session. It is reasonable to expect it to pass in 2004, and it is conceivable by fall of 2005 fiscal year's start that Wyoming will have access to funding for development of these new approaches. Medical liability reform is not on the Senate republican agenda; there, the Patients First Act will get another try. Nonetheless, Sen. Enzi believes he can support tort reform and tort replacement in the long run. **(Text of Stephen Northrup's speech: Stephen Northrup.pdf)**

Kenneth Vines, Wyoming Insurance Commissioner: As directed by the Healthcare Commission, he undertook to locate an actuary who could assist us with the actuarial part of the study due to Legislature by Oct. 15. What the actuary is going to do is give us information on the types of rates that a joint underwriting association would have to charge in order to operate in Wyoming as another insurer selling medical malpractice insurance, or serving as an insurer of last resort if part of current market goes away. He recommended we hire Merlinos and Associates, Inc., of Georgia, which as done similar work for other states. The commission members were polled and agreed to approve this. We have informed Merlinos that we do want to hire them, and they are starting to request

information they'll need in order to conduct this study. We hope to have it done by the deadline.

Director Diane Harrop said that since the Healthcare Commission was just created and also since we had the deadline of Oct. 15 to report to the Legislature on the feasibility of a joint underwriting association, we were able to gain a bid waiver from state government and didn't have to go through entire lengthy process of doing this by bid. Future studies will not be subject to the same bid waiver. We do have a $25,000 ceiling and hope to come in under that. I have confidence we will. Ken Vines and the Wyoming Insurance Department will administer the contract with Merlinos and Associates. All Commissioners voted to consent to proceeding with Merlinos and Associates.

Commissioner Bryce motioned and Commissioner Vandel seconded to ratify the vote. Commissioner Bussart asked what the terms and conditions of the contract are. Ex-Officio Commissioner Vines said the contract is capped at $25,000 and he will keep an eye on costs. He has had some indications they're going to be able to complete the study for less than that but there is flexibility built into the bid. The contract is being drafted right now and will have to be approved by Commission Chairman Muirhead and the Attorney General's and Governor's offices. The contract will specify what the deliverables are. The contract is with the Commission, not the state Department of Insurance. Motion carried unanimously.

Ex-Officio Commissioner Vines provided basic education on what kind of data is received by the Wyoming Department of Insurance from medical malpractice insurance companies. More detailed information can be solicited from specific companies, however. Commissioner Vines provided numerous handouts **(Ken Vines.pdf)** detailing the profits and losses of the two main medical malpractice insurance providers in Wyoming (OHIC and The Doctor's Company) and Wyoming-specific costs. There are about 1,130 companies licensed to do business in Wyoming and each one files an annual statement -- which is public record. The same data is provided to the National Association of Insurance Commissioners in electronic format. It's many pages long and includes really detailed financial information on each company for that year. Discussion followed concerning what data the Commission needs, what is readily available from the Insurance Department and what will have to be requested from the insurance underwriters. Independent audits insurance companies are required to have also are submitted to state Insurance Departments. The insurance company statements show companies have lost money on underwriting but have made money on investments, which in the past gave them a net income. In 2002, their net investment gain went way down. By looking at that net income information you can see where the company made and lost their money and what their bottom line is in raw numbers.

You can see that OHIC lost about $9 million last year, but in the previous two years, they did make money. You can see that The Doctor's Company is a much larger company. OHIC lost $4.8 million in 1999 but made money in 1998. That's a way you can tell on a raw number basis whether they are making money in their business. On handout 1, line 26, on the left, that essentially is the surplus of the company. You can see that The

Doctor's Company has a $331 million surplus, down from the prior year's $380 million. They're required to carry a surplus because that's what they pay their claims from. Risk based capital is a complicated formula taking into account all the risks that company has. You can see that the Doctor's Company has a lot more surplus and is not apparently in any danger of being in financial trouble. OHIC is much closer to a risk based capital situation where their home state might take a look at their financial wellbeing. Commissioner Vandel asked if the same information could be obtained for COPIC, and medical malpractice underwriter registered to do business in Wyoming that is not underwriting here at this time. Commissioner Vines: I didn't check, but I should have that. I could get it for you. Commission Chairman Muirhead directed Vines to start a "to do" list of information to be gathered from insurance companies, including a breakout between jury verdicts and settlements that was requested by Commissioner Bussart. Discussion followed regarding what data the commission would like the Insurance Commissioner to gather and report back. Commissioners agreed that if they were able to develop a schedule that has this information on it, it would chart out what the situation is with regard to the claims in Wyoming. Commissioner Bussart moved and Commissioner Lang seconded a motion to have Commissioner Vines gather a set of data specific to Wyoming showing what it costs to do business in the state, what profits are generated and what is paid out in claims. Motion carried unanimously.

Comments from audience:

Brion Domman, of the Frontier Group, said his company represents 183,000 rural health care providers in all 50 states, Canada, Mexico, and overseas. On the health insurance side, his group has 10,000 covered lives. They also have a purchasing association with 700 to 800 covered lives, and members include the Wyoming Nursing Association. The number one concern we have here is health insurance. He said he and Casper attorney Rob Shively are writing a five-part article on medical economics, on what we see in medical malpractice. It is generally purchased through a healthcare association in a state. They sponsor a healthcare professional liability. The problem we see is often there is just one carrier of professional liability insurance. Competition lowers rates. In 1996, Mr. Domman went to the Wyoming Medical Society, he said, and proposed bringing in another carrier. He brought in OHIC and tried to sign up providers, reportedly offering savings of $25,000. They told us to take a hike. Those same providers are calling us now. In 1996, the average obstetrician/gynecologist was paying $55,000 for medical malpractice insurance coverage. We lowered that premium to about $24,000. Now what has happened is, those rates have gone up just like all other insurance products have gone up significantly. Yes, we do have a crisis. Yes, there are fewer carriers. Competition will help solve the problem. One solution is to increase patient satisfaction with their healthcare providers. Satisfied patients are less likely to sue. Another solution is education -- review patient charts to make sure there is informed consent. The Frontier Group offers risk management seminars teaching those techniques. Commissioner Bussart: Explain to me why someone offered a $25,000 savings on insurance costs would tell you to take a hike? Mr. Domman: We had them. In Wyoming as you know, things happen slowly here.

Craig Smith, Orthopedic Surgeon, said it appeared that the Commission is focusing on The Doctor's Company and OHIC, when making data requests. He said the focus should equally be upon determining why other companies don't want to be underwriting in Wyoming. Answer that question -- on why there's no competition. If this were a great place to write insurance, they'd be looking at us. Those questions you asked seemed appropriate but you have to look at why the other companies are not here. From a personal level, this is a big deal. He said his practice sent out 30 letters in effort to recruit a surgeon, but no one's interested in coming to Wyoming. We were successfully able to recruit one physician but we need another one and 30 letters netted no responses. He said although physicians in the past were offered lower cost insurance via Brion Domman's efforts, they rejected that product because they wanted to be able to trust that insurance would continue to be available to them over time. Cost is important but the ability to keep insurance is more important. At some point, the lines are going to cross. It doesn't matter what the insurance costs, if insurance companies won't write it for you, you're out of luck. A lot of people who had been with The Doctor's Company were reluctant to save money for something that was unknown. Our group decided because of the difference in price to switch to OHIC. They may regret it, he said, since The Doctor's Company now appears to be more financially viable than OHIC.

Eric Munoz, a Casper cardiac surgeon, said when tort reform legislation failed this year, he felt personally slighted by the fact that our society cares so little for us that they can't pass some legislation that would help us out. I think personally in Casper we provide excellent care. You don't have to go anywhere else to get good care in this state. We're going to have to do something to turn the scenario around for us if you want to keep physicians in the state. There are multiple examples of physicians leaving the state because they can't get medical malpractice insurance – if you get sued, a lot of times the insurance companies will drop you. He said he also wanted to address physician and hospital reimbursement for care provided. He sits on the executive cardiac steering committee for Wyoming Medical Center and we cover issues such as how much it costs us, and how much we charge vs. what we expect to get back from Medicare. Somehow the numbers are not adding up. This is going to have to be addressed. To give you an example, the average cost for a heart bypass was $44,000, while reimbursement was $22,000. Costs are 60 percent of what the charges are. We are still losing about $6,000 a case. That doesn't address elaborate procedures. It's a real concern in terms of how we're going to stay in business without laying off employees. It's something our hospital deals with every day and something this Commission might want to address. Commissioner Vandel: Has your hospital compared its charges to those of other hospitals in like areas? Dr. Munoz: Some of that has been done. We have a problem with volume in a rural area -- there's a certain amount of fixed costs just to run the program. It's hard to recoup costs in Wyoming. I think that's a problem with every hospital here doing specialized procedures – there's a volume issue. I don't know if there's any compensation for that.

Kathy Delisa, an advocate for not capping medical liability damages via tort reform, told the story of her 5-year-old daughter's medical journey through multiple surgeries in another state for a cranial deformity that resulted in long-term illness and eventual brain damage. Her child is going to be uninsurable for the rest of her life, Ms. Delisa said, and

has incurred $500,000 in medical bills. But there is no reason for the medical care delivery system to take responsibility for her child's problems – in order for that to occur, the family must prove in court that something went wrong, she said. Ms. Delisa asked the Commission to allow the medical liability system to remain as is, thereby permitting people who sue to receive unlimited jury awards for economic damages and pain and suffering.

Dr. Hugh DePaolo, a Casper obstetrician/gynecologist said he has been dramatically affected by the medical malpractice crisis. Physicians still feel they're accountable for patient care, and accountable for outcomes. They're not asking to have patients' ability to sue removed. He has had suits filed in last year that rendered him uninsurable, even though there's been no settlement nor has he gone to court over claims. His insurance cost has nonetheless increased more than 300 percent. I have a fairly large practice, Dr. DePaolo said, and were he to stop practicing, many women would simply be without a doctor in Casper because there aren't enough others to pick up more patients. What's happening is, physicians are being put out of business because they can't afford malpractice coverage. Everybody has a finger they want to point at somebody else. This is a monumental mess right now and it has to be fixed some way. There is an interesting story about a physician in Wyoming who dropped his malpractice coverage because he couldn't afford it anymore. He got sued. If we're talking about making someone accountable using the system available, the suit should have gone forward. But when the plaintiff's attorney found out that there was no money in the uninsured physician's pocket, he dropped that physician from the suit and went after the people who provided care to the same patient in Colorado.

If you look at the way this has to be dealt with, it has to be dealt with first on the physician level. We're seeing larger and larger settlements. I think if you take cases to court, the people in Wyoming are capable of saying wait a minute, wait a minute, this is not malpractice this is maloccurence. If you look at what the insurance companies pooh-pooh, and the trial lawyers, too, the question becomes: what are the settlements, we're talking *big* settlements. The physicians won't talk about settlements because we're bound by our settlements not to talk about it. This is going to be resolved only if the trial lawyers sit down with physicians and legislators to come up with ways to work on this. There are some other steps that states have taken that might help alleviate the pressure on the medical malpractice system in Wyoming, such as an obstetrician-supported fund to compensate families that have a "bad baby." It used to be that cerebral palsy was considered to be a birth accident, although science has shown in later years that there are many causes of cerebral palsy that begin well before birth. Nonetheless, the perception has lingered and in Florida, families with babies with cerebral palsy may apply to receive assistance with medical expenses, clothing and care from the obstetricians' fund.

We need a medical malpractice review board, Dr. DePaolo said, and not just physician board – a broad based board with people outside the profession represented. The decisions of that board should be binding. He served on a committee years ago that reviewed cases and at that time, though there were many suits brought against physicians, few went to court. Malpractice insurance companies have us over a barrel with a gun to

our head. Few of us will be able to stay and it's not because there are too few patients or the community doesn't want us to stay. Medicaid reimbursement is too low and that coupled with malpractice fees makes it impossible to stay in business. We've already lost one physician who moved to Minnesota, where his malpractice insurance cost dropped to about $5,000 per year. My perception is our state Insurance Commissioner is afraid to say anything. It's time to stop being held hostage. We need a self-insurance plan. If you look at the state of Wyoming, a large section of our economy is based on medicine. I'm asking you as a practicing physician who does a lot of primary care to really think about this wholeheartedly. We have to come up with a solution. I've been in practice since 1984 in Wyoming in Casper. I've seen the same issue come up three times and every time it gets pooh-poohed and swept under the carpet. Even the states with caps are having problems now. It has to do with, I guess, with us producing more lawyers then we are doctors because we're outnumbered in the state considerably. I think there are some real basic solutions.

Approval of July 28-29 meeting minutes: Commissioner Dr. Volz motioned and Commission Bryce seconded approval of the July 28-29, 2003, meeting minutes. No discussion. Vote unanimous in favor of approval of the minutes.

The Wyoming Health Care Commission's next meeting will be Monday, Sept. 22, 2003 in Casper. The Commission's health care access and tort reform/medical malpractice liability subcommittees will meet on Sunday, Sept. 21 in Casper, at the Parkway Plaza Hotel.

Meeting adjourned at 3:30 p.m.