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Injured Patients and Families Compensation Fund

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Introduction

The Injured Patients and Families Compensation Fund ("the fund") provides medical malpractice insurance to Wisconsin health care providers in excess of their primary coverage limits. Created in 1975 as the "patients compensation fund," the fund was renamed in 2003 as one of several changes to Chapter 655 of the Wisconsin Statutes.

State statute requires most physicians practicing full-time in Wisconsin, as well as many other health care providers and organizations, to participate in the fund. All fund participants must a have a primary layer of medical malpractice insurance coverage at least equal to the minimum set by law, and must pay an annual assessment to the fund. The fund provides the participating health care provider with unlimited medical malpractice insurance for claims in excess of the primary layer of coverage. Assessments paid by participating health care providers finance the fund.

This paper provides an overview of the fund's management, participation, and financing provisions. The paper also summarizes the process that patients and their families use to recover money from the fund. That discussion describes the damages medical malpractice victims can recover under Wisconsin law, and how legal developments have affected those amounts. Finally, the paper provides information about the fund's finances.

Management of the Fund

A 13-member Board of Governors ("the Board") manages the fund, comprised of the following representatives:

- The Commissioner of Insurance (or his or her delegate) who serves as Chairperson of the Board;
- Three representatives of the insurance industry appointed by the Commissioner of Insurance;
- One person named by the State Bar Association;
- One person named by the Wisconsin Association for Justice (formerly the Wisconsin Academy of Trial Lawyers);
- Two people named by the Wisconsin Medical Society;
- One person named by the Wisconsin Hospital Association; and
- Four members of the public 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).

The Board's duties include approving the annual health care provider fee schedule and contracting with entities that provide services to the fund, such as the fund's actuary. The Board receives support from staff provided by the Commissioner of Insurance, various Board committees, and outside service providers. By March 1 of each year, the Board must present fund members and the standing committees on insurance in each house of the Legislature with a summary of fund activities in the previous calendar year.

The investments in the fund are managed by the State of Wisconsin Investment Board. As of

June 30, 2008, the fund had total assets of $771,072,238.

Health Care Provider Participation in the Fund

The following list identifies the major categories of health care providers that must participate in the fund.

- Physicians and certified registered nurse anesthetists (CRNAs) whose "principal place of practice" is Wisconsin, and who practice their profession in Wisconsin for more than 240 hours in a fiscal year. The term "principal place of practice" means either the state in which the provider furnishes health care services to more than 50% of their patients, or the state in which they derive more than 50% of their income in a fiscal year from the practice of their profession.

- Corporations or other organizations operated in Wisconsin for the primary purpose of providing the medical services of physicians or CRNAs;

- Partnerships of physicians or CRNAs organized and operated in Wisconsin for the primary purpose of providing the medical services of physicians or CRNAs;

- Hospitals that operate in Wisconsin, and hospital-affiliated entities that operate in Wisconsin that diagnose, treat or care for patients of the hospital;

- Ambulatory surgery centers that operate in Wisconsin;

- Nursing homes whose operations are combined as a single entity with a hospital, whether or not the nursing home operations are physically separate from the hospital operations.

Chapter 655 also identifies several groups of health care providers who have the option of participating in the fund. Most of the health care providers who have the option of participating in the fund are either part-time practitioners or providers not based in Wisconsin. These providers include physicians or CRNAs for whom Wisconsin is a principal place of practice but who practice less than 241 hours a year, other physicians or CRNAs who practice in Wisconsin but for whom Wisconsin is not their principal place of practice, and graduate or medical education programs operating in Wisconsin.

For these providers, as well as providers that must participate in the fund, the fund's excess medical malpractice insurance covers not only the health care provider, but also (with some exceptions) their employees who acted within the scope of their employment while providing health care services.

Table 1 summarizes the number of health care providers, by type, who were actively participating in the fund as of December 31, 2007. The number of health care providers participating in the fund has steadily increased over the past decade, growing from 11,485 participants on December 31, 1996, to 14,424 participants as of December 31, 2007.

Table 1: Participating Providers by Type as of December 31, 2007

Provider Category	Number	% of Total Participants
Physicians	12,169	84.4%
Certified registered nurse anesthetists	586	4.1
Corporations	1,411	9.8
Hospitals	127	0.9
Partnerships	46	0.3
Ambulatory surgery centers	32	0.2
Hospital-affiliated nursing homes	31	0.2
Hospital-owned or -controlled entities	21	0.1
Cooperatives	1	< 0.1
Total	14,424	100.0%

Finally, Chapter 655 exempts several categories of health care providers from participating in the fund. As the following list indicates, most of these statutory exemptions relate to health care providers in the public sector.

- Physicians or CRNAs employed by the state, county, municipal, or federal government or contractor covered under the federal tort claims act, acting within the scope of his or her employment or contractual duties;

- Facilities such as county hospitals, juvenile correctional facilities, county homes and infirmaries, and public health dispensaries that are exempt from certain hospital regulations under s. 50.39(3) of the statutes or operated by any governmental agency; and

- Physicians or CRNAs who provide professional health care services under the state's volunteer health care provider program described in s. 146.89 of the statutes, with respect to those professional services covered by s. 165.25 of the statutes and considered an agent of the Department of Health Services.

These exemptions apply only to professional activities covered by the exemption, and not to activities performed by an exempted health care provider outside the scope of that employment (for example, a physician employed by a county hospital also practicing in a private clinic). Fund participation is required for all non-exempt activities that meet the mandatory participation criteria. In such cases, the fund's coverage applies only to malpractice claims arising from the provider's non-exempt activities.

As of December 31, 2007, 11,551 health care providers had been granted exemptions from participating in the fund. As Table 2 indicates, most of those exemptions arose either because Wisconsin was not the provider's principal place of practice, or because the provider, for a variety of reasons (including retirement, professional inactivity, or the temporary cessation of their practice), practiced less than 240 hours during the fiscal year.

Table 2: Providers Exempted from Participating in the Fund As of December 31, 2007

Basis For Exemption	Number	% of Total Exemptions
Practicing less than 240 hours	2,945	25.5%
Practicing Outside of Wisconsin	2,973	25.7
Not Yet Practicing or Never Practiced	1,839	15.9
Retired Providers	1,658	14.4
State, County or Municipal Employees	1,399	12.1
Federal Employees	518	4.5
Temporarily Ceased Practice	219	1.9
Total	11,551	100.0%

Prerequisites to Obtaining Insurance Coverage from the Fund

Primary Layer of Medical Malpractice Insurance. To benefit from the fund's excess medical malpractice insurance, health care providers must satisfy two primary obligations. First, they must maintain the statutorily required minimum level of primary medical malpractice insurance. Currently, those minimum coverage amounts are $1,000,000 per occurrence or claim and $3,000,000 for all occurrences or claims in any policy or reporting year. The health care provider can maintain higher levels of primary coverage than the statutory minimum, in which case the fund's excess coverage triggers when the provider's primary layer of coverage is exceeded.

A health care provider can satisfy the primary insurance requirement by purchasing coverage from an insurer licensed to do business in Wisconsin, or by qualifying as a self-insurer. Rules adopted by the Commissioner of Insurance specify that an insurance policy must contain a number of provisions to satisfy a provider's insurance obligations under Chapter 655. While most providers buy primary coverage from a private insurer, some purchase the requisite coverage from the Wisconsin health care liability plan, a separately-licensed health care liability insurer created by statute and

governed by the same board that manages the fund. As of June 30, 2008, the plan provided primary medical malpractice coverage to 367 providers.

While Wisconsin statute allows health care providers to obtain either occurrence coverage or claims-made coverage to satisfy their statutory obligations, the fund itself provides occurrence coverage. That means the fund offers excess medical malpractice insurance coverage for incidents of medical malpractice that occur during a year in which the participating health care provider has coverage under the fund, regardless of when the patient or family makes the a claim.

Annual Assessment. Health care providers must also pay an annual assessment to participate in the fund. The Board of Governors sets the assessment amount, and the Commissioner of Insurance promulgates the administrative rule. The amount is based on factors such as the risk level of a participating physician's area of practice, the past and prospective loss and expense experience of the fund, and the provider's own loss and expense experience (subject to peer review as described below). Pinnacle Actuarial Resources Inc., the fund's actuary, analyzes the fund's estimated liabilities and financial position to help determine the assessment amount.

As noted, the provider's own medical malpractice loss and expense experience may affect the provider's assessment level. Under statute, every insurer that writes medical malpractice insurance in Wisconsin and every self-insurer must file reports with the fund's Board of Governors identifying each claim paid for damages from the rendering of health care services. The Board, along with a peer review council, (a five-member committee appointed by the Board), reviews those claims to determine if a surcharge should be added to that provider's annual fund assessment. Since the peer review council was established in 1986, through December 31, 2007, only two providers have been assessed a surcharge under these provisions.

Chapter 655 states that not more than four payment categories can exist based on the amount of surgery performed and the risk of services provided by the physician. The fund's fee schedule establishes four physician payment classes grouped by specialties or types of practice that are similar in their degree of exposure to loss. For example, family or general practitioners are in Class 1, while OB/GYN surgeons are in Class 4.

Within these four payment classes, fees vary based on factors such as the number of hours the physician practices during the fiscal year. Table 3 identifies the annual fees, by class, for physicians for whom Wisconsin was a principal place of practice, and the fees for CRNAs for whom Wisconsin was a principal place of practice, for fiscal years 1997-98 through 2008-09. The individual health care provider annual fees have decreased significantly since 1997-98, due to the fund's positive overall financial performance during that period.

Table 3: Annual Fees for Physicians and Certified Nurse Anesthetists (Fiscal Years 1997-98 through 2008-09)

	Physicians				Certified Registered Nurse
Year	Class 1	Class 2	Class 3	Class 4	Anesthetists
1997-98	$2,647	$5,294	$11,382	$15,882	$678
1998-99	2,721	5,170	11,292	16,326	678
1999-00	2,531	4,809	10,504	15,186	632
2000-01	1,898	3,606	7,877	11,388	475
2001-02	1,538	2,769	6,384	9,231	378
2002-03	1,461	2,630	6,063	8,766	359
2003-04	1,534	2,761	6,366	9,204	377
2004-05	1,227	2,209	5,092	7,362	302
2005-06	859	1,546	3,565	5,154	211
2006-07	1,074	1,933	4,457	6,444	264
2007-08	1,128	2,030	4,681	6,768	277
2008-09	1,128	2,030	4,681	6,768	277

The Board of Governors also sets fees for participating organizations. Those fees vary with the size of the organization and the types of health care professionals it employs. For example, under the fund's 2008-09 fee schedule, a participating corporation with a total number of shareholders and

employed physicians or nurse anesthetists greater than 100 is subject to a base assessment of $969 plus the fees listed in Table 4 for each of the types of health care providers employed. As with the assessments to individual health care providers, the fund's annual fees to organizations based on the types of health care professions they employ have decreased significantly since 1997-98.

Table 4: 2008-09 Annual Fees for Participating Corporations, by Type of Health Care Professional Employed

Type of Employee	Annual Fee to Employer Corporation
Podiatrists-Surgical	$4,794
Advanced Nurse Midwives	2,594
Nurse Midwives	2,482
Oral Surgeons	1,692
Chiropractors	451
Advanced Nurse Practitioners	395
Advanced Practice Nurse Prescribers	395
Nurse Practitioners	282
Dentists	226
Optometrists	226
Physician Assistants	226

Injured Patients and Families Claims Procedure

Chapter 655 establishes the process individuals must follow to assert medical malpractice claims in Wisconsin, including claims against the fund. Patients, their representatives, and health care providers are bound by these provisions. Furthermore, any patient, patient's representative, or spouse, parent, minor sibling or child of a patient having a derivative claim for injury or death on account of medical malpractice is subject to Chapter 655.

Mediation Process. Before seeking damages for medical malpractice through court action, claimants may participate in the mediation system created in Chapter 655. The stated legislative intent behind this mediation requirement is to provide an informal, inexpensive, and expedient means for resolving disputes without litigation. While Chapter 655 established mediation as mandatory, court cases have found the mediation process to be voluntary.

To initiate a Chapter 655 mediation, the claimant must submit a written request for mediation to the Director of State Courts that contains identifying information about the claimant, the patient (if different), and the allegedly negligent health care provider. The mediation request also must describe the condition or disease that was treated and the injury alleged to have been caused by provider negligence. The Director of State Courts sends a copy of the mediation request to all health care providers identified in the request, and to the fund. The Director of State Courts then appoints a three-person mediation panel comprised of a health care provider, a lawyer, and member of the public who is neither a health care provider nor a lawyer, to hear the dispute.

The mediation process is designed to be relatively informal and inexpensive, and is conducted without a stenographic record, other transcript, or the administration of any oaths. The statute also prohibits the order of physical examinations, the production of records, the subpoena of witnesses, and the parties' use of expert witnesses, opinions or reports. However, mediation participants must provide to each other and to the mediation panel all patient health records of the claimant. The statute also allows participants, including the fund, to be represented by a lawyer.

The mediation period expires 90 days after the Director of State Courts receives the request for mediation if the request is delivered in person, or 93 days if the request is sent by registered mail, unless the parties agree to extend these periods. Participation in mediation is not a mandatory prerequisite to taking a malpractice claim to court.

Legal Representation. The fund retains and pays for its own legal counsel to appear and actively defend the fund on each claim. Chapter 655 generally limits the contingency fees a claimant's legal counsel can collect to a maximum of one-third of the first $1,000,000 recovered. If liability is stipu-

lated to within 180 days after the filing of the original complaint and not later than 60 days before the first day of trial, the fee cannot exceed 25% of the first $1,000,000 recovered. The contingency fee on any portion of a recovery that exceeds $1,000,000 is limited to 20%. A court may approve contingency fees in excess of these amounts under exceptional circumstances. In addition, an attorney can offer to charge the client on an hourly or per diem basis, in which case the fees are not subject to the previously-stated limitations.

Court Actions. A person filing a malpractice claim can recover from the fund only if the allegedly negligent health care provider has coverage under the fund, the fund is named as a party in the court action, and the action against the fund commences within the same time limitation in which the action against the provider must commence.

Damages Available to the Plaintiff. Plaintiffs in medical malpractice cases often seek both economic and non-economic damages. Economic damages can include past and future medical costs and past and future lost income. Chapter 655 does not place any explicit statutory limits on the amount of economic damages plaintiffs can recover in a medical malpractice case. As a result, there is no statutory limit to the liability the fund may incur for economic damages if a participating health care provider commits medical malpractice.

The analysis of non-economic damages is more complicated. Chapter 655 defines noneconomic damages as compensation for pain and suffering, humiliation, embarrassment, worry, mental distress, loss of consortium, society and companionship, or loss of love and affection. Non-economic effects of disability include the loss of enjoyment of the normal activities, benefits and pleasures of life and the loss of mental or physical health, well-being, or bodily functions;

Prior to 2005, Wisconsin law limited the recovery of non-economic damages for certain types of claims in medical malpractice cases to $350,000, adjusted annually for inflation. In 2005 the Wisconsin Supreme Court struck down that limit in Ferdon v. Wisconsin Patients Compensation Fund, holding that it violated the equal protection guarantees of the Wisconsin Constitution. Wisconsin law also limits non-economic damages for wrongful death claims in cases of medical malpractice. Those limits ($500,000 per occurrence in the case of a deceased minor and $350,000 per occurrence in the case of a deceased adult) were not addressed in Ferdon and remain in effect.

In response to Ferdon, the Legislature enacted 2005 Wisconsin Act 183, raising the limit on noneconomic damages for medical malpractice claims to $750,000 for occurrences on or after April 6, 2006. As a result of Ferdon and the subsequent legislative response to that decision, Wisconsin statute does not limit the recovery of non-economic damages for medical malpractice claims arising from occurrences prior to April 6, 2006. However, there is a $750,000 limit on such damages for medical malpractice claims arising from occurrences after that date.

Chapter 655 also defines the manner and timing in which certain claimants receive money from the fund. First, if a settlement or judgment provides for more than $100,000 in future medical expenses, the portion of such damages in excess of $100,000 is paid into the fund and disbursed for those expenses until the money is exhausted or the patient dies. Second, if a settlement or judgment causes the fund to incur liability for future payments in excess of $1,000,000 to any person under a single claim, the fund pays the full medical expenses each year, plus an amount not to exceed $500,000 per year that will pay the remaining liability over the person's anticipated lifetime, or until the liability is paid in full.

Ferdon's Estimated Impact on the Fund. In its 2005 Functional and Progress Report, the fund's Board of Governors estimated that Ferdon increased the fund's undiscounted, unpaid liabilities by approximately $173 million. When discounted, this would result in a $140 million decrease in the fund's surplus position. The Board

of Governors also stated that as a result of this increase in the fund's estimated liabilities, the fund's future financial statements would reflect a deficit. Following these actuarial estimates, the Board approved a 25% increase in the fund's provider assessments for 2006-07 as compared to the 2005-06 assessment levels.

Financial Operations of the Fund

This section of the paper reviews the fund's recent financial operations and financial position. Additional information regarding these topics is available in two other reports. The first is the October, 2007, audit of the fund prepared by the Wisconsin Legislative Audit Bureau (LAB), available on the LAB website. Wisconsin's statutes require the LAB to audit the fund at least once every three years. The second is the annual Functional and Progress Report prepared by the fund's Board of Governors, available on the website of the Office of the Commissioner of Insurance.

According to the fund's 2007 Functional and Progress Report, from July 1, 1975, through December 31, 2007, 5,461 claims were filed in which the fund was named a party. Of that total, the fund paid 646 claims totaling approximately $666 million. Of the remaining claims, 4,614 were closed with no indemnity payment, and 201 remained open. As of June 30, 2008, the fund had paid 648 claims for a total of $699.5 million.

Table 5 provides a cash-flow analysis for each fiscal year from 2000-01 through 2007-08. The fund's primary sources of cash include the assessments collected from fund participants and the investment income earned on assets held by the fund. Cash flows are used to pay operating expenses including losses, with any positive cash flows used to purchase new investments. The purchase of new investments ensures the continual receipt of investment income to discount reserves.

This cash-flow analysis does not show the liabilities incurred by the fund that do not result in indemnity losses until some time in the future. For example, during 2007-08, the fund paid $41,262,000 in indemnity losses and loss adjusted expenses (LAE, which are estimates of the future costs to settle claims). That same year, however, incidents of medical malpractice occurred that will not result in losses to the fund until the malpractice is discov-

Table 5: Injured Patients and Families Compensation Fund -- Cash Flow (Fiscal Years 2000-01 through 2007-08)

	2000-01	2001-02	2002-03	2003-04	2004-05	2005-06	2006-07	2007-08
Fees Collected	$37,134,000	$31,663,000	$30,051,000	$33,290,000	$29,782,000	$15,422,000	$24,262,000	$24,347,000
Losses and LAE* Paid	-42,436,000	-45,769,000	-26,300,000	-24,756,000	-24,341,000	-37,125,000	-39,594,000	-41,262,000
Underwriting Expenses	-716,000	-764,000	-940,000	-876,000	-896,000	-972,000	-996,000	-1,114,000
Other Expenses Paid	-64,000	-56,000	-24,000	-44,000	-40,000	-84,000	-10,000	-36,174,000
Total Cash from Underwriting	-6,082,000	-14,929,000	2,783,000	7,618,000	4,503,000	-22,760,000	-16,338,000	-54,203,000
Cash Income from Investments and Capital Gains	33,643,000	19,695,000	36,855,000	32,758,000	34,279,000	31,855,000	43,593,000	13,616,000
Other Income (Expenses)	82,000	4,327,000	1,956,000	3,250,000	242,000	7,754,000	145,000	-826,000
Net Cash from Operations	$27,646,000	$9,093,000	$41,595,000	$43,625,000	$39,024,000	$16,848,000	$27,400,000	-$41,413,000

*Loss adjusted expenses

** "Other Expenses Paid" includes Transfer to MA Trust Fund (-$71,500,000) and reclassification of State Investment Fund account balance ($35,338,000).

ered, a claim is filed, and the case is resolved.

The annual "Statement of Net Equity" addresses this and other aspects of the fund's financial position. This report estimates the fund's total assets, total liabilities, and total net equity as of the end of each fiscal year. Table 6 summarizes the fund's Statement of Net Equity as of June 30, 2008. According to this statement, the fund had total assets on June 30, 2008, of $771,072,300, total liabilities of $832,561,900, and a resulting total net equity (total assets minus total liabilities) of -$61,489,600. A positive total net equity is also referred to as the fund's "surplus;" a negative total net equity position is referred to as the fund's "deficit."

As Table 6 indicates, the fund held over three quarters of a billion dollars in assets as of June 30, 2008. Those assets accumulated over time as a result of the positive cash flows generated by the fund's operations. The assets themselves are invested in a range of asset classes, with oversight by the State of Wisconsin Investment Board pursuant to guidelines established by the fund's Board of Governors. Most of the fund's assets are invested in fixed-income securities, with a substantially smaller percentage invested in equities (limited to 20% of the total portfolio). As the cash-flow analysis shown in Table 5 demonstrates, returns generated by the fund's investment portfolio have significantly contributed to the fund's positive net cash flow in recent years.

The Statement of Net Equity in Table 6 also quantifies the fund's total liabilities. Those liabilities, reported on a present value basis, include liabilities associated with claims against the fund that have already been reported and liabilities related to medical malpractice occurrences that have been incurred but not reported (IBNR). The majority of the total liabilities stated in the Statement of Net Equity reflect an actuarial estimate of these IBNR liabilities.

Uncertainty of Liability Estimation. Estimating the fund's total liabilities is an important function, not only for financial reporting purposes, but also because the Board uses those liability estimates as one of the factors to establish the level of annual assessments. Accurately estimating those liabilities is difficult. As acknowledged in the 2007 Functional and Progress Report, the actual amounts paid to satisfy the fund's liabilities will differ from the actuary's estimates because of "the uncertainties inherent in projecting the frequency and severity of large claims because of [the fund's] unlimited liability coverage, and extended reporting and settlement periods."

Table 6: Statement of Net Equity as of June 30, 2008

Assets	
Total Current Assets	$84,386,800
Total Non-Current Assets	686,685,500
Total Assets	$771,072,300
Liabilities:	
Total Current Liabilities	$144,730,200
Total Non-Current Liabilities	687,831,700
Total Liabilities	$832,561,900
Total Net Equity	-$61,489,600

Given these difficulties, the fund's estimated liabilities are continually reviewed and adjusted based on a number of factors such as the fund's evolving loss experience, changes in interest rates, and other changes to the economic and legal context within which the fund operates. An external actuarial audit found that Pinnacle's estimates of expected losses to be on the "high" or conservative side of an actuarially reasonable range. Previous audits of Pinnacle's predecessor, Milliman Inc., reached the same conclusion that estimated losses were conservative but reasonable.

Proposals for Transfers from the Fund. In his 2003-05 biennial budget, the Governor proposed transferring $200,000,000 in 2003-04 out of the fund and into a health care provider availability and cost control fund to support medical assistance (MA) benefits costs. The Legislature deleted that proposal from the budget, and subsequently enacted 2003 Wisconsin Act 111, which repealed and recreated s. 655.27 (6) of the statutes, stating that the

fund "is held in irrevocable trust for the sole benefit of health care providers participating in the fund and proper claimants. Moneys in the fund may not be used for any other purpose of the state. "

Two years later, in his 2005-07 biennial budget, the Governor proposed transferring $169,703,400 in 2005-06 and $9,714,000 in 2006-07 out of the fund into a proposed health care quality improvement fund, to support MA benefits costs and to support a new program to provide grants and loans for health care quality improvement activities. The Legislature again deleted those proposed transfers from the enacted budget.

In his 2007-2009 biennial budget, the Governor proposed a transfer from the fund to a health care quality fund (HCQF), a provision that the Assembly deleted. However, the Conference Committee on the budget restored the provision, but changed the transfer of funds to the MA trust fund and deleted provisions in the bill that would have created the HCQF. These provisions were included in the final 2007-09 biennial budget bill (2007 Wisconsin Act 20). The transfer totals $200,000,000 over the biennium ($71,500,000 in 2007-08, and $128,500,000 in 2008-09). Act 20 also established a sum sufficient GPR appropriation, limited to $100,000,000, to fund any claim that the fund must pay but has insufficient monies for the payment.

The Wisconsin Medical Society (WMS) challenged the legality of this transfer, filing a suit in Dane County Circuit Court in October, 2007. WMS filed the suit on the basis that the transfer constitutes an "unconstitutional taking without just compensation" from health care providers and injured patients and families, represents an unconstitutional impairment of contract, violates equal protection under the law, violates statute, deprives constitutional rights outside the authority of state law, and is an invalid tax. Oral arguments were heard in August, 2008, in front of Circuit Judge Michael Nowakowski.

On December 19, 2008, Judge Nowakowski dismissed the WMS lawsuit, finding that the transfer from the fund was legal. In his ruling, the judge found that all of the claims made by WMS (with the exception of the unconstitutional takings claim) were barred by the doctrine of sovereign immunity, which prevents the state from being sued in certain circumstances. The judge also dismissed the unconstitutional takings claim on the basis that the plaintiffs do not have a "protectable property interest in the Fund," even though the doctrine of sovereign immunity does not apply to that claim.

The actuarial estimates cited in the fund's 2007 Functional and Progress Report reflect the changes imposed after Ferdon, the $750,000 limit on non-economic damages for medical malpractice claims arising from occurrences after April 6, 2006, and the Act 20 provision that transferred revenue from the injured patients and family's compensation fund to the MA trust fund.